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Dinh Q. Tran
Clinicians' Perceptions of Their Role
In Grief Counseling

ABSTRACT

The experiences and perceptions of grief counselors regarding their work is an often ignored, though highly valuable topic. Previous literature suggests that practicing grief clinicians are largely utilizing outdated grief theories in their practices. This study seeks to elucidate the meaning of these findings, explore what grief clinicians are actually doing in the field, and learn from the insights and clinical innovations of these contemporary clinicians. In this study, 10 clinicians, who have all practiced grief counseling within the last five years, were interviewed using a semi-structure interview model. Their theoretical models, most commonly used interventions, and conceptualizations of grief are revealed in the findings of this study. Emerging from the data are findings demonstrating the endorsement of interventions such as witnessing the client, creating a space for the client to express and experience their emotions in relation to the grief, and the non-judgemental/non-pathologizing stance of the clinician towards the client. The findings in this study echo findings in prior studies, but suggest a movement towards greater utilization of contemporary research. Similarly, it demonstrates a greater integration of holistic approaches to treating grief, with the utilization of other contemporary theories and interventions such as trauma theories, spirituality, and wellness.

CLINICIANS' PERCEPTIONS OF THEIR ROLE IN GRIEF COUNSELING

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

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CHAPTER I

Introduction

The purpose of this research is to answer the question: “How do grief counselors perceive their therapeutic role in grief counseling?” “Grief counselors” for this study was operationalized as counselors who currently provided or had provided grief counseling in the five years prior to this study. “Therapeutic role” was operationalized as the counselors’ experiences of their professional work and their relationship to this work.

I conducted this study to ameliorate a void in the research literature regarding grief counselors’ perceptions of their work in grief counseling. While much research (Bonanno, Wortman, & Neese, 2004; Stroebe & Schut, 1999; Worden, 2009) has focused on the phenomenology of grief, grief theory, and best practices in grief counseling, very little research (e.g., Breen, 2010; Payne, Jarrett, Wiles, & Field, 2002) has probed the experiences and practices of actual grief counselors practicing in the field. The research that has been conducted provides only a sketch of what is occurring in the field (Breen, 2010; Payne et al., 2002). For example, the findings reported in Breen (2010) and Payne et al. (2002) suggest that mental health professionals often do not have the time or resources to access academic research regarding grief counseling, but that they do read and update their clinical knowledge often by attending workshops or reading clinical reports; further, that their counseling practice includes focusing both on helping the client orient themselves to the new demands of a life without the deceased as well as helping the bereaved focus their grief. On the other hand, Wiles, Jarrett, Payne and Field

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(2002), interviewing general practitioners in the UK found that the majority of these health providers were not aware of the multiple directions that grief theory and grief research has progressed in recent years, citing Kubler-Ross's (1969) Stage Theory as their predominant clinical model. What is clear is that there is not yet enough replication of Breen's (2010), Payne et al.'s (2002) or Wiles et al.'s (2002) studies to draw wide-reaching conclusions about the state of grief in the field of clinical practice. Therefore, this study's aim is to help the field of Social Work and Psychology better understand how grief counseling is currently being practiced.

It is unclear why the research literature has not adequately addressed this particular research question to date. It is possible that this void simply reflects the general disconnection between research and practice. Despite this reason, it is crucial to bridge the research and practice divide in order to ensure that clinical practice is benefitting from research and that research is staying abreast of the newest innovations in the field.

This study was conducted by interviewing a sample of ten clinicians who worked with grieving clients. I asked the participants about what they thought were best practices in grief counseling, about how they conceptualized grief, and what they saw as their roles in the grief counseling encounter. Study participants were recruited through snowball sampling and contacting clinicians through the web portal at Psychology Today. Interview questions were taken from Breen's (2010) guide in order to replicate her and Payne et al.'s (2002) study.

Grief counseling is an often ignored area of counseling practice. The participants interviewed spoke to their perception of the discomfort in the counseling field with regards to dealing with issues of grief and death. This discomfort seems to be reflected in the scarcity of social work programs that have integrated grief and loss courses as required subject material for the degree. It is intended that this study will help clinicians feel more comfortable with the

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practice of grief counseling through examining the experiences of clinicians in the field working with grieving clients.

CHAPTER II

Literature Review

In this chapter, we will explore the origins of bereavement research, the theoretical models employed by practitioners, the perceptions that health and mental health workers have regarding grief, and the sociocultural factors influencing the presentation and understanding of grief.

Origins of Bereavement/Grief Research

Freud (1917) was the first to publish bereavement and grief research with grief as a psychological process. Since this time his ideas have been challenged and adapted, and continue to serve as the foundation through which we examine grief today. In Freud's seminal article (1917) he distinguished mourning, which he considered a normative response to loss, from "melancholia," a state of unresolved and pathological mourning. In terms of what would later be considered "grief work," Freud introduced the concept of gradually removing one's psychological and emotional energy from the deceased (decathexis) and reinvesting that energy in others (cathexis). Freud believed that this process of decathexis from the deceased would never completely be finished (Berzoff, 2003; Granek, 2010).

Helene Deutsch (1937) in *The Absence of Grief*, expanded and deepened Freud's concepts of pathological grief and "grief work". In her writing she referred to a "normal course" of mourning and that if grief is "absent," or not manifested (such as in intense emotional states of behavioral impairments), then the grief was pathological (p. 12). Further, she popularized the

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concept of the “unmanifested energy” of grief. This means if this unmanifested energy is not “worked through,” then the grief will remain unresolved. According to Deutsch (1937), the process of mourning as a loss must be “carried to completion” (p. 21).

Lindeman (1944) expanded Freud (1917) and Deutsch (1937) research with his study of the survivors and relatives of the Cocoanut Grove nightclub fire, in which nearly five hundred individuals died. While Freud introduced decathexis and cathexis as a possible form that grief process can take, Lindemann (1944) added three basic tasks for the healthy resolution of bereavement: detachment from the deceased (called decathexis by Freud), readjustment to life without the deceased, and the formation of new relationships (similar to Freud’s idea of cathexis, which was the investment of emotional energy into another person) (Rothaupt & Becker, 2007).

Bowlby (1961, 1980) added to the field of grief research by conceptualizing grief responses through the lens of attachment theory. Bowlby wrote that the fear of being abandoned and the desire to recapture the time before the loss manifested in intense feelings of loss. Bowlby introduced the concept of the bereaved expressing their feelings about the loss in order for the grief to successfully resolve, a concept termed “grief work” that remains popular among practitioners and the public today (Breen, 2010; Raphael, 1983).

Rando (1985, 1986) was one of the first grief researchers to challenge the notion that emotional detachment from the bereaved was necessary for healthy grieving. In her work with parental bereavement, she found that the majority of parents in her study who continued to bereave their children continued to hold emotional connections with their children, even in death. This finding was in opposition to the notion that continuing to hold onto bonds with the deceased was abnormal and pathological.

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Countering the stage and phase models popularized by Elizabeth Kubler-Ross (1969) and Bowlby (1980), Worden (1991, 1996, 2002) introduced a task model of bereavement. Worden's work contrasted with stage models by suggesting that these tasks could be completed in any given order and were likely to be revisited by the bereaved over time (1991). Worden would later incorporate work done by Rando (1985, 1986) by revising his fourth task of bereavement: relocation of the emotional attachment of the bereaved within oneself.

Indeed, this theoretical advancement regarding continuing bonds was further empirically supported by Gamino, Sewell, and Easterling (2000). In their study, 85 mourners were measured for personal growth following a period of bereavement. The authors found that individuals endorsing spontaneous positive memories of the deceased were correlated with greater personal growth following bereavement.

