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CERTIFIED REHABILITATION COUNSELORS' SELF-PERCEIVED COMPETENCY IN FACILITATING END-OF-LIFE CARE SERVICES

A Dissertation

by

MIRANDA LÓPEZ

Submitted to the Graduate College of
The University of Texas Rio Grande Valley
In partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

December 2018

Major Subject: Rehabilitation Counseling

CERTIFIED REHABILITATION COUNSELORS' SELF-PERCEIVED COMPETENCY IN FACILITATING END-OF-LIFE CARE SERVICES

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by
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December 2018

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ABSTRACT

López, Miranda., Certified Rehabilitation Counselors' Self-Perceived Competency in Facilitating End-of-Life Care Services. Doctor of Philosophy (PhD), December 2018, 130 pp., 7 tables, 14 figures, 134 titles.

As of 2010, certified rehabilitation counselors (CRC) have been provided ethical guidelines addressing end-of-life care (EOL) service delivery for persons with disabilities. Due to the plethora of pertinent knowledge and skills sets needed to facilitate comprehensive EOL issues, it is vital to examine rehabilitation counselors' self-perceived competence in facilitating EOL care service delivery. The study was conducted as a non-experimental exploratory design. Based on the study's sample (N = 188), descriptive statistics reported 70% of counselors lacked education while 69% had not participated in EOL training. Approximately 81% of the participants reported the need for EOL education and training. In addition, the study was able to identify age, level of spirituality and state of residence as contributing predictor variables for EOL care knowledge scores. As the need for EOL care service delivery is included in the U.S. health care system, it is imperative CRCs are educated and trained adequately in order to provide quality EOL care service delivery.

DEDICATION

First and foremost, I thank God for all of my blessings. To my parents: my memory is full with your daily counsel, sacrifices, but most importantly, the love you bestowed upon me. I live my life the way you taught me: to love God, to be humble, be respectful, help others, live for today, appreciate the little things, and to love with all my being. I owe all of my wonderful attributes to you. Muchas gracias por todo el apoyo, enseñanzas, y amor. Los amo con todo mi ser.

To my only sister, Magali, you have been a role model for me since I was a little girl. Your life's work included catapulting this family into unchartered territory. Your passion, strength, bravery, and perseverance are truly a sight to behold. From the bottom of my heart, thank you for being there for me, always. You are the epitome of a virtuous woman.

To my brothers Jesse, Joey, and Jaime: I love and cherish each one of you. To my sisters-in-law Connie and Gracie, I love you both. Thank you all for checking in on me, providing support, and for always believing in me. All of you are always present in my heart and I treasure you immensely. To the next López generation: Ysabella, Madeline, Miriam, and Jesse. Thank you for keeping me young in the process. Your endless affection has kept me focused on what matters most. Most importantly, my message to you, my dear nieces and nephew, you will experience happiness, sorrow, triumph and failure, but you will always prevail by believing in God and with the love of your family.

ACKNOWLEDGEMENTS

In the future, when I look back at this time in my life, I will always consider myself fortunate to have been blessed with my dissertation chair, Dr. Bruce J. Reed. Not only did he serve as my dissertation chair, he is an extraordinary mentor that provides continual moral support, and invaluable professional guidance. Thank you, Boss, for your unwavering faith in me.

At this time, I would also like to thank my committee member, Dr. Eva Miller. She has been an inspirational source in my life. Dr. Miller's knowledge, passion and dedication in teaching is second to none. Thank you, Eva, for your camaraderie, candor, and precious heart. You have made me better personally and professionally, and for that, I am forever indebted to you.

In addition, I would like to thank my statistician committee member, Dr. Pierre Lu. Dr. Lu is a phenomenal statistician. Thank you for making statistics friendly, comprehensible and an actual enjoyable experience. Your mentoring has inspired me to continue learning the complexities of statistics and I will forever cherish your confidence in my abilities. You are a gem!

Finally, thank you to my framily for sharing this remarkable journey with me. I was truly blessed with the greatest of peers and I hope we keep growing together in friendship and in our careers as well. Our mutual support will never be forgotten. I wish you all the best in life!

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CHAPTER I

INTRODUCTION

An estimated 53 million adults in the U.S. live with mobility, cognitive, independent living, vision impaired, or self-care functional disability (Courtney-Long et al., 2015). According to the Centers for Disease Control and Prevention (2016), chronic diseases are the leading cause of death and disability, affecting approximately 117 million U.S. adults. Due to the myriad services needed among persons with chronic illness and disability, professionals known as certified rehabilitation counselors (CRCs) are being educated and trained to provide multidimensional aspects of care (Maki & Tarvydas, 2012). The Bureau of Labor Statistics (2015) projects employment of rehabilitation counselors to increase 20% from 2012 to 2022. The Commission of Rehabilitation Counselor Certification (CRCC) has been established as the largest organization of certified rehabilitation professionals devoted to improving the lives of persons with disabilities (PWD) by facilitating comprehensive services in order for consumers to achieve their personal, career, and independent living goals through the application of the counseling process (CRCC, 2017). Therefore, it is imperative CRCs are adequately prepared to provide services for PWD across life domains.

CRCs are trained in broad scopes to assist PWD in dealing with a variety of issues, including adjustment to disability, vocational training, and medical and psychosocial aspects of disability in order to provide case management, advocacy, assessments/intakes, and counseling in order to execute a multi-dimensional approach to help consumers achieve their desired quality of life. CRC professionals specialize in catering to the needs of PWD (Saunders, Barros-Bailey, Chapman, & Nunez, 2009). Ultimately, the rehabilitation profession has been setting the standard of servicing the needs of PWD by addressing, developing and implementing best practices for this growing population (Maki & Tarvydas, 2012).

Prior to becoming a CRC, most current professionals graduated from academic programs accredited by the Council on Rehabilitation Education (CORE). Most rehabilitation education programs across the country were governed by this organization and must have provided instructional coursework designed to cover specific domains in order to receive accreditation. The following are examples of the type of knowledge domains implemented in CORE curriculums: scope of practice; ethics; legislation related to people with disabilities; informed consumer choice and empowerment; mental health counseling; individual empowerment and rights; and implications of cultural and individual diversity including cultural, disability, gender, sexual orientation, and aging issues (CORE, 2014).

With the growth of the rehabilitation profession and the population served, it is evident new areas of content, specialization, competence and knowledge must be identified and addressed in order to stay abreast of current and projected domains for training a competent workforce. In order to establish exemplary standards for the profession, the academic and professional organizational entities continually strive to identify, address, and implement relative

issues which may have yet to be addressed through course curriculum or professional development.

Professional codes of ethics provide standards to guide professional competencies. The Code of Professional Ethics for Rehabilitation Counselors has determined *Standard A.9. EOL Care for Terminally Ill Clients* has been deemed essential and was first introduced in 2010. The standard mandates the following:

a. Quality of Care. When the need arises, rehabilitation counselors advocate for services that enable clients to: (1) obtain high quality EOL care for their physical, emotional, social, and spiritual needs; (2) exercise the highest degree of self-determination possible; (3) be given every opportunity possible to engage in informed decision-making regarding their EOL care; and (4) receive complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf from mental health professionals who are experienced in EOL care practice (CRC Ethics Handbook, 2017, p. 8)

The incorporation of standard A.9 reflects the need for training in EOL care among health care disciplines such as physicians, nursing, social work and counselors (Almack, Cox, Moghaddam, Pollock, & Seymour, 2012; Cicchetti, McArthur, Szirony, & Blum, 2016; Giovanni, 2012; Shallcross, 2012). EOL care has been identified as a topic needed to be addressed by all professional caregivers. The Kaiser Health Tracking Poll revealed 89% (n=496) of adults between the ages of 18-49 reported EOL issues should be discussed between patients and healthcare providers (DiJulio, Firth, & Brodie, 2015). In response to this growing issue, Medicare and Medicaid programs proposed the inclusion of paying healthcare professionals to provide EOL care counseling (e.g., hospice, advanced directives) to voluntary consumers

(Medscape, 2015). In essence, EOL care presents complex topics which need to be addressed by healthcare professionals facilitating EOL services to individuals with terminal illnesses and disabilities.

Statement of the Problem

EOL care services present a broad spectrum of variants that must be identified and addressed by professionals working with consumers during this delicate stage (Giovanni, 2012). Not only is it important to be empathetic and attentive while assisting PWD to explore EOL options, but CRCs must also possess the needed knowledge and competencies in order to provide quality EOL care. Case, Blackwell, and Sprong (2016) stated the CRCC standards identify the unique role rehabilitation counselors hold in guiding consumers with EOL issues and how those decisions should be approached with knowledge, competence, and voluntariness by both parties. Rehabilitation counselors are held accountable for providing quality services for PWD throughout the consumer's lifetime. The majority of academic and professional rehabilitation training has been focused on career counseling, vocational training, case management and professional ethics. Henriksen Jr., Wiesner III, and Kinsworthy (2008) conducted a study surveying counseling professionals regarding whether they thought programs should be expanded from 48 to 60 hours of coursework. In their findings, participants reported a shorter academic program (i.e., 48 hours) only provided the basics of the profession which resulted in deficient time for in-depth specialization subject matter; however, a 60-hour curriculum allowed for more specialized curriculums.

The complexities when addressing EOL care issues among PWD should be presented to the consumer in a timely fashion in order to provide continued autonomy and empowerment when exploring medical, legal, psychosocial, and spiritual decision-making options (Lillie &

Werth, 2007). Since EOL issues are broad in the context of a consumer's life, it is evident professional caregivers should be part of developing an inclusive health care system with expert stakeholders willing to work through disability-related issues. Through this comprehensive approach, counselors will be able to facilitate EOL options which will maximize quality of life for PWD (Ouellette, 2013/2014). From the recent implementation in the Revised CRC Code of Ethics (2017), CRCs should be an instrumental asset to assisting PWD explore EOL options. However, it is vital to assess rehabilitation counselors' self-perceived competence in facilitating EOL care services. Due to the plethora of pertinent knowledge and skills sets needed to facilitate EOL care services, the field of rehabilitation may need to innovatively implement further academic and professional training for its professionals in order to adequately prepare CRCs to become more knowledgeable in providing EOL service care delivery.

Purpose of the Study

The purpose of the present study was to assess the educational needs of rehabilitation counselors in order to improve academic curriculums which will train professionals in the field to adequately address EOL care services. The study also explored the correlations between counselors' level of death acceptance, their attitudes toward euthanasia/physician assisted death (PAD) and their level of EOL competency. Specifically, the study examined the current status of self-reported education and training in the area of EOL care to provide baseline information on how CRCs currently identify the need for EOL training. Furthermore, it was hypothesized the variables of attitudes toward death, age, race/ethnicity, gender, religion, spirituality, years of professional experience and state of employment are contributing factors in EOL competence. Contingent upon the study's findings, academic and professional development training can be formulated to address the educational needs of CRCs on EOL care.

Research Design

The research design for this study was a non-experimental, exploratory study that examined CRCs' self-perceived competence in facilitating EOL care services. The study assessed the following nine independent variables: level of death acceptance, attitude toward euthanasia, age, race/ethnicity, gender, religion, spirituality, years of professional experience and state of employment. The dependent variable for this study is the level of competence regarding EOL care services.

Research Questions

The research study intended to answer the following overarching research questions:

RQ1: What is the current status of training on EOL care among certified rehabilitation counselors across the U.S.?

RQ2: What is the current status of education on EOL care among certified rehabilitation counselors across the U.S.?

RQ3: Is there an association between rehabilitation counselors' level of death acceptance, attitudes towards euthanasia and their level of EOL competence?

RQ4: Which demographic variables (e.g., age, race/ethnicity, gender, religion, years of experience) best predict EOL competence level?

RQ5: Does EOL knowledge differ among counselors that serve in states where physician-assisted death is legal versus counselors working in states where it is not legal?

Significance of the Study

The significance of this study was to identify the possible need to provide academic and professional development on EOL care services for CRCs. In essence, the study was designed to

evaluate whether current professionals indicate whether they received adequate education or training in order to provide EOL services. As previously stated, the CRC code of ethics provides statues to guide professionals on how to approach EOL care service delivery, yet it is unknown whether education or training has been appropriately provided in order for counselors to attain EOL competencies.

Operational Definitions

Attitudes towards Death: Conceptual response of the person to the various aspects of death (e.g., approach acceptance, fear of death, death avoidance, escape acceptance, and neutral acceptance) which are based on individual psychosocial and cultural experience (Neimeyer, 1994).

Competence: The quality of being competent; adequacy; possession of required skill, knowledge, qualification, or capacity (*The American Heritage Science Dictionary, 2017*).

EOL care: Multidimensional and multidisciplinary physical, emotional, and spiritual care of the patient with terminal illness, including support of family and caregivers. (*"EOL care", 2009*).

*EOL care Education: C*urriculum for undergraduate and graduate students including but not limited to the following: the demographics of aging and dying; the process of dying; loss, mourning, and grief; attitudes toward dying and death; quality of life issues; needs of the dying, their loved ones, and their caregivers; understanding the culture of the medical setting; ethical issues involved; quality of care issues; the importance of ritual at the EOL; gender and diversity issues in EOL care and decision-making; incidence and effects of depression, dementia, and delirium at the EOL; and clinical training in assessment of people at the EOL (American Psychological Association, 2017).

Palliative Care: Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention

and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (World Health Organization, 2017)

PWD: Persons who have a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. (Americans with Disabilities Act, 1990)

Physician-Assisted Death: "Physician assisted death (PAD) means that a physician knowingly and intentionally provides a person with the knowledge or means or both required to end their own lives, including counseling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs. This is sometimes referred to as physician assisted suicide." (Canadian Medical Association, 2014, p. 1)

Terminal Illness: An advanced stage of a disease with an unfavorable prognosis and no known cure. (*"Terminal illness", 2009*)

Assumptions, Limitations, and Delimitations of the Study

The data utilized in this study was comprised of self-reported measures; therefore, it is assumed the participants provided truthful and honest responses. The sample used in the study was also a limitation due to the accessibility of its member base. The organization only allowed access to 1,500 of its members for a period of three months from the time access was granted. Furthermore, the sample provided to the researcher included only 1,500 of its 16,000 members. As such, generalizability was a limitation in this study. Inclusive, social desirability bias may have affected the operation of this study because social and cultural trends can influence how professionals respond to achieve socially favorable responses. Religious, spirituality and cultural biases regarding EOL care was also considered as a possibility of affecting responses. In

addition, the study did not acquire qualitative data and was based solely on quantitative statistical analyses which only determine variance of assignable causation or identify correlations.

First and foremost, delimitations of this study included the chosen sample. The sample did not include individuals who were currently attending academic programs to become certified rehabilitation professionals. The researcher chose the sample because current CRC professionals are actively involved in academia and research which provides insight of the current or potential needs of its professionals. In addition, the EOL Professional Caregiver Survey (Lazenby, Ercolano, Schulman-Green, & McCorkle, 2012) used in the present study is not specifically designed for counselors; however, the survey was generalized to identify academic/knowledge needs of professionals from different disciplines who provided end of life care services. Therefore, the researcher found the survey appropriate to utilize in this study.

Organization of Remaining Chapters

The following sections in Chapter One provide the foundation of the research: an introduction, a purpose statement, and identification of the need for the study. Chapter Two provides a literature review which focuses on previous and current EOL care education and training for professional health caregivers, attitudes toward death in relation to EOL care, the role of CRCs regarding EOL care, and physician assisted-death implications on EOL care. Chapter Three illustrates the methodology of the study, data collection processes, and analyzation of data. Chapter Four provides descriptive and inferential analysis of data. Chapter Five is comprised of the study's findings, determined conclusions, and research implications for the future.

CHAPTER II

LITERATURE REVIEW

The literature review's purpose is to assist the researcher in formulating a solid study via the following methods: bringing clarity and focus to the research problem, improving the researcher methodology, broadening the knowledge base in the chosen research area, and contextualizing research findings (Kumar, 2011). Within this respective literature review, the researcher describes and identifies the theoretical framework utilized to develop content, describe topics directly related to the need for the study, and literature reviewed to assist in providing clarity of the importance in conducting this study. The combination of a conceptual framework and empirical studies is integrated in order to provide support for the nature and focus of this study.

Theoretical Framework

A theoretical framework is an integral foundation in assisting the researcher in discussing two factors (1) discussion of the *research problem* and (2) the *rationale for conducting an investigation of the problem* (Creswell, 2009). EOL care services is a multifaceted and complex topic. Due to the compounding personal, medical, social, and legal complexities, it is imperative to utilize a theory which would appropriately address all aspects involved when addressing EOL care services. The establishment of the theoretical framework assisted the researcher in

identifying and justifying the need to assess rehabilitation counselors' competency when providing EOL care services.

The Ecological Model of Health Behavior (McLeroy, Bibeau, Steckler, & Glanz, 1988) proposes health behaviors (e.g., choosing EOL options) are influenced by beliefs, values, social, and cultural systems. In addition, the theory proposes five determinants which must be evaluated or taken into consideration when reaching certain outcomes regarding choices in health behaviors. The five determinants intermingle with one another in order to produce a specific pattern or choice. McLeroy et al. (1988) identified intrapersonal traits, interpersonal processes, institutional regulations, and community and policy factors as key identifiers of health behaviors. The intrapersonal factors may be defined as characteristics such as knowledge, attitudes, behavior, skills and self-concept. The interpersonal factor refers to the individual's family, friends, colleagues, and other networks which comprise their social support system. At the institutional level, social institutions with formal and informal rules of operations are also considered a factor. Within defined boundaries, relationships among organizations and informal networks form the community factor. Lastly, policy factors such as local, state and federal laws formulate a critical factor in analyzing individual health patterns. The ecological model for health behavior suggests these five factors must be analyzed in order to fully understand behavior patterns.

The Ecological Model of Health Behavior (McLeroy et al., 1988) offers a theoretical framework for categorizing the key factors in CRC's knowledge on EOL care issues. In identifying such factors, we must have resourceful and profound information for developing methods to better prepare our professionals when providing EOL care services. Although the complexities of the human experience may not fully be assessed, this ecological framework

provides a blueprint of what is and what may be. This section presents a categorization and presentation of the key determinants affecting CRC's knowledge on EOL care.

Figure 1 illustrates how the Ecological Model of Health Behavior theoretical structure may be applied when categorizing these five intricate factors and the determinants involved on measuring CRC's knowledge on EOL care services.

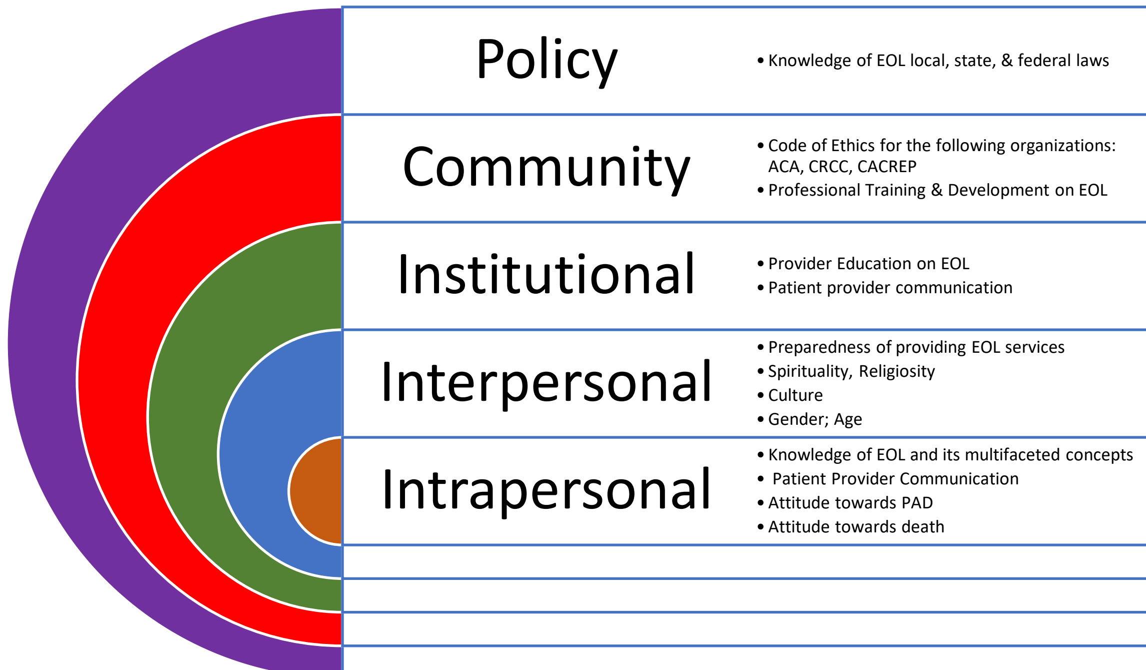

Figure 1: Ecological Model of Health Behavior Application in Identifying Determinants of CRCs

EOL Care Services as Addressed in the American Counseling Association (ACA) and the Commission on Rehabilitation Counselor Certification (CRCC) Codes of Ethics

The need to address EOL options with clients has prompted the discussion of tackling ethical standards that will appropriately guide psychiatrists, psychologists, and counselors when addressing EOL options with their clients. Longevity of life, medical advancements, and accessible treatment have paved the need to discuss long term care and EOL care services for Americans. Due to the aforementioned circumstances, organizations such as the American Counseling Association (ACA) and the Commission on Rehabilitation Counselor Certification

(CRCC) have developed and provided statutes in their respective code of ethics to assist counselors working with clients wanting assistance in learning about their EOL care options.

