Running Head: PRACTICE ANALYSIS OF GRIEF COUNSELORS

A Practice Analysis of Grief Counselors

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Abstract

This study examined the work behaviors of individuals with graduate degrees who provide clinical services to terminally ill individuals, family members, and the bereaved. An instrument was developed to assess the frequency and importance of work behaviors of individuals working with dying individuals and their families. Participants were randomly chosen from graduate level practitioners belonging to a preeminent organization in death and dying, 177 participants returned the survey. Factor analysis and MANOVA were used to examine the data. The results suggest a five-factor model of clinical thanatology; general counseling, grief counseling, counseling children, hospice counseling, and professional activities. There were no significant differences on most of the factors for any of the independent variables, with the exception of funeral directors. Implications for training and certification examinations for clinical thanatologists are discussed. This information also may be useful to inform developing certification processes, and in the creation of supporting training programs needed to address the special knowledge areas identified in this study.

A Practice Analysis of Grief Counselors

Thanatology, the interdisciplinary study of death and death-related behavior, has a long and distinguished history beginning with the first written works in 2500 B.C. (Bardis, 1981). Throughout the ages, great philosophers such as Socrates, Bacon, and Descartes have pondered the mystery of death . Only in the second half of the 20th century, however, have social scientists in the fields of counseling, psychology, and social work taken an interest in thanatology (Kastenbaum & Aisenberg, 1976).

Practice analyses are most common in business where they provide the legal foundation for job descriptions (Uniform Codes, 1978). Though less frequently used in human service professions, practice analyses have been completed in the helping professions to determine the current state of the profession (Fitzgerald & Osipow, 1986), examine the current training needs of individuals performing the work (Vacc, 1989), and provide evidence of validity for certification examinations (Dosser & Frisch, 1998; Loesch & Vacc, 1993).

There has never been, however, a systematic examination of the practice of clinical thanatology. This lack of close examination leaves certification efforts, particularly efforts at curriculum formation and certification examination, open to speculation and contention (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 1999; Frisch, Forker, & Lavin, 1998). Examinations based on practice analyses are the most effective, defensible examinations (Loesch & Vacc, 1993). Without a practice analysis, questions remain about training curriculums and content validity of certification examinations.

This practice analysis provides information on the type of behaviors performed by clinical thanatologists, frequency with which they engage in such behaviors, and the relative

importance of these behaviors in service provision. This provides needed information in describing the current state of the field of clinical thanatology.

The primary research question guiding this study focused on identifying the underlying factor structure of the work behaviors of clinical thanatologists. The frequency and importance of these work behaviors was examined as well as the combined frequency and importance. A secondary focus of this study was to assess for differences in work behaviors based on type of degree, work setting, or field of study of the participants.

Method

Participants

To provide a representation of the multidisciplinary field of thanatology, a random sample of 670 members of the Association for Death Education and Counseling (ADEC) who indicated their primary work setting to be clinical practice and who held a graduate degree at time of data collection were invited to participate. Of the 670 survey packets mailed out, 177 were returned for a response rate of 26%. Of the 177 returned survey packets, 42 were returned blank as requested in the instructions if the individual did not consider themselves a clinician; 135 (21%) were returned completed and these respondents served as the sample for this study.

Demographic characteristics of respondents were compared to the demographic characteristics of the members of ADEC to assess the extent to which they represent the graduate level clinical membership of the organization. In this study, there were proportionately more Psychologists and Social Workers than the general ADEC membership; also, a higher percentage of individuals over the age of 63 responded to this survey than would be found in ADEC at the time of data collection.

Instrumentation

A survey was developed for this study. The survey development occurred in three phases (initial item generation, item and format refinement, and field-testing the survey), with the goal of developing an instrument that would accurately and reliably measure the types of work behaviors performed by clinical thanatologists.

Initial Item Generation. An initial list of work behaviors was drawn from the literature, including relevant items from the studies conducted by Loesch and Vacc (1993) and Nassar-McMillan and Borders (1999). This process resulted in a list of 132 work behavior statements.