Colin Murray Parkes, a student of Bowlby's, supported Bowlby's formulations about grief. Parkes and Weiss (1983) postulated that the attachment behaviors observed in children when separated from their caregivers were the same behaviors exhibited by the bereaved when losing their loved ones to death. As grief research progressed and newer research began to demonstrate the ability of the majority of mourners to find a reduction in their symptoms without the aid of a counselor (Bonanno, Wortman, & Nesse, 2004), researchers turned their attention towards delineating specific sub-populations among the bereaved that were more likely to benefit from clinical intervention. Parkes (2002) found that older men who have lost spouses, mothers who have lost children, and survivors of losses with traumatic features were all more likely than other sub-groups to benefit from clinical intervention. Other individuals likely to benefit were those with pre-existing psychological disturbances such as depression, substance abuse, post-traumatic stress disorder, and a history of psychosis.

Theories of Mourning and Grief

Donald W. Winnicott (1896-1971) wrote about the internalization process of loss. As the child develops, each loss and experience of the caregiver not meeting the child's need unfurls a process of internalization of the "object," or caregiver. As the caregiver becomes increasingly internalized into the child's psychic structure, the child becomes more skilled in soothing itself. Winnicott writes that if an individual does not have a solid capacity to hold internal representations of others, that a loss of a loved one could wreak havoc on the person's ability to soothe themselves. Winnicott also stated that this dearth of internal representations puts an individual at risk of developing complicated mourning (Berzoff, 2003).

Winnicott's theory of grieving grew out of his formulations on transitional objects. A child develops the capacity for internal representations through the use of transitional objects. When a caregiver leaves a child alone for a short time before returning to soothe and care for the child, the child uses its transitional representation of the caregiver to soothe itself as it waits. These transitional representations, or "objects," are internalized over time and forms one's internal representation of the caregiver. If the caregiver is irregular or negligent, e.g. leaving the child for too long, the child foregoes using these transitional representations as it ceases to believe that the caregiver will return to soothe it (Berzoff, 2003).

John Bowlby (1907-1990), writing from the lens of Attachment Theory, postulated that the grief response is instinctually based in our attachment system and further, that it exists outside of our conscious awareness unless the attachment is threatened. The death of an attachment figure such as a mother or father would be an example of such a threat. From an attachment perspective, the emotional bonds that people form with their attachment figures are

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based in the need to be in proximity to the caregiver who can provide the self with safety and anchoring in the world (Winokeur & Harris, 2012)

Bowlby delineated four types of pathological grief: a persistent and unconscious yearning to recover the lost attachment figure, persistent and unconscious anger displaced towards others and the self, absorption in caring for someone else who is mourning, and denial that the attachment figure has been lost (Berzoff, 2003).

William Worden (1991, 1996, 2002) suggested that the grieving process can be likened to the developmental process. As with human development, in which notable theorists (e.g., Erick Erickson) have postulated tasks fundamental to human growth and development, Worden similarly formulated four tasks for the bereaved to move towards resolving grief. These tasks include acknowledging the reality of the loss, processing the pain of grief, adjusting to a world in which the deceased is missing, and finding an enduring connection with the deceased as one continues on in life. Worden states that these tasks can be revisited at any time and completed in any order (Worden, 1991; Worden, 1996; Worden, 2002).

In acknowledging the reality of the loss, Worden asserts that the bereaved must accept that their loved one is truly dead and cannot return to life. In this task the mourner must examine the true nature of the loss without minimizing or exaggerating it. In processing the pain of grief, the bereaved are supporting in feeling the sadness, despondency, anger, fatigue, and distress of grief. Worden encourages people to experience these emotions in appropriate and supported ways, as to not to have to continuously deal with them throughout their lives. In the third task, adjusting to a world without the deceased, Worden acknowledges that the task of assuming new roles and redefining oneself takes some time to realize. This process is facilitated by introducing new coping skills into one's repertoire and refocusing attention on new activities and other

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people. In the final task, one must find an enduring connection with the deceased. Worden writes that it is important for the bereaved to allocate the deceased internally in a place where they can maintain an ongoing emotional connection. (Worden, 1991, 1996, 2002)

Stroebe and Schut (1999, 2001) conceptualized the grieving process through a dual process model (DPM). Stroebe and Schut (1999, 2001) write that the bereaved not only search for meaning in their losses, but also attempt to reconfigure their lives in order to adjust and adapt to their loss. The researchers call these two positions loss orientation (LO) and restoration orientation (RO), and suggest that the bereaved oscillate between these orientations as they cope with the loss. During the loss orientation, the mourner focuses on the lost bond with the deceased, while in the restoration orientation they deal with the new challenges found in a world without the deceased. Stroebe and Schut emphasize that mourners do not become stuck in either orientation permanently because the flow of everyday responsibilities distract the bereaved. Stroebe and Schut write that while these loss and restoration processes can be beneficial for the bereaved, they also have the possibility of becoming maladaptive (Stroebe & Schut, 2001).

Operational Definitions of Grief and Bereavement

Grief. In this study, grief referred to the psychological state of an individual mourning a loss.

Loss. Loss referred to the emotional or physical absence of a significant emotional object. A loss did not need to be death related. A loss was conceptualized as the impossibility of returning to some aspect of life that was deemed valuable to the individual (Winokeur & Harris, 2012).

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Mourning/Bereavement. Mourning and bereavement was defined as the process by which the mourner integrated the loss into their ongoing life (DeSpelder & Strickland, 2005, p. 269).

Traumatic Grief / Complicated Grief / Complicated Mourning. These terms are used interchangeably in the literature. The following criteria were proposed for traumatic grief/complicated grief / complicated mourning, though none of these terms are in the DSM-V (Jacobs & Prigerson, 2000): the individual has lost a significant other and the individual experiences intrusive and distressing preoccupation of the deceased person. Some of the following symptoms are marked or persistent: frequent efforts to avoid reminders of the deceased; purposelessness or feelings of futility about the future; subjective feeling of numbness, detachment, or an absence of emotional responsiveness; feeling stunned, dazed, or shocked; having difficulty imagining a fulfilling life without the deceased; feeling that a part of oneself has died; experiencing a shattered worldview; assuming symptoms or harmful behaviors of, or related to, the deceased person; and excessive irritability, bitterness or anger in relation to the death. These disturbances must last at least two months and must cause clinically significant impairment in occupational, social or other important areas of functioning (p. 492). Other researchers (Prigerson & Maciejewski, 2005; Zhang, El-Jawahri, & Prigerson, 2006) suggest that a duration of six months is necessary before being able to distinguish between normal and complicated grief.

Disenfranchised Grief. This term referred to losses in the bereaved's life that were not officially sanctioned within the social climate (Worden, 2009). Disenfranchised grief applied to situations in which the loss was not considered valid (Doka, 1989, 2002). Examples in our

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society (American) include the mourning of the death of someone with whom the bereaved had an affair or mourning the death of an unborn child.

Grief Research

The grief response for each individual is unique. According to Winokeur & Harris (2012), attributes such as an individual's personality, the presence of stressors, the nature of the loss, and the cultural context all shape and sequence an individual's grief process..

Rando (1985, 1986) was one of the first researchers to provide evidence that emotional detachment from the deceased was not necessary in mourning. In her work on parental bereavement, Rando found that the majority of parents held continuing bonds with their children. Her work provided empirical data against the prevailing notion that decathecting from the deceased was "normal." Rando's (1985, 1986) data was a step towards depathologizing continuing bonds. Further, in a study of 30 widows and 30 widowers, Stroebe and Stroebe (1991) found that "grief work," i.e., discussing the emotions surrounding the loss and decathecting, was less essential to healthy adjustment as grief theorists and grief counselors had reported.