The ACA is the primary governing body which holds all professional counselors accountable for ethical practice, regardless of whether the professional is a member of the organization (American Counseling Association, 2017). Therefore, professional counselors should be aware of recent and significant changes within the code of ethics. The ACA Code of Ethics is revised every 10 years and first introduced EOL care statues into its ethical professional guidelines in the 2005 revised edition. To begin with, counselors were provided a valuable statute in Standard A.9.b which allowed counselors to decline from assisting clients in exploring the option of physician assisted death ([ACA], 2005). The ACA explained that counselors may not feel comfortable in assisting clients in their exploration of EOL issues and should have the professional option to decline professional assistance as long as the client is referred to a professional that will assist the client in their endeavors.

The most recent ACA Code of Ethics (ACA, 2014) provides guidelines for counselors who are providing services to terminally ill individuals who are considering hastening their own deaths. According to Standard B.2.b, counselors have the option of maintaining confidentiality on these sensitive cases. In such instances, counselors must remain cognizant of applicable laws and the specific circumstances in which counselors should make a professional determination regarding whether confidentiality should be breached based on consultation or supervision received from professional and legal parties. The organization is reinforcing the relevance and importance of the counselor's need to learn about legal and ethical issues on EOL care services.

The ACA's decision to include EOL care ethical guidelines has been described as visionary in terms of leading their constituents to better comprehension of EOL care and,

ultimately, to better serving clients while they are exploring their EOL options. The EOL section is focused on helping terminally ill clients live their ideal quality of life based on their perception; it recognizes the unique needs/desires of an individual to maintain their autonomy while making choices, receiving emotional support, and hopefully, are receiving holistic treatment while still alive (Farber, Egnew, Herman-Bertsch, Taylor, & Guldin, 2003; Gamino & Ritter, 2012; Leclerc, Lessard, Bechenner, Le Gal, Benoit, & Bellerose, 2014). At that point in time, a client's EOL planning will not only affect them, but will also affect their family, caregivers, and community of friends. For this particular reason, the ACA's incorporation of EOL planning provides counselors the foundation to assist in developing and implementing plans that will increase and enhance a client's ability to make decisions and remain as independent as possible before death (Johns, 2006). Needless to say, the new ethical code section makes it evident that professional counselors can play a fundamental role in providing EOL care services for terminally ill clients.

In 2010, the Commission on Rehabilitation Counselor Certification (CRCC) followed suit by developing Section A.9 titled "EOL Care for Terminally Ill Clients.". Much like the ACA's Code of Ethics, the CRCC mandate allows professional CRCs the ability to choose to work or not work with terminally ill clients based on competency concerns (Tarvydas, 2012). In Section A.9, the CRCC Code of Ethics holds counselors responsible for providing or enabling clients to obtain the highest quality of life care by ensuring the following (CRCC, 2010):

- Meeting the client's physical, emotional, social and spiritual needs
- Exercise the highest degree of self-determination or autonomy
- Engage in highest degree of self-determination

- Provide complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf (p. 8)

The CRCC Code of Ethics provides a foundation for professional rehabilitation counselors to adhere to mandates that will appropriately guide them in working with clients exploring EOL options. In addition, it will afford professionals the ability to better serve their clients in this developmental stage of life. The incorporation of EOL care for two major organizations such as the ACA and CRCC supports the need to professionally address competence in this fundamental area.

Rehabilitation Counselor Education

As previously mentioned, CORE had been the organizational entity responsible for oversight of curriculums for future certified rehabilitation counselors. Since 1972, CORE had been ensuring graduate programs across the country met curriculum standards in order to be accredited. CORE provided accreditation to approximately 96 graduate programs aimed to foster enriching learning environments providing essential knowledge to future rehabilitation professionals in hopes of delivering quality service to PWD (CORE: Council on Rehabilitation Education, 2016). On July 20, 2015, CORE and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) announced an organizational merger (*CORE-CACREP Merger Announcement*, 2015). The nature of the merger was described as an action to strengthen the counseling profession via a unified single accreditation body for counselor preparation programs.

On July 1, 2017, all CORE accredited master's level programs were subsumed by CACREP. In addition, all new PhD counseling rehabilitation education graduates were grandfathered into CACREP until January 1, 2018. Furthermore, as of October 2016, CACREP

announced a specialized taskforce was assembled in order to incorporate disability curriculum into its 8 standards. Therefore, it is imperative to examine further the standards which must now be met by all rehabilitation counselor education programs. Upon reviewing the CACREP standards, there does not seem to be any standard directly associated with incorporating EOL content. The standards focus directly on the following: foundations of rehabilitation counseling, advocacy for persons with disability, and continuum care ranging from personal to medical aspects of disability (*CORE-CACREP Merger Announcement*, 2015). As per the theoretical framework organizing this study, CRCs' community factor has organizations (e.g., ACA, CRCC, CACREP) regulating the rehabilitation profession which may seem as incongruent regulation on training priorities. On one hand, we have the ACA and CRCC Code of Ethics implying needed EOL knowledge; however, CACREP has not incorporated this vital dimension into rehabilitation counseling curriculum.

Neukrug (2012) stated all counselors, regardless of specialty, have addressed psychosocial, mental health, addiction, ethics, cultural, familial, and lifespan issues; however, the future of counseling must incorporate adequate training on EOL care services in order to completely become multifaceted experts. CRCs have transferable skills in approaching EOL counseling such as advocacy, case management, and rehabilitation assessment, yet may not possess the adequate training to deliver specific counseling (e.g., grief, EOL) services competently. EOL care services training for rehabilitation counselors has been identified as an overlooked component which needs to be addressed in order for professionals to acquire the competency required to serve PWD whom are choosing to explore their EOL options (Cichy & Leslie, 2017; Glover-Graf, 2012).

CACREP is responsible for providing overarching standards for counselors specializing in various areas such as: rehabilitation, geriatric, addictions, mental health, career and guidance practitioners. When contemplating changing graduate curriculums from 48 to 60 hours, CACREP launched a study to determine pros and cons of extending program length. The survey was sent to counselor educators across the country. An argument to increase the semester hours stated counselor graduate students would have the ability to have more in depth training as opposed to the basics of the profession as found in a 48-semester program (Henriksen Jr. et al., 2008).

Legislation

The passage of Death with Dignity laws has supported the need to discuss EOL care options. Oregon was the first state to pass a Death with Dignity statute and has successfully implemented it for the past twenty-two years (Ganzini, 2017). Not only has it provided a template to build and improve legislation, but Oregon has also paved the way for other states to examine its legislation and implementation of the Death with Dignity Act of 1994 (Steinbrook, 2008; Miller, 2000). Most states that have passed death with dignity laws have utilized Oregon's legislation as a guide to help them successfully pass their own state laws (Ganzini, 2017).

Death with dignity laws do not grant every individual the right to die. Safeguards or statutes have been designed in order to prohibit this law from being abused my patients, practitioners, and family members of patients (Gardner, 2017). An individual must be found mentally competent and must be a state resident with a terminal illness or a confirmed prognosis of having six or fewer months to live. The individual must voluntarily request physician assisted death. By adding a voluntary option to the continuum of EOL care, these laws give patients dignity, control, and peace of mind during their final days with family and loved ones. The

safeguards are attempting to ensure that the patient remains the driving force in their own EOL care decisions (Petrillo et al., 2017).

For health professionals that will be working with individuals requesting PAD, it is vital to know and understand the procedural safeguards that are in place to protect not only the patient but the health professional from legal issues (Campbell, 2017). Once the patient meets the minimal requirements such as: residency status, age limit, and mental competency, the following safeguards are found in most Death with Dignity Acts (Death with Dignity, 2018):

• The patient must make two oral requests to his or her physician, separated by at least 15 days.

• The patient must provide a written request to his or her physician, signed in the presence of two witnesses.

• The prescribing physician and a consulting physician must confirm the diagnosis and prognosis.

• The prescribing physician and a consulting physician must determine whether the patient is capable.

• If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination.

• The prescribing physician must inform the patient of feasible alternatives to DWDA, including comfort care, hospice care, and pain control.

• The prescribing physician must request, but may not require, the patient to notify his or her next-of-kin of the prescription request (p. 10)

The aforementioned safeguards are crucial to health professionals that will be involved in working with persons electing physician assisted death (PAD) as their EOL choice. These safeguards were a pivotal part in providing a favorable outcome in the passage of death with dignity laws. Due to these proactive measures, lawmakers ensured individuals requesting PAD would comply with a thorough and thoughtful process when considering EOL care (Sumner, 2017).

EOL Care Counseling

In 2016, the federal government initiated a 5-year longitudinal study to examine whether EOL care services provided by interdisciplinary teams (e.g., physician, counselors, social worker, and nurses) would result in a "better death" for elderly and terminally ill patients. These services would include the following informational options: advanced directives, pain management, hospice, and counseling. In providing such services, the study aimed to provide baseline data on the need for EOL counseling (Ollove, 2015). The term "*EOL*" may be defined as a developmental phase in an individual's life when imminent death influences daily and future decision and actions (American Psychological Association, 2017). The following aspects of life are typically affected: spiritual/religious, familial, emotional, financial, and legacy. As discussed in the study's theoretical framework, these interpersonal and intrapersonal factors will have direct impact while individuals are presented with their EOL options.

Traditionally, advanced directives, palliative care, and hospice are options provided for terminally ill patients. However, death with dignity laws have been approved in the following states: Oregon, Washington, Vermont, Colorado, District of Columbia, and Hawaii (Death with Dignity, 2018). The death and dignity statutes provide persons with terminal illnesses the ability to elect physician assisted death which includes the right to end their own life.

EOL and PWD

Rehabilitation counselors have been trained to assist persons with disabilities (PWD) to achieve personal, career, and independent living goals. Among counseling professionals, CRCs have been deemed as the leading advocates in bringing political, social, environmental, and cultural change in order to empower PWDs in all aspects of life (Sales, 2012). Traditionally, PWDs have been a marginalized group in our society. When discussing EOL options, healthcare practitioner's direct assessment, treatment, and options information to family member, caregivers, and at times, make the decision themselves (Gelech, Desjardins, Mathews, & Graumans, 2017; Kirkendall, Linton, & Farris, 2016; Pendo, 2015). Due to such circumstances, it is imperative rehabilitation counselors become competent in EOL life issues in order to advocate and navigate through EOL options with their clients.

The need for increased public health approaches and training of professional caregivers in regards to providing EOL care delivery has been identified universally (Etkind, et al., 2017; Tuffrey-Wine, et al., 2015). Reimer-Kirkham, et al., (2016) suggested death is a social issue in which disparity for equal access in dying with dignity exists, specifically for PWD. Kirkendall, Linton, and Farris (2016) examined literature from 2000 to 2014 on EOL decisions for persons with intellectual disabilities. Across the 14 years included in their study, the researchers found 38 articles; only 12 articles focused directly on EOL decision making. Based on their work, the following themes were identified as barriers/challenges when providing adequate EOL option for persons with intellectual disabilities: assumption of lack of capacity, inconsistency in evaluating capacity and communication challenges, and third-party decision.

Emmanuel, Onwuteaka-Philipsen, Urwin, & Cohen (2016) collected 2015 annual physician-assisted death (PAD) patient characteristic information for Oregon, Washington,

Belgium and the Netherlands. The study's results indicated 70% of cases granted were for individuals in the late stages of cancer. Individuals with neurodegenerative, respiratory, cardiovascular, mental or other health disorders accounted for a small percentage of PAD deaths.

A study conducted in the Netherlands after the first year of PAD legalization provided different characteristics of individuals that were granted death with dignity. Snijdewind, Willems, Deliens, Onwuteaka-Philipsen, & Chambaere, (2015) conducted this study and defined the groups as the following (1) somatic conditions (e.g., cancer, cardiovascular diseases, neurologic [physical], pulmonary, rheumatoid, other physical discomfort, or a combination thereof); (2) psychological condition (e.g., psychiatric or psychological condition); (3) somatic and psychological condition (e.g., patients who had both a psychiatric or psychological condition and one of the somatic conditions); (4) cognitive decline (e.g. neurologic [cognitive]); and (5) tired of living with chronic illness (Snijdewind, et al., 2015). As opposed to the previous study mentioned, this study indicated patients with quick cognitive decline as the population with the most granted PAD petitions. Individuals with somatic conditions came in with the second most requested and granted petitions. It is imperative to note patients with mental health disorders had the least requests and least granted petitions in both studies.

EOL care services is currently being addressed in general since death is imminent for all human beings. However, previous research suggests the focus of EOL care options for PWD is still not being addressed due to lack of palliative care led by disability services organizational model (Grindrod & Rumbold, 2017), insufficient collaboration between disability and palliative care services (Friedman, Helm and Woodman, 2012; Stienstra, D'Aubin, & Derksen, 2012) and knowing how to incorporate the patient's fragility or vulnerability (e.g., medical knowledge,

progressive symptoms, declining health) while living with chronic illness and disability (Wagemans, et al., 2013).

EOL and Religion/Spirituality

Perspectives on death tend to be molded by our beliefs systems. Patients' spirituality, religion, beliefs, and practices become integral when coping with imminent death (Balboni & Balboni, 2017). When incorporating spiritual or religious values into EOL care services by healthcare professionals, patients may feel holistic treatment has been provided. The following described empirical studies emphasize the need to address spirituality and religion for terminally ill individuals.

Park, Lim, Newlon, Suresh, and Bliss (2014) conducted a study on dimensions of spirituality and religion and their relation to well-being (e.g., physical, mental, and existential). The study utilized patients (*n* = 111*)* with chronic heart failure and distributed pre-and post-questionnaires over a 3-month period. The patients focused on their religious/spiritual identity, positive religious coping skills, belief in the afterlife, and daily spiritual experiences. The findings suggest spiritual and religious strongly related to existential well-being.

During their stay at an inpatient medical center, 150 patients with advanced cancer were surveyed and reported the following percentages of participants both desired and received spiritual care from their health care providers (67%), religious community (78%), and hospital chaplain (45%) (Pearce, Coan, Herndon, Koenig, & Abernathy, 2012). A subset of participants reported receiving less spiritual care than desired. The patients who received less spiritual care than desired reported more depressive symptoms, less meaningful existence and peace.

Counselors and PAD

Due to the safeguards enacted in death with dignity laws, certified professional counselors are an integral part of the process when a chronically/terminally ill patient elects to end their own life (Case, Blackwell, & Sprong, 2016). In all death with dignity laws, a psychiatrist or psychologist must deem the patient as mentally competent in order to even be approved when requesting PAD (Quill, 2012). In addition, cases where the client is either considering suicide or requesting help in seeking a physician-assisted death, the counselor may work with the client in discussing values, spiritual issues, and relational consequences of an EOL decision (Westefeld et al., 2013). The counselor must be cautious not to breach legal and ethical obligations in order to provide the client the right to have autonomy and freedom to choose their EOL care (Case et al., 2016). Due to these intricate and delicate professional obligations, it is essential for the counseling community to better understand the topic of physician assisted death.

Ethical Dilemmas

In order to understand the delicacy of the counselor role and the potential ethical dilemmas, we must delve into the foundation of counselor ethics that may collide when working with individuals requesting physician assisted death. Fulmer (2014) identified the following five ethical principles: autonomy, non-maleficence, beneficence, fidelity and justice as the main ethical standards that practitioners should follow when developing their strategies to assist persons wishing to receive assistance in dying. Due to the sensitive nature of PAD, counseling professionals find themselves in situations where ethics collide not only with their own personal views, but also with perspectives of the client and their families (Case et al., 2016). All EOL choices and medical decisions have complex psychosocial components, ramifications, and

consequences that have a direct impact on the client's EOL planning experience (Behuniak, 2011).

EOL Care Professional Caregiving Training and Education

With the passage of death with dignity laws, EOL care services delivery has become a focal point on the need to educate and train multi-disciplinary professionals such as physicians, nurses, psychologists, counselors, and social workers that may potentially provide services to clients exploring EOL care options. Interestingly, these professions have unanimously identified the lack of EOL care curriculum and professional training (Giezendanner, et al., 2017; Gillan, van Der Riet, & Joeng, 2014; Perez, et al., 2015; Weisbrod, Carroll, O' Connor, & Quill, 2017). A unique commonality among the studies sheds light on the little that is known about the type of education or training that has been afforded to these practitioners.

Horowitz, Gramling, and Quill (2014) examined the incorporation of EOL education for medical students across different universities in the U.S. As of 2000, the mandate known as Liaison Committee on Medical Education implemented a directive in all U.S. medical schools to include EOL curricula. Ironically, the study's sample (*n* = 51), reported a huge discrepancy on how this mandate is incorporated which produced a wide discrepancy of curriculum formats which ranged from 2 hours of coursework to weeks of palliative/hospice clinical rotations. The researchers suggested even after implementing a mandate, quantifiable data is not known as to the type, amount, and or delivery of EOL knowledge for future medical professionals. Giezendanner, et al., (2017) conducted a study in Switzerland assessed essential EOL competencies in physicians. In their respective study, results indicated physicians needed more training in their curriculum from the current 14.5 hours of coursework out of the 40-hour recommendations by the European Palliative Care Associations.

The lack on EOL curriculum within the nursing undergraduate education mirrors the experience of physicians' educational experiences. Gillan, van Der Riet, and Joeng (2014) performed a review of the literature on publications specifically identifying preparation of nursing students on EOL knowledge. The researches extensively reviewed publications via various search engines (e.g., Mosby's Index, Scopus, Eric) for the following years ranging from 1984 to 2012. Only 18 publications were identified as assessing EOL curriculum for nursing students. Within this review, a publication by Wells, et al., (2003) indicated that out of 311 nursing programs, only 3% incorporated EOL content into the curriculum. For nursing programs incorporating EOL content, a study yielded 14 hours or less was implemented into coursework (Dickinson, Clark & Sque, 2008).

After an exhaustive review of the literature, no further information was found to report or examine the EOL curricula in the following disciplines and its practitioners: psychologists, counseling, and social work. Most importantly, the aforementioned research for EOL education and training for physicians and nursing is sparse. With the lack of information found to report on the quantity and quality of EOL education and training in these respective disciplines may indicate the need to further investigate how EOL competence is being addressed by educational institutions.

Attitudes towards Euthanasia and PAD

Other than education or training, other factors such as the attitudes towards euthanasia and physician-assisted death (PAD) may influence a professional caregiver's willingness to learn and address EOL care services. First of all, it is essential to address the difference between euthanasia and PAD. Radbruch, et al., (2016) determined the distinction between these two concepts by stating euthanasia entails a physician takes an active role in "killing" the person

upon the patient's request while PAD is referred to aiding the person in ending their own life by providing prescription drugs. The importance of deciphering the two may influence professional caregivers on their attitudes in participating in either domain based on their personal, psychological, spiritual, social, cultural, economic and other sociodemographic factors.

A study conducted in New Zealand examined doctors' and nurses' view on legalizing PAD. The results indicated 37% of doctors (n = 298) and 67% of nurses (n = 474) were supportive of PAD legalization. Qualitative themes were extracted from professionals' recorded responses as to why they would not support PAD legalization. Wilson, Oliver and Malpas (2018) reported respondents provided the following barriers for not supporting PAD: moral or ethical objections, professionals' caregivers may perform involuntary euthanasia, and the spiritual belief that there is value in suffering. Additionally, the researchers also acquired qualitative data for this study. One of the participants, a doctor, provided this response based on his moral beliefs:

> The taking of a person's life is a conflict to me; therefore, if the person is able to be set up to take their own life by administering it to themselves that would be preferable to me. (Wilson, Oliver, & Malpas, 2018, p. 19).

In the following example, a physician provides his response of not wanting to engage in PAD due to the social pressures/judgement placed on physicians that do participate in providing these types of services:

> That the uninformed, uneducated masses will rise to their soapboxes, on the internet, the press and various other media and spread misinformation and fear throughout the general public. Otherwise, I feel we are capable of legislating and implementing a

> secure, safe, ethical, auditable system to provide legal assisted death (Wilson, Oliver & Malpas, 2018, p. 21).

