An Exploratory Study of Grief Counseling Training and Competencies in Counseling Students at CACREP-accredited Institutions

A dissertation presented to

the faculty of

The Patton College of Education of Ohio University

In partial fulfillment

of the requirements for the degree

Doctor of Philosophy

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May 2015

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This dissertation titled
An Exploratory Study of Grief Counseling Training and Competencies in
Counseling Students at CACREP-accredited Institutions

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Abstract

IMHOFF, BRAD A., Ph.D., May 2015, Counselor Education

An Exploratory Study of Grief Counseling Training and Competencies in Counseling Students at CACREP-accredited Institutions

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Research suggests that graduate students in counseling and beginning counselors rate grief and death-related topics as those with which they are most uncomfortable (Kirchberg & Neimeyer, 1991; Kirchberg, Neimeyer, & James, 1998). Yet, historically, little training has been provided to students in the area of grief counseling (Allen & Miller, 1998; Ober, Granello, & Wheaton, 2012; Stephenson, 1981). This is concerning given that research also suggests professional training and experience is a strong predictor of perceived grief counseling competencies in helping professionals (Charkow, 2002; Ober et al., 2012).

This study explored grief counseling training and competencies with master’s level counseling students in the field experience part of their training. The Grief Counseling Experience and Training Survey (GCETS) was used to assess professional training and experience with grief and the Death Counseling Survey (DCS) and its five subscales (Personal Competencies, Conceptual Skills/Knowledge, Assessment Skills, Treatment Skills, and Professional Skills) were used to assess perceived grief counseling competencies.

Descriptive information revealed participants lacked grief counseling training, despite nearly three-fourths of them having already worked with grieving clients.
Further, respondents rated themselves as competent on general counseling skills related to grief (e.g., practicing self-care, exhibiting genuineness, providing a supportive setting in counseling, etc.), but scored much lower on grief-specific knowledge and skills (e.g., having knowledge of grief theories, being able to articulate developmentally appropriate grief reactions, and recognizing complicated grief symptoms, etc.).

Regression analyses were used to explore the relationship between perceived grief counseling competencies and the variables of age, gender, professional training and experience with grief, and type of grief counseling training received. Age was found to be a significant predictor of Personal Competencies and gender a significant predictor of Overall Grief Counseling Competency, Conceptual Skills/Knowledge, Treatment Skills, and Professional Skills; though, these variables accounted for little unique contribution. Professional training and experience with grief was a significant predictor of all the competency subscales and accounted for much more unique contribution ($\beta = .22 - .70$).

The data analyzed in this study suggest a lack of grief counseling training opportunities despite professional training and experience being a strong predictor of perceived competencies. Further, students rate themselves as competent on general counseling abilities, but their scores decline drastically on grief specific skills and knowledge.
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Chapter 1 - Introduction

Grief is a universal experience, an inescapable reality of being human. Regardless of age, all people can expect to grieve the loss of a loved one at some point in their lives. Aside from losing loved ones, individuals may also grieve losses such as moving, terminal illness, divorce, the loss of a pet, the loss of safety in bullying incidences, loss of military parents to deployment, and many others; loss issues can often go beyond bereavement (Humphrey, 2009).

As a result of the prevalence of loss, both death-related and non-death related, counselors can expect to have to address grief issues in their work (Ober, Granello, & Wheaton, 2012). In some instances, grief may be a presenting problem for which an individual has specifically sought out counseling services. In many others, however, individuals may present with a particular issue, but thorough assessment reveals past unresolved grief issues. Regardless of how it presents, because of the likelihood of encountering grief issues, it may behoove counselors to be trained and prepared to work with grief-related issues in their clientele.

The following introduction offers a brief overview of grief and grief counseling as it pertains to adults and children, as well as the competency of school and mental health counselors to address such issues. A background of the proposed study is provided, as well as a statement of the problem. The research questions are listed and the significance of the study discussed. Delimitations and limitations of the study are disclosed and key terms that will be used throughout the study are defined.
Understanding Grief

Grief is identified as the cognitive, emotional, and behavioral experience of an individual after losing a loved one (Worden, 2009). Scholars also recognize that grief experiences can occur due to any important loss, not just death (Humphrey, 2009; Kelley, 2010; Neimeyer, 2000a; Viorst, 1986). While universally experienced, reactions to loss are unique to each individual because of one’s relationship to that which was lost, the event or way in which the loss occurred, and the variety of contexts in which the loss has an impact (Humphrey, 2009). That is, grief reactions occur very much on a personalized, individual basis. These reactions manifest in various ways, but for some people, involve significant distress that can occur over a prolonged period of time (Kelley, 2010; Weiss, 2001).

Though grief is a universal experience, grief counseling is not always necessary for a healthy grieving process. Neimeyer (2000a) suggested that grief therapy should be engaged in selectively and only with those individuals whose grief is traumatic or prolonged, so as to not disrupt the healthy, self-help efforts of individuals who navigate the grief process healthily on their own. Further, the distinction has been made in the literature between “uncomplicated” and “complicated” grief. Assessing for, and distinguishing between, these two types of grief can be helpful in determining the symptoms and needs of clients as well as identifying points of intervention (Humphrey, 2009).

Uncomplicated grief is that which is sometimes referred to as “normal” grief. Those whose grief is uncomplicated generally recognize their symptoms (e.g., sadness,
yearning, numbness, confusion, etc.) as normal in response to their loss, and they experience a gradual diminishing of these symptoms over time – often a six month to one year period. These are also individuals who are able to recognize and accept the reality of the loss and integrate the loss into their lives as they move forward (Humphrey, 2009).

Conversely, complicated grief has sometimes been identified in the literature as “abnormal” grief. The terms “uncomplicated” and “complicated” have become more widely used because they do not carry the baggage or same stigma as “abnormal” grief may (Humphrey, 2009). Complicated grief is that which does not take an expected trajectory of diminishing symptoms and loss integration into one’s life. Individuals who experience grief in this way may have a continually difficult time accepting the reality of the loss and their symptoms may be prolonged, intensify rather than diminish over time, and they may have difficulty continuing to live in an adaptive, functioning manner (Humphrey, 2009; Neimeyer, 2000a).

Worden (2009) further identified four types of complicated grief – delayed, masked, chronic, and exaggerated. Delayed grief is that which is put off at the time of the loss, but resurfaces later. This may occur when an individual experiences a loss at a particularly stressful or overwhelming point in life and does not take the time to grieve. The grief is delayed and often reappears later when triggered by a subsequent loss. Masked grief is grief that is not clearly evident following a loss, but for which symptoms may appear later or more intensely. This may be the case when an individual does not fully recognize the impact of the loss and he or she may be caught by surprise later at the intensity of the emotional reaction. Sometimes these symptoms manifest later as physical
pain (e.g., chest pain, anxiety attacks, etc.) or as maladaptive behavior, especially in youth (e.g., risk-taking behavior, acting out, etc.); thus, making it more challenging to identify it as a grief issue. **Chronic grief** is experienced for extended periods of time, even for many years. Individuals often recognize their grief is problematic, but have had difficulty integrating the loss into their lives and adapting to life without the deceased. It is not uncommon for these individuals to persistently yearn and long for their dead loved one and to have fantasies of being reunited with him/her soon. Finally, **exaggerated grief** occurs when symptoms of uncomplicated grief are amplified to levels that become problematic. For example, sadness may evolve into clinical depression, anger may evolve into fits of rage, and loneliness may evolve into withdrawal and isolation (Worden, 2009).

Disenfranchised grief, a term first introduced by Doka (1989), is another form of grief that has been identified in the literature and may initiate complicated grief. Disenfranchised grief occurs when a loss is not socially supported or validated, is not or cannot be openly acknowledged, and is not publicly observed – oftentimes limiting a person’s ability to grieve (Doka, 2002). The kind of loss that has been experienced can be one reason for disenfranchised grief. For example, losses related to pregnancy, such as stillbirth, miscarriage, infertility issues, and abortion, are oftentimes not socially acknowledged or discussed and are not always recognized by others as being devastating losses, despite their very distressing nature. Another example is death by suicide. Sometimes family members choose to not release the nature of this type of death, for fear of stigma or judgment, and therefore may experience disenfranchised grief when they
cannot not be fully open about their loss (Kelley, 2010). In these instances, griever may lack the social support that is often helpful in enduring a loss.

Another reason for disenfranchised grief can be the kind of relationship that was lost. For example, sometimes the grief processes of friends of the deceased can be overlooked because so much focus is put on the family of the deceased. Friends may come to the aid and support of family members in such a way as to ignore their own emotions and reactions to the loss. Another example includes individuals who identify as gay or lesbian whose partner has died. If their relationship was not socially acknowledged or accepted by family members, their impact of the loss may not be fully recognized or underappreciated. Another example is an individual who was having an extramarital affair, whose lover has died, may also experience disenfranchised grief. In this instance, the individual has experienced a close loss, but may be unable to publicly grieve it, discuss it openly, or acknowledge the impact it has had (Humphrey, 2009).

Doka (2002) pointed out that individuals who experience disenfranchised grief may experience reactions like those common in complicated grief. Their symptoms may not only be intensified, but may be dominated by feelings of loneliness, isolation, resentment, guilt, and self-condemnation. It is for individuals like this, who experience complicated grief, that grief counseling may be most appropriate and effective (Neimeyer, 2000a). This highlights the importance of counseling professionals understanding grief reactions, being able to assess for types of loss, and recognizing the symptoms that are present.
Grief in the Diagnostic and Statistical Manual of Mental Disorders (5th edition). Grief issues are in the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5) in two areas. First, bereavement is discussed at it relates to major depressive episodes and major depressive disorder. In the discussion about depressive disorders, it is noted that bereavement, despite causing great distress, generally does not induce major depressive disorder. Further, it is noted that in instances that major depressive disorder does co-occur with bereavement, the symptoms and level of impairment are more severe and the prognosis is lower in comparison with bereavement that does not include major depressive disorder (American Psychiatric Association, 2013).

The American Psychiatric Association (2013) also provided information about distinguishing grief from major depressive episodes. It is noted that major depression is generally persistent, cognitively involves self-criticism and pessimism, and emotionally one lacks the ability to anticipate happiness or pleasure. Grief on the other hand, tends to occur in waves, especially evoked by thoughts or memories of the deceased, and symptoms generally lessen in intensity over days and weeks of time.

The second area in which grief is in the DSM-5 is in the chapter about conditions for further study. While disorders in this chapter are not diagnosable mental illnesses in the DSM-5, they are disorders on which further research should be conducted in an effort to inform whether or not they should be included in future editions of the DSM (American Psychiatric Association, 2013). One of the disorders proposed in this chapter is Persistent Complex Bereavement Disorder. Many of the proposed criteria for this
possible disorder are like those symptoms and durations described earlier pertaining to complicated grief. For example, to meet the proposed criteria, an individual must be experiencing, to a clinically significant degree, things like preoccupation with the deceased or circumstances of the death, intense emotional pain, difficulty accepting the death, maladaptive self-appraisals, excessive avoidance of loss reminders, desire to die in order to be with the deceased, difficulty in pursuing interests, and many others. While many of the criteria are symptoms common in grief reactions, it is their severity and duration that would lend to this potential disorder. For example, symptoms must be to a clinically significant degree – meaning it causes significant impairment in an individual’s functioning – and it must be present for longer than a year with adults and longer than six months with children (American Psychiatric Association, 2013). The inclusion of this disorder in the chapter on conditions for further study suggests awareness that over time, symptoms of grief should diminish and become less intrusive on a person’s life; when this is not the case it merits greater attention.

**Background of the Study**

This study focuses on grief counseling competency and training, but prior to discussing the research on these areas, it is important to establish why such competency or training may even be necessary. To do so, this section will discuss the prevalence of loss, while highlighting how early in life it often begins. From there, a developmental approach will be discussed with a focus on the importance of understanding grief reactions at various age and developmental levels. Having explained the prevalence of loss and common developmental reactions to it, the helping role of counselors will be
explored. Finally, having established the value of counselors understanding and being able to work with grief issues, prior research on grief competency and training will be briefly discussed in the subsequent section – statement of the problem.

**Prevalence of loss.** “To love is to one day mourn” (Wolfelt, 2001, p. 93).

Implied in this statement is the notion that all people will eventually lose a loved one and experience the grief that follows. As previously discussed, this can be a very difficult time for anyone, especially in circumstances of complicated grief. Sadly, children are not exempt from such experiences either. In fact, a brief review of the literature reveals that death and loss are quite prevalent even at young ages. While this section focuses a great deal on the experiences of children, one can infer that these same losses impacting children are also affecting adults. For example, while a child might grieve the loss of a classmate or friend, the death of that classmate also affects a variety of adults like parents, relatives, and school personnel. This section will explore how early in life individuals begin to be impacted by loss and how common it is.

Whether it is the death of a family member or peer or one of the other numerous types of losses that exist, children are not shielded from difficult experiences and the emotions that follow. The National Center for Health (2007) reported that nearly a quarter of a million teenagers die each year in the United States. These teenagers leave behind peers, siblings, parents, and other relatives who are left to grieve their death. In fact, the National Center for School Crisis and Bereavement (n.d.) notes that 40% of students will experience the death of a peer by the time they graduate high school.
Similarly, Ringler and Hayden (2000) found in their sample of college-aged students that 44% of respondents lost a peer while in high school.

In addition to the loss of peers, by the age of eighteen approximately five percent of people will experience the loss of one or both parents (Steen, 1998; Stevenson, 2004). Many researchers have identified the death of a parent as being especially difficult for children (Brent, Melhem, Donohoe, & Walker, 2009; Haine, Ayers, Sandler, & Wolchik, 2008; Heath & Cole, 2012). Losing a parent during childhood may have long-term consequences as well. If the loss is not grieved adequately, it can lead to depression and an inability to form close relationships later in life (Worden, 2009). Therefore, the possibility also exists of counselors being required to work on grief issues that are not initially identified as a presenting problem. Counselors may discover that years of unresolved grief are playing a role in the current concerns of their clients, whether children or adults.

**Grief responses by developmental level.** As discussed, there are a variety of losses that individuals might experience at a young age, and it is not uncommon for them to do so. The death of a loved one in children’s lives can be especially challenging because it may be the first significant loss they have experienced. As a result, they may not have in place adequate coping skills or the emotional or cognitive ability to understand and process the challenges that come with the loss (Webb, 2011). Children may struggle with complicated ideas, such as the fairness and meaning of life or the nature of death, but do so without the fully developed conceptual framework of adults (Morgan & Roberts, 2010; Noppe & Noppe, 1987). This highlights the importance of
counselors, in both clinical and school settings, being competent to facilitate grief processes and working through grief issues with children.

Part of this competency is having an understanding of common grief reactions at different developmental levels. Despite the universal nature of loss, reactions are often unique and individualized. This is especially true among children, who make up a wide variety of ages and developmental levels. Researchers are clear about how important it is to know the ages of children and understand their developmental level when offering grief support (cf. Balk, Zaengle, & Corr, 2011; Morgan & Roberts, 2010; Sormanti & Ballan, 2011; Webb, 2011).

Preschool children do not have a mature understanding of death and, therefore, are not able to view it as final and irreversible (Jellinek & Okoli, 2012; Webb, 2011). However, this does not keep children at this age from experiencing sadness or grieving in their own way when a loved one dies (Morgan & Roberts, 2010). Children at this age may feel especially guilty for the death, even believing they caused it by arguing with a parent, being angry at a sibling, or not cleaning their room. As evidence of their lack of understanding about the finality of death, children at this age may also ask questions about when the deceased will be coming back or how the deceased is able to breathe when dead (Morgan & Roberts, 2010; Webb, 2011).

School-aged children, approximately ages seven through eleven, begin to understand the finality of death. However, they may view death as far-removed from their own lives, as something that only happens to the old or weak (Webb, 2005; Webb, 2011). This idea may be challenged depending on the circumstances of the death or who
it was that died. In some instances, children at this age may worry about their own safety or the impact of the death on their family (Jellinek & Okoli, 2012). Guilt can also still play a significant role in the grieving process, though it may shift from feeling responsible for the death to questioning how they may have prevented the death or should have seen it coming (Jellinek & Okoli, 2012; Morgan & Roberts, 2010; Webb, 2011).

Adolescents begin to develop more abstract thoughts about death and may fixate on its finality (Jellinek & Okoli, 2012). Though, some may not fully understand its finality and instead romanticize it by wondering who would come to their own funeral or what people might think if they died (Morgan & Roberts, 2010). Adolescents often begin to question the purpose of existence (Jerome, 2011) and may benefit from deeper discussions, for example, about the meaning of life (Jellinek & Okoli, 2012). Also common in this age group is a shift between intense emotional grief reactions and periods of returning to normalcy. For example, adolescents may report intense sadness, anger, or simply loss of interest, but shortly after return to normal functioning for a period of time. Such intervals can last throughout adolescence and should be monitored over time (Christ, Siegel, & Christ, 2002).

As individuals move into adulthood, Worden (2009) described a number of symptoms of grief that can be experienced as feelings, behaviors, cognitions, and physical sensation. Common feelings include, but are not limited to, sadness, anger, helplessness, guilt, loneliness, and fatigue. Behaviors one may exhibit after the loss of a loved one include sleep and appetite disturbances, absentmindedness, social withdrawal, crying, and having dreams about the deceased. Additionally, some of the cognitions a
bereaved individual might experience are disbelief, confusion, preoccupation or obsessions, and even auditory and visual hallucinations. Finally, individuals may experience physical sensations such as tightness in one’s stomach or chest, lack of energy or weakness, sense of depersonalization, and oversensitivity to noise.

Many of these grief reactions are considered normal responses to a loss. As discussed above, Worden (2009) discussed the idea of complicated grief, when grief reactions are chronic, delayed, exaggerated, or masked. In such instances, individuals may struggle to return to typical functioning even years after a loss. Others may experience such intense grief that it results in maladaptive behaviors. For example, an individual might develop clinical depression resulting from a loss or perhaps anxiety that reaches the level of panic attacks or phobias (Worden, 2009). Counselors who are not trained to assess for and recognize the role of loss and grief may overlook the underlying cause of clinical presentations such as these.

Role of counselors. Regardless of age, death-related concerns of clients pose one of the most urgent issues for which counselors need to be prepared (Kirchberg, Neimeyer, & James, 1998). The death of a loved one and the subsequent grief is something that impacts all facets of an individual’s life. For adults, it means that they are faced with memories and emotions of the loss throughout their day, whether at home, work, during social occasions, or any other activities and interactions they have. For children, this includes time at home, school, and any extracurricular activities in which they are involved. Based on the statistics described earlier, which reveal the prevalence of loss in life, and the large number of students present in a school system, school
counselors may expect to encounter grief issues in their work. Additionally, many clinical mental health counselors work with child clients or spend time working directly in school systems or in conjunction with schools. Given that children spend a large portion of their day at school, the National Center for School Crisis and Bereavement (n.d.) identifies it as an important place of support and care during their grieving process; thus, highlighting the important role counselors can play in facilitating healthy grief.