In a study of coping behaviors during bereavement, researchers found that gender differences in coping styles were not as differentiated as were expected. COPE, a 53 item self-report questionnaire that measures coping strategies during bereavement, was administered to 261 parents whose child, 12-18 died within 26 weeks of the study. As expected, researchers found that mothers utilized more emotion-focused strategies while fathers used more problem-focused strategies (e.g., restraint and acceptance). However, the researchers found that a significant proportion of the mothers and fathers used both emotion-focused and problem-focused coping styles. This finding contradicted the prevailing notion that women only use

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emotion-focused coping strategies and men use only problem-focused coping strategies (Murphy, Johnson & Weber, 2002).

Jordan and Neimeyer (2003), in a review of the efficacy of grief therapies, found that generic interventions targeted to the general bereaved population are unlikely to be productive. The findings from their reviews suggested that bereavement interventions aimed at high-risk mourners, such as those bereaved by suicide, or bereaved mothers, are more likely to benefit from therapeutic intervention. Similarly, interventions targeted at individuals suffering from prolonged and unresolved grief (i.e. those in complicated mourning) were also more likely to find intervention beneficial. Parkes (2002) and Stroebe & Schut (2001) found that other at-risk bereaved populations, which include older men who have lost spouses, survivors of traumatic or sudden losses, and individuals with preexisting psychological features such as depression, substance abuse, PTSD, and a history of psychosis also may benefit from intervention.

Perceptions of Grief

In the grief literature, there are only a handful of studies that examine counselors' understanding of grief and how they incorporated these understandings into their work (Breen, 2010). Payne, Jarrett, Wiles and Field (2002) interviewed 29 grief counselors in the United Kingdom. In their study, there existed a tension between recognizing that each individual undergoes a unique grief experience and that normative grief has a certain look (i.e., duration, cathexis/decathexis with the loved one). Further, the majority of these clinicians conceptualized grief using the Stage- (Kubler-Ross, 1969) and Task- Models (Worden, 1999). In terms of how clinicians worked with clients, 28% found it useful to discuss what "normative" grief stages looked like, while about 10% found it inappropriate to discuss "normative" grieving with their clients. Many of the clinicians conceptualized grief using the Stage- or Task- Models, and

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counselors in Payne et al.'s (2002) study discussed clients becoming “stuck” in the grief process. Inherent in this conceptualization is the notion of what “normative” grief should look like, and “stuckness” being a function of *not* adhering to the normative process. Counselors in Payne et al.'s study estimated that the normative time-span for grief was about 2 years. Additionally, for several of the clinicians (n = 10; 34.5%), the issue of finding closure with the deceased was a high priority. Ten of the therapists (34.5%) felt that it was important for the grief counselor to provide advice and information to their clients to support them in acquiring new skills. These areas included information on grieving patterns, acquisition of social skills, giving specific information or advice and giving practical help.

Sixty-nine percent of the counselors in Payne et al. study (2002) used a combined counseling strategy of encouraging their clients to talk and using active listening. Eight of the 29 counselors (27.5%) stated that they believed that the counseling session was a place where their clients had the opportunity to talk about their loss, a space not afforded with their friends, their families, with their general practitioners and others. Eight of the counselors (27.5%) emphasized that when their clients talked in the therapy session, they were not simply chatting, but processing the grief in a meaningful way; some described this processing as being facilitated by the counselor's ability to handle the difficult emotions of the client. Six counselors (20%) described the cathartic and therapeutic effect, which speaking about grief allowed their clients. The counselors in Payne et al. (2002) acknowledged that speaking was not the singular way of expressing grief; for example, music was another avenue. Over half of the counselors (55%) responded that “listening” was the main counseling strategy employed. Listening encompassed “being there,” listening and supporting, and active listening. Ten of the counselors mentioned drawing on their own experiences with grief in their work with their clients.

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Breen (2010) interviewed 19 grief counselors in western Australia. Concurring with Payne et al. (2002), the counselors in Breen's study tended to describe grief as more than just bereavement from death. Echoing Payne et al.'s finding, the counselors described grief as being "idiosyncratic" and "unique," and as being affected by factors such as age, the structure of the family, the circumstances of the bereavement, previous losses, concurrent stressors, their relationship to the deceased, previous crises, social support, and the culture in which they live. Several of the counselors in Breen's study described grief as a finite, stage-based and linear phenomenon. Some of these counselors even described grief as something short-term. Many of the counselors discussed that bereaved's "grief work" could either be successful or unsuccessful, and assigned time-frames for bereavement. The participants' in Breen's study discussed a client's capacity to be "stuck" in their grief, and demarcated "stuckness" as being pathological. Many clinicians described the importance of continuing the bond with the deceased.

About half of the counselors in Breen's study had participated in continued education pertaining to grief (n=10) such as through seminars and workshops; however only two of the counselors reported having received formal training in grief as part of their graduate course-load. The majority of the counselors in her study reported finding it important to stay abreast with current grief research. While these therapists updated their knowledge through seminars, books (n=7), and coursework, only 3 of the 19 counselors accessed grief information through journal articles. Some of the therapists (n=6) helped other clinicians better understand grief counseling through providing workshops, seminars, or supervision. In terms of theoretical orientation, Kubler-Ross (1969) was the most highly endorsed writer (n=7). Addressing the low number of clinicians accessing grief information via academic research (i.e., journal articles), Breen (2010, p. 293) says, "academic positions tend to require publications with theoretical rather than

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practical significance whereas practitioners tend to seek research that is applicable specifically to their work demands.”

Hatton (2003) surveyed grief counselors who provided support to those bereaved by homicide. These counselors reported that they believed it was necessary to “work through” the grief with intense emotional expression. Research done by Bonanno, Wortman and Neese (2004) demonstrates that the successful resolution of grief need not be accompanied by emotional expression.

As general practitioners are typically the first-line health professionals that refer clients for further psychological care, it is important that these health care providers are knowledgeable of recent grief research. In a study of the referral practices of 50 general practitioners in the United Kingdom, researchers found that their sample group believed that grief was linear, stage/phase-based, and time-bound (Wiles, Jarrett, Payne, & Field, 2002). As is demonstrated in the literature, grief is seldom linear or stage or phase based. While this research on general practitioners' understandings of grief should be replicated before generalizations are drawn, the findings of this study suggest that there might be a knowledge gap between how general practitioners understand grief and the findings in contemporary grief research.

Why does this discrepancy exist? Simon (2013) suggests that practitioners are not aware of the available evidence regarding grief management because evidence-based treatment guidelines for grief have not yet been formulated. Furthermore, Simon suggests that clinicians may not be aware of how to assess individuals for complicated grief. For this, Simon suggests that clinicians use the Inventory of Complicated Grief (ICG), a 19-item questionnaire developed by Prigerson et al. (1995). However, given (a) the demonstrated complexity and multifarious nature of grief, specifically given Bonanno et al.'s (2004) findings that grief can take several

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distinct trajectories, and (b) that the provision of general practitioners does not necessarily extend to providing quality mental health care, perhaps the focus of future study should lie in coordinating efforts with GPs to more frequently refer bereaved clients to mental health professionals who have greater training in grief counseling.

Currently, the field of grief research has already provided guidance for diagnosis, psychotherapeutic intervention, and antidepressant use in the management of complicated grief (Simon, 2013). As the field continues to evolve, studies that work towards optimizing treatment efficacy and helping us better understand the psychological and biological processes behind grief will move us towards a greater proliferation of an understanding of grief and grief interventions by health and mental health providers.

Sociocultural Factors

The manner by which grief is experienced and expressed is mediated by the culture in which it is found (Rosenblatt, 2008). Culture influences who grieves, how one grieves and to what extent people grieve. For example while in the West, grief is mainly understood as an emotional and psychological phenomenon; in other cultures grief can be found in somatized forms, such as physical illnesses (Abu-Lughod, 1985; Fabrega & Nutini, 1994; Prince, 1993).

The emotions associated with grief vary from culture to culture. Rosenblatt (2008) noted that while in western cultures the term “grief” connotes emotions such as sadness, anguish or sorrow, the predominant emotional states of the bereaved of other cultures vary.