The quotes provided by experienced physicians affirm that professionals' caregivers may be either resistant or accepting of assisting with aiding someone end their life contingent upon the context on whether the action is considered euthanasia or PAD.

Coincidentally, a national study in Canada surveyed psychiatrists' views on providing PAD services to individuals with mental disorders. The sample (*n* = 528) providing interesting findings in regards to providing PAD to individuals with mental health disabilities. Rousseau, et al., (2017) reported 72% psychiatrists would provide PAD services to individuals under general circumstances; however, only 29% would provide services if the individual was diagnosed with a mental health disorder. Much like their physician counterparts, psychiatrists also thematically reported moral objections as a barrier to providing PAD to persons with mental health disorders.

A study conducted in the U.S. at a major academic hospital setting provided results where terminology (euthanasia, PAD) did not have an influence on whether the health care professional would participate in providing these types of EOL care options. The sample (*n* = 221) largely consisted of physician clinicians, researchers, nonclinical staff, and non-practicing physicians. The design of the study provided the participants three scenarios of individuals requesting PAD; therefore, the participant first had to decipher whether it would be legal to provide PAD services and then, support their stance on the legality of the issues with citations provided for them. Interestingly, the sample did prefer to use the term euthanasia when providing services to a person that was deemed incompetent while preferring to use the term *physician-assisted death* when providing these services for an individual deemed competent (Braverman, et al., 2017). Responses in rationale for support of providing services included: providing autonomy (right to

die), monetary savings for the healthcare system, acceptance of death and mercy. Once again, nonsupport for the provision of PAD services were related to: killing patients and suicide is wrong, religious views, slippery slope argument, and palliative care is sufficient to provide comfort until death.

As previously mentioned, other demographic factors may have an influence on whether or not healthcare professionals will affect their perspective on PAD services. Sociodemographic factors being considered for influencing the support or non-support of euthanasia or PAD are the following: age, gender, religion, ethnicity, and geographical setting of healthcare professionals. Tomlinson and Stott (2014) conducted a systematic literature review of publications from 1992 to August 2013. The focal points were to assess attitudes of health professionals, patients, caregivers, and the factors associated with supporting or not supporting PAD for patients with dementia. The researchers indicated age, ethnicity, gender and religion provide varied responses of on their attitudes towards assisted aid in dying for persons with dementia. For example, van Tol, et al. (2010) conducted a study to identify factors that would influence physicians to grant euthanasia requests. Out of their sample (n = 115), age was not an indicator in predicting physician's attitude toward assisted death.

Death Anxiety and Acceptance

As part of Western culture, the topic of death is rarely discussed even though death is imminent for all individuals. In discussing death, individuals become acutely aware of their own mortality. Due to the complex and uncomfortable feelings related to death, the concept of death anxiety has been identified as a prominent source of discomfort, avoidance, and dread when discussing or attempting to explore EOL options. Iverach, Menzies, and Menzies (2014) defined death anxiety as a normal human experience, which may cause paralyzing fear that influences

thoughts, feelings and behaviors. Therefore, professional caregivers may also be reluctant to explore EOL options with their patients depending on their level of death anxiety. Nia, Lehto, Ebadi, and Peyrovi (2016) stated health care providers frequently experience death anxiety which may lead to negative attitudes when providing services for terminally ill patients and their families.

On the other hand, the concept of death acceptance suggests individuals, at some point, will come to terms with the realization death is imminent and once it is accepted, the individual's anxiety will decrease allowing them to prepare for EOL. Wong, Carreno, and Gongora (In press) suggest individuals with spiritual or deeply religious roots that view death as transcendental or gateway to an immortal or positive view of the afterlife formulate a concept known as approach acceptance. For the purposes of this study, the researcher will focus on literature available that focused on death acceptance as an approach to death.

In a qualitative study, the relationship between personal attitudes towards death and communication with terminally ill clients among oncology professionals was explored. The study provided semi-structured guided by an extensive literature review focusing on the following topic: death anxiety as experienced by clinicians, EOL communication and experiences, reactions, and coping with patient death. Rodenbach, et al. (2016) reported the following three themes for death acceptance: full, conditional, or non-acceptance. Most of the respondents fell in the conditional acceptance group which indicated the individuals were accepting of death in a conceptual and intellectual capacity; however, they would not know how they would react if faced with chronic or terminal illness. Furthermore, most clinicians reported a secure belief system (e.g., religion, spiritual) that allowed them to cope with death and

mortality. As per the qualitative study, approach acceptance may allow professionals to effectively communicate with terminally ill patients, but may also lead to better services.

Geographical Location

Currently, only eight states have Death with Dignity Laws. Based on political perspectives, states that have Death with Dignity laws are considered liberal. Interestingly, Montana is the only conservative state where physician assisted death is legal by court, but does not have a death with dignity statute. For this study's purpose, the nominal variable state was collapsed into a dichotomous variable (e.g., legal, illegal).

Political views have long been influenced by moral convictions which often lead to debates causing conflict between moral visions (Skitka & Morgan, 2014). The passage of death with dignity statutes provide a global debate on the need for the inclusion of these services as part of EOL care services. Depending on where a health care professional resides, political ideologies have directly influenced whether EOL care services, specifically physician assisted death education or training are relevant or necessary to practice.

Bulmer, Böhnke, and Lewis (2017) examined individual differences that predicted moral sentiment on physician-assisted death. The researchers focused on the following predictor variables: religion/religiosity, political ideology, authoritarianism, and personality. For the variable political ideology, the respondents were asked how they would rate themselves politically. The answer selections were based on a seven-point Likert scale ranging from *extremely conservative* (1) *to extremely liberal* (2). After conducting an ordinal logistic regression, political ideology was reported as a significant contributor in predicting the support for physician-assisted suicide. Studies examining PAD knowledge based on geographic locations were not found during the literature review process.

Sociodemographic Factors and EOL Care Knowledge

Interpersonal factors such as age, religion, race and ethnicity should be examined to identify whether they play a role in the individual's attitude toward EOL education and didactic experiences. The following are studies providing information on interpersonal factors and how some of these factors have contributed to individual's perception of EOL knowledge.

A web-based survey was disseminated among resident physicians from a single academic institution. The participants must have completed at least one dedicated intensive care unit (ICU) rotation. The researchers intended to examine interpersonal factors such as religion, gender, ethnicity, years of training, and importance of religion and their impact on student's attitudes towards PAD and experiences of residents regards EOL education during their ICU training. The study's sample (*n* = 162), in general, agreed that more education was needed not only to feel more confident in providing EOL services, but to achieve competence as well. Interestingly, females reported having a more positive outlook on EOL education received in the ICU versus their male counterparts. Chen, et al., (2016) conducted a stepwise multiple regression to determine which interpersonal predictors explained EOL education. The results reported none of the predictors (e.g., gender, ethnicity, years of training, and importance of religion) were found to be significant in the model.

A study conducted by Lippe and Becker (2015) assessed learning outcomes on perceived EOL competence after conducting a simulation educational intervention for nursing students. The participants were placed into three cohorts with the following respective sample size: Cohort 1 (*n* = 19), Cohort 2 (*n* = 53), and Cohort 3 (*n* = 56). A pre-test and post-test design was utilized to measure potential changes in EOL perceived competence. Gender, race, and program (e.g., traditional BSN, ADN-BSN) were identified as variables. The students were provided

orientation, education, and discussion in relevance to EOL care after taking the pretest. Then, a simulation exercise was conducted for each cohort where students had to care for a terminally ill patient. After the simulation exercise, the instructors and student debriefed on the exercise and provided feedback. All cohorts were then asked to take a posttest in order to measure perceived EOL competence. Gender and ethnicity differences were not found to be statistically significant on perceived EOL competence.

A cross sectional design study examined nurses' knowledge regarding advanced directives and perceived confidence in EOL care. A sample of 1089 nurses in the U.S., Hong Kong, Israel, Italy, and Ireland comprised the demographic composition. The following demographic information was collected: age, gender, specific discipline, professional experience, and practice area. Based on Chi-squared tests, the following sociodemographic variables were correlated with knowledge of advanced directives: age ($p < .01$), gender, ($p = .004$), years of professional experience ($p < .01$), and area of practice ($p = .047$). When comparing means between advanced directive competence and EOL confidence, Coffrey, et al., (2016) reported that the sociodemographic factors age (older) and years of professional experience (more years of practice) contributed to nurses felt more confident in delivering EOL care services than their younger and less experienced counterparts.

Chow, Wong, Chan, and Chung (2014) contributed to the literature by exploring nursing students' clinical experience, knowledge, attitude, and perceived competency towards EOL care. A sample of 253 students were grouped into three clusters to compare means. The main focus of the study was to identify whether there would be differences in the aforementioned domains contingent upon heterogenous samples. Clusters were formulated by type of nursing program (e.g., bachelor, high school program). Due to the availability of sociodemographic information,

the researchers conducted further analysis with the variable gender. Results were inconclusive in determining whether there is a significant association in perceived competency and attitude in EOL care and gender.

A study in Australia with a sample of 87 third-year nursing students participated in exploring attitudes, knowledge, experience and education concerning EOL care (Adesina, Debellis, and Zannettino, 2014). The study utilized a mixed-methods approached acquiring quantitative and qualitative data. The sample composition consisted of nursing students that were in their final year of the program and had already successfully completed clinical rotations. Adesina, Debellis, and Zannettino (2014) provided the following qualitative themes: the importance of values and beliefs, personal and professional experience, and education and knowledge as the variables in which students identified as a factor for determining feelings of EOL competency. In relevance to values and beliefs, regardless of having a set belief system (e.g., religion, spirituality, atheism), the study suggested the respondents identified it was essential to delve into their own personal beliefs in order to accept death. The theme of personal and professional experience identified students that having professional experience providing EOL care did not increase the feeling of competency; however, having personal experience with death contributed to a positive experience in providing services. Lastly, the qualitative data suggested education and knowledge acquired in the nursing program had taught the students the concepts of self-determination and advocacy. The following response was provided by a student when expressing the acquired EOL care knowledge while in the program: "I have learnt how important it is to not impose my beliefs upon patients, but rather to try and be accepting and accommodate the needs of my patients, even though I personally may not agree" (Adesina, Debellis, & Zannettino, 2014, p. 399).

Generational Groups

A generation is a collective identity for individuals categorized by age interval, special life events, and commonality of a lifespan development stage. According to Rampton (2017), it is imperative to understand generational differences within the workforce in order to accommodate their needs, motivation, continuing education and training. In this study, the predictor continuous variable age was collapsed into the following categories: Millennial (18-34), Gen X (35-46), Boomer I (47-56), Boomer II (57-65), and Silent (66-74) years of age.

In a conceptual paper, Phillips (2016) states the nursing profession should collectively work together and address generational differences in order to produce an effective and strong nursing workforce. The author mentions in bridging the different needs of these generations, the profession will produce an integrative passing of knowledge and skills by mentoring the younger generations by seasoned professionals in areas of leadership, experiential knowledge, and management skills. The author suggests the following five domains to consider when assessing generational differences between a professional workforce: communication, motivation, commitment and individual differences.

In the medical profession, the need to address and educate the next generation of physicians is imminent. Boysen, Dosten, and Northern (2016) state that the current composition of medical physicians will soon be comprised of five coexisting generations; however, the Millennial generation will soon predominate the workforce and already accounts for 100% of physician resident interns. Therefore, the researchers suggest exploring generational characteristics and customize learning material to generational needs and interests. The overall suggestion for this conceptual framework was to employ mentoring programs which would

engage all generations in order to maximize generational characteristics in hopes of a skilled and strong workforce.

Expected Outcomes of the Study

The expected outcomes for this study were designed to assess the current status of education and training and whether CRCs would identify the need for professional development on EOL care competencies. In addition, it was expected the results would find a correlation between two independent variables (e.g., attitudes towards death – approach acceptance, attitudes towards euthanasia) and their level of EOL competence. The results of the study may provide evidenced based knowledge and research indicating the need to educate current and future certified rehabilitation counselors on how death perspectives affect our EOL choices. Another expected outcome is to determine whether demographic variables (e.g., age, gender, race, religion, spirituality, years of professional experience, state of employment) can predict level of EOL competency.

CHAPTER III

METHODOLOGY

The methodology chapter describes the rationale utilized when applying specific procedures to identify, obtain, and analyze information in order to address the research problem. Furthermore, the chapter discusses the sample selected to participate in this study, the instruments used to acquire specific information, the procedure utilized to collect data, and the methods of data analysis. The purpose of this study was to assess the educational needs of rehabilitation counselors in order to improve academic curriculums which will train our professionals in adequately addressing EOL care services. Specifically, the study examined the current status of self-reported education and training which will provide baseline information on how CRCs currently identify the need for EOL training. The following are the research questions addressed in this study:

RQ1: What is the current status of training on EOL care among certified rehabilitation counselors across the U.S.?

RQ2: What is the current status of education on EOL care among certified rehabilitation counselors across the U.S.?

RQ3: Is there an association between rehabilitation counselors' level of death acceptance, their attitude towards euthanasia and their level of EOL competence?

RQ4: Which demographic variables (age, race, gender, religion, years of experience) best predict EOL competence level?

RQ5: Does EOL knowledge differ among counselors that serve in states where physician-assisted death is legal versus counselors working in states where it is not legal?

The research design for this study was a non-experimental, exploratory study examining certified rehabilitation counselors' self-perceived competence in facilitating EOL care services. The study assessed the following nine independent variables: acceptance approach towards death, age, race, gender, religion, spirituality, years of professional experience, state of employment and level of attitude towards euthanasia. The dependent variable for this study is the level of competence regarding EOL care services.

Sample and Selection

Participants for this study were recruited through the Commission on Rehabilitation Counselor Certification which is the largest rehabilitation counseling organization for certified rehabilitation counselors. The organization continually strives to have its members dedicate themselves in improving the lives of PWD. Currently, the CRCC has 16,000 certified members across the United States. For the purposes of this study, 1,500 members across the U.S. were solicited in hopes of providing a reflective representation of practicing CRCs in various regions. Participants were required to be 18 years of age and be an active member in CRCC.

A power analysis was conducted utilizing the GPower 3.1 (Buchner, Erdfelder, & Faul, 1997) in order to anticipate the number of participants needed to obtain a large effect size and a desired power of .80. The power analysis indicated a minimum of 270 participants were needed to attain the desired power and large effect size. In addition, when social science researchers

conduct multiple regression for research questions, it is recommended the ratio of N (number of cases) to k (number of predictors) has to be substantial for regression analysis to provide believable results (Warner, 2013). Tabachnick and Fidell (2007) suggested the following power analysis based on the work produced by Green (1991) which state the larger of the two minimums in *N*s of the following equations should be used: $N > 50 + 8k$ for test of multiple R or $N > 104 + k$. This research study includes 9 predictor variables; therefore, a minimum of 122 participants would be deemed sufficient to equate scientific value to this respective study.

Procedure

The researcher obtained Institutional Review Board (IRB) approval from the designated university. Upon obtaining the IRB approval, the principal researcher submitted documentation along with formal application of the Commission on Rehabilitation Counselor Certification ("*Application*", 2016). Upon approval from CRCC, a list of 1,500 emails were provided to the researcher. Using Qualtrics software, participants were emailed and notified of the opportunity to participate in the study. Once the link was opened, the participant was provided the following information: the purpose of the study, a statement ensuring confidentiality and anonymity of their participation, and advised their participation was completely voluntary. The researcher also expressed all data would be analyzed in aggregate and remain anonymous. Participants were informed the online survey would take approximately 10-15 minutes to complete. In addition, the participants were provided the opportunity to complete the survey in more than one sitting; they could log off and then reopen the survey until completed. The online survey contents included the following: an informed consent, demographic questionnaire, the *EOL Professional Caregiver Survey*, the *Death Attitude Profile-R Approach Acceptance Subscale*, and the *Attitudes Towards Euthanasia Scale*.

The researcher provided the participants three weeks to begin and complete the survey. After the initial launch, the researcher provided a friendly reminder to participants of the approaching deadline to complete the survey on a weekly basis. The survey was available from August to October 2017. Upon the completion of the survey, participants were offered the opportunity to be entered into a raffle for a chance to win one of four $50 gift cards. The participants were informed that recipients of the gift card drawing would be notified upon the completion of the study. Participants were also informed raffle entries were completely voluntary and anonymous as well.

Instrumentation

EOL Professional Caregiver Survey (EPCS)

The *End-of-Life Professional Caregiver Survey* (Lazenby, Ercolano, Schulman-Green, & McCorkle, 2012) is a self-report assessment measuring specifically the palliative and EOL care specific educational needs of multidisciplinary professionals. The validity of the instrument was tested by its distribution among different disciplines (e.g., physician, social workers, nurses) and after an exploratory factor analysis was conducted the instrument yielded a Cronbach $\alpha > .70$. In addition, the three aforementioned factors resulted with an internal reliability α .96 (Lazenby, et. al, 2012). Therefore, the survey is psychometrically sound to be distributed as a single scale among professionals to measure EOL educational needs or competencies. The survey is comprised of 28 items with the following three domains: patient & family centered communication (12 items), cultural and ethical values (8 items) and effective care delivery (8 items). The survey is constructed based on a 4-point Likert scale range as the following: *Not at all* (0), *A little bit* (1), *Somewhat* (2), *Quite a bit* (3), and *Very much* (4). The survey yields a single score by totaling the responses. The possible total score ranges from 0 to 128. A higher

score indicates greater self-perceived competency on EOL care. The following statements are examples from the EPCS:

- I am able to set goals for care with patients and families.
- I am comfortable helping to resolve difficult family conflicts about EOL care.
- I can address spiritual issues with patients and their families am able to be present with dying patients.
- I am able to be present with dying patients.
- I feel confident addressing requests for assisted suicide.
- I am effective at helping to maintain continuity across care settings.

Death Attitude Profile-Revised (DAP-R)

The *Death Attitude Profile – Revised* (Wong, Rekker, & Gesser, 1994) is a questionnaire used to assess the following attitudes towards death: fear of death, death avoidance, neutral acceptance, approach acceptance, and escape acceptance. The 36-item DAP–R was subjected to principal-components factor analysis and was found consistent with the theoretical formulation. Five components were extracted and rotated to an orthogonal (varimax) solution. The five components accounted for 63.1% of the variance as follows: Approach acceptance (29.5%), Neutral Acceptance (13.8%), Fear of Death (8.5%), Escape Acceptance (6.0%), and Neutral Acceptance plus one Escape Acceptance Item (5.3%) (Wong, et al., 1994). The loading factors were restructured which resulted in the 32 item DAP-R with the aforementioned dimensions.

In order to establish internal reliability, the researchers conducted a four-week test-retest trial. After the four-week test-retest trial, the following ranges of Alpha coefficients for internal consistency were found for each respective subscale: *Fear of Death* = .86 to .71, *Death Avoidance* .88 to .61, *Neutral Acceptance* .65 to .64 *Approach Acceptance* .97 to .95, *Escape*

Acceptance .84 to .83 (Wong, et al., 1994). As a whole, the DAP–R scales have good to very good reliability.

The *Approach Acceptance Subscale* primarily measures an individual's attitude towards death based on their belief of happiness in the afterlife. The researchers chose to construct this dimension based on previous literature which suggests people show less fear of death when they have strong religious beliefs of having a better life after death. The Approach Acceptance Subscale is comprised of 10 items documented by a Likert scale coded as: 1) *Strongly Agree*, 2) *Disagree*, 3) *Moderately Disagree,* 4) *Undecided,* 5) *Moderately Agree,* 6) *Agree*, and 7) *Strongly Disagree*. In addition, the following numbered questions comprise the subscale: 4, 8, 13, 15, 16, 22, 25, 27, 28, and 31. In order to score the subscale, a mean scale score is computed by dividing the total scale score by the number of items forming each scale. The following are sample statements of the Acceptance Approach Subscale:

- Death brings the promise of a new and glorious life.
- I look forward to a life after death.
- Death offers a wonderful release of the soul.
- Death is an entrance to a place of ultimate satisfaction.

For this research study, the Approach Acceptance Subscale will be utilized. In addition, sparse research has been conducted to apply the subscale of approaching death with acceptance. The researcher intends to focus on this dimension in order to assess if there is a correlation between death acceptance approach and attitudes towards euthanasia.