The National Center for School Crisis and Bereavement (n.d.) identifies several reasons that the school is one of the best settings to provide support after a loss affects the school community. First, the school is a familiar and generally safe environment. Second, services may be readily available in a school setting, and a large number of individuals can be reached at a time. Third, students can be monitored for emotional and behavioral changes, because several individuals see them on a daily, even hourly, basis over an extended period of time. Heath and Cole (2012) even wrote that schools have been identified by national and international organizations as having unparalleled potential to offer mental health services to children.

The role of counselors working with schools becomes highlighted when it is understood that schools provide an opportune time and place to support grieving children. While many individuals are present in the school to help monitor and support students, there are few who have received the mental health training of counselors. This puts them in a unique position to offer support to grieving students. Counselors may have an opportunity to provide support to students; educate students, staff, and parents about
grief; facilitate healthy grieving; and monitor for mental, emotional, and behavioral challenges in bereaved children.

For counselors who are not working in school systems, their role in helping facilitate a healthy grieving process is not diminished. Currier, Holland, and Neimeyer (2008) wrote that professionals working with dying and bereaved individuals frequently join them in a profound and painful journey of searching for understanding. Oftentimes such counselors are relied upon to assist individuals in addressing questions of meaning following the loss of loved ones. Counselors in both school and clinical settings can serve an important role in helping clients work through current or past grief issues. But, are counselors adequately trained in working with grief issues and do they think they are competent in doing so?

Statement of the Problem

Research on grief training and competence. Research on the training provided in the areas of grief and end-of-life issues, both in the mental health and medical fields, has increased since the 1980s and on into the 2000s (cf. Dickinson, 2007; Dickinson & Field, 2002; Fonseca & Testoni, 2012; Gamino & Ritters, 2012; Humphrey, 1993; Kees, 1987; Wass, 2004; Watts, 2007). Other researchers (Allen & Miller, 1988; Breen 2010, Charkow, 2002; Ho Chan & Tin, 2012, Kirchberg & Neimeyer, 1991; Kirchberg, Neimeyer, & James, 1998; Morgan & Roberts, 2010; Ober, Granello, & Wheaton, 2012; Smith, 2003) have focused their research and writings on practitioners already providing grief support. A brief discussion of some of these findings is worth providing here so as
to discuss the issues this study explored. However, they will be discussed in greater detail in the literature review of chapter two.

Kirchberg and Neimeyer (1991) surveyed beginning counselors and asked them to rate their degree of comfort with fifteen counseling scenarios. Five of these scenarios involved death or loss, while the other ten had different focal points, such as marital problems, rape, career issues, and incestual and physical abuse, among others. Responses to the surveys indicated that beginning counselors felt significantly less comfortable with the scenarios pertaining to death and loss than the other scenarios. Amount of counseling experience was found to be unrelated to the discomfort reported, suggesting that regardless of the respondents’ experience providing counseling, death and loss issues were still reported as being the most uncomfortable.

Humphrey (1993) surveyed 135 counselor education programs about grief counseling training. It was found that 70% of programs indicated grief counseling training was very important or important. However, nearly 67% of respondents did not offer a course in grief counseling. Instead, this information was incorporated into other courses. One of the reasons cited by schools that did not include grief counseling training was that it was not a requirement for accreditation. This is an issue that is discussed at the end of this section.

In a survey of 627 rehabilitation counselors, Allen and Miller (1988) found that 54% had received no formal training in grief issues and 98% reported needing more training than they had. Similarly, Charkow (2002) surveyed 147 members of two associations for marriage and family therapists and found that over half had not received
any training on grief, despite nearly all respondents reporting they worked with clients on grief issues. Other researchers also found grief courses to be lacking in mental health training programs (Freeman & Ward, 1998; Hunt & Rosenthal, 1997).

The previously described lack of training in grief counseling is concerning, because studies involving other mental health professions have revealed a correlation between the amount of training received and perceived grief counseling competencies. For example, Smith (2003) found that 35% of the variance in self-perceived grief counseling skills was explained by specific training on grief and general counseling skills. Additionally, in Charkow’s (2002) survey of marriage and family therapists, participants who reported higher levels on the subscale of Personal Competencies in grief (e.g., overall wellness and ability to articulate thoughts and feelings about grief) also reported higher levels of grief counseling competence. Finally, in a survey of licensed professional counselors Ober, Granello, and Wheaton (2012) found that training and experience in grief counseling were statistically significant predictors of perceived grief counseling competence.

**Research Questions**

The goal of this study was to explore the current state of grief counseling training and perceived grief counseling competencies in master’s level counseling students in CACREP-accredited institutions in Ohio. Participants were required to be in the field experience part of their training to ensure they had worked with clients and completed most of their training. Additionally, the relationship between several different variables
and perceived grief counseling competencies was investigated. Specifically, the following research questions were addressed:

1. Among master’s level counseling graduate students in their field experience, what is the extent of professional training and experience with grief counseling, as measured by the Grief Counseling Experience & Training Survey (GCETS)?

2. What are the levels of self-perceived grief counseling competencies of master’s level graduate counseling students, as measured by the Death Counseling Survey (DCS) and its five subscales?

3. What is the difference in the areas of grief counseling experience and training (GCETS) and levels of self-perceived grief counseling competencies (DCS) between school counseling students, clinical mental health counseling students, and those pursuing both?

4. What is the relationship between self-perceived grief counseling competencies (DCS) and the variables of age, gender, professional training and experience with grief (GCETS), degree track, and type of grief counseling training received?

**Significance of the Study**

As evidenced by the prevalence of loss described above, counselors in both school and clinical settings will likely work with individuals facing grief issues. Unfortunately, Kirchberg and Niemeyer (1991) found that beginning counselors were especially uncomfortable working with grief-related issues as compared to other issues. Several other studies (Allen & Miller, 1988; Charkow, 2002; Garfield, Larson, & Schuldberg, 1982; Humphrey, 1993; Ober, Granello, & Wheaton, 2012; Rosenthal, 1981;
Wass, 2004) suggested that a focus on grief counseling is not a significant part of the training helping professionals receive. However, in many of these studies, the majority of respondents believed it should be required and noted they desired more training.

More recently, professional standards have included requirements for grief-related training, which are discussed in chapter two. While not specifically requiring grief counseling, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards require that students be trained to have the knowledge and skills necessary to understand and work with individuals who have experienced a crisis, disaster, or trauma-related event (CACREP, 2009). Furthermore, the ASCA School Counselors Competencies require that school counselors understand responsive counseling services, such as those for grief and bereavement, and that they be able to “provide counseling during times of transition, separation, heightened stress, and critical change” (ASCA, 2012).

This study explored the level of grief training, experience, and perceived grief counseling competencies in master’s level school and clinical mental health counseling students. Findings offered insight into the most current grief counseling training students receive as opposed to a retrospective look that would occur by surveying professionals already working in the field. This study augments the current literature regarding grief counseling competencies in mental health professions and explored how prepared students feel to work with grief issues. This study also provides more information about the reliability and validity of the Grief Counseling Experience and Training Survey
(GCETS) and Death Counseling Survey (DCS) – instruments used to assess grief counseling training, experience, and competencies.

Additionally, this study adds to the body of literature by exploring these issues as they pertain to individuals still in training. This has already been done with clinical counselors as well as marriage and family therapists. In a study of marriage and family therapists, it was found that higher levels of grief counseling competencies were reported by respondents who had higher scores on the Personal Competencies subscale of the Death Counseling Survey (DCS) (Charkow, 2002). In another study, Smith (2003) found that 35% of the variance in counselor’s perceived grief counseling skills was explained by specific training in grief and general counseling skills. Additionally, in a study involving professional counselors, it was found that professional training and experience was a statistically significant predictor of perceived grief counseling competence (Ober, Granello, & Wheaton, 2012). This study will add to the current body of research by exploring these areas in master’s level counseling students who are currently completing their training.

By exploring the current state of grief counseling training and the perceived competencies of counseling students, counselor education programs will have an opportunity to reflect on the grief counseling training opportunities available to their students. Similarly, on a personal level, students and counselors may be encouraged to reflect on their own grief counseling competencies and training, which could promote those who feel lacking in such areas to pursue professional development opportunities.
Delimitations of the Study

There are a few delimitations to be considered for this study. It is difficult to identify the variables which predict grief counseling competencies, as research on the topic is very limited and the results are inconsistent (Charkow, 2002). The independent variables selected for this study were age, gender, professional training and experience with grief as measured by the Grief Counseling Experience and Training Survey (GCETS), degree track, and type of grief counseling training received. The first three variables were selected based on the literature and their involvement in previous studies, so as to further corroborate or challenge what has been learned so far. The latter two variables were included to further expand the current body of knowledge. Since this study was exploring grief counseling training, these two variables were used to explore differences and relationships in the types of training counseling students receive. The use of these selected variables both further explored past research in the literature and created new opportunities to further explore counseling training.

Another delimitation is that only master’s level counseling students in Ohio who were in their field experience participated in this study. The data collection method used limited the sample to Ohio, as is further explained in chapter three. Surveying only students who were in their field experience helped ensure students had completed the majority of their coursework and could provide a more thorough appraisal of the type of grief counseling training they received in their programs. Additionally, they all had at least the potential for working in their field experience with individuals facing grief issues. On the contrary, students who were not in their field experience were not used for
the study. They would not have had the opportunity to work with clients on grief issues, and it is less likely they would have completed the majority of their coursework. Therefore, they would not be able to respond as thoroughly to the grief training and experience available and utilized in their programs.

**Limitations of the Study**

There are limitations to consider in this study. First, the use of self-report data relies on a subjective, personal assessment of participants’ grief counseling competency. Thus, the results relied on an assumption of honest and accurate responses by participants. There are currently no objective assessments in the profession that students, supervisors, or other evaluators could use to determine a counselor’s grief counseling competency. Additionally, the self-report nature of the assessment has been recognized in this study by using the language of “perceived” grief counseling competencies, as opposed to only grief counseling competencies. This was done in an attempt to clarify that the study only explored how prepared and competent students believe they are, not objectively assessing their actual skill in working with grief issues.

Second, the generalizability of the results in this study is limited. The sample of respondents included master’s level counseling students in Ohio and was predominantly white (79.2%) and female (75.3%). Further generalization (e.g., nationally or generalization to all counselors) is ill advised based on the sample. That said, these statistics are very similar to those found in Ober, Granello, & Wheaton (2012), which studied professional counselors in the same state.
Third, the use of the Death Counseling Survey (Charkow, 2002) and Grief Counseling Experience and Training Survey (Deffenbaugh, 2008) is a limitation in that these are relatively newly developed instruments and have not been used extensively in the research. However, as described later in chapter three, they have been found to demonstrate sufficient psychometric properties and are the only instruments available to assess for grief counseling competencies and experience and training in grief counseling. Furthermore, their use in this study further adds to the understanding of their psychometric properties.

Definition of Terms

For clarification, the subsequent terms used in this study are defined as follows:

Field experience. In CACREP-accredited institutions, clinical mental health counseling students are required to complete a supervised field experience during which they provide counseling services to bona fide clients. In Ohio, the Counselor, Social Worker, and Marriage and Family Therapist Board stipulates that students complete a practicum experience of 100 hours, 40 of which must be in direct service to clients. An additional 600 hours of internship must also be completed, and 240 of these must include direct service and the diagnosis and treatment of mental and emotional disorders. The Ohio Department of Education, the licensing body for school counselors, stipulates that school counseling students must complete a field experience internship that consists of 600 contact hours in a school setting (Lawriter, 2010).

Grief. Grief can be understood as an individual’s emotional, cognitive, and behavioral experiences after a loss (Worden, 2009).
**Perceived grief counseling competencies.** The dependent variable in this study was perceived grief counseling competencies, as measured by the five scales on the Death Counseling Survey developed by Charkow (2002). The instrument is self-report and uses a Likert-type scale to ask respondents to rate their level of confidence, from “This Does Not Describe Me” to “This Describes Me Very Well,” on statements concerning their experiences, beliefs, and abilities with grief and grief counseling. The instrument results in a total score, as well as scores on five subscales of Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills. These are discussed in greater detail in chapter three.

**Summary**

This chapter began by providing a brief overview of grief and the background of this study by highlighting key literature in the topic area. The problem statement was provided, as well as the research questions that were addressed. The significance of the study was explained and the delimitations and limitations were disclosed. Finally, the key terms used in this study were defined. The following chapter will more thoroughly review the existing literature relevant to this area of study.
Chapter 2 - Literature Review

Introduction

As outlined in chapter one, loss is prevalent among individuals of all ages and the grief that ensues has an impact on all areas of a person’s life. Given the prevalence of loss, it is likely that both school and clinical mental health counselors will work with individuals on grief issues. At times these may be presenting concerns, but at other times, grief issues may be present without open acknowledgement or understanding on the part of the client. Thus, such issues may be overlooked if counselors are unable to, or simply do not, assess for unresolved grief issues in clients presenting with other concerns.

This chapter opens with a review of grief theories and then discusses previous literature that focuses on counselors’ experiences with grief issues and their feelings of preparedness to work with them. It also reviews studies that explored the amount and type of grief counseling training that professionals have had. While the literature specific to school and clinical mental health counselors is limited, many of these studies explored these topics in mental health professions such as marriage and family therapists, hospice workers, and rehabilitation counselors. Throughout this chapter, information will be organized with a focus on chronology by first providing background studies and then discussing more recent studies that have been conducted.

Theories of Grief

Psychoanalytic understanding of grief. Pertaining to the field of mental health, Sigmund Freud developed some of the earlier ideas about loss and grief in his writings on psychoanalysis, especially in *Mourning and Melancholia* (1917). In this work, Freud
identified the major task of mourning as withdrawing energy (i.e., emotions, attention, etc.) from that which has been lost and reinvesting it or redirecting it toward new or existing relationships. Grief that became pathological would occur when the surviving individual was unable to reinvest this energy and instead focused too much on the absence of the loved one or internalized negative feelings that were held toward the deceased. In this instance, negative feelings became a part of the survivor’s sense of self, often resulting in lowered self-esteem or self-blame and guilt (Freud, 1957).

**Stage theories.** Phases or stages of grief were first developed by Colin Parkes and John Bowlby, as they built on Bowlby’s attachment theory (Servaty-Seib, 2004) and became especially well known to the general public and culture with the development of Elisabeth Kubler-Ross’ stage model (Humphrey, 2009; Kelley, 2010). Bowlby, based on his work on child and parent attachments, suggested that grief involved separation anxiety linked to the attachment to the deceased, the disruption of the bond between the living and the deceased, and the necessity for emotionally detaching from the lost loved one (Bowlby, 1969, 1973, 1980). Parkes (Bowlby & Parkes, 1970; Parkes, 2001) worked collaboratively with Bowlby and his attachment theory to develop phases of grief that occur when an individual loses a loved one. These phases include numbness, yearning and searching, disorganization and despair, and reorganization. Like Freud’s approach to grief, this phase approach moved from the initial emotional response individuals experience due to loss to eventually detaching emotionally from the deceased.

Kubler-Ross (1969) proposed a stage theory based on her work in a hospital with terminally ill patients who were dying. Despite often being extrapolated to grieving
individuals and used in counseling texts and courses (Humphrey, 2003; Kees, 1987), her stages were initially a five-stage theory on the dying process, not necessarily the grieving process. These five stages include denial, anger, bargaining, depression, and acceptance. Kubler-Ross’ stage paradigm has been deeply embedded in grief counseling and in our culture (Kelley, 2010), despite a lack of empirical evidence (Bonanno & Kaltman, 1999; Hansson & Stroebe, 2007; Lindstrom, 2002; Stroebe & Schut, 1999; Wortman & Silver, 2001). Criticism for phase and stage theories often focus on the notion that these models assume grief is a predictable process in which individuals are expected to advance linearly through particular phases or stages as their grief is resolved. Kubler-Ross responded to this criticism in her final book by explaining that the stages were not meant to be rigid, rather a general guide for grief that allowed for individuality and overlap among and within the stages (Kubler-Ross & Kessler, 2005).

**Task theories.** Similar to the stage theories described above, Rando (1993, 1995) and Worden (2009) have theorized processes or tasks through which individuals proceed as they grieve and mourn the loss of a loved one. Despite implying some progression, these tasks were meant to be distinct from stages in that the authors proposed the tasks overlapped and could be revisited over time. Both identified completion of the tasks as necessary for individuals to healthily integrate a loss into their lives.

Rando (1993) identified six processes that included recognizing the loss, reacting emotionally to the separation, recollecting and reexperiencing the deceased and the relationship, relinquishing old attachments and assumptions, readjusting to an altered world, and reinvesting in new relationships. Worden (2009) identified four tasks that
included accepting the reality of the loss, working through the pain of grieving, adjusting to an environment in which the deceased is missing, and emotionally relocating the deceased and moving on with life. Despite susceptibility to being viewed as stage-like, these tasks models have been praised for their action-oriented manner (Servaty-Seib, 2004).

**Dual process theory.** Stroebe and Schut (1999, 2001) developed a dual process model of grief that was an integration of previously developed grief theories, cognitive stress theories, and coping models. The authors suggested a need for a stressor-specific approach to grief, because multiple and diverse stressors cause challenges following loss, not just a single stressor (i.e., the death). They suggested that confronting and avoiding stressors along two dimensions is necessary for adapting to loss. These two dimensions include loss-oriented stressors and restoration-oriented stressors.

Loss-oriented stressors are associated with the loss itself and focus on the disrupted bond with the deceased. These include stressors such as reviewing the events surrounding the loss, experiencing memories of the deceased, and emotionally reacting to and ruminating on the loss. Restoration-oriented stressors arise as individuals deal with life changes that occur because of the loss. For example, an individual may experience a change in financial status or responsibility, increased responsibilities at home such as chores and childrearing, and having to adapt to new family roles and patterns of communication. These are secondary consequences that have to be adapted to as a result of the primary loss (Humphrey, 2009; Servaty-Seib, 2004; Stroebe & Schut, 2001).
The dual process model incorporates a few components that have been identified as critical to its applicability to the grieving process. First is the notion of confrontation and avoidance. Stroebe and Schut (2001) noted that when individuals experience stressors, they sometimes choose to confront them and other times choose to avoid them, which is an adaptive part of the grieving process. For example, an individual may choose to feel and express sadness when discussing the loss with other loved ones. This individual has elected to confront those feelings in that moment. On the other hand, this same person may choose to avoid experiencing these feelings at work, because he or she does not want to be overcome by emotion while on the job. In this situation, the individual may actively distract himself or herself with busyness and tasks to help avoid difficult feelings.