Individuals in given cultures will attempt to maintain grieving processes that they perceive as normative. Many cultures have ideas about pathological grief (Rosenblatt, 1997). Of course, given the differences between grieving experiences across cultures, how each culture defines pathological grief is different. Some indices that cultures examine in determining

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pathology include the length of the grief and the level of expressiveness during the grieving process (Rosenblatt, 2008). Rosenblatt (2008) reviewed the literature on pathological grieving processes around the world and found that what is pathological in one culture may be acceptable in others. For example, Wikan (1988) wrote that mothers in Egypt may be catatonic with grief for several years after the death of a child and such behavior would not be considered pathological. In contrast, for the Balinese (Wikan, 1990), any visible sorrow is viewed as deviant. In Taiwan, while widows are expected not to cry in front of the body of their recently deceased husband, they are permitted to cry, and with intensity, some time afterwards (Hsu, Kahn, & Hsu 2002).

The grieving process becomes complicated when the bereaved cannot access the same resources, such as social or governmental support, that those grieving a more normative or societally-accepted death would. Disenfranchised grief is a grief that is not considered legitimate in its cultural context. Depending on the culture, the situations in which disenfranchised grief arises can range from losses of people who were political opponents of the state, to the deaths of people forced into a dangerous migration, to the death of an unborn child. Rosenblatt (2008) describes the deaths of those impacted by political turmoil as an example. Relatives grieving the disappearance or murder of their family members from political violence typically refrain from communicating their thoughts and feelings about their loss (Hollander, 1997). Such self-censorship of one's grief might complicate one's grief by creating distance from others, instilling fear, creating a sense of unreality, and forming a gap between how the bereaved behaves in private versus in public (Rosenblatt, 2008).

Recognizing differences in grief processing across cultures is useful in clinical practice because such knowledge increases the efficacy of clinical work. For example, western grief

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counseling focuses on the individual (Sharp, Beckstein, Limb, & Bullock, 2015). When working with Native American clients however, this approach may seem lacking in spiritual elements and a holistic view of the world. Furthermore, our individualistic approach to grief counseling may be ineffective to an individual of Native American culture whose way of being is borne out of a relational culture, where extended family, one's community, and one's tribal elders are the principal support network. An ignorance of (or worse, an antagonism to) these dynamics could hinder the therapeutic process. As Sharp et al. (2015) state, knowledge of mourning customs, grief expressions and cultural traditions can help practitioners to avoid pathologizing their clients unnecessarily.

The shift in societies around the world towards greater industrialization and globalization has acute effects on the ways in which people grieve their losses. Of course, with any shift in society, grief practices and rituals have had to adapt in order to best suit the bereaved. Also immutable has been the gap between those who are served by their culture in their grief process and those who are not. With the particular shift in today's society towards globalization and industrialization, we are witnessing greater individualism, which has an affect on, as well as is a result of, changes in economic and family structures. Though beneficial in certain ways, this shift has left many individuals across all cultures in a position in which their grief is supported at a less than optimal level. Take, for example, Korea. As industrialization continues, family structures that were firmly embedded in communities are being cast apart, as young people are moving to cities and living more independently (Cho & Sung, 2015). However, when family members die, a significant amount of guilt is harbored as individuals feel that they have not properly reconciled their relationships with the recently deceased, nor have they performed ancient rituals important to their culture. In another example, Korea is witnessing an increase in

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suicide. Given that suicide is deeply stigmatized in Korean culture, more and more individuals are unable to properly grieve their loved ones. Such individuals, facing a disenfranchised grieving process, do not have access to the same social support or grieving rituals that are available to the bereaved of more normative losses. In order to help the bereaved in a changing Korean culture, Cho and Sung (2015) suggest efforts be made on various fronts: methods for helping more independent individuals reconcile their relationships with their families before death, and searching for new ways to adapt ancient rituals to new contexts. Cho and Sung also call for efforts to reduce the stigma around suicide in order to foster greater support and a more open grieving process for those bereaved by suicide. Simply opening a space for individuals, whether through grief counseling or other means, even years after the death, could be helpful (Cho and Sung, 2015).

Summary

The research demonstrates that the way in which grief is expressed, experienced and processed differs from culture to culture. We have seen how aspects of grief, from the emotions felt to the attitudes individuals hold about the deceased, are constructed within the culture and are not, in fact universal. Understanding this helps clinicians in their work within the context of western cultures as well. Beginning with the understanding that individuals living in western countries will nonetheless have distinct cultural backgrounds, and expanding our awareness of grief through the cross-cultural grief research found in the research literature, clinicians can work more sensitively and effectively with clients. Each individual, even those who have lived in these countries for some time, carry a cultural heritage. With this come sets of rituals, customs, and meanings behind death and grief. A sensitive clinician will attempt to learn about what each client brings to counseling in terms of the rituals and the meanings associated with grief in their

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culture(s). Cacciatore and Defrain (2015) state that cross-cultural grief research is especially useful in helping clinicians to not pathologize an individual's grief reaction, one that might actually be appropriate in their culture. Furthermore, such cross-cultural grief research enables clinicians to provide better, more culturally informed support.

CHAPTER III

Methodology

This qualitative study is an exploration of the research question: How do grief counselors perceive their therapeutic role in grief counseling? The purposes of this study were to ameliorate the dearth of research literature on this subject and improve the generalizability of research done by Payne, Jarrett, Wiles and Field (2002) (conducted in the UK) and Breen (2010) (conducted in Western Australia) by replicating their research in the Northeastern United States. A qualitative design, using semi-structured interviews, was chosen for this study in order to explore the phenomenon of grief counseling from the perspective of the clinicians who experience it.

A general inductive approach was used in this study. Thomas (2006) describes inductive analysis as “approaches that primarily use detailed readings of raw data to derive concepts, themes, or a model through interpretations made from the raw data by an evaluator or researcher” (p. 238). The general inductive approach was used to develop a framework of the experiences and processes within the raw data. As the raw data is worked through, subsequent patterns and concepts are reworked through earlier interviews until all interviews are examined using all the patterns and concepts developed throughout this process.

Sample

Participants in this study were mental health counselors who met the following criteria: licensed and currently or within the past five years provided grief counseling. There were no limitations based on race, age and gender. All clinicians were English speaking. Participants

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practiced in the following settings: private practice, hospice care, and hospitals. All participants met inclusion criteria and therefore no participants were excluded from participating in the study.

Recruitment

This study and all safeguards ensuring the ethical standards of social work research were obtained from the Smith College School for Social Work Human Subjects Review Committee prior to the recruitment of participants (Appendix A). Recruitment for this study utilized purposive and snowball sampling. I searched Psychology Today for clinicians in the region who listed “grief therapy” among their specialties. Each potential participant received a recruitment email (Appendix A), which described the research topic, inclusion criteria, and a description of the interview. Once the interview was concluded, I asked the participant if they could refer any other clinicians who might be willing to participate in the study.

If the participants agreed to be in the study, I emailed a copy of the consent form for them to sign. I either met with the participants in person for the interview or we arranged a telephone interview. In the case of a telephone interview (n=2) the participants emailed me a copy of the signed consent form and I emailed them back a scanned copy that included my signature (Appendix B). Appendix C is the list of questions I asked all study participants. I gave my interviewees a chance to read over the consent and ask any questions they had, in order to ensure that they understood the requirements and rights in their participation. The participants were informed that they had the right to withdraw from the study any time before April 1st, 2016.

Ethics and Safeguards

Protection of confidentiality. Given the nature of conducting over-the-phone and in-person interviews, participation in this study was not anonymous. However, the participants' responses to the interview questions were kept confidential. Confidentiality was maintained

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using the following system: each interview was conducted in a private setting, the transcripts of the interviews were each coded to link interviewee with their responses, and these codes (linking the two) are kept on encrypted and password protected online servers. The audio recordings of the interviews were destroyed after transcription. In the transcripts themselves, and all identifying information have been stripped.