Attitudes Towards Euthanasia (ATE) Scale

The *Attitudes Towards Euthanasia Scale* was developed by Wasserman, Clair, and Ritchey (2005) with the following theoretical considerations: a scale was needed to properly

delineate between active and passive euthanasia, address patient and doctor autonomy on decision-making, and whether the respondent approves of euthanasia when considering chronic pain and illness. The ATE scale is a 10-item self-report assessment which measures attitudes towards euthanasia by the evaluating the following dimensions: the medical condition (e.g., severe pain or no recovery), the locus of decision-making (e.g., patient's request or doctor's authority), and the method of administration (e.g., actively ending the patient's life or withdrawing life support).

After conducting a confirmatory analysis, internal consistency was established with a Cronbach's alpha = .871 with item to scale correlations ranging from .578 to .821 (Wasserman, Clair, & Ritchey, 2005). Construct external consistency was established by correlating the scale with other predictors such as race and spirituality (Aghababaei & Wasserman, 2013; Aghabababei, Hatami, & Rostami, 2011).   The scale is constructed based on a 5-point Likert scale range as the following: *Strongly Disagree* (1), *Disagree* (2), *Undecided* (3), *Agree* (4), and *Strongly Agree* (5). The possible score ranges from 0 to 5. The scores indicate the following: 5 = strong support for euthanasia, 3 = neutral, and 1 = strong opposition to euthanasia.. The following are examples from the ATE Scale:

- If a patient in severe pain requests it, a doctor should remove life support and allow that patient to die.
- If a dying patient requests it, a doctor should prescribe enough medicine to end their life.
- If a patient in severe pain requests it, a doctor should prescribe that patient enough medicine to end their life.

Data Analysis

To examine the five research questions, a combination of descriptive and inferential analysis, two simultaneous regressions, and an independent samples *t-test* were utilized to analyze survey data. Descriptive statistics provided the mean, standard deviation, and frequencies for both dependent and independent variables.

In order to address research questions one and two, exploratory data analysis provided graphical illustrations to assess the current status of education and training on EOL care for rehabilitation counselors. The use of frequencies and percentages provided descriptive data to assess the current status of education and training on EOL care as per participant responses to the following questions included in the demographic section:

1. Did you take coursework on how to address EOL care?
2. Have you participated in EOL care training? (e.g., seminars, conferences)
3. Have you worked with clients requesting EOL care services?
4. How do you rate your knowledge on addressing EOL care?
5. Do you feel CRC professionals need more training on EOL care?

Questions 1, 2, and 3 were assessed by categorical dichotomous responses coded 1 = Yes and 2 = No. The frequency and percentages of these responses were displayed based on the self-reported responses provided by the participants. Question 4 provided a Likert scale response coded as the following (1) *Extremely competent*, (2) *Somewhat competent,* (3) *Neither competent or incompetent,* (4) *Somewhat incompetent,* and (5*) Extremely incompetent.* The frequency and percentages of these responses were displayed by based on self-reported responses provided by the participants. Lastly, question 5 also provided a Likert scale response coded as the following

(1) *Strongly agree*, (2) *Somewhat agree*, (3) *Neither agree or disagree*, (4) *Somewhat disagree,* and (5) *Strongly disagree*.

In order to adequately address research questions 3 and 4, a simultaneous multiple regression was indicated. For research question 3, the level of acceptance approach towards death measured by the DAP-R Approach Acceptance Subscale and the level of attitude towards euthanasia measure by the ATE scale were utilized as predictor variables while the level of EOL knowledge measured by the EPCS was used as the criterion variable. For research question 4, the following were used as predictor variables: age, race, gender, religion, spirituality, years of professional experience and state of employment while the level of EOL knowledge was used at the criterion variable.

In order to properly assess the best-model fit, the following eight assumptions were met in order to conduct the simultaneous regression for questions 3 and 4. The following were the eight assumptions met (1) one continuous dependent variable,(2) two or more independent variables that are measured on either continuous or nominal scale, (3) independence of observations, (4) a linear relationship between (a) the dependent variable and each of your independent variables, and (b) the dependent variable and the independent variables collectively, (5) homoscedasticity of residuals, (6) no multicollinearity, (7) no significant outliers, (8) and residuals were normally distributed (Laerd, 2015).

Lastly, an independent samples *t-test* was used in order to examine research question 5. The dependent variable is the level of EOL knowledge which is measured by the EPCS which produces a single score. The higher the score reflects a higher degree of knowledge as per self-reported responses. The independent variable was a categorical dichotomous which was

dependent on the respondents' state of employment. Participants were divided into the following two categories: (1) PAD legal and (2) PAD not legal.

In order to successfully conduct the *t*-test for this respective question, the following six assumptions were met (1) one dependent variable measured at the continuous level, (2) one independent variable that consists of two or more categorical independent groups, (3) independence of observations, (4) no significant outliers, (5) normality of distribution, and (6) homogeneity of variance (Huck, 2012). In summary, the methodology of this research study is a quantitative survey design. This chapter has described the participants, procedures, instruments, research design, and the data analysis used to complete the study.

CHAPTER IV

RESULTS

Chapter IV will present the results of the analyses conducted in order of the respective research questions. In order to provide specific and supportive value to the analyses, the researcher will provide visual aids (e.g., charts, graphs) to supplement the statistical language of the results. In addition, sample composition, descriptive statistics, and inferential statistics will be utilized to address research questions. The following analyses were utilized in this study: one simultaneous multiple regression (1), one stepwise multiple linear regression (1), one-way analysis of variance (ANOVA) (2), and two *t*-tests (2). The purpose of this chapter is to specifically provide the results of each statistical analyses applied to each research question; however, the interpretation of these results will be further discussed in Chapter V.

Preliminary Data Screening

The Qualtrics link was sent to one thousand five hundred individuals registered from the CRCC database. Originally, two hundred twenty-two (222) respondents opened the Qualtrics link, and consented to take the survey. By utilizing the following formula $\frac{\#\ of\ survey\ responses\ received}{\#\ of\ surveys\ sent}\ x\ 100$, a response rate of 14.8% was calculated. The researcher reviewed the submitted responses, then proceeded to assess missing data, normality of distribution, and check for potential outliers. After reviewing the raw data, cases in which the

participants did not complete more than 20% of the survey were deemed incomplete and removed. After this screening, twenty-five cases were removed. As part of the eligibility criteria to participate in this research study, the participants had to identify themselves as certified rehabilitation counselors. Five cases were deemed not eligible due to the participant criteria and were removed from the raw data. Four individuals chose to participate, but did not provide consent and were removed from the data set. After the initial screening for missing data, a total of 188 cases were retained for further analyses.

The dependent variable in this study is the End of Life Professional Caregiver (EPCS) survey. The survey was developed to be distributed to samples in health care professions with the intention of assessing healthcare professionals' self-reported perception of their knowledge about end of life care services. Therefore, the researcher conducted a reliability analysis to assess the appropriateness of the instrument's dissemination to this sample. The reliability analysis indicated the EPCS with this sample yielded Cronbach $\alpha = .967$. According to Tavakol and Dennick (2011), a Cronbach's $\alpha \geq .90$ indicates excellent internal consistency.

The researcher then proceeded to assess normality of distribution for the scores on the dependent variable, the End of Life Professional Caregiver Survey (EPCS). Testing the normality of the scores included interpreting descriptive statistics based on mean and 5% trimmed mean, assessing the Kolmogorov-Smirnov statistic, and checking for outliers utilizing a histogram and boxplot. After executing the descriptives explore analysis, the descriptives table provides the mean and 5% trimmed mean of the cases. The 5% trimmed mean is calculated by removing the top and bottom 5% of cases in order to calculate a new mean. The purpose of this is to compare the original mean and the new computed mean in order to identify whether extreme scores are having a strong influence on the mean. If the values do not vary greatly, this

indicates the extreme scores are not having a strong influence on the mean and further indicates normality of distribution (Pallant, 2013). For this study, the original mean is 87.67 while the 5% trimmed mean is 87.93. Therefore, the mean and trimmed mean indicate extreme scores are not strongly influencing scores.

According to Pallant (2013), Tests of Normality examine whether the data is well modeled by a normal distribution. It is essential to test this assumption in order to be able to conduct parametric analyses. In order to assess the normality, you must attain the Kolmogrov-Smirnov statistic. The Kolmogrov-Smirnov statistic must obtain a non-significant result (e.g., $p > .05$) in order to attain a normality of the distribution of scores. Our sample yielded a statistic of $p < .001$ which indicates the assumption of normality has been violated. In order to attain a normal distribution, a square root transformation was conducted. Once the transformation was conducted, the Kolmogrov-Smirnov reported a non-significance at .20. To further assess the normality of distribution among the dependent variable, the researcher inspected a Histogram to visually assess the distribution of scores. Figure 2 displays the Normal Q-Q plot inspected to support the histogram provided in Figure 3 in order to comprehensively assess the distribution of EPCS scores.

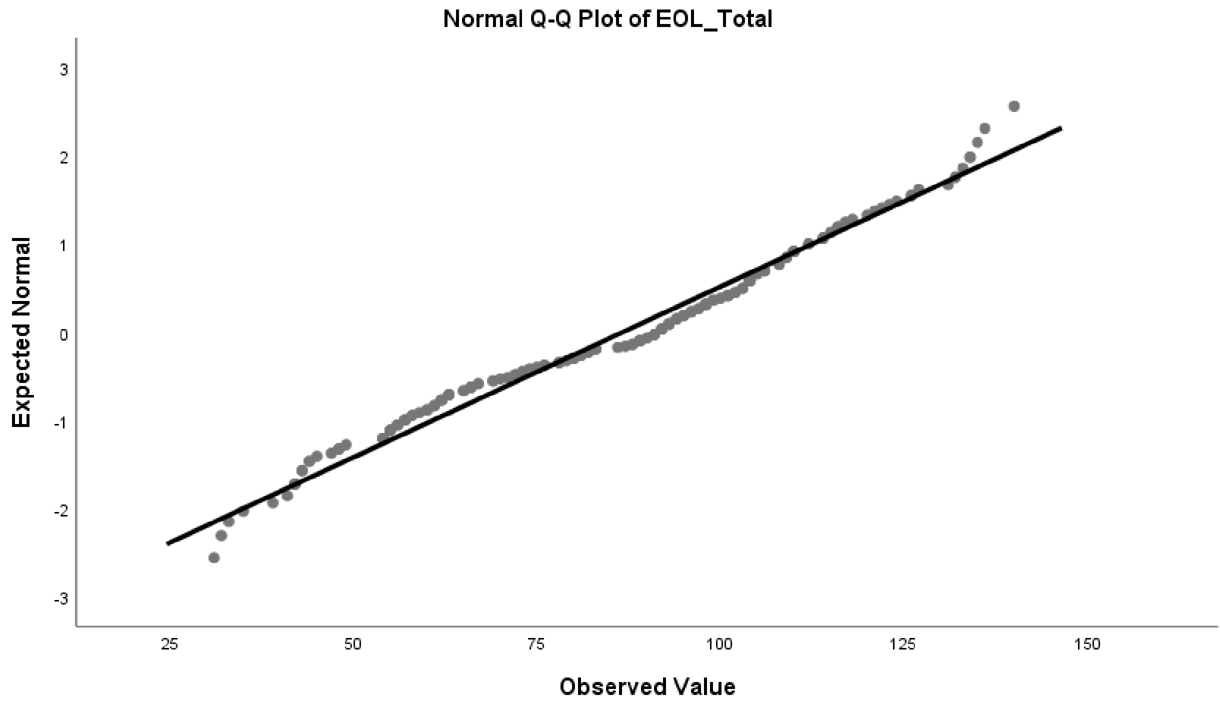

Figure 2: Normal Q-Q Plot of EPCS Scores

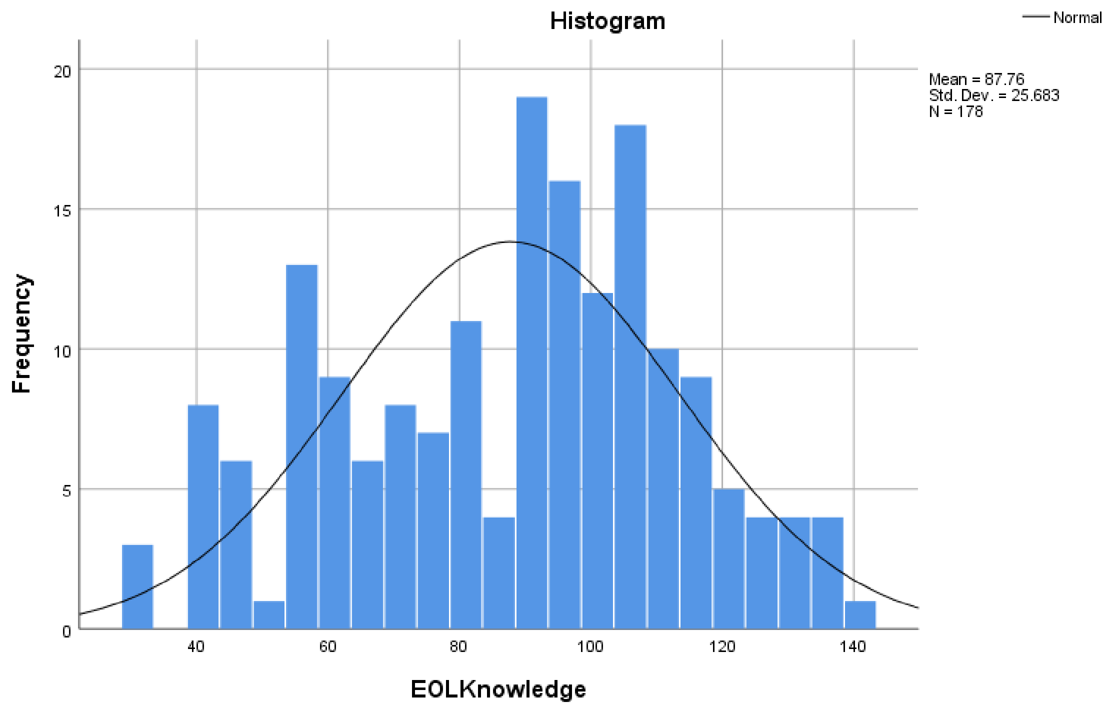

Figure 3: Histogram of EPCS Scores Distribution

Furthermore, a boxplot was reviewed to check if scores had any potential outliers on this dependent, continuous variable. The boxplot provides the distribution of scores presented by a box and protruding lines also known as whiskers. The length of the box illustrates the dependent variable's interquartile range exhibiting 50% of cases. Within the box, a line located in the middle represents the median value. Cases that do not fall within a normal range and are found either too high or too low from the remainder of the sample are called outliers. The boxplot will illustrate these outliers as small circles with a number attached which is the identified case that has deviated from the sample. For this study, the boxplot did not identify any outliers for this respective sample group. Figure 4 displays a boxplot of EPCS scores.

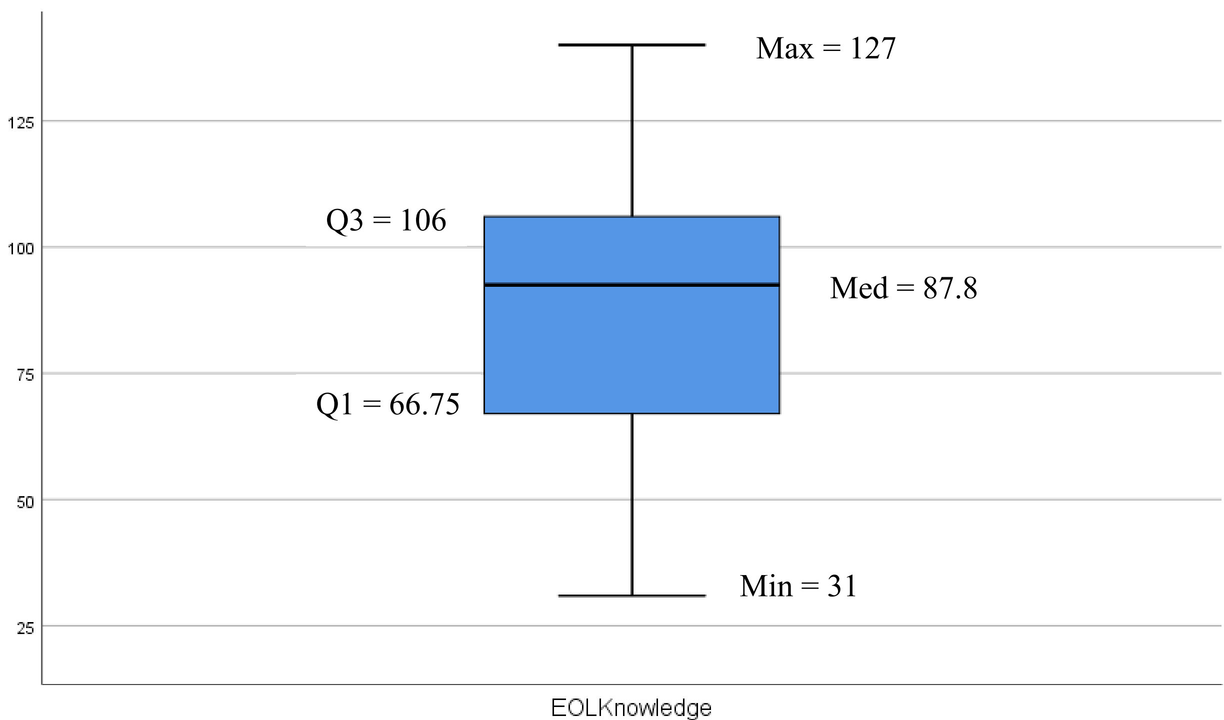

Figure 4: Boxplot of EPCS Score Distribution

The boxplot also illustrates the EPCS scores identifying the minimum of 31 to a maximum of 127 which established a range of 96 points from the lowest to highest score. The mean of scores

was reported as 87.8. Overall, 188 cases were deemed usable based on the descriptives explore analysis.

Correlational Analyses

Correlational analysis allows researchers to describe the strength and direction of relationship among variables. The following correlational analysis were utilized to determine the strength of the relationship among dependent and independent variables: Pearson's Product Moment Correlation (*Pearson r*), Point Biserial Correlation, and Eta (η) Coefficient.

Before running a series of Pearson's *r*, scatterplots for the independent variables (e.g., age, DAP scale, ATE scale and professional years of work) were screened and assessed for normal distribution of data. The Shapiro-Wilk's *p* values were above .05 and z-values for Skewness and Kurtosis were between -1.96 to +1.96. All values for the Shapiro-Wilk's *p* were under under 0.05 indicating the data did not deviate from a normal distribution. Furthermore, analyses were conducted to confirm the assumptions for multicollinearity, linearity, homoscedasticity, and independence of residual were all met. The collinearity diagnostics illustrated that multicollinearity did not exist among the independent variables. The following are the variance inflation factors reported for each predictor variable: ATE Scale (VIF=1.158), DAP-R AA Subscale (VIF=1.972), age (VIF=3.577), gender (VIF=1.512), race (VIF=1.059), state (VIF=1.1.047), religion (VIF=1.607), spirituality (VIF=1.744) and years of professional experience (VIF=3.224). Due to these procedural assessments, the data met all assumptions which maintained the appropriateness to utilize the selected statistical analyses for its respective research questions.

A series of Pearson's r were conducted to assess the relationship between the dependent variable, end-of-life care knowledge (EPCS scores), and the following independent variables: age, death acceptance (DAP-R), attitude towards euthanasia (ATE) and years of professional experience. The researcher used pairwise deletion meaning only cases relating to each pair of variables with missing data involved in an analysis were deleted. A positive linear relationship was found for end-of-life knowledge (EPCS) and age, $r(186) = .26$, $p < .001$. A positive small correlation was found for end-of-life knowledge (EPCS) and years of professional experience, $r(177) = .23$, $p < .01$. Death acceptance (DAP-R) and end-of-life knowledge (EPCS survey) did not produce a correlation, $r(187) = .08$, $p > .01$. In addition, attitudes towards euthanasia and end-of-life knowledge was not found as a significant correlation relationship, $r(187) = -.02$, $p > .01$.

For dichotomous categorical independent variables (e.g., gender, state) biserial point correlations were conducted to assess the relationship with the dependent variable. Biserial point correlations are utilized to assess relationship among variables when you have a dichotomous and continuous variable. The following assumptions were met in order to run these analyses: boxplots to assess outliers, Shapiro-Wilk's test of normality, and the Levene's test for Equality of Variance. After assessing boxplots for the independent variables, there were no outliers reported for removal. In addition, the Shapiro-Wilk's test of normality exhibited non-significant p values indicating normal distribution. The Levene's test should be non-significant indicating equal variances among the two groups. Both Levene's test for the independent variables of gender and race were non-significant. Therefore, all assumptions were met in order to conduct the biserial point correlation analyses. For gender and end-of-life knowledge, there was an inverse weak correlation $r_{pb} = -.07$, $n = 185$, $p = .72$. For this research study, the

independent variable, state, was collected in the survey by allowing the participant to elect the state of residence. This respective variable was collapsed to a dichotomous variable with the following groups: legal and illegal. The legal group means physician assisted death (PAD) is allowed to be conducted by death with dignity laws while the illegal group do not have legal mandates to legally conduct PAD. The biserial point correlation found a significant inverse correlation for state and end-of-life knowledge, rpb = -.19, n = 178, p = .68.