A second important component is what theorists have termed “oscillation,” or the shifting back and forth between the loss-orientation and restoration-orientation. This adaptive, healthy process is one necessary for effective coping. It allows individuals to oscillate, over time or even in a single day, between focusing on the loss and focusing on restoring an adaptive, new way of life. It has been identified as the core of the dual process model because it allows griever the space to both move on with life and still remain connected to the deceased – two difficult-to-reconcile aspects of grief (DeSpelder & Strickland, 2002; Humphrey, 2009; Servaty-Seib, 2004).

**Meaning-making theory.** Neimeyer (2000a, 2001) developed a grief model of meaning-making, in which he suggests meaning reconstruction is the central process to grief. In a narrative, constructivist approach, he writes that humans are the authors of our
own lives and we struggle to develop a meaningful account of important events as we revise, edit, and sometimes rewrite our beliefs and assumptions when they are challenged by unanticipated events. With a focus on meaning-reconstruction, the goal of grieving becomes less about returning to a pre-loss level of functioning and instead becomes about developing a meaningful life with the deceased no longer present (Wortman & Silver, 2001).

Neimeyer (2000b) pointed out that the process of meaning reconstruction is more about discovering or creating meaning and less about searching for meaning that already exists. As a result, this process becomes highly individualized and unique for each grieving person. It is a continual process for which there are no predetermined tasks or stages that, once accomplished, terminate the grief process. Since meanings associated with death are continually revised, the focus is on the process as opposed to an outcome or achievement.

Furthermore, Neimeyer (2000b) suggested it is important for counselors to facilitate the meaning making process when clients struggle to do so, but cautions against initiating the process if clients have not already begun it themselves. While counselors should provide a space for clients to reshape a shattered world, promote personal growth and insight, and guide meaningful actions in response to loss (Gillies & Neimeyer, 2006), it is believed the search for meaning is best started spontaneously by the client and not initiated by the counselor (Neimeyer, 2000b).

**Continuing bonds theory.** Whereas many of the early perspectives on grief involved disengagement and detaching emotionally from the deceased, contemporary
theorists posit the idea of continuing bonds. Instead of severing the bond and detaching, a more normative approach is believed to involve a continued dynamic connection. Rather than, “moving on” or “saying goodbye,” as grievers are often expected to do, continuing bonds allows for the continued relationships between the griever and the deceased – albeit in a revised or altered way (Klass et al., 1996). This approach is not to deny the loss has occurred, but to recognize the meaningfulness of the relationship and draw comfort from it, while still adjusting to changes and being open to other relationships and experiences (Humphrey, 2009). Worden (2002) wrote that this is a way for grievers to, “remember the deceased while feeling comfortable reinvesting in life” (p. 52).

Counselors’ Experiences with Grief Issues

Having discussed theoretical approaches to grief, this section will review studies that pertain to counselors’ experiences with grief issues. The first of these was a dissertation in which Kees (1987) conducted a study exploring differences in students trained in grief counseling and those who were not. The purpose of the study was to examine whether or not those who had received grief counseling training had higher levels of comfort and feelings of preparedness to work with grief issues. The study also explored the effect of a number of variables, including age and gender, personal loss history, and feelings of having resolved personal losses, on reported level of comfort and preparedness. Sixty-two master’s-level counseling students participated in the study with 27 students who had taken a grief counseling course and 35 who had not. The
The instruments used in the study were developed by the author, as no appropriate instruments were available at the time.

Kees (1987) concluded through the analyses that age, gender, and personal loss history were not significant factors in predicting comfort level and feelings of preparedness with grief counseling situations. However, it was discovered that students who had taken a course on grief counseling were more likely to rate their personal losses as having been resolved than students who did not. This is important in light of more current researchers (Ho Chan & Tin, 2012; Watts, 2007) who suggested that part of working effectively in grief counseling involves not only knowledge and skills, but also includes a more personal component of reflection on, and development of, attitudes, values, and beliefs about death.

Kees (1987) also found that respondents had not covered issues of grief and death in classes outside of the one designed specifically for that purpose. Only 19% of the treatment group and 14% of the control group reported that these issues had been thoroughly covered in a course other than the grief counseling course. This suggests that students who did not take the specific grief counseling course were unlikely to cover the topics of grief and death in other classes.

This study provides limited evidence as a result of its small sample size and the use of previously unused instruments, but there was noteworthy qualitative data that was also collected. It was found that students who had taken the grief counseling course identified professional training as the primary reason for their greater level of comfort and preparedness for working with grief issues. This, and the findings previously
discussed, suggests students who received training specifically in grief counseling recognized the value of having done so and felt more prepared to work with grief issues than those who had not received such training (Kees, 1987).

Kirchberg and Neimeyer (1991) also conducted a study to explore the level of comfort beginning counselors had with death and grief issues. A sample was used of 81 graduate students, who had counseling experience ranging from zero to 15 years. The mean amount of years of experience, however, was only 1.8, so most participants had limited experience as a counselor. Additionally, the sample was not very generalizable, as 84% of individuals were female and 88% were white. Students were presented with a variety of counseling scenarios, five of which were death-related scenarios and ten with other focal points.

Participants in the study reported significantly more discomfort with the scenarios that were death-related and also ranked them consistently as more challenging than the other scenarios. In fact, five of the top eight scenarios ranked as most difficult were death-related. The researchers concluded that beginning counselors experience a great deal of discomfort when faced with death-related issues and that more research needs to be done so appropriate death education training programs can be developed (Kirchberg & Neimeyer, 1991).

Terry, Bivens, and Neimeyer (1995) conducted a follow-up study related to the one previously described. In the first study, graduate students were used, but in this study the authors surveyed experienced grief counselors, whose mean years of experience was over 14. This contrasted the previous study in which the mean years of experience was
only 1.8. Participants were also more varied, as 68% were female and 32% were male, with a variety of counseling setting experience (e.g., hospital, churches, funeral homes, etc.). The authors also noted that the instruments used in the study also exhibited strong test-retest reliability, internal consistency, and construct, face, and discriminant validity (Terry, Bivens, & Neimeyer, 1995). One of the surveys administered was the same 15-scenario survey that was used with graduate students that described five death-related scenarios and ten non-death-related scenarios.

The results of this study contrasted with those of the graduate students. In this study, the experienced counselors did not rank any death-related scenarios in the top four in terms of discomfort and overall found death-related scenarios as less distressing than non-death-related scenarios. Additionally, empathy and comfort levels with death-related scenarios were significantly correlated with years of formal education and experience in grief counseling (Terry et al., 1995). The authors, in a summary of the two studies, suggest that aversion to, and discomfort with, grief counseling and death-related scenarios occur primarily among counselors with little formal training or experience in such work (Kirchberg, Neimeyer, & James, 1998); potentially highlighting the value of including grief counseling in training programs.

A third study was conducted by Kirchberg et al. (1998) to further explore distress with grief counseling scenarios among beginning counselors. Fifty-eight counseling students in their practicum experience participated in the study. Surveys to assess for discomfort and fear of death, as well as videotaped scenarios – four death-related and four non-death-related – were used to assess for levels of discomfort and a relationship
between fear of death and discomfort. The survey instruments used exhibited sound psychometric properties including high reliability and construct validity (Kirchberg et al., 1998). Similar to the first study involving counseling students, the results of this study also revealed that students experienced significantly more distress with death-related scenarios than non-death-related. Additionally, it was found that an individual’s fear of death was positively correlated with discomfort with death-related scenarios. That is, as one’s fear of death increased, discomfort with death-related scenarios also increased (Kirchberg et al., 1998). Since the participants in this study were beginning counselors, their experience was very limited; however, it is an important study in that it lends insight into the discomfort novice counselors have with death-related issues.

**Grief Counseling Training**

Little research has been done regarding the training of clinical mental health and school counselors. However, there has been some research done in other helping fields with regard to the amount of grief counseling training received. The findings described in the Kirchberg et al. (1998) study, that fear of death and discomfort with grief issues are positively correlated, may support the notion that grief counseling training should include not just the acquisition of knowledge and skills, but also a focus on students’ attitudes, beliefs, and values regarding death (Ho Chan & Tin, 2012; Watts, 2007). It also calls into question whether or not such information and personal reflection can be covered without a course specifically focused on grief. Wass (2004) suggested that offering grief counseling training in only a few lectures of other courses does not allow for the necessary depth for effective education and leaves graduates unprepared to work with
grief issues. While it is suggested by some that courses devoted solely to grief issues are
necessary, there is strong evidence that there may be a complete lack of training, in any
format, in grief issues. This will be discussed in this portion of the chapter.

Stephenson (1981) surveyed 119 members of The American Association of
Marriage and Family Therapists regarding their experiences with death, grief counseling,
and formal education related to grief. Many participants were expected to work with
grief issues, as 91% of respondents stated they had counseled a family that had lost a
member to death, while 74% reported having counseled a dying individual. Despite
being called upon for such services, when asked if they viewed themselves as competent
to do grief counseling, 40% responded they did not. Furthermore, among the 60% who
reported feeling competent, 90% said they had received little or no formal training in the
area. With regard to the lack of training, 97% of all respondents believed death education
needed to be a part of formal training and 77% reported they did not received adequate
training. In light of these findings, the author suggested that death is too significant and
sensitive of a topic to not be included as part of formal training in preparation programs
(Stephenson, 1981).

Similarly, Allen and Miller (1988) surveyed a large number of rehabilitation
counselors and found that over half of the 627 respondents had no formal training in
grief. Despite the lack of training, these professionals were confronted with grief issues
in their work, as evidenced by 61% having had a client die within the previous year and
40% working with a terminally ill client. Given the demand for such services and little to
no training, it is not surprising that 98% of the respondents reported they needed more training on the topic of grief.

Humphrey (1993) surveyed graduate training programs that prepared professional counselors. The goal of the study was to explore the extent to which programs are teaching grief counseling. Specifically, the opinions of counselor educators were explored, the manner in which grief counseling is included in curricula, and reasons for not including grief counseling in the training of students. Surveys were returned by 135 counselor education programs, of which 122 offered a school counseling track and 113 offered a mental health counseling track.

The majority of respondents (70%) reported they believed teaching grief counseling was important or very important. However, nearly 20% of respondents indicated that grief counseling was not being addressed at all in their training programs, and a variety of reasons were offered as to why. These included a lack of funding, having no room for it in the curriculum, not having qualified faculty to teach it, having no demand for grief counseling or it not being considered important, and that it was not required for accreditation (Humphrey, 1993). This study was published in 1993 and, as discussed in chapter one, the training standards implemented by CACREP and ASCA have since changed the requirements for grief and grief-related training.

The type of training offered was also explored in the study. Over 66% of the respondents indicated their programs did not offer a course focused specifically on grief counseling. However, 73% indicated they included grief counseling information in other courses. The most identified area in which grief counseling training was infused was
field experiences. This is concerning in that students are already seeing clients by the
time they have received any grief counseling training. Based on the prevalence of client
issues pertaining to loss, the author suggests it is essential for counselor training
programs to provide students with the knowledge and strategies needed for effective grief
counseling (Humphrey, 1993).

Breen (2010) conducted a qualitative study that explored issues and dilemmas
facing grief counselors. Of the 19 counselors interviewed, only two had accessed grief
information from their formal studies and even then they did not find it useful in
providing grief support for clients. Many grief counselors also expressed concern about
the sensitivity of grief counseling and noted that effects can be detrimental or damaging
to clients if counselors are not competent in this area. This notion is further supported by
researchers who note that grief counseling should be engaged in selectively, as it is not
always required for those who experience a loss and can sometimes even be detrimental
to them (Neimeyer, 2000b). These findings speak to the importance of training and the
development of competencies in grief counseling.

**Professional standards.** The most recent iterations of professional standards that
guide the training of counselors call for training in grief and grief-related areas, such as
crisis response. For example, the Council for Accreditation of Counseling and Related
Educational Programs (CACREP) does not explicitly require grief training, but does
require that clinical mental health counselors be trained to have the knowledge of how
people are impacted by crises, disasters, and other trauma-causing events in addition to
knowing the principles of intervention for such events (see Appendix D). Additionally,
students are required to be able to differentiate between developmentally appropriate and diagnosable responses to such events (CACREP, 2009). As described earlier, understanding developmentally appropriate responses, as well as understanding uncomplicated versus complicated grief reactions is especially relevant in providing grief support. Further, the standards call for students to be able to promote optimal human development. As Worden (2009) indicates, unresolved grief issues early in life can manifest as emotional and relational problems throughout one’s development.

The CACREP standards have similar requirements for the training of school counselors, as they are expected to understand the potential impact of these events on students and know the skills necessary for intervention. They are also to be prepared to work with students and support systems to address any areas that affect student success. Given the significant impact of loss and its influence on all areas of an individual’s life, grief reactions may be a temporary or on-going challenge to student success.

Finally, the CACREP standards also require that students in school counseling programs understand the American School Counselor Association (ASCA) National Model. Organized around this model are the ASCA School Counselor Competencies (ASCA, 2012) that require school counselors to understand, “responsive services (counseling and crisis response) including grief and bereavement” (p. 8). Additionally, it is expected that they be able to, “provide counseling for students during times of transition, separation, heightened stress and critical change” (p. 9). Times of loss certainly fall under each of these standards, and school counselors would be expected to be able to provide grief-related services to students when necessary.
Grief Counseling Competencies

Charkow (2002) developed the Death Counseling Survey (DCS) and used it in her dissertation, which studied grief counseling competencies. The DCS assesses not just knowledge and skills related to grief counseling, but attitudes and personal philosophy regarding death and personality characteristics. It was developed using relevant literature in the area of grief counseling and by consulting individuals who were considered experts in the grief counseling.

The experts in grief counseling were defined as individuals who had earned at least a master’s degree and had at least five years of grief counseling experience. These included practitioners, researchers, and educators. A total of 34 participants were involved in developing the DCS. Participants took part in three rounds of surveys that asked for a variety of information regarding grief counseling content and competencies. For example, participants were asked in one survey to identify the three to five most important components they would include in a course on grief counseling, as well as what three to five characteristics would be most important for them to consider when hiring a counselor to work with in the field of grief counseling. After categorizing these responses, the author sent the participants a list of 111 characteristics and competencies related to grief counseling, as determined by a literature review and clinical experience. The respondents were asked to rank the characteristics and competencies from one to five – not important to essential when working with grief issues – as well as provide any open-ended suggestions for additional items to consider. All of these responses were analyzed and a new list of characteristics and competencies was developed and sent out
for another round of ranking. This final iteration was again analyzed and items were deleted and adjusted as necessary based on the feedback received. From this series of surveys and literature reviews came the final DCS, which was then used to assess grief counseling competencies in members of two marriage and family therapist associations in the study described next. Additional details and information on the psychometric properties of the DCS can be found in chapter three.

Charkow (2002) used a sample of 147 individuals that represented only a 7-8% response rate to the survey, thus limiting the generalizability of the information acquired. The results of the study suggested the majority of counselors surveyed believed they had the personal competencies necessary to provide effective grief counseling. These personal competencies include practicing wellness and self-care, attitudes and beliefs about death, sense of humor, spirituality, and displaying genuineness and empathy in interactions with others. However, when it came to scales assessing for knowledge and skills related to grief counseling, respondents reported themselves much lower. These items include assessment for unresolved grief issues, knowledge of grief theories, ability to provide clients with psychoeducation related to grief, facilitating grief counseling sessions, and treating grief-related issues. In summary, respondents viewed themselves as competent with regard to personal factors necessary for grief counseling, but viewed themselves as much less competent when it came to knowledge and skills (Charkow, 2002). This study provided an important distinction in that it separated grief counseling into multiple facets and explored the different areas that comprise it. Unfortunately, the
areas regarding specific skills in grief counseling were those with which respondents felt least competent.

Another study that had a similar scope was reported by Smith (2003). In that study, the construct of licensed counselors’ ability to cope with death, both professionally and personally, was studied in relation to counseling self-efficacy, grief training, and personal experience with grief. Ability to cope with death was measured by the Coping with Death Scale (CDS) that Charkow (2002) used to determine high concurrent validity with the Death Counseling Survey. Amount of grief training was studied by asking respondents to report the number of clock hours they spent in training on grief counseling. Personal experience was studied simply by asking a dichotomous, yes or no, question about personal bereavement; that is, had they experienced the loss of a friend, family member, or close relative. Counseling self-efficacy was measured using five factors of the Counselor Self-estimate Inventory developed by Larson et al. (1992).

In this study of 257 counselors, it was found that general counseling skills and training on grief counseling accounted for 35% of the variance in self-perceived grief counseling skills. The results also suggested that individuals who had high counseling self-efficacy and awareness of their values and attitudes about death viewed themselves as better able to express their feelings regarding loss. Personal bereavement did not make a significant contribution to explaining how counselors cope with death. Based on the results, the researcher concluded that counselors benefit from specific training on grief counseling issues (Smith, 2003).
Deffenbaugh (2008) also assessed grief counseling competencies in a dissertation study published as a journal article in 2012 (Ober, Granello, & Wheaton, 2012). For the sake of clarity throughout this paper, “Deffenbaugh” and “Ober” is the same author, but her dissertation was completed under the former and the article later published under the latter. The purpose of the study was to explore grief counseling competencies among licensed professional counselors in the state of Ohio. A sample of 369 counselors was used with a response rate of 37%. Individuals reported on their personal and professional experiences with grief, grief training, and grief counseling competencies. Personal experience with grief was measured using the Texas Revised Inventory of Grief (TRIG), which assesses for the intensity of grief responses to the loss of a loved one on scales of both past and present feelings. Professional experiences and training in grief issues were measured using the Grief Counseling Experience and Training Survey (GCETS). No instrument exists to assess for this, so it was developed, with permission, by adapting the Sexual Orientation Counselor Competency Scale (SOCC). The adaptation included changing the language from gay, lesbian, and bisexual clients to clients who present with grief to make it appropriate for the study. The instrument was used in a pilot study prior to using it in the larger study. Reliability was evidenced with a reliability coefficient of 0.86 (and a Cronbach’s alpha of 0.97 in the larger study) and validity was demonstrated through follow-up interviews with respondents. Finally, the DCS was used to measure perceived grief counseling competencies (Ober et al., 2012).

Nearly 55% of respondents indicated they had not completed a grief counseling course, while 73% reported having completed a course that infused grief in a significant
way. Sixty nine percent of participants also reported having completed professional
development hours related to grief. The vast majority of participants (91%) believed that
grief counseling training is necessary or should be required (Ober et al., 2012).