Item Refinement. The initial list of items was reviewed by two focus groups consisting of four people in each group representing clinical thanatologists in the local community. Participants in the first focus group had training in counseling, nursing, social work, and the ministry. The participants, two men and two women, including the researcher, had an average of 12 years of experience working in clinical thanatology. The second focus group consisted of individuals with training in nursing, counseling, and gerontology. The average experience for the second group, comprised of all women and including the researcher, was seven years. The purpose of the focus groups was to eliminate duplicate items, clarify or reject confusing items, and add or delete any items necessary to best represent the work behaviors of clinical thanatologists.

The refined list of work behaviors generated by the focus groups formed the initial practice analysis survey. At that point, the format of instrument was a five-point likert-type scale to measure frequency (1 = never, 2 = rarely, 3 = occasionally, 4 = frequently, and 5 = always) and importance (1 = no importance, 2 = little importance, 3 = moderate importance, 4 = very important, and 5 = crucial). To further refine the instrument, it was field tested on 17

individuals who were experts in clinical thanatology. Minor format revisions were made to the instrument based on feedback from these experts. A copy of the survey is available from the primary researcher.

Data Analyses

To determine the underlying factor structure of the frequency, importance, and combined ratings, principle component factor analyses of the Clinical Thanatologists Survey were performed followed by an orthogonal transformation using the varimax rotation. The first five factors accounted for the majority of the variance in the data set; therefore, these five factors were used in the subsequent analyses. Titles for the factors were chosen to represent the type of work behavior most commonly reported within each factor. Reliability analyses were performed to provide additional evidence of the reliability of each factor. Cronbach's alpha for the frequency factors were as follows: General Counseling (.92), Counseling Children (.95), Grief Counseling (.92), Hospice Counseling (.93), and Administrative/Professional Duties (.89). The Cronbach's alpha for the importance factors were: General Counseling (.93), Counseling Children (.88), Grief Counseling (.90), Hospice Counseling (.91), and Administrative/Professional Duties (.90).

Results

Factor Analyses of Work Behaviors

The frequency, importance, and the combined frequency and importance ratings loaded on five factors that accounted for the majority of the variance in the data set. The same five factors loaded for each set of items (frequency, importance and combined) with very similar items in all sets. Since the combined frequency and importance factor set did not provide unique information, further analyses on the combination of frequency and importance were not

performed. The results of the frequency factor loadings for items that loaded at .50 or higher are presented in Table 1, the results of the importance factor loadings are presented in Table 2.

Table 1

Factor Analysis with Varimax Rotation and Five Factor Solution: Frequency Ratings

Item	Factor Loadings				
	1	2	3	4	5
F093 Provide individual counseling to children	**.91**				
F098 Counsel bereaved children	**.90**				
F094 Provide short term counseling to children	**.83**				
F092 Discuss disposition of dead body with children	**.83**				
F089 Use art in counseling children	**.81**				
F100 Counsel adolescents	**.81**				
F088 Use play therapy with children	**.81**				
F102 Work with traumatic loss issues with children	**.79**				
F097 Create memory books of the deceased	**.77**				
F095 Provide long term counseling to children	**.76**				
F090 Use music in counseling children	**.76**				
F091 Discuss dying process with children	**.73**				
F099 Consult with parent of child client	**.73**				
F101 Provide extended counseling for children	**.73**				
F096 Provide grief workbooks for children	**.72**				
F042 Consult with teachers	**.59**				

F055 Use creative arts in counseling	**.58**		
F028 Participate in mourning rituals for client	**.51**		
F124 Give client permission to grieve		**.76**	
F119 Describe grief processes		**.75**	
F123 Encourage telling the story of the death		**.73**	
F122 Encourage emotional release		**.70**	
F125 Encourage recognition of the reality of death		**.69**	
F128 Support the development of new identity		**.67**	
F129 Encourage life review		**.66**	
F115 Assess relationship with deceased		**.66**	
F130 Encourage expression of blocked emotions		**.65**	
F104 Facilitate normal grief processes		**.63**	
F120 Encourage discussion of life without the deceased		**.62**	
F126 Encourage realistic appraisal of the relationship with the deceased		**.62**	
F118 Normalize emotional reactions		**.62**	
F116 Assess for complication in the grieving process		**.61**	
F113 Encourage memory sharing		**.58**	
F114 Help develop practical skills for autonomy		**.54**	
F117 Gather history of previous losses		**.52**	
F073 Discuss anticipatory grief with survivors		**.52**	
F074 Encourage search for meaning in life		**.51**	
F066 Assess for depression			**.76**
F010 Conduct diagnostic clinical interviews			**.75**