For correlational analyses between multinomial categorical independent variables (e.g., race, religion) and the continuous dependent variable, an Eta (η) coefficient must be attained. The analysis does not describe linearity, but instead provided the variance of how much dependent variable is explained by the independent variable. The Eta (η) coefficient can range from 0 to 1. For the race variable, the following was reported: n = 186, η= .156, η^2 = .023. The coefficient attained for religion yielded the following: n = 181, η= .231, η^2 = .053. Both race and religion variables yielded a small effect size.

Sample Composition and Demographics

The survey was comprised of demographic questions and forty-eight items distributed between the following three assessments: End of Life Caregiver Survey (28 items), Death Attitude Profile-Revised Acceptance Subscale (10 items), and the Attitudes Towards Euthanasia scale (10 items). The following sample composition was based as part of the demographic questions within the survey. The sample consisted of 130 females (69%) and 56 males (29.8%) with two unidentified values (1.1%). The mean age of the sample was 47.52 (*SD* = 12.55) ranging from the minimum of 24 to the maximum of 74 years of age. Figure 5 displays a stem and leaf plot providing a visual representation of age and the frequencies reported.

```
Frequency    Stem & Leaf

    1.00        2 .  4
   21.00        2 .  566666788888999999999
   11.00        3 .  00112333344
   27.00        3 .  555566667777777888999999999
   16.00        4 .  0111122222333344
   28.00        4 .  5566666667777777888888899999
   18.00        5 .  001122233333333444
   19.00        5 .  5555555667788889999
   28.00        6 .  0000000000111222222233333444
   14.00        6 .  55566667777779
    3.00        7 .  014

Stem width:       10
Each leaf:       1 case(s)
```

Figure 5: Age: Stem-and-Leaf Plot

The researcher utilized the U.S. Census Bureau to identify the following categories as race: White, Black/African American, American Indian or Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Hispanic/Latino, Mixed or Other. Based on self-report responses, the following percentages were identified in the race variable: White (70.6%), Black/African-American (8.6%), American Indian or Alaskan Native (2.1%), Asian (2.1%), Native Hawaiian/Pacific Islander (1.1%), Hispanic/Latino (11.2 %), Mixed (1.1%) and Other (2.7%).

In this study, religions found categorized in the U.S. Census Bureau were used to collect further demographic information. One hundred eighty-one participants provided a response while six participants did not respond. The following were the percentages identified in each respective religion: Christian (35.6%), Catholic (18.6%), Jewish (3.8%), Muslim (5%), Buddhist (3.3%), Mormon (1.1%), Unaffiliated (12.2%), Atheist (6.6%), Agnostic (8.2%), Other (7.7%)

and six (3.2%) participants did not provide a response. Figure 6 provides a pie chart of religion percentages based on sample responses.

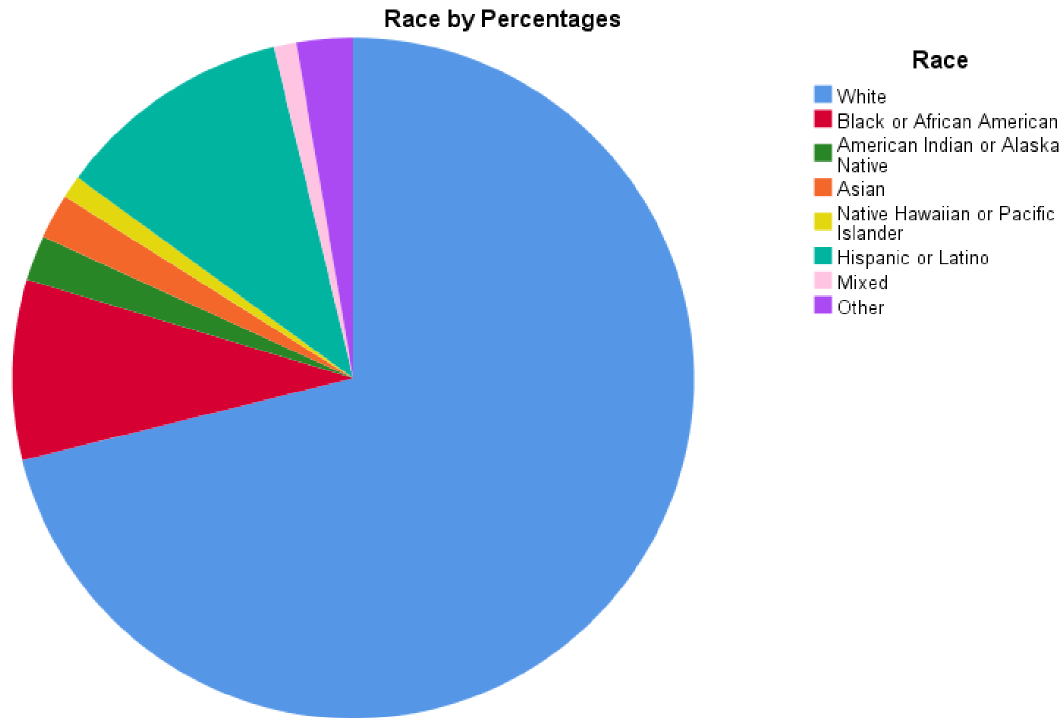

Figure 6: Piechart Categorized by Race

The sample population provided numerical data on number of years spent working in the profession as a CRC. Based on the number of responses (n = 178), the mean of professional working years was 18.04 (SD = 11.99), ranging from one year to forty-nine years of experience. The mode was 30 and there were 10 participants that did not provide a response. Figure 7 is a stem and leaf plot displaying years of professional work experience.

```
Frequency    Stem & Leaf

   22.00        0 .  1122222222223333333444
   36.00        0 .  555555555555666666677777778888899999
   24.00        1 .  000000001111222222222234
   15.00        1 .  555567888899999
   20.00        2 .  00000000011233344444
   18.00        2 .  555555555566777899
   21.00        3 .  000000000000111224444
   11.00        3 .  55555677889
    9.00        4 .  000000001
    1.00        4 .  9

 Stem width:       10
 Each leaf:        1 case(s)
```

Figure 7: Yrs. of Experience: Stem-and-Leaf Plot

As part of the survey, for the variable spirituality, participants were asked to respond to the following question: How much does spirituality play a role in your life? The sample provided the following responses: Not at all (9.0%), A little (21.8%), A moderate amount (29.3%), and A great deal (39.9%). All 187 participants answered this question with *SD* = .99. The demographic composition is presented in Table 1.

Table 1 *Descriptive Statistics: Demographic Composition of Survey Sample*

Variable	Frequency (*f*)	Percentage (%)
Gender (*n* = 186)		
Male	56	29.8
Female	130	60.1
Age Group (*n* = 186)		
Millennial (18-34)	33	17.7
Gen X (35-46)	52	28.0
Boomer I (47-56)	47	25.3
Boomer II (57-65)	40	21.5
Silent (66-74)	14	7.5
Race (*n* = 186)		
White	132	70.6
Black/African American	16	18.6
American Indian/Alaskan Native	04	2.1
Asian	04	2.1
Hispanic/Latino	21	11.2
Mixed	02	1.1
Other	05	2.7
Religion (*n* = 188)		
Christian	67	35.6
Catholic	35	18.6

Jewish	07	3.8
Muslim	01	0.5
Buddhist	06	3.3
Mormon	02	1.1
Unaffiliated	23	12.2
Atheist	12	6.6
Agnostic	15	8.2
Other	14	7.7
Years of Professional Experience (*n* = 188)		
1-10	66	35.1
11-20	40	21.3
21-30	42	22.3
31-50	30	16.8
Spirituality (*n* = 188)		
Not at all	17	9.0
A little	41	21.8
A moderate amount	55	29.3
A great deal	75	39.9

Research Question 1:

> What is the current status of training on End-of-Life care among certified rehabilitation counselors across the U.S.?

On IBM SPSS 25, descriptive statistics were conducted to assess the responses by using a dichotomous (e.g., yes, no) as to whether the participants had taken any training via the form of seminars, conferences, workshops, or professional development in end-of-life care. Out of 188 respondents, 58 (30.9%) reported to participating in training while 130 (69.1%) claimed not to have participated in training. Participants that reportedly have received training were then asked to rate self-perceived level of competence after receiving training on EOL care by selecting one of the following responses: (1) strongly agree, (2) somewhat agree, (3) neither agree or disagree, (4) somewhat disagree, and (5) strongly disagree. 48% of individuals that received EOL training reported that 9 (32.1%) strongly agreed, 14 (50%) somewhat agreed, 1 (.5) neither agreed or disagreed, and 4 (14.3%) somewhat disagreed to their self-perceived competence after EOL training. Figure 8 illustrates frequencies by percentage of reported adequate training on EOL care.

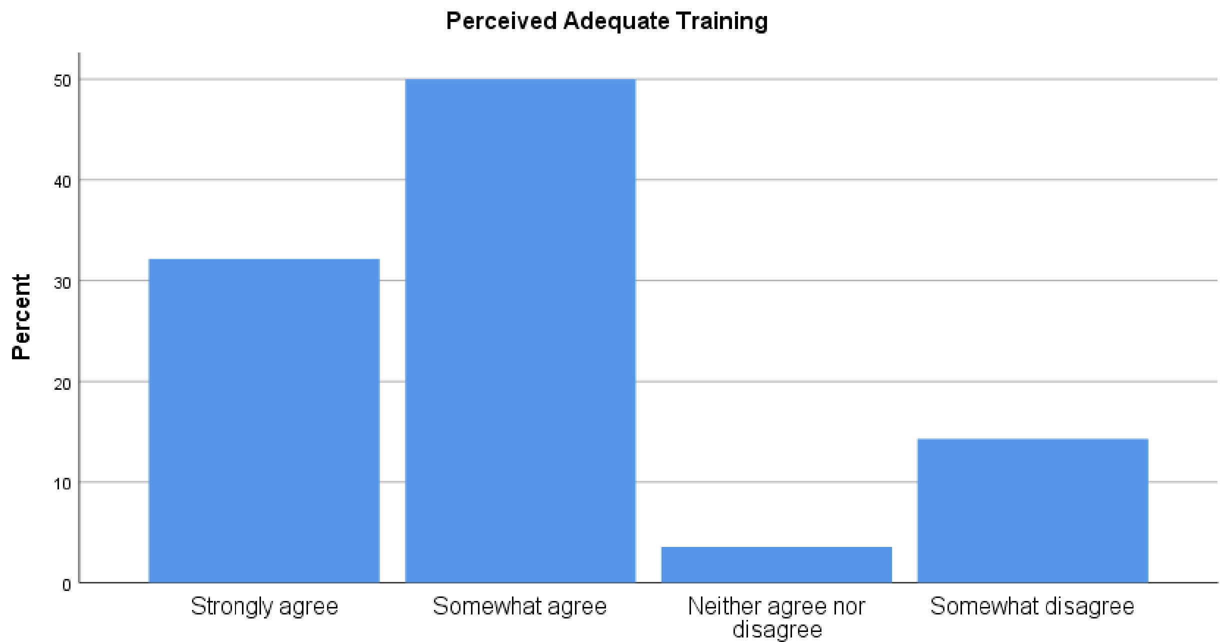

Figure 8: Perceived Adequate Training

Research Question 2:

> What is the current status of education on End-of-Life care among certified rehabilitation counselors across the U.S.?

Descriptive statistics were conducted to assess the responses of dichotomous variables (e.g., yes, no) as to whether participants in this study had received previous coursework about addressing end-of-life care issues. Frequencies and percentages were obtained in order to address this respective research question. This sample (*N*= 188) reported 55 (29.3%) participants claimed to have receive coursework while 133 (70.7%) had not taken coursework on EOL care. Participants that responded as having taken coursework were then provided a follow-up question asking whether the participants perceived gained knowledge on EOL services after coursework. The participants selected one of the following responses: (1) strongly agree, (2) somewhat agree,

(3) neither agree or disagree, (4) somewhat disagree, and (5) strongly disagree. 50% of the participants that took coursework responded as follows in relevance to perceived gain knowledge: 14 (50%) strongly agree and 14 (50%) somewhat agree.

In an attempt to supplement research questions, I and II, additional questions addressed self perceived knowledge on EOL services, whether CRC professionals felt there was a need for more training on EOL services, and whether they had conducted EOL services for clients during their professional experience. When asked to rate their self-perceived knowledge, the following options were provided as responses: (1) extremely competent, (2) somewhat competent, (3) neither competent or incompetent, (4) somewhat incompetent, and (5) extremely incompetent. Descriptive statistics were conducted and reported the following in frequency and percentages in terms of self perceived knowledge of EOL care services: 16 (8.5%) extremely competent, 57 (30.3%) somewhat competent, 41 (21.8%) neither competent or incompetent, 49 (26.1%) somewhat incompetent, and 23 (12.2%) extremely incompetent. Figure 9 illustrates the responses and valid percentages of the sample's response to rating their knowledge on EOL care.

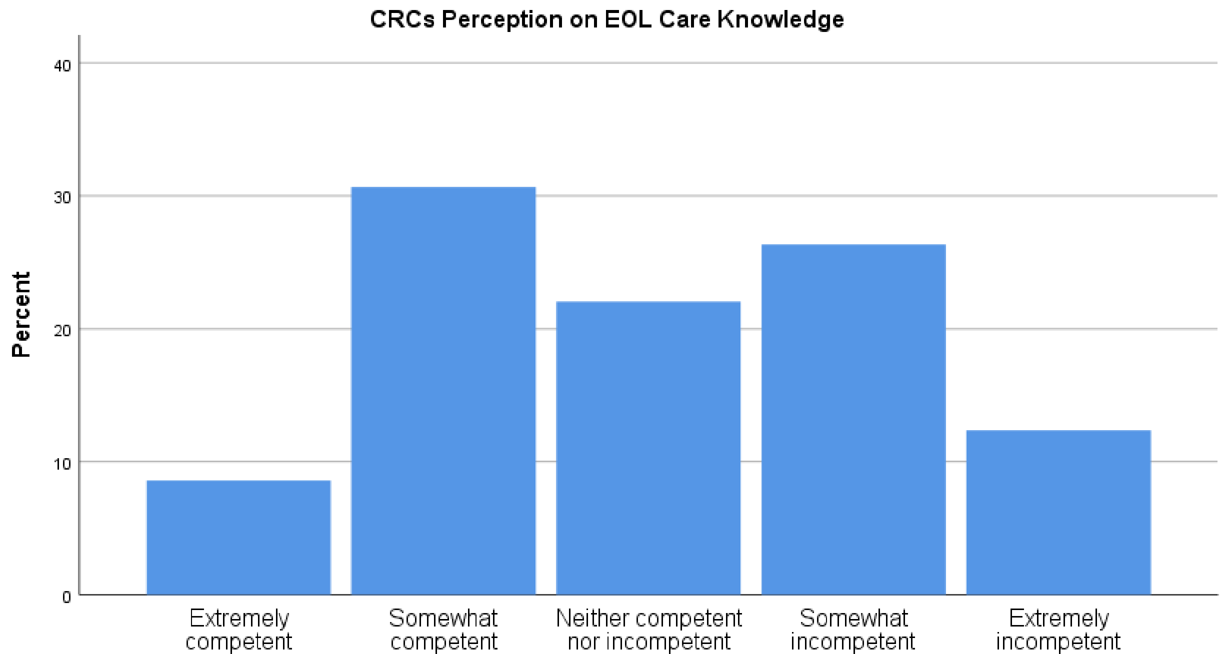

Figure 9: CRCs Perception on EOL Care Knowledge

The study also attempted to establish if CRC professionals have any experience in delivering EOL care. The question asked whether the professional had provided services for clients thay may have requested EOL care counseling or services. A dichotomous response (e.g., Yes, No) was provided as an answer selection. Descriptive statistics indicated 34 (18.1%) had provided EOL care while 154 (81.9%) had not. For participants that responded yes, a follow-up question was provided asking them to rate whether they felt competent during their experience in delivering EOL services. The following options were provided as responses: (1) strongly agree, (2) somewhat agree, (3) neither agree or disagree, (4) somewhat disagree, and (5) strongly disagree. Descriptive statistics indicated the following responses when rating self-perceived competency after delivering EOL services: 12 (35.3%) strongly agree, 15 (44.1%) somewhat agree, 3 (8.8%) neither agree or disagree, and 4 (11.8%) somewhat disagree. Figure 10 provides CRCs perceived competency in EOL service delivery by percentages.

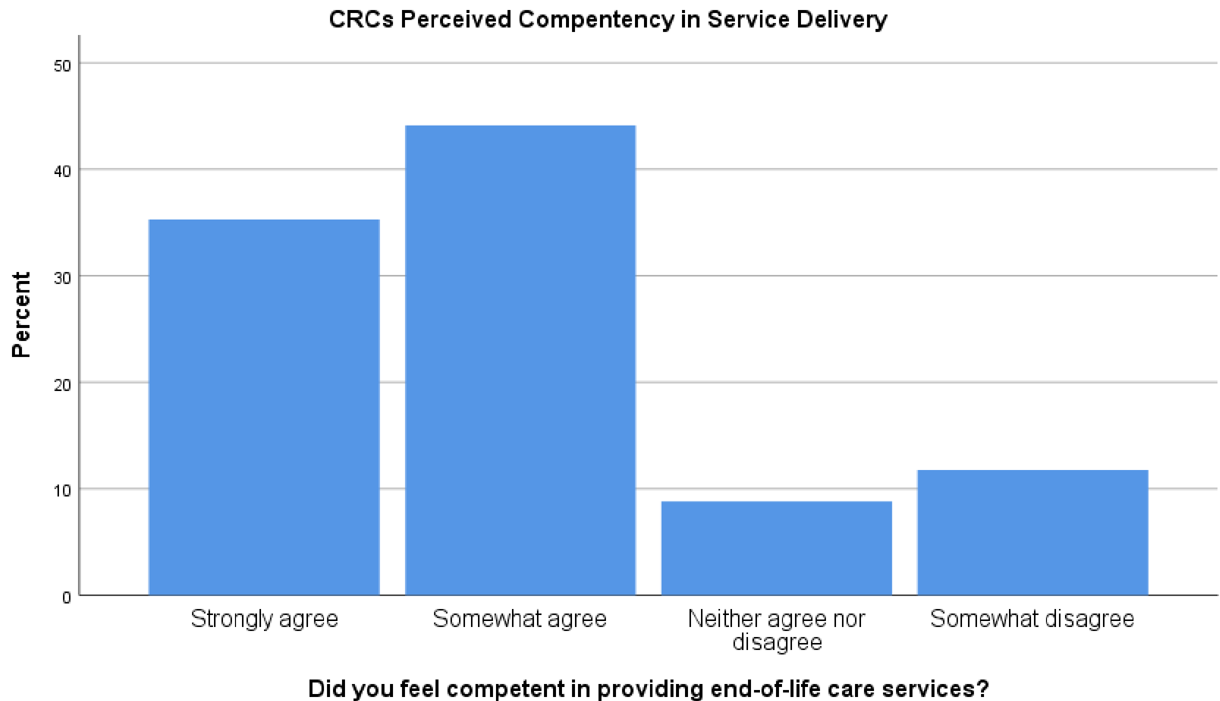

Figure 10: CRCs Perceived Competency in Service Delivery

Another supplemental question was provided in order to obtain information whether how much experience (e.g., cases) CRC professionals possessed in delivering EOL services. The question allowed the participants to respond numerically. No data was acquired for this question. Participants were asked whether CRC professionals need training on providing EOL care services. The following were the selection options to this question: (1) strongly agree, (2) somewhat agree, (3) neither agree or disagree, (4) somewhat disagree, and (5) strongly disagree. Descriptive statistics conducted revealed the following frequencies and percentages for this question: 75 (40.1%) strongly agree, 77 (41.0%) somewhat agree, 26 (13.9%) neither agree or disagree, 6 (3.2%) somewhat disagree, and 3 (1.6%) strongly disagree. Figure 11 displays a bar graph of CRC professionals' perception of need for training by percentages.