In terms of competencies, findings similar to those in Charkow (2002) were
discovered. Participants rated themselves highest on the Personal Competencies
subscale, but lower on the knowledge and skills subscales, with the Conceptual Skills and
Knowledge subscale being the lowest. While not unexpected, based on the results from
Charkow (2002), the lower scores on the knowledge and skills scales are concerning.
The authors point out that while the characteristics that make up the Personal
Competencies (e.g., empathy, self-care, sense of humor, etc.) are valuable, they cannot
replace necessary grief counseling skills such as assessment of unresolved losses,
understanding cultural influences on grief, and developing treatment plans to help resolve
grief – all of which are skills on the subscales on which participants scored lower. The
latter of these skills are those that would be developed through grief counseling training,
while the personal competencies may be developed elsewhere (Ober et al., 2012).

In addition to exploring the training and competencies of the counselors, Ober et
al. (2012) also created regression equations to explore predictors of each of the grief
counseling competencies subscales. This would allow for better understanding of the
specific strengths and weaknesses of the respondents and could help inform training
programs. Predictor variables of age, gender, years of professional experience as a
counselor, training and experience in grief counseling (GCETS), and personal experience
with grief (TRIG) were used. The criterion variables were each of the DCS subscales
(Personal Competences, Assessment Skills, Treatment Skills, Professional Skills, Conceptual Skills and Knowledge) (Ober et al., 2012).

Professional training and experience, as measured by the GCETS, was the strongest predictor variable on all five subscales, accounting for the most variance and providing strong evidence for its influence on perceived competencies. It accounted for between 50% and 69% of the variance in four of the five subscales. Gender also accounted for unique, significant variance with women scoring significantly higher on three of the subscales – Personal Competencies, Assessment Skills, and Treatment Skills. Age also accounted for unique, significant variance, with younger counselors scoring higher on Conceptual Skills and Knowledge. However, the authors admit that the overall relationship between age and the variables was very small and may not be a useful predictor of competencies. Years of experience as a counselor and personal experience with grief were not found to be significant contributors to any of the regression models (Ober et al., 2012). This is interesting in light of the Terry et al. (1995) study which found that experience and formal training in grief counseling was correlated with higher levels of comfort with death-related scenarios. The findings of the two studies may indicate that specific training and experience in grief may be more related to comfort and perceived competency than just general counseling experience.

Another interesting finding related to grief counseling training that came from this study relates to the theories with which professional counselors are most familiar. Participants were asked to identify their level of familiarity, from none to a lot, with five grief counseling theories – stage, task, dual-process, meaning-making, and continuing
bonds. Participants were most familiar with Kubler-Ross’ (1969) stage theory, with nearly 50% reporting they had a lot of familiarity with it and nearly 43% reporting they had some familiarity with it. Niemeyer’s (2001) meaning-making theory and Worden’s (2009) task theory were familiar to only about one-quarter of respondents and 40% reported having no familiarity at all with either of them. Dual-process theory (Stroebe & Schut, 1999) and continuing bonds theory (Klass, 2001) were unknown to approximately 50% of respondents.

The results indicate that stage theories, like Kubler-Ross’ are still the most well-known by counselors. As described earlier, this theory does not have empirical support and has been challenged by many researchers in its use in grief counseling (Bonanno & Kaltman, 1999; Lindstrom, 2002; Maciejewski, Zhang, Block, & Prigerson, 2007; Payne, Jarrett, Wiles, & Field, 2002). On the other hand, respondents reported little familiarity with some of the other theories, such as dual-processing and meaning-making, which do have some empirical support (Lindstrom, 2002; Richardson, 2007; Richardson & Balaswamy, 2001). While this was not explored further in the study, the authors raise concerns that training that does occur could potentially be inadequate if it primarily involves theories not validated by empirical research (Ober et al., 2012).

Summary

In summary, the literature on grief counseling competencies is limited and little has been concluded about the variables that explain these competencies. One variable that has been shown in multiple studies to have a significant relationship with competencies is grief counseling training. However, a review of the literature also
suggests that grief counseling training has historically been limited in preparation programs for mental health professionals. Typically, respondents in these studies report not having had a course on grief counseling, but having some information incorporated into other classes. Other respondents report having no training at all. Furthermore, there is some evidence that grief counseling theories most familiar to practitioners are those with no empirical support for their effectiveness and use. Regardless of the amount of training, respondents often report having to work with grief-related issues in their practice and most believe that training in grief counseling is necessary and/or should be required.
Chapter 3 - Methodology

This chapter describes the research design. The research questions are provided as well as an explanation of the data analyses. The operational definitions of the variables are explained, as well as the method and identification of the population. A detailed explanation of the research instruments to be used in this study is also provided.

Research Design

The purpose of this study was to explore the grief counseling training, experience, and self-perceived grief counseling competencies of master’s level counseling students. Simply stated, this study explored how prepared master’s level counseling students thought they were to work with grief-related issues with their clients. Additionally, the self-perceived grief counseling competencies were explored in relationship to a number of variables. These included age, gender, professional training and experience with grief counseling as measured by the GCETS, degree track, and type of grief counseling training received.

Specifically, the following research questions were explored:

1. Among master’s level counseling graduate students in their field experience, what is the extent of professional training and experience with grief counseling, as measured by the Grief Counseling Experience & Training Survey (GCETS)?

2. What are the levels of self-perceived grief counseling competencies of master’s level graduate counseling students, as measured by the Death Counseling Survey (DCS)?
3. What is the difference in the areas of grief counseling experience and training (GCETS) and levels of self-perceived grief counseling competencies (DCS) between school counseling students, clinical mental health counseling students, and those pursuing both?

4. What is the relationship between self-perceived grief counseling competencies (DCS) and the variables of age, gender, professional training and experience with grief (GCETS), degree track, and type of grief counseling training received?

**Null Hypotheses**

With regard to the third and fourth research questions, the following null hypotheses were examined:

3. There is no significant difference in grief counseling training and experience, or self-perceived grief counseling competencies, in school counseling students and clinical mental health counseling students.

4. There is no significant, linear relationship between self-perceived grief counseling competencies and the variables of age, gender, professional training and experience with grief (GCETS), degree track, and type of grief counseling training received.

**Operational Definitions of Variables**

**Age.** Age is a continuous ratio variable and was reported by participants with an open-ended question on the demographic questionnaire that asked for their age in years. In their study on grief counseling competencies, Ober, Granello, and Wheaton (2012) found that age provided unique, significant contribution to the regression model.
regarding the grief counseling competencies subscale of Conceptual Skills and Knowledge. In that study, younger counselors scored higher on the subscale, though, the authors report that while it was statistically significant, the overall contribution of age to the variance in the scale was small and may not be a useful predictor of competencies.

The current study hoped to explore this further.

**Gender.** Gender is a categorical variable and was reported by participants responding to one of four options – male, female, transgender, other – on the demographic questionnaire. While Robbins (1992) found that gender did not have a significant relationship to grief counseling competency in hospice workers, Ober et al. (2012) found that women scored significantly higher on three of the five DCS subscales. The authors suggested that gender be included in future research regarding grief counseling competency.

**Professional training and experience with grief.** Participants’ professional training and experience with grief was measured using the Grief Counseling Experience and Training Survey (GCETS). This is a 12-item assessment that uses a Likert-type scale for respondents to indicate from one to five (“Not true at all” to “Totally true”) their agreement with statements about their formal education, training, experience, and supervision in grief counseling. This instrument is discussed in greater detail later in this chapter.

Ober, Granello, and Wheaton (2012) used the GCETS in their study of professional counselors. In their regression analysis, it was found to be the most significant predictor of grief counseling competencies. It accounted for 50% to 69% of
the variance in four of the five Grief Counseling Competencies subscales of the DCS. Other studies, as described in chapter two, also suggested that experience and training in grief counseling influences comfort level and perceived competencies of counselors (Kees, 1987; Kirchberg & Neimeyer, 1991; Terry et al., 1995).

**Degree track.** Degree track is a categorical variable through which respondents were asked to identify if their focus was school counseling, clinical mental health counseling, or both. If they selected both, respondents also had an opportunity to identify which degree was their primary track. Since perceived grief counseling competencies have not been explored with graduate students or even school counselors, this is not a variable that has been explored in the literature. The CACREP standards do not explicitly require specific grief counseling training, but require training in similar areas (e.g., response to crisis and trauma-causing events). On the other hand, ASCA explicitly calls for grief counseling skills as part of school counselor competencies. This study explored whether individuals in the two degree tracks differ in their level of perceived grief counseling competencies and training.

**Type of grief counseling training received.** Respondents were asked on the demographic questionnaire to indicate the type of grief counseling training they have received. The literature suggests that many programs do not offer courses dedicated to grief counseling and that most training in this area is accomplished through infusing information into other classes (Humphrey, 1993; Wass, 2004). This study further explored this notion by asking students to report on the availability of grief counseling courses in their programs. That is, they indicated whether required or elective grief
counseling courses were available to them. Furthermore, they were asked to report the number of courses they completed that focused specifically on grief and the number of courses they took that infused grief information into the class in a substantial way.

Charkow (2002) and Ober et al. (2012) both asked practitioners in their studies to report this information. However, it was not explored as a variable in relation to perceived grief counseling competences. This researcher hoped to expand upon this information by using it for descriptive purposes, but also to explore whether or not the type of training received was a significant predictor of perceived grief counseling competencies.

**Perceived grief counseling competencies.** Perceived grief counseling competencies were measured using the Death Counseling Survey (DCS) (Charkow, 2002). The DCS is a 58-item instrument that assesses self-perceived grief counseling competencies on five subscales – Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills. Participants are asked to indicate on a Likert-type scale, from one to five (“This does not describe me” to “This describes me very well”) their confidence in performing particular grief counseling-related skills. This instrument is discussed in greater detail below. As the only measurement available to specifically measure grief counseling competencies, the DCS has been used in two studies of competencies – first with marriage and family therapists by Charkow (2002) and again with professional counselors by Ober et al. (2012).
Identification of the Population and Sampling Plan

The target population for this study was master’s-level counseling students who were enrolled in CACREP-accredited school or clinical mental health counseling programs in the state of Ohio. A purposeful sample was obtained by using the CACREP website to generate a list of all CACREP-accredited institutions in the state of Ohio, as this was an accessible population from which data could be gathered. This resulted in a list of 15 institutions at the time the list was developed. The list was then randomized and the institutions were contacted in the order they appeared on the list until a sufficient sample size could be obtained. Ultimately, the counseling programs at all 15 of the institutions were contacted about their students taking part in the research. During the data collection process, a 16th institution earned CACREP accreditation and was contacted as well. This decision was made so as to include all CACREP-accredited institutions at the time of data collection and to ensure acquiring the necessary sample size.

Of the 16 counseling programs contacted, seven (44%) agreed to take part in the study. One institution declined to take part in the research, while the other eight were non-responsive. Of the seven programs involved in the study, three were housed in private institutions and four were in public. Two were identified by the CACREP website as being faith-based programs. Additionally, six of the seven institutions had both school counseling and clinical mental health counseling programs, while the remaining one had only a clinical mental health counseling program.
Arrangements were made by the researcher to collect the data in person. By conducting the research in person, as opposed to using an online or mail survey method, the researcher hoped to ensure two things. The first was to include only students who were enrolled in their field experience. It was imperative that students be participating in their field experience, as this was an indication they are nearing the end of their training and completed the majority of their coursework – thus, providing a more comprehensive look into their training experience. Collecting the data in person allowed the researcher to access field experience classes and eliminated the possibility of other students in the program being surveyed. Second, data was collected in person to secure a high response rate. Surveys were administered to 156 students. Of these, only one individual elected to not complete the survey and did not return it. Thus, there were 155 responses from which data was collected. More information about data screening is available in chapter four.

Sample Size

The necessary sample size for this study was calculated using Brooks & Barcikowski’s (2012) Precision Efficacy Analysis for Regression (PEAR) method. Using a desired precision efficacy ($PE$) of .75, an expected medium effect size ($\rho^2$) of .3, a tolerance of .075, and five predictor variables ($k$), a sample size of at least 120 respondents was determined using the following equation:

$$N \geq (k + 1) \frac{(2 - 2\rho^2 + \varepsilon)}{\varepsilon}$$
Instrumentation and Pilot Study

Grief counseling experience and training survey. The Grief Counseling Experience and Training Survey (GCETS) was developed by Deffenbaugh (2008) in her dissertation that assessed professional counselors’ experience and training in grief counseling. The results were later published by Ober et al., (2012). The GCETS was adapted from the Sexual Orientation Counselor Competency Scale (SOCC), created to assess counseling competencies in working with gay, lesbian, and bisexual clients. The GCETS was developed by replacing the phrase, “Lesbian, Gay, and Bisexual Clients” in the original SOCC with “Clients who present with grief.” An item was also added to the instrument that read, “I have sufficient knowledge of grief counseling theories and models.” This adapted instrument was created in response to the lack of instruments available to assess for training and experience in working with grief issues (Deffenbaugh, 2008).

Upon adaptation, the reliability and validity of the instrument were tested in a pilot study of twenty one mental health practitioners. The researcher asked participants whether or not the survey did an adequate job of assessing their experience and training in providing grief counseling. Thirteen of the respondents reported that it did, zero reported that it did not, and the rest did not respond to the question. Cronbach’s alpha was also calculated by the researcher to assess for reliability and it was found to be 0.86, suggesting good reliability. For the final study following the pilot, Cronbach’s Alpha was found to be slightly higher at .93 (Deffenbaugh, 2008).
The GCETS consists of twelve, Likert-type items on which participants are asked to respond to statements related to grief counseling training and experience. These include questions about actual grief counseling experience (”I have a great deal of experience counseling children who present with grief”), training in grief counseling (“I have sufficient knowledge of grief counseling theories and models”), professional development (“I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling”), and competency (“I feel competent to assess the mental health needs of a person who presents with grief in a therapeutic setting”). Participants indicate on a scale from one to five their level of agreement with each item. One indicates the statement is “Not at all true,” three indicates it is “Somewhat true,” and five indicates the statement is “Totally true.” Mean scores can then be calculated for both the entire survey and each item individually (Deffenbaugh, 2008).

Death counseling survey (DCS). The Death Counseling Survey (DCS) was developed by Charkow (2002) to assess grief counseling competencies in a sample of members of the International Association of Marriage and Family Counselors. It has subsequently been used by Deffenbaugh (2008) (published later as Ober et al. (2012)) to assess grief counseling competencies in a sample of licensed professional counselors in Ohio.

The DCS was developed in an attempt to identify the personality characteristics, attitudes, knowledge and skills necessary to work effectively with clients presenting with grief issues. The instrument was developed by consulting relevant literature and conducting multiple surveys that were completed by 27 individuals identified as experts
in the area of grief counseling. Quantitative and qualitative feedback was provided by
the experts and responses were used to identify the necessary competencies for providing
grief counseling. This resulted in the 58-item DCS, which offers an overall grief
counseling competencies score as well as scores on five separate subscales that offer
greater understanding of specific skills (Charkow, 2002).

The five subscales of the DCS include Personal Competencies, Conceptual Skills
and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills. The
Personal Competencies scale makes up Part I of the assessment, which consists of the
first 11 items. Examples of these items include, “I have experienced the death(s) of a
family member and can verbalize my own grief process,” and, “I can articulate my own
philosophy and attitudes regarding death.” Respondents are asked to rate each item from
one to five, with one being, “This does not describe me,” three being, “This somewhat
describes me,” and five being, “This describes me very well.” Mean scores on each item
range from one to five and total scores range from 11 to 55. This scale measures the
participants’ self-care and self-awareness related to grief issues, as well as beliefs about
death, sense of humor, and attitudes regarding death (Charkow, 2002).

The other four scales – Conceptual Skills and Knowledge, Assessment Skills,
Treatment Skills, and Professional Skills – make up the remaining 47 items, described
collectively as Part II: “Skills and Knowledge.” Each of these items is also scored on a
one to five, Likert-type scale, and participants rate their confidence in their abilities to
perform the skills described.
The Conceptual Skills and Knowledge subscale contains nine items with individual mean scores ranging from one to five and a total scores ranging from nine to 45. This scale measures participants’ confidence in their ability to do such things as distinguish functional and dysfunctional coping styles, apply counseling theories to grief counseling, define normal grieving, and define unresolved grief situations.

The Assessment Skills subscale also contains nine items with individual mean scores ranging from one to five and a total scores ranging from nine to 45. This scale measures the participants’ confidence in their ability to do such things as conduct suicide assessments, assess for unresolved losses, and use assessment to determine appropriate treatment modalities.

The Treatment Skills subscale contains 22 items with individual mean scores ranging from one to five and a total score ranging from 22 to 110. This scale measures the participants’ confidence in their ability to facilitate different formats of grief counseling (e.g., individual, group, and family), provide psychoeducation about grief, provide a supportive presence, advocate for the needs of dying individuals, and to provide hope without false assurance, among others.

The final subscale, Professional Skills, contains seven items with individual mean scores ranging from one to five and a total score ranging from seven to 35. It measures the participants’ confidence in their ability to do such things as maintain an updated library of grief resources, read and apply grief literature, and provide grief-related programs and activities in communities and schools (Charkow, 2002).
Charkow (2002) reported the DCS to have a Cronbach’s Alpha of .87, indicating it is a reliable instrument. Cronbach’s Alpha for each subscale ranged from .79 to .94, with specific values as follows: Personal Competencies Scale (.94), Conceptual Skills and Knowledge (.92), Assessment Skills (.87), Treatment Skills (.94), and Professional Skills (.83). In her study, Charkow also administered the DCS in conjunction with Bugen’s Coping with Death Scale and found the DCS to have concurrent validity with a correlation of $r = .73$ (Charkow, 2002).

**Demographic questionnaire.** Based on previous literature (Charkow, 2002; Deffenbaugh, 2008) a demographic questionnaire was developed to be used in this study. Participants were asked to provide demographic information such as their age, race, identified gender, and religious/spiritual background. Participants were also asked to identify whether their primary degree track is school or clinical mental health counseling.

Additionally, participants were asked to respond to a number of grief training related questions. These included indicating the number of courses they completed specifically focused on death or grief issues, the number of courses they completed that incorporated information on death and grief issues into the coursework, and the number of hours they spent attending workshop or conference sessions on death or grief issues. They were also asked to indicate how many hours of their field experience they completed and whether or not they served individuals for whom grief issues were part of counseling. As was done in Deffenbaugh (2008), they were also asked to rate their level of familiarity with a number of grief counseling theories. Finally, participants were
asked to provide an overall assessment of how adequately prepared they think their training made them to work with death or grief-related issues.

A pilot study was conducted with 32 master’s level, clinical mental health counseling students in the field experience part of their program. Surveys were administered in the same fashion they were subsequently administered for actual data collection. Included in the pilot study was a questionnaire that asked students two additional questions. The first asked them to identify any items they found difficult to answer or understand, and the second was an open-ended question inviting comments about the surveys. Upon review of these responses, it appeared the surveys were clear and understandable, as there were only four items identified in the first question by any participants, and no questions were identified twice. This indicated to the researcher that students were able to clearly understand the questions being asked of them.