Confidentiality regarding client information was briefly, yet explicitly discussed at the beginning of the interview. As is typical in discussing clinical work with others, the participants understood that within the descriptions of their work, they were not to describe or identify their clients in a way that would reasonably reveal their identities.

Risks and benefits of participation. Risks of this research study were minimal. Participants were only asked about their professional experience. The consent form outlined emotions that might surface during the interview, but it was expected that none of these emotions were outside of their day-to-day work as mental health professionals. The emotions were as follows: embarrassment, guilt, sadness, and shame that may be associated with their perceptions of work performance, outcomes, and or emotions. Participants were aware that their participation in the study was completely voluntary.

Participation in the study gave these clinicians the opportunity to discuss and reflect upon their work as grief counselors. Their responses benefit the field of social work by contributing to best practices in grief work, as well as by providing data that can be used to cultivate a more nuanced understanding of the differences (or lack thereof) between grief counseling research and grief counseling practice. In practice, the findings of this study may help clinicians work with grieving clients more effectively.

Data Collection

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For this study, I used semi-structured interviews. The interviews were informal and flexible, which allowed me to adapt to the differences between participants and to draw more information from participants with depths of knowledge in particular subjects. I covered the outline of my interviewed questions with each participant and asked further questions as needed to clarify a response or to draw more information.

The interviews were between 35-90 minutes in length. Each began with a discussion and signing of the consent form, followed by a few minutes of general conversation in order to build rapport. I varied the order of the interview questions based on the personalities and positions of the participants in order to enhance the flow of the conversation. Throughout the interview I mixed demographic questions (age, counseling degree, etc.) with questions pertaining to their work. All participants consented to the audio recording of the interview.

The interview questions were pre-screened by the Human Subjects Review Committee at Smith College School for Social Work and my research thesis adviser.

Following each interview, I transcribed their audio onto a document on Google Drive. As I transcribed, I made sure to erase identifying information. Each transcript was coded numerically with the associated participant and a separate file was made to catalog the code and the participant. Each transcription was read and reviewed for accuracy.

Data Analysis

For this data analysis, I followed the general inductive approach outlined in Thomas (2006). Thomas's guidelines provided a simple and systematic method for analyzing the raw data in a reliable and valid way. I read through the transcripts several times in order to find themes and patterns within my participants' responses. My goal in the analysis was to condense the raw

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data of the interviews into concise and clear groupings and to pull-forth underlying structures inherent in the data through the use of groupings or themes.

First I transcribed the interviews verbatim. Interviews were transcribed from the audio recording directly into a Google Drive document. Each interview was read and reviewed in detail until underlying themes became evident. Themes and patterns were gathered and condensed into a separate "Findings" document. Quotes were pulled from transcripts and placed under headings which denoted themes. The groupings were further refined, elucidated, and reformatted to erase redundancy and improve clarity.

CHAPTER IV

Findings

Participants' Demographic Data

For this study, a total of ten clinicians were interviewed. All were female and the mean age of the cohort was 49. The ages of the participants ranged from 32 to 79 with a median age of 45. All of the participants identified as White, with one identifying as Jewish. Their clinical experience ranged in length from 2 years to 46 years, with a mean of 21 years. While all the participants currently worked in private practice, five had worked or were actively employed in hospice agencies. One participant worked in an Oncology Unit in a hospital. Seven of the participants held a Masters in Social Work degree, two were doctoral level psychologists, and one participant held an Master of Arts in Expressive Arts Therapy. While all participants did individual counseling, four of the participants also conducted group therapy for grief.

Participant Conceptualizations of Grief

All participants in this study conceptualized “grief” as a response to loss. For example, Participant 4 exemplified the multifarious nature of grief as: “Loss can be growing up. You’re not a kid anymore, you’ve lost your innocence. I think we grieve the small and the large things.” Eight out of the 10 participants made it a point to establish that grief can come from non-death losses. Three participants described grief as being a normal response to loss, explicitly stating that grief in all of its forms is non-pathological. In corroboration with this perception, all ten

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participants stated that the manifestation and presentation of grief is unique to each person.

Participant 3 said:

...no one experiences it the same at all. It's such an individualized process that someone will go through after they've lost someone and I think that it's hard to put a definition on something that's such an individualized experience.

Five of the ten participants stated they don't believe that grief (i.e., its symptoms, such as anhedonia, sadness, feelings of meaninglessness, etc.) ends. This position was exemplified in Participant 7's answer: "You're never going to get over this. It's just going to change. This sense of loss will change, it will expand, it will prism out. It will age with you. It will always be there." Further, they described grief as something that could be retriggered by a life event or a reminder of the deceased, and thus bringing about the symptoms of grief once again. Six participants stated they believe that grief is "nonlinear," meaning that it does not follow "stages" or "phases" in a set order. All ten participants described grief as a "process," one that changes and evolves over time.

Six participants described the capacity for grief to be traumatizing. Four participants stated that they believed grief happened to the entire body. These clinicians characterized grief as acting on the nervous system or specified that the emotions attached with grief are located within the body. All participants discussed grief as encapsulating the spiritual, the emotional and the psychological domains.

Participant's Approaches to Providing Grief Therapy

All of the clinicians interviewed described their approaches to grief work as being "integrative." The most popular treatment approach (psychoeducation) was used by all clinicians. Seven clinicians emphasized the importance of working with both the body and the

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mind. Four clinicians indicated the usefulness of trauma-informed therapies, such as Somatic Experiencing. Three clinicians discussed Elizabeth Kubler-Ross's Stage Theory model as influencing their work; however, they underscored that their utilization of the Stage Theory model was non-linear and not rigid. Three of the clinicians interviewed used an Expressive Arts approach to their grief work. Each of the following theoretical orientations were endorsed once: Attachment Theory, the Dual-Process Model (Stroebe & Schut, 1999), Object Relations Theory, Narrative Therapy, the Task Model of Grief (Worden, 2009), and a hospice model for grief, as popularized by Joan Halifax.

The job of the therapist. The participants discussed two issues as being the focus of their grief work: a) helping the bereaved orient themselves to the newfound demands of life after the death of a loved one, and b) helping the clients orient themselves to the task of grieving, i.e., being with and moving through the process of grief. Insofar as the first issue of focus, helping the clients orient themselves to the demands of life, three of the clinicians wrote of the importance of providing psychoeducation to the bereaved around how to manage their relationships. Five participants discussed helping their clients take care of themselves, whether this included implementing "self-care" into their daily schedules or helping the clients navigate systems in order to access resources such as Social Security. Participant Five described this process in the following quote:

Sometimes people are in some kind of a crisis if they're in an acute stage of grieving and so part of the work, even if I'm not doing it as a therapist is being aware of and helping people take care of what needs to be taken care of first; so do they need custody work, do they need to see a psychiatrist, how are they sleeping? That kind of thing.

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In order to help their clients “be with” their grief and process it, the participants employed a large array of counseling practices. All ten therapists reported that “normalizing” their client’s grief symptoms (i.e., identifying the client’s symptoms as being normative to the general population) was an important first step to helping them connect with their grief processes. Two participants described bringing mindfulness and curiosity to their clients’ grief helped the clients feel more in control of their experience. This was done by teaching the clients to localize their emotions to the specific regions in their body in which their emotions arose and helping the clients create a degree of separation between themselves and the emotions attendant with their grief.