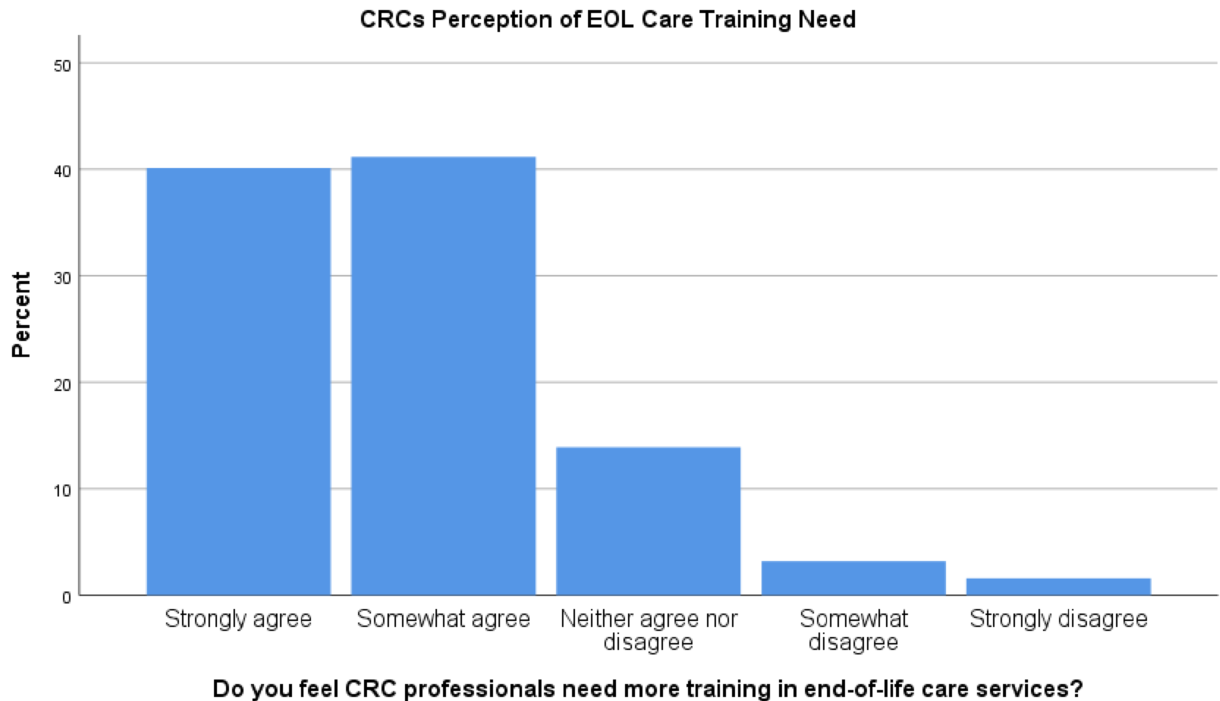

Figure 11: CRCs Perception of EOL Care Training Need

CRC Self-Perceived EOL Competency

The EPCS was the primary instrument of this study. The survey measures EOL care service delivery knowledge by one main score or may also measure EOL competency with the following subscales: patient & family centered communication (12 items), cultural and ethical values (8 items) and effective care delivery (8 items). Due to the focus of this study, it is imperative to provide the measures of central tendencies for EPCS scores based on our sample. The following is the summarization of the central tendency of measures, n = 169, M = 87.76, SD = 25.68. In addition, the following are the central tendency of measure results for each respective subscale, patient and family centered communication: n = 180, M = 39.70, SD = 11.36, cultural and ethical values: n = 184, M = 26.69, SD = 7.02, and effective care delivery: n = 186, M = 21.14, SD = 8.09. Table 2 illustrates percentages calculated for EPCS scores cumulative distribution.

Table 2 *Percentages Calculated for EPCS Cumulative Distribution*

Class Interval	Frequency (*f*)	Percentage (%)	Cumulative Percentage
111-127	21	12	100
95-110	50	30	88
79-94	37	22	58
63-78	23	14	36
47-62	24	14	22
31-46	12	8	8
Total	169		

Inferential Analyses

Research Question 3:

Is there an association between rehabilitation counselors' level of death acceptance, their attitude towards euthanasia and their level of EOL competence?

A simultaneous multiple regression was conducted in order to assess any predictive association between level of death acceptance (DAP-Acceptance Approach Subscale), attitudes towards euthanasia (ATE Scale) and counselor level of EOL competence (EPCS score). The DAP and ATE scores were utilized as the independent variables while the EPCS was identified as the dependent variable. After conducting the regression, the descriptive statistics indicated the following for participant mean scores on all three assessments: EPCS (M = 87.76, SD = 25.68), DAP-R Approach Acceptance Subscale (M = 4.35, SD = .99), and ATE (M = 3.14, SD = .51). The EPCS mean score indicates the sample scored close to a 90 out of 128 possible range. The mean score for the DAP-R Approach Acceptance Scale indicates the sample is undecided on

their attitudes towards belief in a happy afterlife. In addition, the means score for the ATE scale suggest the sample is neutral about their attitudes towards euthanasia. While inspecting the correlations table, both independent variables reported almost no linear relationship with the dependent variable, DAP-R AA (r = .06) and ATE (r = -.03). The analysis reported the following p values for the DAP-R AA (p = .88) and ATE (p = .49) which indicate non-significance. The regression results indicated there is a non-significant correlation between dependent and independent variables, $r^2 = .00$, adjusted $R^2 = -.00$, $F(2, 171) = 2.92$, $p = .747$.

Research Question 4:

> Which demographic variables (age, race, gender, religion, state of residence, spirituality, years of professional experience) best predict EOL competence level?

A simultaneous multiple regression was conducted to examine the relationship between the dependent variable (EPCS scores) and the following seven independent variables: age, race, gender, religion, spirituality, state of residence, and years of professional work experience. Before conducting the analysis, the assumption of sample size was met. According to Warner (2013), it is recommended 20 cases per predictor variable. For this study we have a sample of 188 participants, which 140 participant responses were needed in order to conduct our research question with seven variables. The assumptions of multicollinearity, normality, homoscedasticity, independence of residuals were met. A scatterplot of the dependent variable was observed for outliers. As seen in the Figure 12, the sample was deemed appropriate to continue with the analysis.

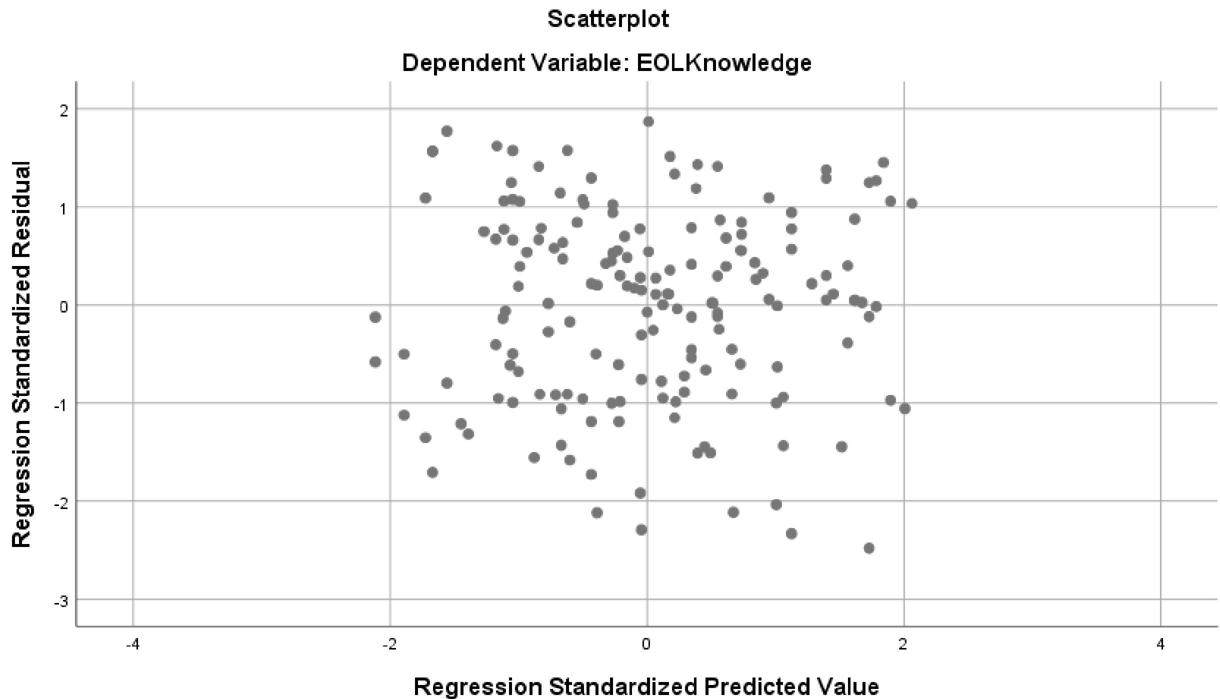

Figure 12: Regression Standardized EPCS Score Scatterplot

The results of the multiple regression indicated there was a significant effect between EOL scores and the demographic variables, $r^2 = .17$, adjusted $R^2 = .10$, $F(13, 155) = 2.50$, $p <.01$. According to the model summary, 17% of EPCS scores variance can be explained by the independent variables. After reviewing the standardized Beta coefficients, the two variables that contributed mostly to explaining the dependent variables were the following: spirituality (β = .241 and age (β = .179). However, after reviewing the significance in the correlations output, only spirituality was reported contributing significant explanation of the dependent variable with $p < .01$. A follow up analysis was conducted in order attempt to attain a model for this relationship.

A stepwise multiple linear regression analysis was performed to examine the relationship between EPCS scores and various potential demographic predictors. The analysis revealed three steps, adding one additional predictor in each model. Step 1, indicated the variable age has a

significant effect on EPCS scores, R^2 = .07, adjusted R^2 = .06, $F(1, 167) = 12.235$, p <.01. The results indicate 7% of the EPCS score may be explained by the model containing the variable age. With only age in Model 1, standardized beta coefficient = .261. In Model 2, age and state (e.g., legal, illegal) were combined and reported a significant effect on EPCS scores, R^2 = .11, adjusted R^2 = .09, $F(1, 166) = 6.718$, p <.01. In Model 2, both independent variables explain 9% of the dependent variable, with the following beta weights: age (β = .275) and state (β = .191). The stepwise linear regression also detected a third model with a significant effect. Model 3 included the following variables: age, state, and spirituality (A great deal). The stepwise regression model reported the following for the significant effect of these three variables on EPCS scores results, R^2 = .13, adjusted R^2 = .12, $F(1, 165) = 5.213$, p <.01. The following were the reported beta weights for model 3: age (β = .253), state (β = .198), and spirituality (β = .167). The individual predictors were examined further and indicated all three variables as a significant in the model: age, (t = 3.452, p = .001), state (t = 2.715, p = .007), and spirituality (t = 2.283, p = .024). Other potential predictor variables such as: years of work experience, religion, race, and gender were excluded from the model and did not indicate significant results. The model prediction equation is as follows: EPCS scores (y) = 42.47 + Age (0.52) + State (10.49) + Spirituality (2.19). Table 3 provides a summary of stepwise regression analysis for independent variables predicting EPCS scores.

Table 3: *Stepwise Regression Analysis Summary: Significant Predictor Models of EPCS Scores*

Variable	*B*	*SE B*	β	R^2	Adjusted R^2	*t*	*p*
Step 1				.068	.063		
Constant	62.295	7.527					
Age	.536	.153	.261**			3.498	.001**
Step 2				.105	.094		
Constant	44.412	10.118					
Age	.564	.151	.275***			3.735	.000***
State	10.136	3.911	.191*			2.592	.010*
Step 3				.132	.116		
Age	.519	.150	.253**			3.452	.001**
State	10.492	3.865	.198**			2.715	.007**
Spirituality	2.187	.958	.167*			2.283	.024*

Note: *$p<.05$; **$p<.01$; ***$p<.001$

Research Question 5:

Does EOL knowledge differ among counselors that serve in states where physician-assisted death is legal versus counselors working in states where it is not legal?

An independent-samples t-test was conducted to compare the EPCS scores for two groups: counselors that work in states where physician assisted death is legal versus counselors that work in states where it is illegal. There was a significant difference in scores for counselors working in states where physician assisted death is legal (*M* = 81.04, *SD* = 25.02) and counselors that work in states where physician assisted death illegal (*M* = 90.75, *SD* = 25.02; *t* (176) = 2.50, *p* = .01, two-tailed). The magnitude of the differences in means (mean difference = 9.70, 95% *CI:* 2.03 to 17.38) was small (eta squared = .03). Table 4 provides the independent *t*-tests analysis results when comparing EPCS scores by PAD legal versus non-legal states.

Table 4: *Independent Samples t-test of EPCS Scores by PAD Legal v. Non-legal States*

States	*n*	*M*	*SD*	*df*	*t*	*p*
PAD Legal	67	81.04	25.022	176	2.50*	.01*
PAD Non-Legal	111	90.75	25.202			

*p<.05

Additional Analyses

The independent variables spirituality and age were found to be significant contributors to explaining EPCS scores after conducting a stepwise linear regression analysis. Both variables were multinomial variables with different levels. Therefore, the researcher conducted a one-way between-groups analysis of variance (ANOVA) with post-hoc tests. For the first ANOVA, the categorical independent variable age was categorized by the following five groups: Millennials

(18-34), Generation X (35-46), Boomer I (47-56), Boomer II (57-65) and Silent (66-74). The participants were divided generationally. The ANOVA indicated a statistically significant difference at the $p < .05$ level in EPCS scores among the five groups: F (4, 171) = 4.6, $p = .002$. Despite reaching statistical significance, the difference in mean scores reported a medium effect. The effect size was calculated using eta squared, which was .10. Post-hoc comparisons using the Scheffe test indicated that the mean scores from Millennials ($n = 33$, $M = 73.37$, $SD = 2.53$) was significantly different from Boomer I ($n = 47$, $M = 90.74$, $SD = 23.90$) and Boomer II ($n = 41$, $M = 98.42$, $SD = 24.84$). Generation X ($n = 51$, $M = 85.69$, $SD = 26.70$) and Silent ($n = 14$, $M = 91.00$, $SD = 27.12$) did not differ significantly with any of the other groups. Boomer II group scored the highest mean ($n = 41$, $M = 98.42$, $SD = 24.84$) on the EPCS while the Millennial group ($n = 33$, $M = 73.37$, $SD = 2.53$) scored the lowest, yielded a 25.05-point difference between the means. The results indicate older professionals will score better on the EPCS than their younger colleagues. Table 5 displays the ANOVA results when comparing means of EPCS scores among age groups. Figure 13 displays a means plot EPCS scores by age groups.

Table 5: *One-Way Analysis of Variance of EPCS Scores by age groups*

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	12480.38	4	3120.096	5.099	. 002*
Within groups	110749.064	181	611.873		
Total	123229.446	185			

*$p < .01$

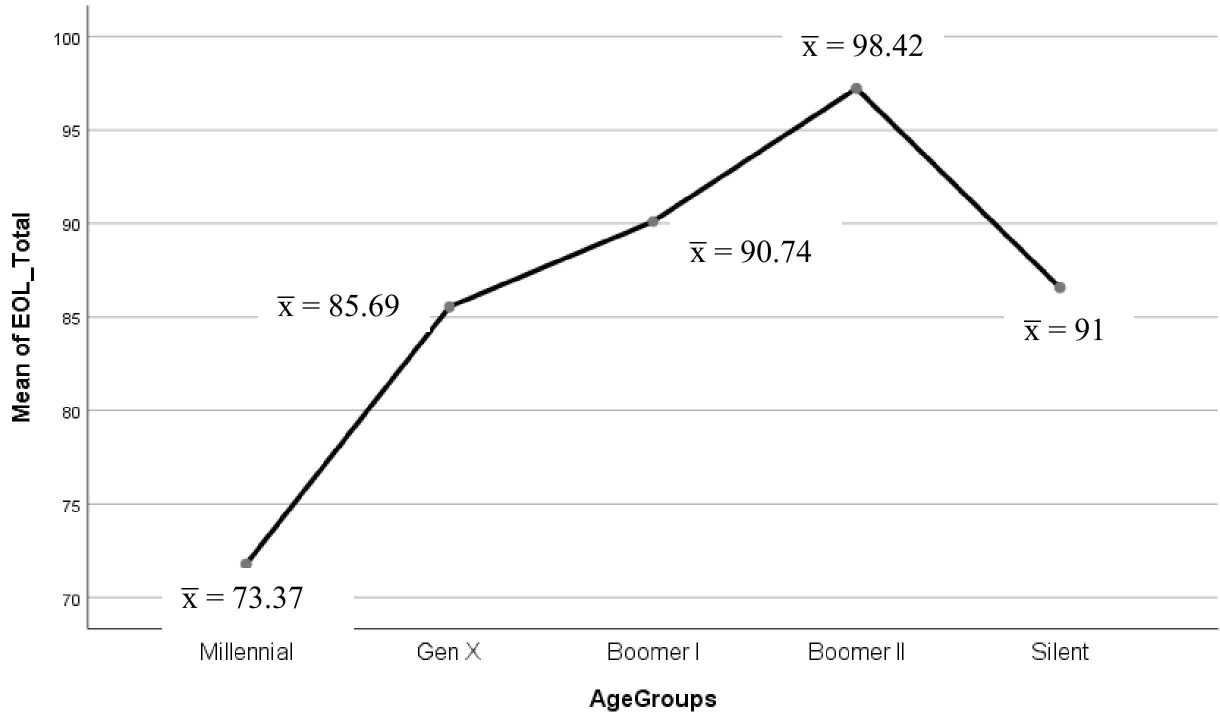

Figure 13: Means Plot Graph of EPCS Scores between Generational Groups

Another ANOVA between groups with post-hoc tests assessed the categorical independent variable spirituality which was divided into the following self-reported levels: (1) Not at all spiritual, (2) A little spiritual, (3) A moderate amount, and (4) A great deal. The ANOVA indicated a statistically significant difference at $p < .05$ level in EPCS scores among the four groups: F (3, 174) = 3.9, $p = .01$. Despite reaching statistical significance, the difference in mean scores reported a medium effect. The effect size was calculated using eta squared, which was .06. Post-hoc comparisons using the Scheffe test indicated that the mean scores from the A great deal group ($n = 75$, $M = 93.04$, $SD = 26.36$) significantly differed from Not at all ($n = 17$, M = 73.24, $SD = 27.97$) and A little ($n = 41$, $M = 78.59$, $SD = 24.10$) groups. The group labeled A moderate amount ($n = 54$, $M = 88.31$, $SD = 23.31$) did not significantly differ from any of the other groups. The group labeled A great deal ($n = 75$, $M = 93.84$, $SD = 26.53$) scored the highest mean while the group labeled Not at All ($n = 17$, $M = 75.63$, $SD = 27.03$) scored the lowest on

the EPCS. The means difference between both groups yielded an 18.21 difference suggesting individuals that perceive themselves very spiritual score better on the EPCS than individuals that do not perceive themselves spiritual at all. Figure 12 displays the means plot for EPCS scores by spirituality groups. Table 6 displays the ANOVA results when comparing means of EPCS scores among levels of spirituality.