**Data Analyses**

The data analyses used in this study included descriptive, inferential, and regression methods. Data were screened for outliers and normality before moving into descriptive statistics and more advanced analyses. That screening is discussed further in the results section. Descriptive statistics (e.g., means, ranges, standard deviations, maximum and minimum scores, frequency distributions) were calculated to both screen the data for entry errors and outliers, and to better understand the sample. The descriptive statistics for GCETS and DCS and its subscales ultimately gave insight into research questions one and two.
A series of One-Way Analyses of Variance were conducted to explore the third research question. This was done to compare mean scores in experience and training, using the GCETS, and perceived grief counseling competencies, using the DCS and its subscales, across disciplines of graduate degree training – clinical mental health counseling, school counseling, and students pursuing both.

Prior to running any regression analyses, data were screened for the assumptions of normality, linearity, homoscedasticity, and multicollinearity. Upon verification of these assumptions, a series of Ordinary Least Squares regressions were conducted to examine associations between DCS scores and age, gender, professional training and experience with grief (GCETS), and type of grief counseling received. Regression analyses were conducted for each of the DCS subscales, as they each measure different areas of competencies and could offer more specific insight into students’ perceived competencies than just overall perceived grief counseling competency.

**Summary**

Chapter three focused on issues of research design. The research questions were provided, and the operational definitions of the variables were explained. The sampling plan was discussed as well as identification of the population, and a description of the institutions from which the sample was obtained. A detailed explanation of the research instruments used in this study was also provided, as well as a brief description of the pilot study that was conducted. The chapter closed with a description of the data analyses conducted, for which the results are described in the next chapter.
Chapter 4 - Results

This chapter describes the results of the statistical analyses completed for each of the research questions. Data screening will first be described, then participant demographics. Subsequently, the results of further data analyses will be provided, which includes the results of the descriptive analyses used to explore the first two research questions and the ANOVA and regression analyses used to explore questions three and four. The research questions addressed were as follows:

1. Among master’s level counseling graduate students in their field experience, what is the extent of professional training and experience with grief counseling, as measured by the Grief Counseling Experience and Training Survey (GCETS)?

2. What are the levels of self-perceived grief counseling competencies of master’s level graduate counseling students, as measured by the Death Counseling Survey (DCS)?

3. What is the difference in the areas of grief counseling experience and training (GCETS) and levels of self-perceived grief counseling competencies (DCS) between school counseling students, clinical mental health counseling students, and those pursuing both?

4. What is the relationship between self-perceived grief counseling competencies (DCS) and the variables of age, gender, professional training and experience with grief (GCETS), degree track, and type of grief counseling training received?
Data Screening

Surveys were administered, in person, to a total of 156 individuals across seven institutions. One individual elected to not complete the survey and did not return it. Using the remaining 155 returned surveys, data were screened for missing items, and there were only three data points (0.03%) that were not completed within the GCETS and DCS surveys. A single participant accounted for all three missing data points on these scale variables. Because these data points were not missing at random (Little & Rubin, 1987), this case was deleted for all analyses. When this single case was deleted, there was no missing data on any variables used in the inferential statistics. Thus, these data analyses involved survey responses from 154 participants out of the 156 surveys administered. The regression analyses included 152 participants, as one individual did not supply an age, while another did not respond to the question about how many grief courses had been taken.

Data were also screened for univariate normality according to standard cutoff criteria for skew (range between -2 and 2) and kurtosis (range between -7 and 7) (Tabachnick & Fidell, 2013). All variables were within the standard criteria, suggesting that scale scores were sufficiently normally distributed. Further data screening, pertaining to assumptions for regression analyses, are discussed in that section of this chapter.

Participant Demographics

Age, gender, race/ethnicity, spiritual background, and personal losses. Age was collected as a continuous ratio variable with participants responding to an open-
ended question on the demographic questionnaire. The mean age of the participants was 34.3 years ($SD = 9.95$) with a range from 21 years to 61 years ($n = 153$). Two individuals did not respond to the item asking their age. Table 4.1 shows a frequency distribution for respondents’ ages.

Table 4.1

*Frequency Distributions for Age (n = 153)*

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 - 30</td>
<td>72</td>
<td>47.1</td>
</tr>
<tr>
<td>31 - 40</td>
<td>45</td>
<td>29.4</td>
</tr>
<tr>
<td>41 - 50</td>
<td>21</td>
<td>13.7</td>
</tr>
<tr>
<td>51 - 60</td>
<td>14</td>
<td>9.2</td>
</tr>
<tr>
<td>61 - 70</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Gender was collected as a categorical variable with participants selecting from one of four options – male, female, transgender, other – on the demographic questionnaire. Of the 154 respondents, 75.3% identified as female and 24.7% as male (see Table 4.2) The percentage of individuals who identified as male and female was comparable to a similar study conducted with professionals in the counseling field from the same state. In that study, 77% of respondents identified as female, 23% as male, and 0.5% as transgender (Ober, Granello, & Wheaton, 2012).
Table 4.2

*Frequency Distributions for Gender (N = 154)*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>116</td>
<td>75.3</td>
</tr>
<tr>
<td>Male</td>
<td>38</td>
<td>24.7</td>
</tr>
<tr>
<td>Transgender</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Race/ethnicity was collected as a categorical variable with participants selecting one of nine options – Black/African-American, White/Caucasian, Asian-American, Hispanic/Latino, Native American, Pacific Islander, Multiracial, or Other. Individuals who checked multiple options were coded as Multiracial. The majority of respondents identified as White/Caucasian (79.2%) with others identifying as Black/African-American, Multiracial, Asian-American, Hispanic/Latino, and Other (see Table 4.3).
Table 4.3

*Frequency Distributions for Race/Ethnicity (N = 154)*

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>122</td>
<td>79.2</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>19</td>
<td>12.3</td>
</tr>
<tr>
<td>Multiracial</td>
<td>6</td>
<td>3.9</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>Asian-American</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>1</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Spiritual background was collected as a categorical variable with participants selecting one of nine options – Jewish, Protestant, Hindu, Muslim, Catholic, Buddhist, Atheist, Agnostic, or Other. More respondents identified as Protestant (43.5%) than any other option, while two participants did not respond, and all nine options were selected within the sample (see Table 4.4). The religious affiliation reported by the respondents is consistent with Gallup (2004) polls from Ohio, on which 52.5% of respondents identified as protestant Christian, 24.8% identified as Catholic, and 0.7% identified as Jewish. A question on the demographic questionnaire also asked participants if they believed their religious or spiritual background is helpful to them in processing grief. They had the option of selecting yes, no, or undecided. The majority of respondents (81.0%) selected yes, while 9.2% selected no, and another 9.8% selected undecided.
Table 4.4

Frequency Distributions for Religious/Spiritual Background (N = 154)

<table>
<thead>
<tr>
<th>Religious/Spiritual Background</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant Christian</td>
<td>67</td>
<td>43.5</td>
</tr>
<tr>
<td>Catholic</td>
<td>37</td>
<td>24.0</td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
<td>18.4</td>
</tr>
<tr>
<td>Agnostic</td>
<td>9</td>
<td>5.8</td>
</tr>
<tr>
<td>Buddhist</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>Atheist</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Hindu</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Muslim</td>
<td>1</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Participants in the study were also asked how many close friends or relatives they had lost to death. Similar to age, this information was gathered as a continuous ratio variable with an open-ended question. The mean number of losses was 4.99 ($SD = 3.98$) with a range from zero to 21 ($n = 151$). For clarity, the responses have been categorized in Table 4.5. Three individuals responded with non-numerical responses (e.g., “a lot” or “many”). These responses were not included, because of their ambiguity and openness to subjective interpretation.
Table 4.5

*Frequency Distributions for Personal Losses Due to Death (n = 151)*

<table>
<thead>
<tr>
<th>Personal Losses Due to Death</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>1-5 Losses</td>
<td>99</td>
<td>65.6</td>
</tr>
<tr>
<td>6-10 Losses</td>
<td>40</td>
<td>26.5</td>
</tr>
<tr>
<td>11-15 Losses</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>16+ Losses</td>
<td>4</td>
<td>2.6</td>
</tr>
</tbody>
</table>

**Education and training items.** Participants were asked a variety of questions on the demographic questionnaire pertaining to their education and training, especially as it relates to familiarity with grief issues. Participants were first asked to identify their degree discipline – school counseling, clinical mental health counseling, or both. Those who were enrolled in both degree tracks were asked to identify their primary track. The vast majority of respondents (83.1%) were in clinical mental health counseling training (see Table 4.6).
Table 4.6

*Frequency Distributions for Degree Discipline (N = 154)*

<table>
<thead>
<tr>
<th>Degree Discipline</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Mental Health Counseling</td>
<td>128</td>
<td>83.1</td>
</tr>
<tr>
<td>School Counseling</td>
<td>17</td>
<td>11.0</td>
</tr>
<tr>
<td>Both</td>
<td>9</td>
<td>5.8</td>
</tr>
<tr>
<td>Clinical Primary</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>School Primary</td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

In order to explore the availability of grief counseling courses in participants’ programs, respondents were asked how many required courses focused specifically on grief counseling and how many elective/optional courses focus specifically on grief counseling in their programs. Of the 154 respondents, 94 (61.0%) indicated there were neither required nor elective grief counseling courses available in their programs. Forty-five respondents (29.2%) indicated there was an elective course available to them, and 15 (9.7%) indicated they were required to take a grief counseling course.

To further explore participants’ involvement in grief counseling courses, they were asked to identify how many courses they had taken focused specifically on grief counseling and how many courses they had taken infused grief counseling concepts into the course. Participants were also asked how many hours of professional development
(e.g., conference sessions, workshops, etc.) they had received on grief counseling-related topics.

There were 122 individuals (79.7%) who indicated they had never taken a course focused specifically on grief, while 29 individuals (19.0%) noted having taken one or two courses, and two individuals (1.3%) reported having taken three courses. Those two respondents identified having taken three courses despite zero respondents indicating in a previous question that there were that many courses available to them in their program. It is possible these three individuals completed such courses elsewhere (e.g., in undergraduate work, in other studies, etc.) and included those experiences in this response.

Though 79.7% of respondents indicated having never taken a course focused specifically on grief counseling, 92 (60.2%) reported having taken a course in which they believe grief topics were infused considerably into the course material (see Table 4.7).

Table 4.7

*Frequency Distributions for Number of Courses Completed that Infused Grief Material (n = 153)*

<table>
<thead>
<tr>
<th>Courses Completed</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Courses</td>
<td>61</td>
<td>39.9</td>
</tr>
<tr>
<td>1-2 Courses</td>
<td>63</td>
<td>41.2</td>
</tr>
<tr>
<td>3+ Courses</td>
<td>29</td>
<td>19.0</td>
</tr>
</tbody>
</table>
A vast majority of respondents (70.6%) reported having had no professional development on the topic of grief, but seeing as the participants were graduate students, this is not a surprise (see Table 4.8).

Table 4.8

_Frequency Distributions for Professional Development Hours Completed on Grief (n = 153)_

<table>
<thead>
<tr>
<th>Completed Professional Development Hours</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Hours</td>
<td>108</td>
<td>70.6</td>
</tr>
<tr>
<td>.5–2 Hours</td>
<td>8</td>
<td>5.2</td>
</tr>
<tr>
<td>3-4 Hours</td>
<td>19</td>
<td>12.4</td>
</tr>
<tr>
<td>5+ Hours</td>
<td>18</td>
<td>11.8</td>
</tr>
</tbody>
</table>

To obtain an idea of the clinical experience of the sample, participants were asked to identify approximately how many hours of their field experience they had already completed. The mean number of hours completed was 283.3 (_SD_ = 357.79) with a range from .5 hours to 3000 hours (_n_ = 153). Of the 153 respondents, 67 (43.8%) had completed less than 100 hours of their field experience. Though the question was open-ended in its response, hour totals are categorized here for clarity and ease of understanding (see Table 4.9).
Table 4.9

*Frequency Distributions for Hours of Field Experience Completed (n = 153)*

<table>
<thead>
<tr>
<th>Completed Field Experience Hours</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 100 Hours</td>
<td>67</td>
<td>43.8</td>
</tr>
<tr>
<td>100-399 Hours</td>
<td>35</td>
<td>22.9</td>
</tr>
<tr>
<td>400-699 Hours</td>
<td>33</td>
<td>21.6</td>
</tr>
<tr>
<td>700+ Hours</td>
<td>18</td>
<td>11.8</td>
</tr>
</tbody>
</table>

Respondents were also asked whether or not they had, at this point in their field experience, worked with any clients on grief issues. If so, they were asked to identify approximately how many adults and children that included. Of the 154 respondents, 113 (73.4%) indicated they had worked with a client on grief issues, while only 40 (26.0%) said they had not. Of the 113 individuals who had, 84 (74.3%) noted they had worked with adults on grief, while 62 (54.9%) indicated having worked with children. These numbers do not equal the total of 113, because some respondents indicated working with both adults and children and, thus, are included in both categories.

Of the 84 respondents who had worked with adults on grief issues, the mean number of clients was nearly eight \( (M = 7.62; SD = 13.93) \) with a range of one to 100. Of the 62 respondents who had worked with children on grief issues, the mean was just above six clients \( (M = 6.21; SD = 9.28) \) with a range of one to 60. Table 4.10 displays the number of adults and children the respondents reported having had worked with on grief issues.
Table 4.10

*Frequency Distributions for Number of Clients with whom Grief Counseling was a Part of Counseling*

<table>
<thead>
<tr>
<th>Number of Adult Clients (n = 84)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 Adults</td>
<td>58</td>
<td>81.0</td>
</tr>
<tr>
<td>6-10 Adults</td>
<td>14</td>
<td>16.7</td>
</tr>
<tr>
<td>11-15 Adults</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>16+ Adults</td>
<td>8</td>
<td>9.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Child Clients (n = 62)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 Children</td>
<td>42</td>
<td>67.8</td>
</tr>
<tr>
<td>6-10 Children</td>
<td>12</td>
<td>19.4</td>
</tr>
<tr>
<td>11-15 Children</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>15+ Children</td>
<td>6</td>
<td>9.7</td>
</tr>
</tbody>
</table>

To explore participants’ familiarity with a variety of grief counseling theories found in the literature, they were asked to indicate their level of familiarity with Stage Theory (Kubler-Ross), Task Theory (Worden), Dual Process Theory (Stroebe & Schut), Meaning Making Theory (Neimeyer), and Continuing Bond Theory (Bonanno & Klass). The aforementioned theorists’ names in parentheses were included in the survey question for reference. For each theory, participants could select “None,” “Very Little,” “Some,” or “A lot” of familiarity with the theory. Two individuals did not respond to the question, so the results include 152 participants. They were most familiar with the Stage Theory of
Kubler-Ross, as 103 (67.8%) of the 152 respondents indicated they had either “some” or “a lot” of familiarity with this theory, and only 21 (13.8%) indicated no familiarity at all. In contrast, respondents were much less familiar with the other four theories. For example, of the remaining theories, the number of respondents indicating no or “very little” familiarity was as follows: Task: 130 (85.5%); Dual Process: 130 (85.5%); Meaning Making: 116 (76.3%); and Continuing Bonds: 134 (88.2%). Tables 4.11-4.15 show the results for each of the theories.

Table 4.11

*Frequency Distributions for Familiarity with Stage Theory (n = 152)*

<table>
<thead>
<tr>
<th>Familiarity with Stage Theory</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>21</td>
<td>13.8</td>
</tr>
<tr>
<td>Very Little</td>
<td>28</td>
<td>18.4</td>
</tr>
<tr>
<td>Some</td>
<td>74</td>
<td>48.7</td>
</tr>
<tr>
<td>A lot</td>
<td>29</td>
<td>19.1</td>
</tr>
</tbody>
</table>

Table 4.12

*Frequency Distributions for Familiarity with Task Theory (n = 152)*

<table>
<thead>
<tr>
<th>Familiarity with Task Theory</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>81</td>
<td>53.3</td>
</tr>
<tr>
<td>Very Little</td>
<td>49</td>
<td>32.2</td>
</tr>
<tr>
<td>Some</td>
<td>20</td>
<td>13.2</td>
</tr>
<tr>
<td>A lot</td>
<td>2</td>
<td>1.3</td>
</tr>
</tbody>
</table>
Table 4.13

*Frequency Distributions for Familiarity with Dual Process Theory (n = 152)*

<table>
<thead>
<tr>
<th>Familiarity with Dual Process Theory</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>92</td>
<td>60.5</td>
</tr>
<tr>
<td>Very Little</td>
<td>38</td>
<td>25.0</td>
</tr>
<tr>
<td>Some</td>
<td>22</td>
<td>14.5</td>
</tr>
<tr>
<td>A lot</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Table 4.14

*Frequency Distributions for Familiarity with Meaning Making Theory (n = 152)*

<table>
<thead>
<tr>
<th>Familiarity with Meaning Making Theory</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>70</td>
<td>46.1</td>
</tr>
<tr>
<td>Very Little</td>
<td>46</td>
<td>29.9</td>
</tr>
<tr>
<td>Some</td>
<td>30</td>
<td>19.7</td>
</tr>
<tr>
<td>A lot</td>
<td>6</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Table 4.15

*Frequency Distributions for Familiarity with Continuing Bonds Theory (n = 152)*

<table>
<thead>
<tr>
<th>Familiarity with Continuing Bonds Theory</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>96</td>
<td>63.2</td>
</tr>
<tr>
<td>Very Little</td>
<td>38</td>
<td>25.0</td>
</tr>
<tr>
<td>Some</td>
<td>17</td>
<td>11.2</td>
</tr>
<tr>
<td>A lot</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>
Participants were asked three other questions as part of the demographic questionnaire. The first required them to indicate how competent they felt in their overall counseling abilities. Respondents could choose from “I need to learn a great deal more before I would call myself competent,” “I have much to learn in order to call myself competent,” “I am comfortable with my knowledge and skill level,” or “I am highly competent.” There were two individuals who did not respond to this question, leaving 152 responses. Of those, no one indicated believing they were highly competent, 53 (34.9%) indicated being comfortable with their knowledge and skills level, 80 (52.6%) believed they had much to learn in order to call themselves competent, and 19 (12.5%) indicated they needed to learn a great deal more before calling themselves competent.

The second question asked participants to indicate how adequately prepared by their graduate training they felt to work with grief-related issues. They had the opportunity to select, “Very inadequately,” “Somewhat Inadequately,” “Somewhat Adequately,” “Adequately,” and “Very Adequately.” Table 4.16 displays the results of this question.
The final question asked them to indicate if they believed education and training in grief counseling was “not necessary,” “necessary,” or “should be required.” None of the 154 respondents indicated that education and training in grief counseling was not necessary. There were 58 (37.7%) respondents who believed it was necessary, though not required, while 96 (62.3%) thought it should be a required part of training programs.