F048 Establish counseling goals	**.70**	
F049 Help develop coping skills	**.69**	
F024 Provide individual counseling	**.68**	
F025 Assess social support	**.68**	
F058 Use cognitive-behavioral counseling	**.64**	
F026 Assess coping skills	**.63**	
F019 Perform suicide assessment	**.60**	
F060 Recognize client defenses	**.59**	
F069 Adapt interventions for individual client	**.58**	
F044 Create plan of care	**.58**	
F127 Assess for substance abuse	**.57**	
F015 Provide counseling for about one hour	**.57**	
F062 Assess for stress disorders (PTSD, Acute Stress Disorder)	**.56**	
F007 Maintain case records and/or files	**.56**	
F105 Help clients develop decision making skills	**.52**	
F050 Obtain informed consent from clients	**.51**	
F106 Discuss sexual needs	**.51**	
F078 Provide information on advanced directives		**.80**
F107 Discuss discontinuing life support		**.76**
F079 Describe dying process		**.74**
F082 Discuss impending death		**.72**
F086 Discuss discontinuing life support		**.67**

F108 Provide information on organ donation	**.67**	
F077 Consult with physician about client's health	**.64**	
F084 Coordinate care with physician	**.60**	
F080 Provide for physical needs	**.58**	
F075 Help client define what is a good death	**.57**	
F087 Discuss funeral arrangements	**.57**	
F081 Assess for burn-out in caregivers	**.56**	
F085 Assess physical condition and monitor pain Levels	**.56**	
F052 Help clients clarify spiritual/moral values	**.51**	
F002 Develop training programs for staff		**.70**
F003 Develop community outreach programs		**.67**
F031 Conduct professional presentations		**.65**
F034 Provide self-development training for staff		**.56**
F004 Coordinate peer counseling programs		**.56**
F045 Solicit group member's feedback on effectiveness of counseling		**.55**
F020 Provide short-term group counseling (eight weeks or less)		**.55**
F037 Describe group counseling rules		**.53**
F006 Administer questionnaires or surveys		**.52**
F023 Provide closed ended groups		**.52**

The means ranged from .17 to 4.6 on a 5-point likert-type scale. Among the frequency data, the five items with the highest means were ; Give client permission to grieve (item 124, M = 4.6, SD = .89); Assess coping skills (item 24, M = 4.6, SD = 1.43); Describe grief processes (item 119, M = 4.5, SD = .92); Facilitate normal grief processes (item 104, M = 4.5, SD = 1.07); and Encourage emotional expression (item 17, M = 4.5, SD = .90).

Table 2

Factor Analysis with Varimax Rotation and Five Factor Solution: Importance Ratings

Item	Factor Loadings				
	1	2	3	4	5
I066 Assess for depression	**.78**				
I105 Help clients develop decision making skills	**.70**				
I048 Establish counseling goals	**.70**				
I117 Gather history of previous losses	**.67**				
I060 Recognize client defenses	**.67**				
I127 Assess for substance abuse	**.66**				
I025 Assess social support	**.66**				
I062 Assess for stress disorders (PTSD, Acute Stress Disorder)	**.62**				
I049 Help develop coping skills	**.61**				
I058 Use cognitive-behavioral counseling	**.58**				
I114 Help develop practical skills for autonomy	**.58**				
I010 Conduct diagnostic clinical interviews	**.57**				