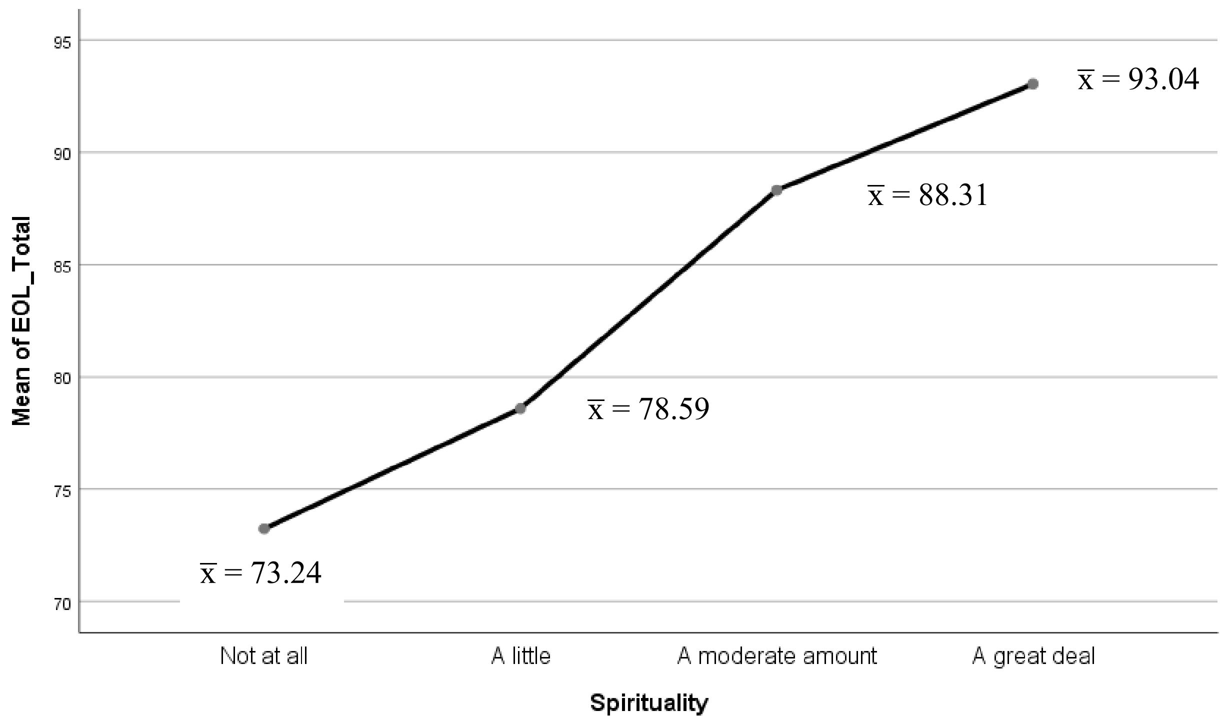

Figure 14: Means Plot of EPCS Scores between Level of Spirituality Groups

Table 6

One-Way Analysis of Variance of EPCS Scores by levels of Spirituality

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	8937.285	3	2979.095	4.711	.010*
Within groups	115721.538	183	632.358		
Total	124658.824	186			

$*p < .05$

An independent samples *t*-test was conducted to compare the EPCS scores for males and females. There was no significant difference in scores for males (M = 89.62, SD = 25.44) and females (M = 86.82, SD = 25.87; t = (175) = .659, p = .51, two-tailed). The magnitude of the differences in the means (mean difference = 2.80, 95% *CI*: -5.59 to 11.19) was small (eta squared = .014). Table 7 provides the independent *t*-test results of EPCS scores based on gender.

Table 7: *Independent Samples t-test analysis of EPCS scores based on gender*

Gender	*n*	*M*	*SD*	*df*	*t*	*p*
Female	125	86.82	25.871	175	.659	.51
Male	52	89.62	25.444			

$*p < .05$

Summary

Chapter IV provided a comprehensive overview of the following: preliminary analysis screening, composition of sample, identification of appropriate statistical analyses, and the statistical results of the study. Descriptive statistics acquired from nine survey questions provided results for research questions on and two. Correlational analyses were performed to assess the relationship of the independent variables on the dependent variables. A multiple

regression conducted revealed no linear relationship among the EPCS, DAP-R Acceptance Approach Subscale, and the ATE scale. A stepwise multiple regression was conducted in order to assess a model of predictor variables for influencing EPCS scores; significant results revealed a model for three independent variables. A *t*-test was conducted to assess mean score differences on EPCS scores between professionals that work in states were PAS is legal v. professionals that work in states where PAS in not legal; significant results were revealed. Another *t*-test was examined to compare EPCS scores by gender; however, the results did not indicate a significant difference between female and male scores. Finally, two ANOVAS were conducted to determine mean differences on EPCS score for the following: age groups and spirituality levels; significant results were revealed for both independent variables.

CHAPTER V

DISCUSSION

For this study, the researcher utilized investigative questions to examine certified rehabilitation counselors' self-perceived knowledge on EOL care services. The purpose of the study was to assess the educational needs of rehabilitation counselors in order to improve academic curriculums, which will train our professionals in adequately addressing EOL care services. Therefore, the research questions will be revisited in order to identify and summarize significant effects of independent variables on the dependent variable.

CRC Current State of Education and Training

Research questions one (EOL training) and two (EOL education) were assessed by descriptive statistics gathered from five investigative questions. In order to comprehensively examine the information, the interpretation of the results will be assessed and discussed independently. A summation will be incorporated in order to procure a holistic discussion.

EOL Training

When asked whether the CRCs had participated in EOL care service delivery training via seminars, webinars, or professional conferences, our sample yielded 31% of participants attended training. The study's sample indicated that 59% of CRCs had not receiving any EOL training. Rehabilitation counseling training opportunities are reflective of other healthcare professions reporting limited or lack of training opportunities (Giezendanner, et al., 2017; Gillan, van Der

Riet, and Joeng, 2014; Perez et al., 2015) Of this sample, participants were then asked to rate their self-perceived competence post EOL training. Approximately 80% felt they strongly or somewhat agreed to be competent post EOL training. The results indicate after participating in EOL training, counselors feel their level of EOL knowledge has increased. The results affirm previous literature establishing that professional caregivers feel more competent in EOL post training (Aldridge, et al., 2016).

EOL Education

Research question two addressed whether participants had taken coursework on EOL life care. Our results indicated the vast majority (70%) had not received any coursework while in higher education. The reasons for participants not having taken coursework is unknown. However, in other disciplines such as physicians, nursing, and social work students, the literature indicates these populations have not taken coursework for EOL education as well (Glajchen, et al., 2018; Lewis, et al., 2017; Meier, et al., 2017; Mitchell, Loew, Millington-Sanders, & Dale, 2016).

Death Acceptance Approach and Attitudes Towards Euthanasia

Death acceptance for this study was measured by the Death Anxiety Attitude-Revised Acceptance Approach subscale. In this study, the acceptance approach subscale measure how well death was accepted by the participants based on the belief that there will be a happy afterlife. Research question three inquired whether there was an association between death acceptance scores, attitudes towards euthanasia, and EOL competence. Results did not find a significant correlation between the approach subscale and EOL competence. Interestingly, prior research has also not provided an association between these three factors (Nia, Lehto, Ebadi, & Peyrovi, 2016).

Potential Factors Influencing EOL Competence

The study examined seven independent variables (e.g., age, race, gender, religion, level of spirituality, years of professional experience, and state of employment) and whether they would have any influence on predictor variable, EOL care competence. The results indicate age, spirituality, and state of employment were significant predictors in explaining the dependent variable. The independent variable of age was found to be a significant predictor variable in the study's model; however, previous literature has found inconclusive or non-significant findings (Tomlinson and Stott, 2014; van Tol, et al., 2010).

On the other hand, race, gender, religion and years of professional experience were not found to be predictors of EOL knowledge. The study affirms previous literature in which gender, race/ethnicity, years of training and religion were not found to be significant in predicting EOL knowledge (Chen, et. al., 2016; Chow, Wong, Chan, and Chung, 2014; Lippe and Becker, 2015).

State of Employment

The final research question addressed whether there was a difference in EOL care (ECPS scores) based on the state of employment. The results indicated a significant different in ECPS scores in which professionals that worked in states where physician-assisted death is illegal scored higher than professionals that worked in states where PAD is legal. Political ideology has been found as a significant contributor in supporting PAD (Bulmer, Bohnke, & Lewis, 2017). Current states implementing death with dignity laws are considered liberal in terms of political perspectives. However, previous literature of geographical location and knowledge on EOL was not found to either affirm or refute a professional's state of employment influences or predicts EOL care competence.

Level of Spirituality

Spirituality was found as a significant factor in explaining the dependent variable. In the original question, level of spirituality was utilized as a multinomial variable that was dummy coded in order to be used as part of the regression analyses. The researcher ran further analyses of the multinomial variable to examine the means between groups in spirituality. The results indicated participants that scored higher on the ECPS also identified as rating "A great deal" (highest level). In addition, participants that claimed spirituality did not play a role in their lives scored significantly lower on the ECPS scores than the rest of the groups. Spirituality has been consistently found to be a predictor of EOL competence (Adesina, Debellis, & Zannettino, 2014; Rodenbach, et al., 2016; Wilson, Oliver, & Malpas, 2018).

Generational Groups

As previously reported, age was found as a significant variable in explaining the variance of the dependent variable. The sample for this study produced an age range from 24 to 74 years of age; therefore, it was necessary to collapse the data in categories formulating another multinomial variable. The following categories were created: Millennials, Generation X, Boomer I, Boomer II, and the Silent generation. The results indicated older professionals scored better on the ECPC than younger professionals. The Boomer II generation scored better than all other groups while the Millennials scored the lowest than their other professional counterparts. The study was reflective of other health care professions and the dynamic interaction of five generations at this point in time (Boysen, Dosten, & Northern, 2016; Philips, 2016). As in previous literature, it is imperative the profession address and meet the educational and training needs of its professionals based on their values, beliefs, and generational characteristics. In

addition, the study affirmed older professionals may feel more competent and confident than their younger counterparts (Coffrey, et al., 2016).

Limitations of the Study

Methodological Limitations

Sample Size

Overall, the sample size needed to conduct the analyses for this study was successfully met. However, the sample acquired was a fairly low response rate. Out of 1,500 possible participants only 14.8% chose to participate in this study. Furthermore, it is essential to note that most of the respondents were from two large states (Texas and California); therefore, a representative distribution of the population cannot be assumed to generalize results for CRC professionals across the country.

Lack of Prior Research

EOL care services is not a new concept and has volumes of previous research. However, the concept of educating and training professional caregivers (e.g., physicians, nurses, counselors) on delivering EOL care is currently a trending topic that needs to be addressed among these professions. Specifically, the researcher did not find studies related to this topic with certified rehabilitation counselors as the sample; therefore, had to rely on literature focusing more on physician, social work, and other specialized counseling professionals. The passage of Death with Dignity Laws and the incorporation of statutes of providing EOL services in professional ethics has placed a unique challenge to health care professionals in rising up to the challenge to acquire competencies in delivering these types of services. At this time, the literature is scarce about education and training available, and most importantly, the current EOL competencies possessed by certified rehabilitation counselors.

Data Collection Measure

The focus of the study was to ascertain if current rehabilitation counselors have been educated or trained on EOL competencies. After conducting the analyses of the research, it is apparent a limitation can be suggested when the study is relying on one instrument to examine EOL knowledge. The reliability analyses of the EPCS indicated this instrument was excellent for this sample. On the other hand, further questions in the survey could have been added to assess the type of training and education the counselors have previously received. For this study, counselors solely reported to dichotomous questions as to whether they had received education or training. The study possessed a deficiency in acquiring thorough information on what type of education or training had been received, the duration of classwork or training, and lack of information on quality of education and training. If this study were to be replicated, the researcher suggests this information would be useful to thoroughly measure whether CRCs are currently being provided adequate education and training on EOL care service delivery.

The method of analysis for this study presents another limitation. This respective research study examined EOL knowledge based solely on quantitative statistic models that can determine correlations of independent and dependent variables, significant predictor variables explaining EOL knowledge, and statistically significant differences in EPCS scores among counselors in states where PAD is legal and where it is not legal; however, this study does not utilize any qualitative aspects for consideration.

Self-reported Data

The survey was disseminated electronically via Qualtrics software. The respondents were responsible for reporting candid responses in all survey items. Nationally, attitudes towards euthanasia and physician-assisted death is still a controversial topic on whether this is

humane or inhumane treatment and whether it should even be considered as a legal EOL care option. Therefore, participants may have provided socially desirable responses to items found in this survey.

Limitations of the Researcher

Accessibility

The CRCC has a database of 16,000 CRC professionals. However, the researcher had limited access to the entire list of professionals because lists are sold on increments of 1,000 potential participants for a fee. Additional lists in 250 increments of potential participants may also be purchased. The researcher did not have outside funding to access a larger sample of this respective organization. Therefore, the study was only disseminated to 9% of registered CRC professionals. Out of the possible 16,000 potential participants, only (n = 188) 1% of CRC professionals participated in this study.

Personal and Cultural Bias

Previous literature emphasizes how professional caregivers may face personal and ethical dilemmas when providing EOL care service delivery, specifically relating to physician-assisted death. The researcher in this study may have incorporated personal positive bias on the need to provide professionals the adequate knowledge and training in order to assist clients with disabilities requesting such guidance. The researcher's personal bias may not coincide with the western culture's perception that the right to die with dignity as an EOL option should not be legalized. It should be known the researcher is not advocating for legislative change in states that do not have Death with Dignity laws; the researcher is simply advocating for education and training for professionals in order to be prepared if they elect to render EOL services when requested by clients where it is legal to do so.

Future Research

The study provided baseline data to examine CRC's self-perceived knowledge on EOL care services. The results indicate this sample suggest there is need for education and training on this specific topic. In addition, the study was able to identify age, level of spirituality and state of residence as contributing predictor variables for EOL care knowledge scores. With this information, it is imperative to expand on this research by identifying other predictor variables that will explain EOL scores since the independent variables in this study only accounted for a small percentage. It would be of great benefit to the profession to conduct further research on the type of EOL curricula that are offered in rehabilitation counseling programs and the types of training offered for established CRC professionals in relevance to EOL care service delivery.

In addition, further research assessing the three aforementioned variables via qualitative means may produce insightful data that may be advantageous in providing depth to the existing findings. Future research may explore sentiments of professionals on PAD and their perception on the following: whether education and training on EOL care service delivery is needed, ethical dilemmas or concerns in providing EOL care services for their clients, and whether they personally believe in Death with Dignity laws. Individual interviews or focus groups of CRCs providing responses in a qualitative form may generate underlying themes that may contribute to EOL care competencies.

Implications

The field of rehabilitation and its professionals are on the cusp of a new frontier when considering providing EOL care services to its client base. The implications for this study may be categorized as: educational and professional training needs in EOL care competencies. When providing EOL care service delivery, it has become apparent psychologists, counselors and

social workers need to be educated and trained on therapeutic approaches addressing existential distress for clients living with chronic illness and disability (Kasl-Godley, King, & Quill, 2014). Incorporating coursework in rehabilitation curricula focused on EOL topics will provide future CRC professionals the basic EOL knowledge needed. Additionally, it is noted counselors must be able to provide counseling services throughout the entire adult lifespan specifically gerontological and life altering (e.g., chronic illness and disability) which typically address comprehensive topics such as family, medical, spiritual, legal, financial options (Wong, Hall, Justice & Hernandez, 2015). Moreover, professional caregivers are cognizant and recognize the need for educational and training opportunities in order to be better prepared to provide EOL care service delivery (Combs et al., 2015; Deangelis, 2002; van de Geer et al., 2018).

Based on this study, CRC professionals are reflecting the need for EOL care education and training. EOL care service delivery has come to the forefront among various health care professional settings. Due to educational and professional standards placed onto future and current professionals, it is imperative that these standards are met by adequately providing the resources needed to educate and train its professionals on EOL care service delivery via coursework curriculum, experiential (e.g., practicum, internships), and continuing professional development (e.g., conferences, webinars, seminars) opportunities.

Conclusion

As the needs of our clients expand, it is essential that the knowledge base of current and future certified rehabilitation counselors' expertise expand as well. With the continual evolution of the profession, implementation of EOL education and training should be included as a primary needed competency domain within our existing knowledge base. This study's main intention

was to assess the CRCs current knowledge of EOL care service delivery. Results indicate current professionals report EOL life care knowledge is a necessity and that they would feel more competent providing EOL service delivery if adequately prepared by being provided education and training.

As the case in all research studies, limitations prevented the study from identifying a larger sample that may not yield the same results. Therefore, it is imperative further research is conducted in hopes of exploring larger samples of CRCs and their insight on the need for more education and training on EOL life care service delivery. Furthermore, there is still research to be conducted in order to identify what other variables may explain self-perceived EOL competence. As the leaders in educating and training individuals to provide multifaceted services for PWD, it is the responsibility of rehabilitation counseling programs across the country to incorporate EOL care curriculum. With the evolution of the CRC profession, it is imperative academic curricula and professional development be expanded in order to adequately prepare the workforce of CRCs in providing EOL care services to PWD (Glover-Graf, 2012; Kevorkian, 2016). As the need for EOL care service is included in our health care system, it is imperative our professionals are educated and trained adequately in order to provide quality EOL care service delivery.

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APPENDIX A

APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

The Institutional Review Board for Human Subjects Protection (IRB)
Division of Research, Innovation, and Economic Development
Office of Research Compliance

July 21, 2017

To: Miranda Lopez, M.A.

From: Institutional Review Board

Subject: Approval of a New Human Research Protocol

IRBNet ID: 1092938-1

IRB# 2017-164-06

Project Title: Certified Rehabilitation Counselors' Self Perceived-Competency in Facilitating End-of-Life Care Services

Dear Researcher,

The IRB protocol referenced above has been reviewed and **APPROVED ON July 14, 2017**.

Basis for approval: Exempt, Category # 2

Approval expiration date: July 13, 2020

Recruitment and Informed Consent: You must follow the recruitment and consent procedures that were approved. If your study uses an informed consent form or study information handout, you will receive an IRB-approval stamped PDF of the document(s) for distribution to subjects.

Modifications to the approved protocol: Modifications to the approved protocol (including recruitment methods, study procedures, survey/interview questions, personnel, consent form, or subject population), must be submitted to the IRB for approval. Changes should not be implemented until approved by the IRB.

Approval expiration and renewal: Your study approval expires on the date noted above. Before that date you will need to submit a continuing review request for approval. Failure to submit this request will result in your study file being closed on the approval expiration date.

Data retention: All research data and signed informed consent documents should be retained for a *minimum* of 3 years after *completion* of the study.

Closure of the Study: Please be sure to inform the IRB when you have completed your study, have graduated, and/or have left the university as an employee. A final report should be submitted for completed studies or studies that will be completed by their respective expiration date.

Approved by: ______________________

Dr. Stephanie Brickman
Interim Chair, Institutional Review Board

- 1 -   Generated on IRBNet

APPENDIX B

APPENDIX B

ELECTRONIC MAIL (E-MAIL) SURVEY RECRUITMENT DOCUMENT

Greetings!

My name is Miranda López and I am a doctoral candidate from the University of Texas Rio Grande Valley (UTRGV)- School of Rehabilitation Counseling and Services. I would like to invite you to participate in my research study to explore certified rehabilitation counselors' self-perceived competency in facilitating end-of-life care services.

This research study has been reviewed and approved by the Institutional Review Board for the Protection of Human Subjects (IRB) at the University of Texas Rio Grande Valley.

In order to participate in this study, you must be 18 years of age or older, must be a U.S. Citizen or Legal Permanent Resident and a member of the Commission on Counselor Rehabilitation Certification (CRCC) member. Participation in this research is completely voluntary, you may choose not to participate without penalty.

No identifying data will be shared with CRCC.

As a participant, you will be asked to complete an online survey which should take about 10-15 minutes to complete. All data will be collected anonymously with no identifying information collected.

Payment for Participation: By completing this online survey you will be eligible to enter in a raffle to win 1 of 4 $50 gift cards. A second survey link will be provided at the end of this research survey for raffle purposes. Compensation for participation in this study will be provided to you by me, the researcher, not by the University of Texas Rio Grande Valley. Please note that any payment(s) you receive for participation in this study is considered income for tax purposes.

If you would like to participate in this research study, please click on the survey link below and read the consent page carefully. If you would like to complete the survey, click on "Yes, I consent". If not, simply exit the web browser or click on "I do not wish to participate".

Survey Link: https://utrgv.co1.qualtrics.com/jfe/form/SV_9B9qv63A6vhg1GB
Please feel free to forward email to CRC professionals that meet the criteria to be participants.

If you have questions related to the research, please contact me by telephone at 956-381-2736 or by email at miranda.lopez01@utrgv.edu.

If you have any questions regarding your rights as a participant, please contact the Institutional Review Board (IRB) by telephone at (956) 665-2889 or by email at irb@utrgv.edu.

APPENDIX C

APPENDIX C

PARTICIPANT CONSENT FORM

Certified Rehabilitation Counselors' Self Perceived-Competency In Facilitating End-Of-Life Care Services

This survey is being conducted by Miranda López, Ph.D. (C), M.A., from the School of Rehabilitation Services and Counseling at The University of Texas Rio Grande Valley (email: miranda.lopez01@utrgv.edu).

The purpose of this study is to examine certified rehabilitation counselors' attitudes towards death, attitudes towards physician assisted death, and their self-perceived competency in facilitating end-of-life care services.

This survey should take about 10 minutes to complete.

Participation in this research is completely voluntary. If there are any individual questions that you would prefer to skip, simply leave the answer blank.

In order to participate in this study, you must be a certified rehabilitation counselor and a registered member of the Commission on Rehabilitation Counselor Certification organization. You must be at least 18 years old to participate. If you are not 18 or older, please do not complete the survey.

All survey responses that we receive will be treated confidentially and stored on a secure server. However, given online surveys may be completed from any computer (e.g., personal, work, school), we are unable to guarantee the security of the computer on which you choose to enter your responses. As a participant in our study, we want you to be aware that certain technologies exist that can be used to monitor or record data that you enter and/or websites that you visit.

Any individually identifiable responses will be securely stored and will only be available to those directly involved in this study. De-identified data may be shared with other researchers in the future, but will not contain information about your individual identity.