**Research Question One**

The first research question explored in this study was, “Among counseling graduate students in their field experience, what is the extent of professional training and experience with grief counseling, as measured by the Grief Counseling Experience and Training Survey (GCETS)?” The researcher calculated Cronbach’s Alpha to assess for reliability of the GCETS; it was found to be .87 for this assessment.

To answer the first research question, descriptive analyses were calculated for the GCETS. The survey includes 12 items that are responded to by selecting a rating from 1
to 5. On all items, except one, selecting a one indicates no experience or training and a five indicates significant training or experience. For the one item, number 10 on the survey, the opposite is true, so it was reverse scored for analyses. Thus, total scores range from 12 to 60, with each individual item ranging from 1 to 5. Total scores were converted to a 5-point scale for clarity, since the items on the instrument are rated on such a scale. The mean score was 2.11 with a standard deviation of 0.64, and scores ranged from 1 to 4.25. Scores for each individual item can also be found in Appendix F.

**Research Question Two**

The second research question explored in this study was, “What are the levels of self-perceived grief counseling competencies of graduate counseling students, as measured by the Death Counseling Survey (DCS)?” The DCS is a 58-item survey that results in a total score as well as scores on five subscales. These subscales include Personal Competencies (11 items), Conceptual Skills and Knowledge (nine items), Assessment Skills (nine items), Treatment Skills (22 items), and Professional Skills (seven items). Reliability was investigated on the whole survey as well as each subscale. The Cronbach’s Alpha scores were as follows: entire DCS (.95), Personal Competencies subscale (.73), Conceptual Skills and Knowledge (.88), Assessment Skills (.81), Treatment Skills (.92), and Professional Skills (.72).

Each item on the survey is rated on a scale of 1 to 5. A rating of one indicated the item did not describe the respondents – they had no confidence in their competency – while a five indicated the item described them very well – they had high confidence in their competency. For clarity, total scores were converted to a scale of 1-5, matching the
format of the instrument, by dividing total scores by the number of items on each subscale. These are reported below in Table 4.17. Mean scores and standard deviations for all items on the DCS can also be found in Appendix G.

Table 4.17

Descriptive Statistics for Death Counseling Survey and Subscales (N = 154)

<table>
<thead>
<tr>
<th>Subscale</th>
<th>M</th>
<th>SD</th>
<th>Range (1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Death Counseling Survey</td>
<td>3.27</td>
<td>.53</td>
<td>1.84 – 4.72</td>
</tr>
<tr>
<td>Personal Competencies</td>
<td>4.26</td>
<td>.43</td>
<td>2.82 – 5.00</td>
</tr>
<tr>
<td>Conceptual Skills/Knowledge</td>
<td>2.82</td>
<td>.79</td>
<td>1.00 – 4.78</td>
</tr>
<tr>
<td>Assessment Skills</td>
<td>3.19</td>
<td>.68</td>
<td>1.33 – 5.00</td>
</tr>
<tr>
<td>Treatment Skills</td>
<td>3.13</td>
<td>.63</td>
<td>1.45 – 4.91</td>
</tr>
<tr>
<td>Professional Skills</td>
<td>2.77</td>
<td>.65</td>
<td>1.29 – 4.43</td>
</tr>
</tbody>
</table>

Research Question Three

The third research question explored in this study was, “What is the difference in the areas of grief counseling experience and training (GCETS) and levels of self-perceived grief counseling competencies (DCS) between school counseling students, clinical mental health counseling students, and those pursuing both?” To answer this question, a series of One-Way Analyses of Variance were conducted to compare mean scores in experience and training, using the GCETS, and perceived grief counseling competencies, using the DCS and its subscales, across discipline of graduate degree
training – clinical mental health counseling, school counseling, and students pursuing both.

The number of respondents identifying as school counseling students and students pursuing both turned out to be limited (\( n = 17 \) and \( n = 9 \), respectively). With that in mind, none of the ANOVA results indicated significant differences in the mean scores of the dependent variables between students in clinical mental health counseling, school counseling, or those in both tracks. The Levene’s Test on each ANOVA was not significant, which indicated that error variance was equal across all groups of the dependent variable. The resulting F-statistic of each separate analysis is reported below. Further, mean scores and standard deviations for each group are listed in table 4.18.

Table 4.18

*Comparison of GCETS & DCS Subscales Mean Scores & Standard Deviations across Degree Tracks*

<table>
<thead>
<tr>
<th>DCS Subscales</th>
<th>Clinical Mental Health ( M;SD )</th>
<th>School ( M;SD )</th>
<th>Both ( M;SD )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Competencies</td>
<td>4.28; 0.41</td>
<td>4.29; 0.44</td>
<td>3.99; 0.57</td>
</tr>
<tr>
<td>Conceptual Skills/Knowledge</td>
<td>2.80; 0.78</td>
<td>2.78; 0.78</td>
<td>3.00; 0.64</td>
</tr>
<tr>
<td>Assessment Skills</td>
<td>3.22; 0.67</td>
<td>2.91; 0.57</td>
<td>3.25; 0.62</td>
</tr>
<tr>
<td>Treatment Skills</td>
<td>3.12; 0.61</td>
<td>3.02; 0.70</td>
<td>3.23; 0.51</td>
</tr>
<tr>
<td>Professional Skills</td>
<td>2.74; 0.65</td>
<td>2.79; 0.48</td>
<td>2.89; 0.47</td>
</tr>
<tr>
<td>GCETS</td>
<td>2.10; 0.56</td>
<td>2.03; 0.52</td>
<td>2.01; 0.45</td>
</tr>
</tbody>
</table>
The first ANOVA conducted, for experience and training (GCETS), was $F(2, 151) = 0.18$, $p = .832$. The second ANOVA, for overall perceived grief counseling competences (DCS total scores), was $F(2, 151) = 0.37$, $p = .691$. The third ANOVA, for the Personal Competencies subscale, was $F(2, 151) = .88$, $p = .418$. The fourth conducted ANOVA, for the Conceptual Skills and Knowledge subscale, was $F(2, 151) = .71$, $p = .495$. The fifth ANOVA, for the Assessment Skills subscale, was $F(2, 151) = 1.27$, $p = .285$. The sixth ANOVA, for the Treatment Skills subscale, was $F(2, 151) = .59$, $p = .554$. The seventh ANOVA, for the Professional Skills subscale, was $F(2, 151) = 1.54$, $p = .225$.

**Research Question Four**

The fourth research question explored in this study was, “What is the relationship between self-perceived grief counseling competencies (DCS) and the variables of age, gender, professional training and experience with grief (GCETS), degree track, and type of grief counseling training received?” Due to there being no significant differences found between degree disciplines in question three, this variable was dropped for the regression analysis. The variable “type of grief counseling training received” included the number of courses taken that focused specifically on grief counseling and the number of courses taken that had infused grief counseling information in a substantial way.

**Data screening and testing of assumptions.**

*Normality.* As mentioned before, data were screened for univariate normality prior to conducting regression analyses. All variables were within standard cutoff criteria for skew (range between -2 and 2) and kurtosis (range between -7 and 7) (Tabachnick &
Fidell, 2013), which suggests scale scores were sufficiently normally distributed. P-P Plots were also used to visually assess for normality. These plots for the dependent variables used in the regression analyses can be seen in Figures 4.1-4.6 below.

*Figure 4.1* Normal P-P Plot for Mean Overall DCS Scores (N=152)
Figure 4.2 Normal P-P Plot for Mean Personal Competencies Scores (n = 152)
Figure 4.3 Normal P-P Plot for Mean Conceptual Skills and Knowledge Scores (n = 152)
Figure 4.4 Normal P-P Plot for Mean Assessment Skills Scores (n = 152)
Figure 4.5 Normal P-P Plot for Mean Treatment Skills Scores (n = 152)
Data were also explored for linearity, which is the assumption that independent and dependent variables have a relationship that is linear. Scatterplots were used to explore the dependent variable of DCS scores and the continuous independent variables, which were age and professional training and experience with grief (GCETS scores). These scatterplots demonstrated weak, but linear relationships, with the GCETS and DCS scores signifying a stronger relationship (see Figures 4.7-4.8).
Figure 4.7 Scatterplot of Age and Mean DCS Scores (n = 152)
Figure 4.8 Scatter Plot of Professional Training and Experience with Grief and Mean DCS Scores (n = 152)

**Homoscedasticity.** Data were also explored for homoscedasticity, or equality in the residuals for all values of the predicted dependent variable. Figures 4.9-4.14 verify this assumption by showing that residuals are spread out over the predicted values for the dependent variables in the regression analyses - the DCS scores and each of its subscales.
Figure 4.9 Residual Plot of Mean DCS Scores as Predicted by Age, Gender, Professional Training and Experience with Grief (GCETS), and Type of Grief Counseling Training Received (n = 152)
Figure 4.10 Residual Plot of Mean Personal Competencies Scores as Predicted by Age, Gender, Professional Training and Experience with Grief (GCETS), and Type of Grief Counseling Training Received (n = 152)
Figure 4.11 Residual Plot of Mean Conceptual Knowledge and Skills Scores as Predicted by Age, Gender, Professional Training and Experience with Grief (GCETS), and Type of Grief Counseling Training Received (n = 152)
Figure 4.12 Residual Plot of Mean Assessment Skills Scores as Predicted by Age, Gender, Professional Training and Experience with Grief (GCETS), and Type of Grief Counseling Training Received (n = 152)
Figure 4.13 Residual Plot of Mean Treatment Skills Scores as Predicted by Age, Gender, Professional Training and Experience with Grief (GCETS), and Type of Grief Counseling Training Received (n = 152)
Figure 4.14 Residual Plot of Mean Professional Skills Scores as Predicted by Age, Gender, Professional Training and Experience with Grief (GCETS), and Type of Grief Counseling Training Received (n = 152)

Multicollinearity. The data were also assessed for multicollinearity. Multicollinearity occurs when two independent variables are highly correlated and it becomes difficult to determine which is responsible for variance in the regression analysis. Thus, the independent variables were explored using a correlation table as well as looking at Tolerance and VIF values in SPSS. Each of these two processes indicated that multicollinearity did not exist. Table 4.19 exhibits the correlation table.
Table 4.19

*Independent Variables Correlation Table for Multicollinearity (n = 152)*

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td></td>
<td>–</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Gender(^a)</td>
<td>.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Courses Taken – Grief Infused</td>
<td>-.11</td>
<td>.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Courses Taken – Grief Specific</td>
<td>-.11</td>
<td>.01</td>
<td>.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Professional Training and</td>
<td>-.08</td>
<td>-.12</td>
<td>.21**</td>
<td>.24**</td>
<td></td>
</tr>
<tr>
<td>Experience (GCETS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)Gender: 1 = male, 2 = female

\(^*p < .01. (2\text{-tailed}).\)

Outliers. Throughout the data screening, outliers were detected and investigated. This process involved exploring the casewise diagnostics in SPSS and looking at studentized deleted residuals, leverage values, and Cook’s Distance values. Using these statistics, it was determined that the outliers were not highly influential, and all Cook’s Distance values were less than one (Cook & Weisberg, 1982).

To further explore and verify the influence of the outliers, each regression analysis was conducted with and without them. The outliers removed included those with studentized deleted residuals three standard deviations above or below the mean, as well as any individuals who reported atypical experiences. For example, one individual reported working with 100 clients on grief issues and noted next to the question that part of her internship was being involved with grief camps. Another individual had
completed 3,000 hours of internship ($M = 283.3$), because she was at the end of completing both school and clinical mental health internships. Atypical cases such as these were removed to explore their influence on the analyses. It was found that the presence, or absence, of these cases had no influence on the resulting significance and had minimal impact on effect sizes. Therefore, the outliers were left in and analyses reported hereafter include all respondents.

**Regression analyses.** After confirming the regression assumptions, a series of Ordinary Least Squares regressions were conducted to examine associations between DCS scores and age, gender, professional training and experience with grief (GCETS), and type of grief counseling training received. For overall perceived grief counseling competencies (total DCS scores), the model was significant, $F(5, 146) = 27.53, p < .001$, accounting for 48.5% of variance in perceived grief counseling competencies. In terms of individual variables, professional training and experience with grief (GCETS) also significantly predicted overall perceived grief counseling competencies, $b = .56$ ($SE = .05$), $\beta = .67, p < .001$. Higher scores on the GCETS, indicating more professional training and experience, were associated with higher scores on perceived grief counseling competencies. Gender also significantly predicted overall perceived grief counseling competencies, $b = .15$ ($SE = .07$), $\beta = .13, p = .039$. Individuals who identified as female were associated with higher scores on overall perceived grief counseling competencies. Age ($p = .07$), amount of courses taken that focused specifically on grief ($p = .43$), and amount of courses taken that infused grief in a substantial way ($p = .35$) did not predict
overall perceived grief counseling competencies. Table 4.20 shows a regression table for the predictor variables and overall perceived grief counseling competencies.

Table 4.20

<table>
<thead>
<tr>
<th>Variables</th>
<th>b</th>
<th>SE</th>
<th>β</th>
<th>p</th>
<th>Part Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>.01</td>
<td>.00</td>
<td>.11</td>
<td>.07</td>
<td>.11</td>
</tr>
<tr>
<td>2. Gender&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.15</td>
<td>.07</td>
<td>.13</td>
<td>.04</td>
<td>.12</td>
</tr>
<tr>
<td>3. Courses Taken – Grief Infused</td>
<td>.04</td>
<td>.05</td>
<td>.06</td>
<td>.35</td>
<td>.06</td>
</tr>
<tr>
<td>4. Courses Taken – Grief Specific</td>
<td>.06</td>
<td>.08</td>
<td>.05</td>
<td>.43</td>
<td>.05</td>
</tr>
<tr>
<td>5. Professional Training and Experience (GCETS)</td>
<td>.56</td>
<td>.05</td>
<td>.67</td>
<td>&lt; .001</td>
<td>.64</td>
</tr>
</tbody>
</table>

<sup>a</sup>Gender: 1 = male, 2 = female

To further explore the data and this research question, regression analyses were also conducted using the same independent variables for each of the subscales on the DCS. Doing so provided additional insight into specific areas of training. For Personal Competencies, the overall model was significant, \( F(5, 146) = 3.27, p = .003 \), accounting for 10.1% of variance in Personal Competencies. In terms of individual variables, age significantly predicted Personal Competencies, \( b = .01 (SE = .003), \beta = .19, p = .02 \). Older ages were associated with higher scores on Personal Competencies. Professional training and experience with grief (GCETS) also significantly predicted Personal
Competencies, $b = .15 \ (SE = .06), \ \beta = .22, \ p = .008$. Higher scores on the GCETS, indicating more professional training and experience, were associated with higher scores on Personal Competencies. Gender ($p = .52$), amount of courses taken that focused specifically on grief ($p = .08$) and amount of courses taken that infused grief in a substantial way ($p = .25$) did not predict Personal Competencies. Table 4.21 shows a regression table for the predictor variables and personal grief counseling competencies.

Table 4.21

*Regression Analyses for Variables Predicting Personal Competencies (n = 152)*

<table>
<thead>
<tr>
<th>Variables</th>
<th>b</th>
<th>$SE$</th>
<th>$\beta$</th>
<th>$p$</th>
<th>Part Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>.01</td>
<td>.00</td>
<td>.19</td>
<td>.02</td>
<td>.19</td>
</tr>
<tr>
<td>2. Gender$^a$</td>
<td>.05</td>
<td>.08</td>
<td>.05</td>
<td>.52</td>
<td>.05</td>
</tr>
<tr>
<td>3. Courses Taken – Grief Infused</td>
<td>.05</td>
<td>.05</td>
<td>.09</td>
<td>.25</td>
<td>.09</td>
</tr>
<tr>
<td>4. Courses Taken – Grief Specific</td>
<td>-.14</td>
<td>.08</td>
<td>-.15</td>
<td>.08</td>
<td>-.14</td>
</tr>
<tr>
<td>5. Professional Training and Experience (GCETS)</td>
<td>.15</td>
<td>.06</td>
<td>.22</td>
<td>.008</td>
<td>.21</td>
</tr>
</tbody>
</table>

$^a$Gender: 1 = *male*, 2 = *female*

For Conceptual Skills and Knowledge, the overall model was significant, $F (5, 146) = 29.24, \ p < .001$, accounting for 50.0\% of variance in Conceptual Skills and Knowledge. In terms of individual variables, professional training and experience with grief (GCETS) significantly predicted Conceptual Skills and Knowledge, $b = .82 \ (SE = .08), \ \beta = .66, \ p < .001$. Higher scores on the GCETS, indicating more professional
training and experience, were associated with higher scores on Conceptual Knowledge and Skills. Gender also significantly predicted Conceptual Skills and Knowledge, $b = .23$ ($SE = .11$), $\beta = .12, p = .038$. Those who identified as female were associated with higher scores on Conceptual Skills and Knowledge. Age ($p = .47$), amount of courses taken that focused specifically on grief ($p = .12$), and amount of courses taken that infused grief in a substantial way ($p = .23$) did not predict Conceptual Skills and Knowledge. Table 4.22 shows a regression table for the predictor variables and conceptual skills and knowledge.

Table 4.22

Regression Analyses for Variables Predicting Conceptual Skills & Knowledge ($n = 152$)

<table>
<thead>
<tr>
<th>Variables</th>
<th>$b$</th>
<th>$SE$</th>
<th>$\beta$</th>
<th>$p$</th>
<th>Part Correlation</th>
</tr>
</thead>
<tbody>
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<td>1. Age</td>
<td>.00</td>
<td>.01</td>
<td>.04</td>
<td>.47</td>
<td>.04</td>
</tr>
<tr>
<td>2. Gender$^a$</td>
<td>.23</td>
<td>.11</td>
<td>.12</td>
<td>.04</td>
<td>.12</td>
</tr>
<tr>
<td>3. Courses Taken – Grief Infused</td>
<td>.08</td>
<td>.07</td>
<td>.07</td>
<td>.23</td>
<td>.07</td>
</tr>
<tr>
<td>4. Courses Taken – Grief Specific</td>
<td>.17</td>
<td>.11</td>
<td>.10</td>
<td>.12</td>
<td>.09</td>
</tr>
<tr>
<td>5. Professional Training and Experience (GCETS)</td>
<td>.82</td>
<td>.08</td>
<td>.66</td>
<td>&lt; .001</td>
<td>.63</td>
</tr>
</tbody>
</table>

$^a$Gender: 1 = male, 2 = female

For Assessment Skills, the overall model was significant, $F (5, 146) = 9.77, p < .001$, accounting for 25.1% of variance in Assessment Skills. In terms of individual variables, only professional training and experience with grief (GCETS) significantly predicted Assessment Skills, $b = .49$ ($SE = .08$), $\beta = .46, p < .001$. Higher scores on the
GCETS, indicating more professional training and experience, were associated with higher scores on Assessment Skills. Age ($p = .37$), gender ($p = .45$), amount of courses taken that focused specifically on grief ($p = .29$), and amount of courses taken that infused grief in a substantial way ($p = .31$) did not predict Assessment Skills. Table 4.23 shows a regression table for the predictor variables and assessment skills.