Seven of the participants discussed the importance of “meeting the client where they are” as a means of helping the client be with their grief. One participant described it as giving the client a space in which they could let their grief exist “as it is.” All of the clinicians emphasized the necessity of attending to the client’s emotions and experiences through empathy. These clinicians utilized techniques such as talk therapy or Expressive Arts Therapy to help their clients express their feelings. In turn, the therapists attended to these emotions by “bearing witness,” i.e., witnessing, acknowledging and respecting the things that the clients share. Alongside providing a safe space for their clients to be with their grief, the clinicians highlighted the importance of “companioning” with them week to week, i.e., staying with the client’s grief process as it emerged, and being a consistent presence for the client. Participant Seven portrayed it thusly in her grief work with children:

My job isn’t so much to interpret what a child does. But to support them and trust the images that are coming to them. That’s where the healing comes from. Being able to express it and being able to process it, and also given empathy and providing a safe space for them to do so.

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Five clinicians highlighted the importance of being non-judgmental towards the client and their grief. Participant One stated, “ I like to remind myself number one that I have no idea what they're going through,” which highlights the finding that the grief clinicians in this study conceptualized grief as being an individualized process for each mourner. Participant Three described the importance of the non-judgmental stance, “ Yeah I don't know, I guess I would say I would not want to conceptualize it because I'd have to put it in a picture frame that somebody would have to stick to.” Participant Three's statement indicates the restrictiveness that the client might feel if their therapist were to judge the appropriateness of their grief reaction. The underlying theme here is that these participants express that they don't know what the grief experience for the client is like, nor do they think that it should be taking any particular form.

Three participants discussed the usefulness of helping the clients better understand death and/or their grieving process. Participants discussed doing this via teaching the clients about the tasks (Worden, 2009) or stages (Kubler-Ross, 1969) of grief, by giving children concrete answers around the nature of death, or by describing to the clients how grief is a mind-body-spiritual phenomenon.

Seven participants discussed the importance of working with the grief inter-modally. By this, they meant using many modes of experiencing and expression, including but not limited to talk therapy, music therapy, art therapy, and somatically-based therapies. Participant 8 summarized this position in the following quote: “Because I felt that the body holds trauma, the body holds grief... and if you can't work -- it was too narrow for me to begin -- to work in one modality. “

When to refer. The participants referred clients to other services when they felt that their clients needed services outside of their expertise. Four participants discussed referring their

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clients and their families to hospice care. Three participants described instances in which they referred their clients to a psychiatrist. One participant talked about referring their clients to additional services in line of the holistic needs of their grieving client; these services included treatments such as acupuncture and massage. When asked how they determined whether they needed to refer their clients, the participants described moments of self-assessment. For example, Participant One described her decision making process as: "I would feel I would know when someone needed to be referred, when I would feel fearful when I didn't know what to say or how to do this... But now I can much more effectively check-in with myself and ask myself, 'Can I help this kid? Can I help this family? If I don't think I can, we need to get help.'"

When to terminate. Six of the participants stated that they believed that there was not and should not be a set length of time for treatment. In fact, Participant 7 described the grieving process as never ending: "You're never going to get over this. It's just going to change. This sense of loss will change, it will expand, it will prism out. It will age with you. It will always be there. So the person's never over it and that's the end of therapy." In concordance, Participant Two stated: "I believe that grief work in that sense, you need to journey with somebody, long-term. And I believe that grief work needs to be done with people who are going to stick around, not just these little like band aids." Participant Two also spoke to the importance of "keeping the door open" for the client if they wanted to return to therapy later in their lives. This participant described the evolving nature of grief in this quote: "Children will grieve through different developmental periods in their lives, so let's say they lost a parent at 8 years old, then all of a sudden they're in middle school and there's some issues and they want to recheck in. Well okay, I'm around."

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When participants did feel it was appropriate to terminate with their clients, they made this determination through a mutual assessment with their client. Generally, the participants felt it was appropriate to terminate with their clients when the client felt “ready and better” (Participant 6) or “more in control of their life and [had] made meaning out of the loss” (Participant 7).

Training in Grief Therapy

While the majority of participants had not taken formalized grief trainings such as through a certificate program or a continuing education course, three participants had (Participants 3, 8 and 9). For these three participants, two of them received training in Elizabeth Kubler-Ross's Stage Theory and one received training as part of her work with the American Foundation for Suicide Prevention.

All clinicians described their grief counseling as being bolstered by their reading. Seven of the participants described gaining their expertise in grief from their own lived-experiences with grief. Five clinicians reported seeking peer-supervision from other counselors around grief counseling and five clinicians spoke to learning about how to conduct grief counseling from their clinical experience doing the grief counseling itself. One participant reported having focused her doctoral level training on grief counseling.

CHAPTER V

Discussion

Key Findings and a Comparison To Previous Literature

In comparison to past studies (Breen, 2010; Hatton, 2003; Payne et al., 2002), participant responses in the present study, regarding conceptualizations of grief, participant approaches to providing grief therapy and participants' training in grief counseling, revealed many of the same tensions within previous studies: adherence to older theoretical bases (e.g., Kubler-Ross and Worden) versus newer models (e.g., The Dual-Processing Model or trauma-informed interventions), and conceptualizing grief as normative or pathological.

The normativity of grief. Therapists in the present study largely spoke towards the non-pathologization of grief in all of its presentations. Clinicians in this study stated that grief does not end, but instead, evolves throughout life. This is in opposition to the positions taken by the clinicians in Breen (2010), who stated that grief is finite and stage-based, and Payne et al. (2002) who described pathological grief as a state of being "stuck" in the grief. Interestingly, a small number of clinicians in the present study ($n=3$) also endorsed Kubler-Ross (1969) as being an influence in their work. Contrastingly, however, these same clinicians stated that while Kubler-Ross's Stage Theory provided a useful psychoeducational reference point that they could teach their clients if their clients were helped by structuring the grief process, none of these clinicians affirmed the determinant and prescriptive qualities inherent in Stage Theory: the clinicians expressed that they believed grief was non-linear, not based in stages, and individual. In fact,

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none of the therapists in the present study conceptualized grief as being finite or linear. There is a slight wrinkle, however, surrounding the concept of pathologization.

It is clear that the participants in the present study found it useful to be a presence for their clients; they discussed their companionship to their clients as their clients processed their grief. While the objective language used by clinicians in Payne et al. (2002) seems to be in contradiction to that of the clinicians in the present study, it is unclear whether clinicians in the present study also make special importance of the concept of being “stuck.” The key here is that the therapists in Payne et al. (2002) associate “stuckness” with pathology, i.e., in their conception, normative grief *flows* along a process while pathological grief is a deviation from that normative process. Do the therapists in the present study also associate “stuckness” with pathology? In fact, they *do* emphasize the importance of *helping their clients process* their grief. While the language is different -- helping one become “unstuck” versus helping someone “process their grief” -- the meaning is the same: some grief needs professional intervention, and is de facto pathological. What therapists in the present study seem to be speaking to when they say that no grief is pathological, is the *stigmatization* that categorizing grief evokes, and their desire to protect their clients from this scrutiny.

The differences between prior research and the present study along the theme of the “normativity of grief” can be summarized as the following: while findings from past research describe clinicians adhering to a stricter, more prescriptive conceptualization of grief, such as in the finiteness and linearity of grief (Breen, 2010; Payne et al., 2002), this prescriptive attitude is not endorsed by clinicians in the present study. Clinicians in the present study highlight the idiosyncrasy of grief presentations and the non-ending quality of grief. However, past and

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present research seem to concur vis-a-vis the notion of pathological grief: that some grief can be ameliorated by attention from a mental health professional.

A relational stance to processing grief. It appeared, through analyzing the responses of clinicians in Breen (2010), Payne et al. (2002) and the present study, that active listening and providing a space to process one's emotions was of crucial importance to the therapy. Given this, we might view the *relational* nature of grief counseling as fundamental to the work. 27% of the counselors in Payne et al. (2002) described the counseling session as a unique place in which their clients could speak about the grief and 55% responded that "active listening" was the main counseling strategy they employed. Even the clinicians in Hatton (2003) describe the importance of grief being "worked through" with intense emotional expression *in the presence* of the therapist.