I056 Use client centered counseling	**.55**	
I116 Assess for complication in the grieving process	**.55**	
I128 Support the development of new identity	**.55**	
I024 Provide individual counseling	**.52**	
I106 Discuss sexual needs	**.52**	
I050 Obtain informed consent from clients	**.51**	
I026 Assess coping skills	**.51**	
I019 Perform suicide assessment	**.50**	
I129 Encourage life review	**.50**	
I070 Discuss developmental understanding of death		**.74**
I119 Describe grief processes		**.73**
I124 Give client permission to grieve		**.69**
I113 Encourage memory sharing		**.67**
I126 Encourage realistic appraisal of the relationship with the deceased		**.63**
I104 Facilitate normal grief processes		**.62**
I115 Assess relationship with deceased		**.60**
I123 Encourage telling the story of the death		**.60**
I121 Co-create rituals to observe the death		**.57**
I120 Encourage discussion of life without the deceased		**.56**
I122 Encourage emotional release		**.56**
I071 Discuss impact of culture on behavior		**.54**

I073 Discuss anticipatory grief with survivors	**.50**		
I034 Provide self-development training for staff		**.62**	
I003 Develop community outreach programs		**.61**	
I041 Consult with self-help groups		**.61**	
I006 Administer questionnaires or surveys		**.58**	
I022 Administer questionnaires or surveys		**.57**	
I043 Participate in staff debriefing		**.57**	
I002 Develop training programs for staff		**.57**	
I004 Coordinate peer counseling programs		**.57**	
I045 Solicit group member's feedback on effectiveness of counseling		**.54**	
I021 Provide long-term group counseling (more than eight weeks)		**.54**	
I020 Provide short-term group counseling (eight weeks or less)		**.53**	
I037 Describe group counseling rules		**.53**	
I032 Write professional literature		**.51**	
I023 Provide closed ended groups		**.51**	
I012 Provide supervision for volunteers		**.50**	
I078 Provide information on advanced directives			**.77**
I077 Consult with physician about client's health			**.74**
I076 Help client and family communicate with hospital staff			**.72**

I082 Discuss impending death	**.68**	
I085 Assess physical condition and monitor pain Levels	**.66**	
I086 Discuss discontinuing life support	**.65**	
I084 Coordinate care with physician	**.65**	
I107 Discuss discontinuing life support	**.63**	
I080 Provide for physical needs	**.62**	
I079 Describe dying process	**.60**	
I081 Assess for burn-out in caregivers	**.51**	
I093 Provide individual counseling to children		**.69**
I101 Provide extended counseling for children		**.69**
I094 Provide short term counseling to children		**.65**
I095 Provide long term counseling to children		**.65**
I100 Counsel adolescents		**.64**
I088 Use play therapy with children		**.63**
I089 Use art in counseling children		**.60**
I098 Counsel bereaved children		**.58**
I090 Use music in counseling children		**.57**
I097 Create memory books of the deceased		**.56**
I096 Provide grief workbooks for children		**.56**
I102 Work with traumatic loss issues with children		**.53**
I099 Consult with parent of child client		**.51**

The means ranged from .76 to 4.80 on a 5-point likert-type scale. Among the importance data, the five items with the highest means were; Give client permission to grieve (item 124, M = 4.8, SD = .72); Assess coping skills (item 26, M = 4.7, SD = .77); Facilitate normal grief processes (item 104, M = 4.6, SD = .86); provide individual counseling (item 24, M = 4.6, SD = .86); and Read professional literature (item 38, M = 4.6, SD = .72).

To address the question of whether the frequency of work behaviors of clinical thanatologist differed based on demographics, the five factors were treated as dependent variables and the demographic variables were treated as independent variables in a Multivariate Analysis of Variance (MANOVA). There was a main effect for work setting only ($F= 1.81$, $p < .05$). For work setting, there was a significant difference between Hospital (M = 1.33, SD =1.02) and Private practice (M = 1.59, SD =1.21) on Hospice Counseling with more Hospice counseling behaviors occurring in a hospital setting than in private practice.

The five factors for Importance found in the factor analyses were used as the dependent variables and Work Setting, Field of Study, and Type of Degree were used as independent variables. In the Importance Factors, there were main effects for both Work Setting ($F= 1.60$ $p < .05$) and Field of Study ($F= 2.23$, $p < .05$). For both Work setting and Field of study, the main effects were found in General Counseling. Funeral directors (M = 2.37, SD =1.18) responded with significantly lower ratings than did those in Counseling (M =4.10, SD = .52), Psychology (M = 4.21, SD = .35), Social Work (M = 4.07, SD = .55) and Ministry (M = 3.56, SD = .75). Respondents in Ministry (M = 3.56, SD = .75) also reported lower scores than did those in Counseling (M =4.10, SD = .52), Psychology (M = 4.21, SD = .35), and Social Work (M = 4.07, SD = .55) on this factor.