Table 4.23

Regression Analyses for Variables Predicting Assessment Skills ($n = 152$)

<table>
<thead>
<tr>
<th>Variables</th>
<th>$b$</th>
<th>$SE$</th>
<th>$\beta$</th>
<th>$p$</th>
<th>Part Correlation</th>
</tr>
</thead>
<tbody>
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<td>.01</td>
<td>.07</td>
<td>.37</td>
<td>.06</td>
</tr>
<tr>
<td>2. Gender$^a$</td>
<td>.09</td>
<td>.11</td>
<td>.06</td>
<td>.45</td>
<td>.06</td>
</tr>
<tr>
<td>3. Courses Taken – Grief Infused</td>
<td>.07</td>
<td>.07</td>
<td>.08</td>
<td>.31</td>
<td>.07</td>
</tr>
<tr>
<td>4. Courses Taken – Grief Specific</td>
<td>.12</td>
<td>.11</td>
<td>.08</td>
<td>.29</td>
<td>.08</td>
</tr>
<tr>
<td>5. Professional Training and Experience (GCETS)</td>
<td>.49</td>
<td>.08</td>
<td>.46</td>
<td>&lt; .001</td>
<td>.43</td>
</tr>
</tbody>
</table>

$^a$Gender: 1 = male, 2 = female

For Treatment Skills, the overall model was significant, $F(5, 146) = 31.23, p < .001$, accounting for 51.7% of variance in Treatment Skills. In terms of individual variables, gender significantly predicted Treatment Skills, $b = .17 (SE = .08)$, $\beta = .12$, $p = .041$. Respondents identifying as female were associated with higher scores on Treatment Skills. Professional training and experience with grief (GCETS) also significantly predicted Treatment Skills, $b = .69 (SE = .06)$, $\beta = .70$, $p < .001$. Higher
scores on the GCETS, indicating more professional training and experience, were associated with higher scores on Treatment Skills. Age ($p = .11$), amount of courses taken that focused specifically on grief ($p = .25$), and amount of courses taken that infused grief in a substantial way ($p = .53$) did not predict Treatment Skills. Table 4.24 shows a regression table for the predictor variables and treatment skills.

Table 4.24

<table>
<thead>
<tr>
<th>Variables</th>
<th>$b$</th>
<th>$SE$</th>
<th>$\beta$</th>
<th>$p$</th>
<th>Part Correlation</th>
</tr>
</thead>
<tbody>
<tr>
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<td>.00</td>
<td>.09</td>
<td>.11</td>
<td>.09</td>
</tr>
<tr>
<td>2. Gender</td>
<td>.17</td>
<td>.08</td>
<td>.12</td>
<td>.04</td>
<td>.12</td>
</tr>
<tr>
<td>3. Courses Taken – Grief Infused</td>
<td>.03</td>
<td>.05</td>
<td>.04</td>
<td>.53</td>
<td>.04</td>
</tr>
<tr>
<td>4. Courses Taken – Grief Specific</td>
<td>.10</td>
<td>.09</td>
<td>.07</td>
<td>.25</td>
<td>.07</td>
</tr>
<tr>
<td>5. Professional Training and Experience (GCETS)</td>
<td>.69</td>
<td>.06</td>
<td>.70</td>
<td>&lt;.001</td>
<td>.66</td>
</tr>
</tbody>
</table>

$^a$Gender: $1 = \text{male}$, $2 = \text{female}$

For Professional Skills, the overall model was significant, $F (5, 146) = 16.09, p < .001$, accounting for 35.5% of variance in Professional Skills. In terms of individual variables, gender significantly predicted Professional Skills, $b = .25$ ($SE = .10$), $\beta = .17$, $p = .014$. Respondents identifying as female were associated with higher scores on Professional Skills. Professional training and experience with grief (GCETS) also significantly predicted Professional Skills, $b = .60$ ($SE = .07$), $\beta = .59$, $p < .001$. Higher
scores on the GCETS, indicating more professional training and experience, were associated with higher scores on Professional Skills. Age ($p = .10$), amount of courses taken that focused specifically on grief ($p = .80$), and amount of courses taken that infused grief in a substantial way ($p = .63$) did not predict Professional Skills. Table 4.25 shows a regression table for the predictor variables and professional skills.

### Table 4.25

**Regression Analyses for Variables Predicting Professional Skills ($n = 152$)**

<table>
<thead>
<tr>
<th>Variables</th>
<th>b</th>
<th>SE</th>
<th>β</th>
<th>$p$</th>
<th>Part Correlation</th>
</tr>
</thead>
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<td>.00</td>
<td>.11</td>
<td>.10</td>
<td>.11</td>
</tr>
<tr>
<td>2. Gender$^a$</td>
<td>.25</td>
<td>.10</td>
<td>.17</td>
<td>.01</td>
<td>.17</td>
</tr>
<tr>
<td>3. Courses Taken – Grief Infused</td>
<td>-.03</td>
<td>.06</td>
<td>-.03</td>
<td>.63</td>
<td>-.03</td>
</tr>
<tr>
<td>4. Courses Taken – Grief Specific</td>
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<td>.10</td>
<td>.02</td>
<td>.80</td>
<td>.02</td>
</tr>
<tr>
<td>5. Professional Training and Experience (GCETS)</td>
<td>.60</td>
<td>.07</td>
<td>.59</td>
<td>&lt; .001</td>
<td>.56</td>
</tr>
</tbody>
</table>

$^a$Gender: 1 = *male*, 2 = *female*

**Supplementary analyses.** Though not part of the original study, supplementary analyses were conducted with the variable of personal loss included in the model. The GCETS is an instrument used to measure professional experience and training, but does not assess for personal loss, so this was measured with a question in the demographic questionnaire. Kees (1987) and Ober et al. (2012) found in their studies that personal loss was not a predictor of perceived competencies or feelings of preparedness to work
with grief issues, but analyses were run here as a supplement to the original study to see if anything different was found.

Similar to other studies, in the supplemental analyses, personal losses did not significantly predict overall perceived grief counseling competencies (total DCS scores), though it was significant in the regression model for the Assessment Skills subscale, $b = .03$ ($SE = .01$), $\beta = .172$, $p = .042$. Without personal losses in the model, the variables accounted for 25.1% of the variance in Assessment Skills, $F(5, 146) = 9.77$, $p < .001$. When personal losses was included, the variance accounted for increased to 27.7%, $F(5, 146) = 9.06$, $p < .001$.

**Summary**

This chapter provided the results of the data analyses conducted, which explored professional training and experience and perceived grief counseling competencies of counseling graduate students. The average age of the sample was 34.3 years old, and it was largely female (75.3%), white (79.2%), and Christian (67.5%). The majority (65.6%) reported having had experienced the loss of one to five close friends or relatives. In terms of education, 83.1% of respondents were pursuing a degree in clinical mental health, with 11% school counseling, and 5.8% pursuing both degrees. Sixty one percent noted there was no opportunity in their program, required or elective, to take a course specific to grief counseling, though 60.1% also reported having taken a course in which the topic of grief was infused considerably. Still, 50% of respondents indicated feeling somewhat or very inadequately prepared by their graduate program to work with grief issues. Pertaining to clinical experience, 43.8% of respondents identified having
completed less than 100 hours of their field experience, though 73.4% of individuals had already worked with a client on grief issues, and the median number of clients was four.

The GCETS was used to assess professional experience and training on grief. The mean score, on a scale of 1-5 was 2.11. Of the 154 respondents, 87.7% reported below the midpoint value of three. The DCS and its five subscales were used to assess perceived grief counseling competencies. On the overall scale, the mean score of respondents was 3.27. The sample scored the highest on Personal Competencies (M = 4.26) and lowest on Professional Skills (M = 2.77). The other scores were Assessment Skills (M = 3.19), Treatment Skills (M = 3.13), and Conceptual Skills and Knowledge (M = 2.82).

A series of One-Way Analyses of Variance were conducted to compare mean scores on the GCETS and DCS between clinical mental health, school counseling, and those in both degree tracks. Each of the ANOVA indicated no significant differences between mean scores for these groups on any of the scales.

A series of Ordinary Least Squares regressions were conducted to examine associations between DCS and the variables of age, gender, professional training and experience (GCETS), and type of grief counseling training received (grief-specific courses and courses with grief material infused considerably. The regression model accounted for 48.5% of the variance in overall DCS scores, with professional training and experience (GCETS) and gender significantly predicting overall grief counseling competencies. Professional training and experience (GCETS) was a significant predictor for all the subscales as well, while gender contributed significantly to the subscales of
Conceptual Skills and Knowledge, Treatment Skills, and Professional Skills. The other variables did not significantly predict overall grief counseling competencies or any of the subscales.
Chapter 5 - Discussion

This chapter focuses on a discussion of the results from this study. Included in this discussion is a brief overview of the purpose of the study, followed by discussion of relevant findings related to each research question. Further, implications of this study’s findings will be addressed as they pertain to practitioners as well as counselor educators and counseling education programs. Finally, this chapter will also include a discussion of the limitations of the study and implications and suggestions for future research.

Purpose of the Study

The purpose of this study was to explore the grief counseling training, experience, and self-perceived grief counseling competencies of master’s level counseling students in CACREP-accredited institutions in Ohio. Simply stated, this study explored the extent and type of training received and how prepared students thought they were to work with grief-related issues. Additionally, the self-perceived grief counseling competencies were explored in relationship to a number of variables. These included age, gender, professional training and experience with grief (GCETS), and type of grief counseling training received.

The target population for this study was master’s level counseling students in CACREP-accredited institutions in Ohio who were in the field experience part of their training. By being in their field experience, these students were working with actual clients, had the possibility of addressing grief issues in their work, and could provide a rather comprehensive view of their training experience. A random cluster sample of
accessible students in Ohio was used in the study. A total of 156 students were administered surveys with 154 returning completed surveys.

The sample was largely female (75.3%), white (79.2%), and identified as having a Christian religious/spiritual background (67.5%). Demographic information for graduate students is not available via CACREP, so it is difficult to know how this compares to the larger population of master’s level counseling students. It is however, similar to the demographics reported in Ober et al. (2012) that sampled professional counselors from the same state. In that study, the majority of the sample was also female (77%), white (92.7%), and Christian (73.8%).

**Significant Findings**

**Grief training.** The data collected via the demographic questionnaire in this study indicated little availability of grief counseling training. Sixty one percent of respondents noted there were no grief counseling courses available to them in their programs, and 79.7% indicated having never taken a course that focused specifically on grief. These findings are very similar to other findings in the literature when it comes to grief training in helping professions. In a survey of rehabilitation counselors, Allen and Miller (1988) found that 54% had completed no courses on grief counseling, while Humphrey (1993) found that 66% of the counselor education programs surveyed noted their training programs did not offer a grief counseling course. Similarly, in a survey of professional counselors, Ober et al. (2012) found that 54.8% of respondents in their study had completed zero courses on grief counseling. It is somewhat surprising the percentages found in the present study were so high considering standards like ASCA’s
School Counselor Competencies (ASCA, 2012) and CACREP standards (CACREP, 2009) include grief as part of their training expectations. These are standards that were not necessarily in place 20-30 years ago when Allen and Miller (1993) and Humphrey (1993) conducted their studies; nevertheless, the results have not improved.

The data were more encouraging about individuals who had gleaned information on grief through other courses. Despite few respondents having completed a course focused specifically on grief counseling, 60.2% of respondents did indicate having taken a course in which they believe grief topics were infused considerably into the material. This is similar to the findings in Ober et al. (2012) where 73.2% of respondents indicated they had taken at least one course that infused grief material significantly. Though this question was not explored further with follow-up questions, one student wrote in next to the response that one such course was crisis counseling. Gaining knowledge and skills pertaining to crisis response is required both by CACREP standards (CACREP, 2009) and the ASCA’s School Counselor Competencies (ASCA, 2012), so this is likely one course students are picking up some information related to grief. It is also possible students pick up grief information in a course that covers the lifespan or human development, as this generally includes information relevant to issues later in life, such as death and loss.

Although it is encouraging the majority of students are receiving some grief information in other courses, the literature suggests grief counseling training should go beyond acquiring knowledge and skills, and also include a more personal, intentional focus on exploring students’ attitudes, values, and beliefs about death (Ho Chan & Tin,
Whether or not this level of personal attention and detail pertaining to loss and death can be incorporated into a course not focused specifically on grief is questionable. Wass (2004) suggests that merely infusing grief into a few lectures in separate courses does not allow for the necessary depth or exploration of grief issues and may leave students unprepared to address them in their clinical work.

Despite limited attention to grief issues within their training, the large majority of respondents indicated grief counseling is already a part of their clinical work. The participants in this study were largely new to clinical work, as the average amount of field experience hours completed was 283.3 hours; this is less than half of the required total for both clinical mental health (700 hours) and school counseling (600 hours) students. However, despite limited experience, 73.4% of respondents indicated having had already worked on grief issues with a client. Further, the median number of clients was four; many students have been addressing grief with multiple clients. It is somewhat disconcerting students appear to receive little focus on grief issues in their training, but are expected, very early on, to be able to work with them clinically. Given what has been found in previous research about the discomfort students and beginning counselors have with death-related issues (Kees, 1987; Kirchberg & Neimeyer, 1991; Kirchberg et al., 1998), it seems it would benefit these young practitioners to have more attention directed toward death and grief issues in their preparation for clinical work.

**Grief theories.** The data collected regarding familiarity with a variety of grief theories was disconcerting as well, though not surprising. It has been suggested that some of the conflicting results in the literature about the efficacy of grief counseling may
be in part due to the lack of attention given to the theoretical approaches being used. Whereas overall counseling efficacy is often studied in relation to specific theories (e.g., Cognitive Behavioral Therapy, Reality Therapy, Interpersonal Psychotherapy, etc.), grief counseling efficacy research generally lacks in identifying a theoretical foundation (e.g., Stage Theory, Meaning-making Theory, Dual Process Theory, etc.) and may too often involve counselors using invalidated theories (Corr, 1993; Neimeyer, 2000b).

As an example, when attention has been given to empirically validating grief theories, the stage theories do not have any empirical support (Bonanno & Kaltman, 1999; Hansson & Stroebe, 2007; Lindstrom, 2002; Stroebe & Schut, 1999; Wortman & Silver, 2001), while meaning making and dual process do have evidence for their effectiveness (Lindstrom, 2002; Richardson, 2007; Schut, Stroebe, van den Bout, & Terheggen, 2001). However, Kubler-Ross’ Stage Theory is one of the most well-known and engrained ideas about grief in our culture and practice (Humphrey, 2009; Kelley, 2010). It is possible too many clinicians, potentially as a result of lack of training, are adhering to outdated, unsupported perspectives on grief.

Further supporting this concern are the data obtained in the present study. Even as the aforementioned research is becoming more available about the efficacy and validity of grief counseling theories, the students in this most recent study reported being most familiar with Kubler-Ross’ Stage Theory with very little familiarity of any other theoretical approaches. Nearly 68% of respondents indicated having “some” or “a lot” of familiarity with Kubler-Ross’ theory. This is in comparison to 14.5% with Task Theory, 14.5% with Dual Process Theory, 24.6% with Meaning Making Theory, and 11.9% with
Continuing Bonds Theory. These results were not surprising when considering other literature on this topic. For example, in Ober et al. (2012) those who reported “some” or “a lot” of familiarity with the stages went as follows: Stage Theory (42.8%), Task Theory (28.2%), Dual Process Theory (15.4%), Meaning Making Theory (25.5%), and Continuing Bonds Theory (14.9%). Students in the present study were more familiar with Stage Theory than the professional counselors in Ober et al. (2012), less familiar with Task Theory, and about equally as familiar with the others. Clearly, in both studies, there is an imbalance when it comes to the knowledge of theoretical foundations.

This raises two concerns. First, there is the fact that respondents were so unfamiliar with grief counseling theories at all. Aside from Stage Theory, not even one-quarter of respondents in this study indicated “some” or “a lot” of familiarity with any other theory. Considering 73.4% of respondents reported having already worked with a client on grief issues, this raises great concern about their approach to working with these clients. The data indicate a severe lack of theoretical foundation or understanding of grief from which they can address these issues with clients. Furthermore, a second concern is that the theory with which respondents were most familiar, Stage Theory, is one that lacks empirical support. While grief has been identified in the literature as a very personalized and unique process (Humphrey, 2009; Kelley, 2010; Neimeyer, 2000b), Stage Theory is susceptible to linear expectations for how grief “should” occur (Servaty-Seib, 2004), which may have negative consequences for individuals who find themselves experiencing grief in a way very different from these expectations. On the other hand, the theories for which there is evidence of efficacy (e.g., Meaning Making
and Dual Process) were very much unknown to respondents. This suggests they may simply be missing out on more effective ways to help their clients deal with grief issues, because they are not aware of these theories.

**Research question one.** The first research question explored in this study was: Among master’s level counseling graduate students in their field experience, what is the extent of professional training and experience with grief counseling, as measured by the Grief Counseling Experience and Training Survey (GCETS)? The GCETS assesses for an individual’s experience and training specific to grief on twelve, Likert-type items. Each item has a possible score of one to five with higher scores representing more experience or training. Respondents in this study had a mean score of 2.11 ($SD = .64$), which was just over halfway between 1, indicating “not at all true,” and 3, indicating “somewhat true” to the items. There are no standardized cutoff scores to indicate levels of training and experience (high, low, etc.), but the mean score clearly represents limited amount of training and experience with grief. This score can also be looked at in comparison to another study that utilized this instrument. In Ober et al. (2012), a sample of licensed professional counselors had a mean score of 2.7 ($SD = 0.9$). It is logical the students in training in the present study would score lower than individuals in the Ober et al. (2012) study who have been working in the field for many years; though, it is interesting both samples scored within the range of 2-3. This may represent a lack of grief training and experience in the field as a whole.

To further analyze the data collected by this instrument, scores on individual items were explored as well. The highest mean score ($M = 3.03$) (the item was reversed
scored) was in response to the item, “Currently, I do not have sufficient skills or training to work with a client who presents with grief.” This is not a surprise given what has been found in the literature about graduate students and beginning counselors and their feelings of discomfort with and unpreparedness for working with grief issues (Kees, 1987; Kirchberg & Neimeyer, 1991; Kirchberg et al., 1998). However, it is alarming given the number of respondents (73.4%) in the present study who have reported already working with clients on grief issues.