The usefulness of solution-focused work in the early stages of grief. The therapists in the present study voiced that helping their client navigate the demands of everyday life without the deceased was a major area of work, especially in the early stages of the client's grief. They did this through providing psychoeducation ($n=3$), doing solution-focused work ($n=5$), helping the clients "be" with their grief and not feel stigmatized by their particular grief reaction ($n=10$), and teaching mindfulness ($n=2$). 34% of the counselors in Payne et al. (2002) endorsed helping their clients learn new skills in order to readjust to their predicament. In sum, the findings in past and present research suggest that a critical aspect of grief counseling deals with helping the bereaved readjust to life.

Training in grief counseling. Similar to the findings in Breen (2010), very few of the counselors interviewed in the present study had undertaken any formal grief training (as through a course or through a certified workshop) ($n=3$). However, all therapists endorsed that their grief

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counseling was informed through reading, supervision, and discussion with colleagues. Many reported that their expertise in grief counseling was informed by their grief experiences themselves or through their work with grieving client. The counselors in Breen (2010) described the difficulty of staying abreast of the contemporary grief research, citing the cost of accessing academic literature and the difficulty of doing so if unaffiliated with an institution of higher learning.

Implications for Social Work Practice

The research presented here, though similar to findings in Breen (2010) and Payne et al. (2002), suggest that there has been a progression in the field since the time of these two prior studies. On an unspoken, yet clear level, the clinicians in the present study endorse a dual-processing model to bereavement: orientation towards readjusting to life without the bereaved and orientation to the loss itself, with all of the attendant experiences, feelings, and thoughts. Overall, this dual-process is strikingly similar to Stroebe and Schut's (1999) Dual-Process Model. While the clinicians in Breen (2010) and Payne et al. (2002) spoke to the importance of helping their clients with both aspects of the work, the clinicians in the present study have moved on from an adherence to the "linearity," "stage-based nature" or "finitude" of the grief process; instead endorsing a conception of grief as never-ending and ever-evolving.

As the whole of psychotherapy evolves, adding to its understandings of trauma, neurobiology and mindfulness, so too as these disciplines weaving themselves into grief counseling. Whereas these areas of practice were not discussed in Breen (2010), Payne et al. (2002) or Hatton (2003), all of these practices appeared in the present study. These changes can be seen as an holistic "updating" of psychotherapeutic technique towards one that incorporates understandings of the body, of neurobiology, and of spirituality, in a more integrative way.

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While the findings of the present study testify to the changes in the field itself, within and without the subdomain of grief counseling, they might affect the field of social work practice by suggesting that within grief counseling, there is now a closer integration between research and practice. This stands in contrast to the concerns raised by Breen (2010): that contemporary research was not sufficiently integrated into contemporary grief counseling practice; a conclusion she wrote as being informed by her respondents' endorsement of Kubler-Ross's (1969) Stage Theory. It is unclear exactly what effect this integration will have on the field of social work; however, given the relatively similar findings vis-a-vis the importance of the holding environment, active listening, and empathy, from Payne et al. (2002) all the way to the present study (2016), we might be discovering the fundamental importance of these particular dimensions of grief counseling.

Limitations of the Present Study

The generalizability of the current study is hampered by the small number of participants interviewed ($n=10$). Furthermore, given that this was designed as a preliminary study into the practices and perceptions of grief counselors, more rigorous interview questions that could have more deeply probed the meanings behind the participants' responses were not implemented. Furthermore, given the geographic sampling of the participants', it is unclear whether the findings herein can be generalized to the state of American grief counseling in general, let alone the international community. It should be noted that Breen (2010) was conducted in western Australia and that Payne et al. (2002) was conducted in the United Kingdom.

Recommendations for Future Research

Future research would benefit from utilizing a more representative sample and a more comprehensive interview manual. This would allow for greater reliability and validity in the

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perceptions and practices of contemporary grief counselors. In sum, replication and more representative samples are indicated.

Conclusion

The present study sought to understand the state of contemporary grief counseling by interviewing grief clinicians on their perceptions of their work. The research revealed differences from previous work conducted by Breen (2010), Hatton (2003), and Payne et al. (2002). Key findings included the importance of helping the client orient themselves to life without the deceased as well as to processing the loss itself, and that the overwhelming majority of clinicians in this study had not received formalized grief training; learning of their craft through research literature, their own experiences with grief, and the expertise of their colleagues, instead. Given that the findings of the present study suggest that the gap between grief research and grief practice has narrowed considerably, future research into this topic may not be needed for the time being, outside of demonstrating the validity of the present study and increasing its generalizability.

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Appendix A

Interview Questions

1. What type of counseling training have you received?
2. How do you understand grief? How do you conceptualize grief?
3. What type(s) of training in grief have you undergone?
4. From where do you access grief information? (books, databases, articles, conferences, from other counselors, etc.)
5. What do you consider is best-practice grief counseling?
6. What is your approach to grief counseling? What is the style of your interventions?
7. How do you determine whether and when to refer your clients, if indicated?
8. How do you determine whether and when to terminate services with your client?
9. What theorists or theories do you use in your work?
10. How do you maintain your own mental, physical and spiritual self-care as a counselor?
11. What aspects of your work do you find challenging?

Appendix B

Consent Form

2015-2016



SMITH COLLEGE

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC)

Title of Study: Clinicians' Perceptions of their Role in Grief Counseling
Investigator(s): Dinh Tran, Graduate Student, Smith College School for Social Work, xxx-xxx-xxxx

.....

Introduction

You are being asked to be in a research study of the perceptions of clinical practitioners' work with grieving clients. You were selected as a possible participant because of your clinical experience with grieving clients. 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 better understand the lived experiences of clinical practitioners who work with grieving clients. By collecting and analyzing this data, we hope to better prepare clinicians for their work with grieving populations, including examining methods to maintain their own well-being while doing this work, and probing what aspects of the work are particularly difficult. This study will also generate directions for future study. This study is being conducted as a research 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: participate in one semi-structured interview, lasting approximately 30 - 40 minutes. This interview will be audio recorded (with your permission) and transcribed at a later date.

Risks/Discomforts of Being in this Study

There are minimal risks to participating in this study. Sometimes being asked about one's personal feelings and emotions, knowledge within a certain practice area, or self care

CLINICIANS' PERCEPTIONS OF THEIR ROLE IN GRIEF COUNSELING

approaches feels invasive and uncomfortable. However, these feelings are generally short-term and may parallel daily life events such as an airplane flight or doctor visit.

Benefits of Being in the Study

The benefits of participation are having the opportunity to talk about one's experience counseling grieving clients.

The benefits to social work and society include an enhanced understanding of the experience of professional clinical practitioners counseling bereaved clients. This research will help to demystify the process of counseling the bereaved, and will provide insight into self-care approaches.

Confidentiality

Your participation will be kept confidential. Interviews can take place in the location of the participant's choosing, including, for example one's office **and/or a private room in a library**. The only individuals to know of your participation in the study will be myself, my thesis advisor, and if needed, a transcriber who will help me write out the audio versions of our interview. The transcriber will be required to sign a confidentiality agreement. The records of this study will be kept strictly confidential. Audiotape recordings of the interviews will be used solely by myself, and potentially a transcriber. Audiotapes will be destroyed following the completion of this study. Audiotapes, saved as digital audio files, will be destroyed by deleting them off the hard drive of the device. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

You will not receive any financial payment for your participation.

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* (up to the date noted below) 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 up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by 4/1/16. 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, Dinh Tran at dtran@smith.edu or by

CLINICIANS' PERCEPTIONS OF THEIR ROLE IN GRIEF COUNSELING

telephone at xxx-xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. 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.