Payment for Participation: After completing this online survey, you will be eligible to register for a drawing for the chance to win a $50 gift card. Four random winners will be selected and notified by email. Compensation for participation in this study will be provided by the principal investigator, Miranda López. The University of Texas Rio Grande will not be held accountable for compensation. Please note that any payment(s) you receive for participation in this study is considered income for tax purposes.

This research has been reviewed and approved by the Institutional Review Board for Human Subjects Protection (IRB). If you have any questions about your rights as a participant, or if you feel that your rights as a participant were not adequately met by the researcher, please contact the IRB at (956) 665-2889 or irb@utrgv.edu.

APPENDIX D

APPENDIX D

COMPENSATION TO HUMAN SUBJECTS AGREEMENT

COMPENSATION TO HUMAN SUBJECT PARTICIPANTS PROVIDED BY RESEARCHERS' PERSONAL FUNDS

Agreement

I Miranda López acknowledge that I am submitting a human subject study for Institutional Review Board (IRB) approval where I propose to provide compensation in the form of one $50 gift card to four participants who complete the survey and choose to participate in the raffle. The completion of the survey and participation in the raffle is entirely voluntary. Four winners will be selected from the participants who complete the Qualtrics survey.

I understand that the payment of compensation is subject to Internal Revenue Service (IRS) and that I am responsible for complying with such regulations. I also understand that I will need to provide the corresponding disclaimers in the participants' consent form, to the effect that: (1) compensation is to be provided by me and not UTRGV, and (2) compensation received is considered income for tax purposes.

I agree to keep track of the amount and quantity of compensation provided to study participants for a period of 3 years after the study is completed.

Name of Researcher: Miranda López, Ph.D.(C), M.A.

Title of Study:
Certified Rehabilitation Counselors' Self Perceived-Competency In Facilitating End-Of-Life Care Services

APPENDIX E

APPENDIX E

DEMOGRAPHIC QUESTIONNAIRE

D1.1 Did you take coursework on how to address or provide end-of-life care services?

- Yes (1)
- No (2)

D1.2 Have you participated in end-of-life care services training? (e.g., seminars, conferences, workshops)

- Yes (1)
- No (2)

Display This Question:

If Did you take coursework on how to address or provide end-of-life care services? Yes Is Selected
And Have you participated in end-of-life care services training? (e.g., seminars, conferences, workshops) Yes Is Selected

D1.3 Do you believe you gained knowledge on facilitating end-of-life care services?

- Strongly agree (1)
- Somewhat agree (2)
- Neither agree nor disagree (3)
- Somewhat disagree (4)
- Strongly disagree (5)

Display This Question:

If Did you take coursework on how to address or provide end-of-life care services? Yes Is Selected

And Have you participated in end-of-life care services training? (e.g., seminars, conferences, workshops) Yes Is Selected

D1.4 Do you believe the training you received is adequate in helping you feel competent to provide end-of-life care services?

- Strongly agree (1)
- Somewhat agree (2)
- Neither agree nor disagree (3)
- Somewhat disagree (4)
- Strongly disagree (5)

Display This Question:

If Have you facilitated end-of-life care services for a client? Yes Is Selected

D1.6 How many times have you provided end-of-life care services?

D1.5 Have you facilitated end-of-life care services for a client?

- Yes (1)
- No (2)

Display This Question:

If Have you facilitated end-of-life care services for a client? Yes Is Selected

D1.7 Did you feel competent in providing end-of-life care services?

- Strongly agree (1)
- Somewhat agree (2)
- Neither agree nor disagree (3)
- Somewhat disagree (4)
- Strongly disagree (5)

D1.8 How do you rate your knowledge on addressing end-of-life care services?

- Extremely competent (1)
- Somewhat competent (2)
- Neither competent nor incompetent (3)
- Somewhat incompetent (4)
- Extremely incompetent (5)

D1.9 Do you feel CRC professionals need more training in end-of-life care services?

- Strongly agree (1)
- Somewhat agree (2)
- Neither agree nor disagree (3)
- Somewhat disagree (4)
- Strongly disagree (5)

D1.10 Age

D1.11 Which Gender do you identify with?

- Male (1)
- Female (2)

D1.12 Race

- White (1)
- Black or African American (2)
- American Indian or Alaska Native (3)
- Asian (4)
- Native Hawaiian or Pacific Islander (5)
- Hispanic or Latino (6)
- Mixed (7)
- Other (8)

D1.13 In which state do you currently reside?

- ❍ Alabama (1)
- ❍ Alaska (2)
- ❍ Arizona (3)
- ❍ Arkansas (4)
- ❍ California (5)
- ❍ Colorado (6)
- ❍ Connecticut (7)
- ❍ Delaware (8)
- ❍ District of Columbia (9)
- ❍ Florida (10)
- ❍ Georgia (11)
- ❍ Hawaii (12)
- ❍ Idaho (13)
- ❍ Illinois (14)
- ❍ Indiana (15)
- ❍ Iowa (16)
- ❍ Kansas (17)
- ❍ Kentucky (18)
- ❍ Louisiana (19)
- ❍ Maine (20)
- ❍ Maryland (21)
- ❍ Massachusetts (22)
- ❍ Michigan (23)
- ❍ Minnesota (24)
- ❍ Mississippi (25)
- ❍ Missouri (26)
- ❍ Montana (27)
- ❍ Nebraska (28)
- ❍ Nevada (29)
- ❍ New Hampshire (30)
- ❍ New Jersey (31)
- ❍ New Mexico (32)
- ❍ New York (33)
- ❍ North Carolina (34)
- ❍ North Dakota (35)

- Ohio (36)
- Oklahoma (37)
- Oregon (38)
- Pennsylvania (39)
- Puerto Rico (40)
- Rhode Island (41)
- South Carolina (42)
- South Dakota (43)
- Tennessee (44)
- Texas (45)
- Utah (46)
- Vermont (47)
- Virginia (48)
- Washington (49)
- West Virginia (50)
- Wisconsin (51)
- Wyoming (52)
- I do not reside in the United States (53)

D1.14 Religion

- Christian (1)
- Catholic (2)
- Jewish (3)
- Muslim (4)
- Buddhist (5)
- Unaffiliated (6)
- Atheist (7)
- Agnostic (8)
- Mormon (9)
- Jehovah's Witness (10)
- Other (11)

D1.15 How much does spirituality play a role in your life?

- ❍ Not at all (1)
- ❍ A little (2)
- ❍ A moderate amount (3)
- ❍ A lot (4)
- ❍ A great deal (5)

D1.16 Years of professional experience

D1.17 Which certificates or licenses do you possess. Check all that apply.

- ❑ CRC (1)
- ❑ LPC (2)
- ❑ LCDC (3)
- ❑ Other (4)

APPENDIX F

APPENDIX F

PERMISSION TO USE ATTITUDES TOWARDS EUTHANASIA (ATE) SCALE

Re: Attitude Towards Euthanasia (ATE) Scale Consent

Jason Wasserman <wasserman@oakland.edu>

Tue 3/14/2017 9:34 AM

To: Miranda Lopez <miranda.lopez01@utrgv.edu>;

5 attachments (1 MB)

Aghababaei and Wasserman 2013.pdf; Aghababaei, Farahani, Hatami, 2011.pdf; EAS.pdf; Tordella and Neutens 1979.PDF; Wasserman, Clair, and Ritchey - ATE Scale.pdf;

Hi Miranda,

Certainly feel free to use our scale.

There are several options for attitudes scales related to euthanasia. The EAS scale was actually developed by Tordella and Neutens 1979 and Chong and Fok 2005 made some important methodological observations about that. Both articles are attached.

My ATE scale is at the end of another attached article, as is a piece by Aghababaei et al 2011 that compares the EAS and the ATE in an Iranian population. The short of it is that EAS may be more responsive to psychological/personality factors, whereas ATE may be more responsive to sociological factors (race, class, religiosity, etc).

Good luck with the project and certainly keep me updated on your work.

Take care,
Dr. Wasserman

On Mon, Mar 13, 2017 at 8:43 PM, Miranda Lopez <miranda.lopez01@utrgv.edu> wrote:

> Greetings Dr. Wasserman:
>
> I am currently a doctoral candidate at The University of Texas - Rio Grande Valley. I am requesting your permission to utilize the instrument "Attitude Toward Euthanasia" for dissertation puposes. My dissertation will be attempting to identify variables predicting whether certified rehabilitation counselors will assist persons with disabilities with end of life issues, including physician assisted death. Would I need to purchase the instrument? Please advise. I hope this message finds you well and I hope to be granted your consent to use your respective instrument.
>
> Warmest regards,
> Miranda Lopez

-

APPENDIX G

APPENDIX G

PERMISSION TO USE DEATH ATTITUDE PROFILE-REVISED (DAP-R) SCALE

Re: Permission to use Death Attitude Profile-Revised Scale

Paul TP Wong <dr.paul.wong@gmail.com>

Tue 3/14/2017 10:45 AM

To: Miranda Lopez <miranda.lopez01@utrgv.edu>;

Hi Miranda,

I am pleased to grant you the permission to use Death-Attitude Profile-Revised Scale for research purposes.

Best,

Paul

Paul T. P. Wong, Ph.D., C.Psych. (www.drpaulwong.com)
President, International Network on Personal Meaning
President, Meaning-Centered Counselling Institute Inc.

On Mon, Mar 13, 2017 at 8:24 PM, Miranda Lopez <miranda.lopez01@utrgv.edu> wrote:

> Greetings Dr. Wong:
>
> I am currently a doctoral candidate at The University of Texas - Rio Grande Valley. I am requesting your blessing/permission to utilize the instrument "Death Attitude Profile - Revised" for dissertation puposes. I found the scale on your documents list, but I know I need your permission to use it. I have purchased the Textbook : Death Anxiety Handbook which lists the psychometric properties of the instrument and how to best apply it. I hope this message find you well and I hope to be granted your consent to use your respective instrument.
>
> Warmest regards,
> Miranda Lopez

APPENDIX H

APPENDIX H

PERMISSION TO USE COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION DATABASE

Request for Use of CRCC Database

Kathleen Gehring <KGehring@CRCCertification.com>
Thu 8/10/2017 7:49 AM

To:Miranda Lopez <miranda.lopez01@utrgv.edu>;

Importance: High

UTRGV Rental Agreement 20170810.pdf; Credit Card Payment Form.docx;

Good morning, Miranda.

Congratulations! The Standards and Examination Committee has approved your request for use of CRCC's Database for your research project. The next step is to provide a contract for rental of the Mailing List in order to provide the requested data.

Attached is the Rental Agreement for use of CRCC's Mailing List for the purpose of research. Please review and if you find acceptable, sign under the Lessee section on page two and return with the rental fee of $250. As you will receive the Mailing List in an electronic format, as noted under Section 7 of the Agreement, upon the expiration of the agreement (three months from receipt of the electronic file), you must promptly return the Mailing List to CRCC in the same form and condition as it was furnished. You also agree that no copies of the Mailing List are retained or used except as stipulated in the Agreement.

For your convenience, I have also attached a credit card payment form, should you choose to pay by this option.

Please let me know if you have any questions.

Regards,

Kathleen

Kathleen Gehring, Certification Manager Commission on Rehabilitation Counselor Certification
1699 E. Woodfield Road, Suite 300
Schaumburg, IL 60173
847-944-1325 Main
847-944-1322 Direct 847-944-
1346 Fax
kgehring@crccertification.com
www.crccertification.com Note:
The information transmitted is
intended only for the person(s) to

APPENDIX I

APPENDIX I

END-OF-LIFE PROFESSIONAL CAREGIVER SURVEY

End-of-Life Professional Caregiver Survey

Below is a list of statements that other end-of-life professional caregivers have said are important. **Please circle one number per line to indicate your response as it applies to you today.**

		Not at all	A little bit	Some-what	Quite a bit	Very much
P1	I am comfortable helping families to accept a poor prognosis	0	1	2	3	4
P2	I am able to set goals for care with patients and families ...	0	1	2	3	4
P3	I am comfortable talking to patients and families about personal choice and self-determination........	0	1	2	3	4
P4	I am comfortable starting and participating in discussions about code status	0	1	2	3	4
P5	I can assist family members and others through the grieving process........	0	1	2	3	4
P6	I am able to document the needs and interventions of my patients	0	1	2	3	4
P7	I am comfortable talking with other health care professionals about the care of dying patients	0	1	2	3	4
P8	I am comfortable helping to resolve difficult family conflicts about end-of-life care	0	1	2	3	4
P9	I can recognize impending death (physiologic changes)	0	1	2	3	4
P10	I know how to use non-drug therapies in management of patients' symptoms........	0	1	2	3	4
P11	I am able to address patients' and family members' fears of getting addicted to pain medications........	0	1	2	3	4
P12	I encourage patients and families to complete advanced care planning	0	1	2	3	4
C1	I am comfortable dealing with ethical issues related to end-of-life/hospice/palliative care........	0	1	2	3	4
C2	I am able to deal with my feelings related to working with dying patients	0	1	2	3	4

English (Universal)
Copyright 2012
http://dx.doi.org/10.1089/jpm.2011.0246

C3	I am able to be present with dying patients........................	0	1	2	3	4
C4	I can address spiritual issues with patients and their families	0	1	2	3	4
C5	I am comfortable dealing with patients' and families' religious and cultural perspectives	0	1	2	3	4
C6	I am comfortable providing grief counseling for families ..	0	1	2	3	4
C7	I am comfortable providing grief counseling for staff	0	1	2	3	4
C8	I am knowledgeable about cultural factors influencing end-of-life care	0	1	2	3	4
E1	I can recognize when patients are appropriate for referral to hospice..	0	1	2	3	4
E2	I am familiar with palliative care principles and national guidelines	0	1	2	3	4
E3	I am effective at helping patients and families navigate the health care system	0	1	2	3	4
E4	I am familiar with the services hospice provides	0	1	2	3	4
E5	I am effective at helping to maintain continuity across care settings..	0	1	2	3	4
E6	I feel confident addressing requests for assisted suicide.....	0	1	2	3	4
E7	I have personal resources to help meet my needs when working with dying patients and families	0	1	2	3	4
E8	I feel that my workplace provides resources to support staff who care for dying patients.......................................	0	1	2	3	4

APPENDIX J

APPENDIX J

DEATH ATTITUDES PROFILE-REVISED (DAP-R)

Death Attitude Profile-Revised (DAP-R)

Wong, P.T.P., Reker, G.T., & Gesser, G.

This questionnaire contains a number of statements related to different attitudes toward death. Read each statement carefully, and then decide the extent to which you agree or disagree. For example, an item might read: “Death is a friend.” Indicate how well you agree or disagree by circling one of the following: **SA** = strongly agree; **A**= agree; **MA=** moderately agree; **U**= undecided; **MD**= moderately disagree; **D**=disagree; **SD**= strongly disagree. Note that the scales run both from *strongly agree* to *strongly disagree* and from *strongly disagree* to *strongly agree*.

If you strongly agreed with the statement, you would circle **SA**. If you strongly disagreed you would circle **SD**. If you are undecided, circle **U**. However, try to use the undecided category sparingly.

It is important that you work through the statements and answer each one. Many of the statements will seem alike, but all are necessary to show slight differences in attitudes.

1. Death is no doubt a grim experience.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
2. The prospects of my own death arouses anxiety in me.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
3. I avoid death thoughts at all costs.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
4. I believe that I will be in heaven after I die.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
5. Death will bring an end to all my troubles.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
6. Death should be viewed as a natural, undeniable, and unavoidable event.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
7. I am disturbed by the finality of death.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**

8. Death is an entrance to a place of ultimate satisfaction.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
9. Death provides an escape from this terrible world.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
10. Whenever the thought of death enters my mind, I try to push it away.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
11. Death is deliverance from pain and suffering.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
12. I always try not to think about death.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
13. I believe that heaven will be a much better place than this world.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
14. Death is a natural aspect of life.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
15. Death is a union with God and eternal bliss.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
16. Death brings a promise of a new and glorious life.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
17. I would neither fear death nor welcome it.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
18. I have an intense fear of death.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
19. I avoid thinking about death altogether.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
20. The subject of life after death troubles me greatly.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**

21. The fact that death will mean the end of everything as I know it frightens me.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
22. I look forward to a reunion with my loved ones after I die.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
23. I view death as a relief from earthly suffering.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
24. Death is simply a part of the process of life.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
25. I see death as a passage to an eternal and blessed place.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
26. I try to have nothing to do with the subject of death.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
27. Death offers a wonderful release of the soul.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
28. One thing that gives me comfort in facing death is my belief in the afterlife.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
29. I see death as a relief from the burden of this life.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**
30. Death is neither good nor bad.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
31. I look forward to life after death.	**SA**	**A**	**MA**	**U**	**MD**	**D**	**SD**
32. The uncertainty of not knowing what happens after death worries me.	**SD**	**D**	**MD**	**U**	**MA**	**A**	**SA**

Scoring Key for the Death Attitude Profile-Revised

Dimension	Items
Fear of Death (7 items)	1,2,7,18,20,21,32
Death Avoidance (5 items)	3,10,12,19,26
Neutral Acceptance (5 items)	6,14,17,24,30
Approach Acceptance (10 items)	4,8,13,15,16,22,25,27,28,31
Escape Acceptance (5 items)	5,9,11,23,29

Scores for all items are from 1 to 7 in the direction of *strongly disagree (1)* to *strongly agree (7)*. For each dimension, a mean scale score can be computed by dividing the total scale score by the number of items forming each scale.

For further information on the theoretical rationale and the psychometric properties of the scale consult the following source:

Wong, P.T.P., Reker, G.T., & Gesser, G. (1994). Death Attitude Profile-Revised: A multidimensional measure of attitudes toward death. In R.A. Neimeyer (Ed.), *Death anxiety handbook: Research, instrumentation, and application.* (pp. 121-148). Washington, DC: Taylor & Francis.

For information on the original DAP, consult the following source:

Gesser, G., Wong, PT.P., & Reker, G.T. (1987-88). Death attitudes across the life span: The development and validation of the Death Attitude Profile (DAP). *Omega, 18*, 113-128.

APPENDIX K

APPENDIX K

ATTITUDES TOWARDS EUTHANSIA (ATE) SCALE

Table 1 . Atttiudes toward Euthanasia (ATE) Scale—
Items and Dimensions

Item	Dimensiona
1.If a patient in severe pain requests it, a doctor should remove life support and allow that patient to die.	NR / DA / ACTIVE
2. It is okay for a doctor to administer enough medicine to end a patient's life if the doctor does not believe that they will recover,	sp / PR / ACTIVE
3. If a patient in severe pain requests it, a doctor should prescribe that patient enough medicine to end their life.	NR / DA / PASSIVE
4.It is okay for a doctor to remove life-support and let a patient die if the doctor does not believe the patient will recover.	
5. It is okay for a doctor to administer enough medicine to a suffering patient to end that patient's life if the doctor thinks that the patient's pain is too	SP / DA / ACTIVE
6. Even if a doctor does not think that a patient will recover, it would be wrong for the doctor to end the life of a patient.[b]	
7.It is okay for a doctor to remove a patient's life-support and let them die if the doctor thinks that the patient's pain is too severe.	SP / DA / PASSIVE
8. If a dying patient requests it, a doctor should prescribe enough medicine to end their life.	NR / PR / ACTIVE
9. Even if a doctor knows that a patient is in severe, uncontrollable pain, it would be wrong for the doctor to end the life of that patient.[b]	
ION If a dying patient requests it, a doctor should remove their life support and allow them to die.	NR / PR / PASSIVE

SP / PR / PASSIVE

BIOGRAPHICAL SKETCH

Miranda López received her Bachelor of Science degree in Rehabilitative Services from The University of Texas – Pan American in 2001. In 2002, Ms. López graduated with her Master of Arts degree in Rehabilitation Counseling from The University of Arizona. Miranda graduated with a doctorate of philosophy (Ph.D.) in rehabilitation from The University of Texas Rio Grande Valley in December 2018.

Ms. López has over 10 years of experience in case management, intake evaluations, and individual and group counseling. In addition, she possesses 5 years of career counseling, grant writing, and grant management skills. As a clinical lead counselor, her work experience allowed her to provide services in the areas of substance abuse, chronic illness, mental and behavioral disorders. Moreover, Miranda has been an advocate for traditionally underrepresented and marginalized groups such as: persons with disabilities, at risk youth, and economically disadvantaged populations.

While in academia, Ms. López, has two accepted publications, presented at three national conferences, show cased five poster presentations and co-wrote two funded grants. In addition, she has taught undergraduate classes for four years in higher education. Her research interests include rehabilitation education supervision and leadership, end-of-life care services, and rehabilitation policy.

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