Discussion

This study was performed to identify the discrete work behaviors of clinical thanatologists. This study focused on individuals providing clinical services to people who were dying, family members, and to the bereaved.

The frequency, importance, and the combined frequency and importance ratings loaded on five factors that accounted for the majority of the variance in the data set.

Factor One, General Counseling

The first factor contained items related to providing general counseling services and behaviors that would be expected in any helping field, such as assessing social support, providing individual counseling, and assessing for depression. This factor accounted for the greatest amount of variance for the frequency item set but ranked third in the importance item set. An examination of the means of each factor revealed that participants performed general counseling work behaviors more frequently than any other set of work behaviors across all three independent variables; work setting, field of study, and type of degree. Considering that thanatology is a multi-disciplinary field, it is interesting that these behaviors fell out separate and that these work behaviors were most frequently performed.

In the Multivariate Analysis of Variance (MANOVA), there were significant effects for both the frequency and importance ratings for this factor. Ministers reported lower frequency scores in General Counseling but not in the importance scores. It appears that even if ministers do not perform general counseling services often, they consider these work behaviors to be important.

Factor Two, Counseling Children

The second factor clearly differentiated counseling children with items such as: use art therapy with children, provide long-term counseling for children, and discuss disposition of dead body with children. Included in this factor were items that would be expected to be performed when providing services to children such as provide family counseling and consult with parent of child client.

The multivariate analysis indicated counseling children was performed more frequently in hospice type settings than in hospitals and that social workers performed this service more frequently than nurses. This could be a reflection of the treatment of childhood terminal illnesses, which tends to be more aggressive than those in adulthood while the child is in the hospital. Also, children seen in hospice type settings often are being counseled for the loss or potential loss of someone close to them rather than for their own illness.

Factor Three, Grief Counseling

The third factor (Grief Counseling) identified behaviors specific to grief counseling, such as facilitate normal grief processes, assess for complications in the grieving process, and co-create rituals to observe the death. It is interesting that grief counseling loaded as a separate factor from either general counseling or hospice type counseling. This may indicate that grief counseling is a distinct specialty area. The mean scores of this factor indicate that participants feel the work behaviors included in grief counseling are the most important behaviors they perform, regardless of type of degree, work setting, and field of study.

The items that were included in the grief-counseling factor provide interesting insight into what practitioners consider to be frequent and important behaviors in this area. For example, items such as “describe the grief process” assume the clinician understands the grief

process. Similarly, for the clinician to "assess for complications in the grief process" he or she would need a solid understanding of not only healthy adaptation after loss but also knowledge of what constitutes complicated grief.

Factor Four, Hospice Counseling

The fourth factor (hospice-type counseling) identified items that would be performed in a hospice setting or before the death of an individual, such as discuss impending death, describe the dying process, and discuss discontinuing life support. The multivariate analyses identified a difference between hospital settings and private practice on this factor in that more hospice counseling behaviors were reported in hospital settings than in private practice. This is not a surprising finding and makes substantive sense.

Factor Five, Administrative/Professional Duties

The fifth factor (Administrative/Professional Duties) related to administrative or professional duties that may not be in direct service to clients, such as develop training programs for staff, provide supervision for students, and all the available items for group counseling skills (e.g. provide open ended groups, assess suitability for group counseling, and provide closed ended groups).

It is noteworthy that group counseling loaded with administrative-professional duties rather than any of the counseling-type factors. This could be indicative of the type of group counseling that is typically performed in thanatology. Group counseling in thanatology is generally peer-run and of a support nature rather than therapeutic. Therefore, groups could be run by individuals with training other than that required for providing counseling type services.