.....

Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] taped for this interview:

Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

Form updated

Appendix C

Recruitment Letter

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC)

Dear [insert name],

My name is Dinh Tran and I am a graduate student at Smith College's School for Social Work. I am writing to invite you to participate in my research study about the perceptions of counselors of their therapeutic role in grief counseling. You're eligible to be in this study because you have done clinical work with grieving clients. I obtained your contact information from [describe source].

If you decide to participate in this study, you will be interviewed for a duration of about 30 - 40 minutes. I would like to audio record our conversation and then I'll use the data gathered from you and other clinicians to run a content analysis.

Remember, this is completely voluntary. You can choose to be in the study or not. If you'd like to participate or have any questions about the study, please email or contact me at dtran@smith.edu.

Thank you very much.

Sincerely,
Dinh

MSW Intern at Bard College
Smith College School for Social Work

Appendix D

HSR Approval Letter



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

January 1, 2016

Dinh Tran

Dear Dinh,

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,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.

CLINICIANS' PERCEPTIONS OF THEIR ROLE IN GRIEF COUNSELING

Co-Chair, Human Subjects Review Committee

CC: Narviar Barker, Research Advisor

POINTS TO REVIEW/COMMON PROBLEMS

CHECKED BY:
STUDENT ADVISOR SEQUENCE

- | | | | |
|--|--------------|--------------|-------|
| 12. No heading is separated on a page from its following text. | <u> j </u> | <u> a </u> | _____ |
| 13. Any underlining is continuous (unbroken between words). | <u> j </u> | <u> a </u> | _____ |
| 14. Labeling of Appendices agree in text and on the Appendices (A =A, B = B, etc.) | <u> j </u> | <u> a </u> | _____ |
| 15. There is exact correspondence in <u>number</u> and <u>content</u> between works cited in text and listed on the reference list. | <u> j </u> | <u> a </u> | _____ |
| 16. Spacing, indenting, and format of the entries on the reference list is in APA 6 th ed. Style and consistent throughout. | <u> j </u> | <u> a </u> | _____ |
| 17. For all <u>empirical</u> projects—Human Subjects Consent Form and the Approval Letter from the Human subjects Review Committee must be included as <u>appendices</u> . | <u> j </u> | <u> a </u> | _____ |
| 18. The general appearance of the manuscript is good, clean, etc. | <u> j </u> | <u> a </u> | _____ |
| 19. One copy on 20 lb. Paper (regular copy paper). when submitting theses, each copy must be in a separate, manila, clasped envelop. | <u> j </u> | <u> a </u> | _____ |
| 20. One <u>additional</u> copy (on regular paper) of your abstract is collected with the thesis submission for listing in the <i>Smith Studies</i> . | <u> j </u> | <u> a </u> | _____ |
| 21. Email files of the complete thesis both PDF and WORD format to Laurie Wyman, Admin. Asst. for The Research Sequence (lwyman@smith.edu) This is for storage and safe-keeping. The complete Thesis from Abstract through Appendices should be submitted as one complete file. | <u> j </u> | <u> a </u> | _____ |
| 22. Completed & signed copy of the Electronic Access Permission form. | <u> j </u> | <u> a </u> | _____ |
| 23. Student's Research Advising Evaluation must be completed on Banner Web to obtain course credit for the thesis. | | | |

NOTE: If there are corrections to the manuscript to be completed after the deadline, it is acceptable only during the fourth week to submit only one copy on photocopy paper until final corrections are made. In the end, 1 or 2 corrected copies must be submitted depending on whether or not the thesis is agency-based.

Appendix M

Worksheet for Thesis Submission

(MUST BE SUBMITTED WITH THESIS)

Student Name: Dinh Tran

Advisor Name: Narviar C. Barker, M.S.W., Ph.D.

Students are responsible for ensuring that each thesis manuscript is prepared in accordance with the directions in the *Guidelines* and in A.P.A. style (see *Manual* and *Guidelines*). This worksheet has been prepared to assist students and advisors in preparing manuscripts for submission.

This worksheet should be filled out BEFORE the Correction Sheet is filled out. **All manuscripts MUST BE submitted along with this Worksheet and a Correction Sheet**, which has been signed by the advisor whether or not additional corrections are needed, to document the fact that the advisor has seen the manuscript in its final, submittable form.

<u>POINTS TO REVIEW/COMMON PROBLEMS</u>	<u>CHECKED BY</u>		
	<u>STUDENT</u>	<u>ADVISOR</u>	<u>SEQUENCE</u>
1. Author's name and thesis title agree exactly on abstract and title pages	<u></u>	<u></u>	<u> </u>
2. Form matches examples in <i>Guidelines</i> for:			
Abstract page	<u></u>	<u></u>	
Title Page	<u></u>	<u></u>	
Table of Contents	<u></u>	<u></u>	
Tables and Figures	<u></u>	<u></u>	
3. Serif typeface is acceptable for text (see examples in <i>Guidelines</i>).	<u></u>	<u></u>	
4. Double spacing is used throughout.	<u></u>	<u></u>	
5. Margins are correct, including that all continuing text pages are the same length.	<u></u>	<u></u>	
6. Right justification of lines is not used.	<u></u>	<u></u>	
7. No running headings are used.	<u></u>	<u></u>	
8. All pages are numbered (lower case Roman numerals for preliminary pages) and the placement of page numbers is consistent throughout—to the LAST page of the thesis.	<u></u>	<u></u>	
9. Table or figure captions and labels should allow the material to "stand alone".	<u></u>	<u></u>	
10. Levels and styles of headings are correct.	<u></u>	<u></u>	
11. Chapter headings are correct.	<u></u>	<u></u>	

Appendix O

Research Project Evaluation

The general comment on the student's overall performance should reflect both strengths of the student, study and advising process as well as suggestions, which will alert students to their individual learning needs. Comments should be as specific as possible. This form should be submitted by the Research Advisor to the Administrative Assistant in the Research Sequence when the thesis is completed. This evaluation is kept in the student's file as a course evaluation.

Student Name: Dinh Tran

Class 2016

Advisor Name: Narviar C. Barker, M.S.W., Ph.D.

Date: June 22, 2016

Thesis Title: Clinicians' Perceptions of their Therapeutic Role in Grief Counseling

Key to the Grid: **Met** – Objective Fully/ Consistently Met: Work in the bold spectrum of high quality master's level performance. **Partially Met** – Objective partially met: Objectives met in part inconsistently. **Not Met** – Objective not met. **NA** – Not applicable: No opportunity to assess this objective.

Objective	Met	Part Met	Not Met	NA
Identified Relevant Social Work Question	X			
Review, Critiqued, and Synthesized Relevant Prior Literature	X			
Developed and Implemented Study Strategy	X			
Considered SW Values & Ethics; Informed Consent	X			
Considered Possible Influences of Racism, Sexism and Other Oppressions	X			
Analyzed Yield of the Study on the Research Question	X			
Connected Study Results with Prior Work	X			
Produced a Clearly Written Report	X			
Appropriately Formatted Final Written Report	X			
Kept Pacing of Thesis to SSW Deadlines	X			
Used Research Advising Efficiently	X			

Comments on Student's overall process and performance:

Dinh did an excellent job pulling his thesis together and organizing it into presentation format. He received supervision and feedback very well and readily integrated it into his work. He asked good, thorough questions, paid attention to detail, and worked hard to obtain as diverse a population group as possible for his study subjects. He remained attentive throughout the process. I believe this research experience proved to be both rewarding in accomplishment and confidence building for Dinh. He had to reach outside himself, engage others, follow-up, and apply assessment and organizational skills to complete the project. This seemed to instill a stronger level of confidence within Dinh, who by nature is somewhat shy. I truly enjoyed working with him and suspect that as his career blossoms, so will his outreach and engagement skills.