Summary of Analyses

The analyses in this study provide interesting insight into the work behaviors of individuals working in clinical thanatology. In addition to the results provided above, it is important to note that there were no significant differences on most of the factors for any of the independent variables, with the exception of funeral directors. Therefore, professional affiliation (e.g., counselor, social work, nurse, psychologist, or a minister) does not seem to affect the types of work behaviors. All perform essentially the same tasks. This is surprising considering that many of the work behaviors such as providing individual counseling services or monitoring pain levels of patients often are considered to be specific to particular fields of study. This seems to indicate that those individuals who desire to work as clinical thanatologists must gain additional training beyond their basic degree to provide adequate services.

Items Not Loading on the Five Factor Model

Several items did not load on any of the five factors for either frequency or importance. For frequency, most of these items had means below 2.5 with a range from .16 to 2.41. One item (Read Professional Literature), however, had a mean of 4.49. In this case, even though reading professional literature did not load on any factor, it is still frequently performed. In contrast, for importance, all the items not loading on any of the five factors, except Create Marketing Materials ($\underline{M}$ = 2.73) and Make Self Disclosure Statements ($\underline{M}$ = 2.86), had means over 3.0 with a range of 3.27 to 4.56. The eleven items with means over 3.0 are provided here: maintain case records and/or files (M = 4.36, SD = 1.12), refer client to another mental health provider (M = 3.89, SD = 1.05), encourage continuing family activities (M = 4.26, SD = 1.12), engage in continuing education (M = 4.44, SD = .97), participate in case conferences (M = 3.61, SD = 1.56), provide crisis intervention (M = 4.25, SD = 1.04), use critical incident stress

debriefing (M = 3.59, SD = 1.60), read professional literature (M = 4.56, SD = .72), provide telephone counseling services (M = 3.27, SD = 1.56), and attend national conferences (M = 3.89, SD = 1.26). These items that did not load on any factor for importance were still considered to be important parts of clinical thanatology by respondents and should be considered an important part of the work behaviors engaged in by clinical thanatologists.

Limitations of the Study

The results of this study should be considered within the context of study limitations. First, the return rate was modest creating difficulties in generalizing the findings. This study sampled a single professional organization and may not be indicative of thanatologists in general. Also, participation in this study was voluntary and there is no way to know how respondents differed from non-respondents. A further limitation is that the work behaviors were measured using self-reports only.

Recommendations for Future Research

The following recommendations for future research are based on this study and attempt to address the limitations previously identified. It would be of interest to conduct this survey with other populations, both within thanatology and outside of thanatology to help determine if these work behaviors are indeed indicative of a specialized field of study. It would also be helpful to observe clinical thanatologists in their work setting and measure the frequency and apparent importance of their work behaviors as they performed them rather than using only a self report instrument.

Summary

This study provides unique and valuable information informing the field of thanatology and counseling of the work behaviors performed by professionals providing clinical services to

dying individuals, family members, and the bereaved. It adds to the existing practice analysis literature in the helping professions. This information also may be useful to inform developing certification processes, and in the creation of supporting training programs needed to address the special knowledge areas identified in this study.

References

American Educational Research Association, American Psychological Association & National Council on Measurement in Education (1999). *Standards for educational and psychological testing.* Washington D.C: Author.

Bardis, P. C. (1981). *History of thanatology*. Lanham, MC: University Press of America.

Dossey, B. M., & Frisch, N. C. (1998). Evolving a blueprint for certification. *Journal of Holistic Nursing, 16,* 33-57.

Fitzgerald, L. F., & Osipow, S. H. (1986). An occupational analysis of counseling psychology: How special is the specialty? *American Psychologist, 41,* 535-544.

Frisch, N. C., Forker, J. E., & Lavin, J. (1998). Evolving a blueprint for certification. *Journal of Holistic Nursing, 16,* 33-57.

Kastenbaum, R., & Aisenberg, R. (1976). *The psychology of death.* New York: Springer.

Loesch, L. C., & Vacc, N. A. (1993). *A work behavior analysis of professional counselors.* Greensboro, NC: The National Board for Certified Counselors.

Nassar-McMillan, S. C., & Borders, L. D. (1999). Volunteers in social service agencies. *Journal of Social Service Research, 24* (3-4), 39-66.

Uniform guidelines for employee selection procedures. (1978). *Federal Register, 43,* 38290-38315.

Vacc, N. A. (1989). An occupational analysis of counselors working with oncology patients. *Counselor Education and Supervision, 29,* 102-110