The second and third highest scores ($M = 2.53$ and $M = 2.45$, respectively) were in response to the items, “I feel competent to assess the mental health needs of a person who presents with grief in a therapeutic setting,” and “I consistently check my grief counseling skills by monitoring my functioning and competency via consultation, supervision, and continuing education.” It is interesting to see what these higher-scored items have in common, and that is a more general counseling focus. That is, they address experiences and training such as “assessing the mental health needs” and, “monitoring my functioning … via consultation, supervision, and continuing education.” These items do not address specific grief counseling experiences like some of the other items. Students learn to assess mental health needs as part of general counseling training regardless if there is a focus on grief. Additionally, all respondents are indeed engaged in consultation and supervision, because it is a required part of their field experience, so it makes sense they reported higher scores on that item.

What respondents lacked was training and experience on more grief-specific items. When it came to these items that addressed more specific grief counseling
experiences, the respondents reported much lower scores. These were items that addressed having experiences like conducting grief groups ($M = 1.65$), counseling individuals who lost a loved one to suicide ($M = 1.71$), and counseling children experiencing grief ($M = 1.79$). There is a bit of dissonance in that respondents reported very low scores on these items despite 73.4% indicating having worked with clients on grief issues. There are a few possible explanations for this. First, it may simply be they lack the variety of the experiences addressed in the instrument, because they are relatively new to the field. That is, maybe they have had the opportunity to work with individuals on grief issues, but have not yet led grief groups or worked with children on grief issues. Second, the language used in the instrument may also lend to the lower scores. That is, several of them read, “I have a great deal of experience…” It is likely, being new to clinical work, that many students may have had some experience, but not “a great deal of experience” with these situations and therefore reported lower scores on these items.

Respondents also scored lower on the items about having completed role-plays involving grief concerns ($M = 1.86$) and having sufficient knowledge of grief counseling theories and models ($M = 2.06$). This is disheartening, because these are items that do not rely on clinical experience, but adequate training. While it is understandable that students had not yet had a great deal of experience addressing grief clinically, items that rely more on training than clinical experience were also scored very low. Furthermore, the lowest mean score reported on the instrument ($M = 1.51$) was in response to attending conference sessions or workshops that focus on grief counseling. Thus, it appears
students are not receiving training on grief issues in the classroom nor are they picking it up via workshops or conferences. In conjunction with very low scores on the survey questions about familiarity with different grief counseling theories, these findings suggest individuals may be approaching grieving clients with very limited training and little to no sound theoretical foundation.

**Research question two.** The second research question explored in this study was: what are the levels of self-perceived grief counseling competencies of graduate counseling students, as measured by the Death Counseling Survey (DCS)? The instrument returns an overall perceived grief counseling competency score, but to provide a more specific scope, there are scores on five subscales as well – personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills. The items on the survey, like the GCETS, are scored Likert-type from one to five. The confidence level associated with the scale is as follows: 1-this does not describe me, 2-this barely describes me, 3-this somewhat describes me, 4-this describes me, and 5-this describes me very well.

The respondents’ overall mean score ($M = 3.27$) is above the midpoint of three and is associated most closely with “this somewhat describes me,” indicating some confidence in their overall grief counseling abilities. This is somewhat surprising given the low scores on the GCETS discussed above. In terms of subscales, the mean score for Personal Competencies ($M = 4.26$) was far higher than the other scales of Conceptual Skills ($M = 2.82$), Assessment Skills ($M = 3.19$), Treatment Skills ($M = 3.13$), and Professional Skills ($M = 2.78$). These scores were consistent with other studies that have
used this instrument, albeit with different populations. In Charkow (2002), a sample of Marriage and Family Therapists scored highest on Personal Competences ($M = 4.46$), as did Professional Counselors ($M = 4.41$) in Ober et al. (2012). Table 5.1 shows a comparison of subscale scores across this study and the two previous studies. It is not surprising that respondents in the present study scored themselves lower than in the other studies, as the participants in this study were students. The other studies involved professionals who had been in the field for much longer and, therefore, likely had more opportunity and experience to hone grief counseling competencies. On average, the students in the present study scored about half of a point lower on all subscales, excluding Personal Competencies, than the Professional Counselors in Ober et al. (2012) and about one point lower than the Marriage and Family Therapists in Charkow (2002).

Table 5.1

*Comparison of DCS Subscale Mean Scores in Present and Past Studies*

<table>
<thead>
<tr>
<th>DCS Subscales</th>
<th>Present Study: Master’s Students</th>
<th>Ober et al., 2012: Professional Counselors</th>
<th>Charkow, 2002: Marriage &amp; Family Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Competencies</td>
<td>4.26</td>
<td>4.41</td>
<td>4.46</td>
</tr>
<tr>
<td>Conceptual Skills/Knowledge</td>
<td>2.82</td>
<td>3.07</td>
<td>3.74</td>
</tr>
<tr>
<td>Assessment Skills</td>
<td>3.19</td>
<td>3.56</td>
<td>3.91</td>
</tr>
<tr>
<td>Treatment Skills</td>
<td>3.13</td>
<td>3.47</td>
<td>4.01</td>
</tr>
<tr>
<td>Professional Skills</td>
<td>2.78</td>
<td>3.19</td>
<td>3.85</td>
</tr>
</tbody>
</table>
In terms of the scores in the present study, it is worthwhile to explore more in depth each subscale score, as this gives even more insight into specific competencies. Each of these scales and their specific items will be discussed in turn.

The respondents scored highest on the Personal Competencies scale, which includes items about experiencing loss, verbalizing one’s own grief process, viewing grief as both systemic and individual, and articulating one’s own attitudes regarding death. These are grief-specific items that are also specific to one’s own beliefs and attitudes – hence the personal nature. The scale also measures things that are relevant to grief work, but less specific to grief. These are items such as having a sense of humor, practicing wellness and self-care, and displaying attributes like genuineness and unconditional positive regard.

A closer look at respondents’ scores on the Personal Competencies subscale reveals some interesting information. The lowest score on this subscale ($M = 3.75$) was in response to “I have a strong sense of spirituality defined as separate from religious beliefs and practices.” This mean score falls within “This somewhat describes me” and “This describes me.” Possible explanations for this score being lower in comparison to others items could be that respondents simply did not have a strong sense of spirituality at all or that they do not view spirituality as being separate from religious beliefs and practices. Given that 92% of respondents in this study reported affiliation to some kind of spiritual or religious background, it is more likely the latter – that some individuals may conceptualize spirituality and religious beliefs as extensions of one another. It is also possible the respondents view a strong connection between grief processes and
religious practices given that 81% of them said their religious or spiritual background is helpful to them in processing grief.

The next four lowest mean scores on the Personal Competencies subscale were in response to, “I practice personal wellness and self-care” ($M = 3.97$), “I can articulate my own philosophy and attitudes regarding death” ($M = 4.02$), “I have experienced the death(s) of a family member and can verbalize my own grief process” ($M = 4.03$), and “I have self-awareness related to my own grief issues and history” ($M = 4.10$). Despite being the lower scores within the scale, all of these indicate a response of, “This describes me.” Several scholars have noted the importance of grief training including personal components like one’s own attitudes and beliefs about loss and death (Ho Chan & Tin, 2012; Wass, 2004; Watts, 2007). So, it is encouraging students rate themselves relatively high on things like their self-awareness about personal loss, philosophies and attitudes on death, and overall self-care. These are also topics that are recommended to be a part of classes focused on grief counseling (Wass, 2004) if students had the opportunity to take them.

Highest scores on the Personal Competencies scale were in response to items about displaying unconditional positive regard and genuineness ($M = 4.64$), recognizing grief can occur as a result of many types of loss, not just death ($M = 4.62$), and having a sense of humor ($M = 4.56$). These are important aspects of grief counseling, but are likely skills and attributes that can be learned either in life outside of counseling training (e.g., developing a sense of humor) or within non-grief-related counseling curriculum (e.g., developing unconditional positive regard and genuineness). Thus, it appears
students rate themselves highest on skills that are learned without grief training, but rate themselves a little lower on items that would require an intentional focus on grief (e.g., articulating one’s philosophy regarding death).

This distinction between specific grief counseling competencies and more general counseling competencies may serve as an explanation for the ordering of mean scores among the five scales. That is, scales which included more items less specific to grief were the scales on which the respondents reported having the most confidence. For example, the Assessment Skills scale had the second highest mean score ($M = 3.19$). However, there are a number of items on this scale that are associated with assessment in general and not necessarily specific to grief counseling. For example, respondents are asked if they can assess for a client’s sense of spirituality ($M = 3.63$), conduct suicide assessments ($M = 3.86$), and identify symptoms that warrant medical attention and referral ($M = 3.57$). In fact, these were the three highest scoring items within the scale. While these are important skills relevant to grief counseling, they are skills that are learned without grief counseling training. Students likely pick up these abilities in assessment classes, treatment planning classes, and crisis counseling classes.

When it came to assessment items specific to grief, respondents scored much lower. These included items like co-creating or participating in mourning rituals for grieving persons ($M = 2.54$), assessing progress on theoretically defined grief tasks ($M = 2.69$), and differentiating bereavement from DSM diagnoses that are similar ($M = 2.81$). On all of these grief-specific assessment skills, individuals are much less confident in their abilities. So, it seems they have confidence in their abilities to conduct more
general assessments, but when asked to do so in relation to grief theories or bereavement-related diagnoses, they perceive themselves less competent. Again, it calls into question the foundation, or lack thereof, from which these individuals are working with clients who present with grief.

This same trend, of scoring high on items more applicable to general counseling and lower on items specific to grief is true on the Treatment Skills scale as well. This scale represented the third highest reported scores out of the five scales with a mean score of 3.13 and also includes a number of more general items. Participants rated themselves very high on treatment skills like exhibiting active listening skills ($M = 4.71$), establishing rapport ($M = 4.53$), and providing a supportive presence during difficult times ($M = 4.40$). While important to grief counseling, these are skills that are fundamental to all counseling approaches and issues, and they are taught throughout the counseling curriculum. Participants rated themselves much lower on their ability to do things like facilitate family grief counseling sessions ($M = 2.21$), facilitate group grief sessions ($M = 2.31$), and even conveying to adults how to best talk to children about death, grief, and loss ($M = 2.10$). It is encouraging that students believe they can establish rapport, actively listen, and provide a supportive presence, as these are all skills fundamental to effective counseling. However, the drop from scores in the “This describes me very well” range to “This barely describes me” for grief specific treatment skills is disheartening. These are items that would require more grief-specific training, which students appear to be lacking.
The Conceptual Skills scale, which measures things like respondents’ confidence in understanding styles of grief, recognition of functional and dysfunctional coping skills of grieving individuals, and understanding theoretical grief models was the second lowest score of the five scales ($M = 2.82$) and one of two on which respondents were below the midpoint of three. Given the trends on the other scales and the lack of grief-specific training the respondents reported, it was not a surprise scores were low on this scale. Each of the items on this scale is very specific to grief counseling. They are skills that would be less likely to be addressed elsewhere in the counseling curriculum or developed throughout one’s life in a way that students could acquire these skills elsewhere.

These grief specific items included knowing what are appropriate levels of death understanding for children based on their developmental level ($M = 2.40$), what constitutes as uncomplicated bereavement according to theoretical models ($M = 2.48$), and understanding the nature and symptoms of complicated or unresolved grief ($M = 2.63$). Mean scores for these items were all within the range of, “This barely describes me,” to, “This somewhat describes me.” The scores are concerning given the literature discussed earlier in chapters one and two about children having differing, but age-appropriate understandings of and reactions to grief. Researchers are clear about the importance of understanding developmental levels when providing grief support (cf. Balk, Zaengle, & Corr, 2011; Morgan & Roberts, 2010; Sormanti & Ballan, 2011; Webb, 2011). If counselors are not aware of typical grief responses in children, they run the risk of not providing appropriate levels of care or misunderstanding a child’s grieving process. Furthermore, on the treatment scale discussed earlier, participants rated
themselves low on their ability to communicate to parents how to talk to their kids about death and grief. These findings together suggest that respondents have a lack of knowledge of developmentally appropriate grief responses, which then cannot be discussed with parents and other adults who could then become more informed sources of support for children. School counselors, especially, may benefit from learning about these developmental levels, as they are likely to have children across a variety of stages in a single school setting.

Additionally, Neimeyer (2000b) suggested grief counseling may be most appropriate to engage in with clients who are experiencing complicated grief. If clinicians have not been trained to recognize complicated versus uncomplicated grief, it would be difficult for them to effectively assess for this and determine if it should be a part of treatment. Similarly, disenfranchised grief is that which often carries a stigma and results in symptoms similar to those experienced with complicated grief (Doka, 2002). The counseling office could become a confidential place for someone experiencing disenfranchised grief to openly discuss and grieve the loss in a manner they are not able to do publicly. That said, if counselors are not attuned to the nuances of disenfranchised and complicated grief symptoms, they may overlook an opportunity to make this a focus of counseling.

The lowest scale score of the five was on Professional Skills. This was not a surprise for a few reasons. First, this scale was the second lowest scoring in the previous two studies using this instrument (Charkow, 2002; Deffenbaugh, 2008), so it seems to be a weakness among professionals in general. Second, some the items on this scale involve
skills that are less likely to be fully developed in students (e.g., conducting a workshop about grief).

However, a closer look at scores on specific items reveals weaknesses in areas related to grief training. Respondents had a mean score of 1.99 on, “I can provide developmentally appropriate programs about grief and loss issues in schools.” This score indicates a response of, “This barely describes me.” One explanation of this low score could be that the majority of respondents (83.1%) were in clinical mental health counseling and, therefore, rate themselves lower on items about schools. Another explanation is that respondents simply did not have good understanding of what is developmentally appropriate when it comes to grief. This explanation is supported by scores discussed earlier related to the Treatment Skills and Conceptual Skills. Likely, it is a combination of the two that lend to the lower score, but, either way, it is clear the respondents are not confident about providing such services.

A second item respondents scored surprisingly low on (M = 2.56) was, “I can provide crisis intervention services to schools and/or community settings.” This score falls within the range of “This barely describes me” to “This somewhat describes me.” Respondents exhibit little confidence in their ability to provide crisis intervention, despite this being a required part of training per CACREP (CACREP, 2009) and ASCA (ASCA, 2012) standards. Given this item includes both school and community settings, it is unlikely the low score is related to the sample’s degree track, but is instead simply indicative of a lack of confidence in providing crisis services.
In summary, the scores across and within the five scales of the DCS seem to indicate a pattern. Students in the present study report much more confidence in their general counseling abilities than those more specific to grief counseling. Students are picking up skills that are learned outside of, or elsewhere within, the counseling curriculum, but miss out on skills that can only be acquired via specific grief counseling training. So, when it comes to their ability to do things like actively listen, exhibit unconditional positive regard, and have a sense of humor, they are comfortable with their skills. However, when it comes to skills like understanding grief theories, identifying developmentally appropriate grief responses, or distinguishing between complicated and uncomplicated grief, there is a lack of confidence in their skills. More about this will be discussed in the “Implications” sections later in this chapter.

**Research question three.** The third research question explored in this study was: what is the difference in the areas of grief counseling experience and training (GCETS) and levels of self-perceived grief counseling competencies (DCS) between school counseling students, clinical mental health counseling students, and those pursuing both? To explore this question, a series of One-Way Analyses of Variance (ANOVA) were conducted. This allowed for comparisons of means on the GCETS and the DCS and its scales across the different degree tracks.

A discussion of degree representation is warranted in relation to these analyses. In the sample size, an overwhelming majority of respondents (83.1%) were involved in a clinical mental health counseling track, while only 11% were in school counseling and 5.8% were pursuing both degrees. This occurred despite the researcher’s efforts to
collect data across all degree tracks. Of the 16 institutions in Ohio that had CACREP accreditation at the time of data collection, 15 had school counseling programs in addition to their clinical mental health counseling program. Therefore, an equal opportunity existed for collecting data across both programs when the schools were contacted. One explanation for the imbalance in numbers may be that it was summer when a portion of the schools agreed to participate in the research. While clinical mental health counseling students continue seeing clients through the summer, primary and secondary schools are not in session and school counseling students are likely not meeting in field experience classes as a result. Thus, by the timing of data collection, it is possible there were fewer school counseling students available to survey.

The concern was that with a small representation of school counseling students or students pursuing both degrees, an extreme score from an individual in these groups could have a much larger impact on the overall mean scores. For example, if a school counseling student experienced the death of a student at school, this respondent might report much more experience or perceived competency dealing with grief based on what was learned through that process. This score could then skew the mean for the entire group of school counseling students because of its greater impact on the smaller sample. That said, this fear was assuaged by conducting the Levene’s test to test for equal variance across groups. The results were insignificant across all dependent variables, which indicated there was indeed equality in variance across the three groups.

Part of the rationale for this research question was to explore whether or not training might be different across the groups. For example, since ASCA’s School
Counselor Competencies (ASCA, 2012) directly call for grief training and CACREP’s Clinical Mental Health Counseling standards include it more indirectly within crisis response, would school counseling students report more training and experience or competencies with grief? The results of the ANOVA indicated no, as there were no significant differences in mean scores across the groups. In fact, mean scores on the professional training and experience with grief (GCETS) differed by only 0.09 on a five-point scale – a difference of only 1.9%.

Respondents in both groups also reported very similar scores on the overall perceived grief counseling competencies as well as the five scales. On none of the scales was Levene’s test significant, and the largest mean difference between the groups on any scale was only 0.34 on a five-point scale. The results of these tests suggest there is no difference between the groups when it comes to grief counseling training and experience or perceived competencies. So, despite the school counseling standards more explicitly calling for grief counseling skills, it appears training is very similar across degrees. That said, further research on this would benefit from larger and more equal sample sizes to increase observed power and explore these groups further.

**Research question four.** The fourth research question explored in this study was: what is the relationship between self-perceived grief counseling competencies (DCS) and the variables of age, gender, professional training and experience with grief (GCETS), degree track, and type of grief counseling training received? Given that the data in the previous research question indicate no differences between the degree tracks, this variable was removed from the regression equations conducted for this question.
The regression models were significant for overall perceived grief counseling competencies (DCS), as well as all the subscales. The amount of variance explained by the model, for each criterion variable, was as follows: Overall Grief Counseling Competencies (Total DCS) (48.5%), Personal Competencies (10.1%), Conceptual Skills/Knowledge (50.0%), Assessment Skills (25.1%), Treatment Skills (51.7%), and Professional Skills (35.5%). As observed here, the model explained the least amount of variance within the Personal Competencies and Assessment Skills subscales. These were also the two subscales on which respondents rated themselves the highest ($M = 4.26$ and $M = 3.19$, respectively).

As discussed earlier, a pattern emerged with the scores in that the scales that contained more general counseling skills were those on which respondents scored highest. Those were also the scales for which the selected variables accounted for the least variance. In terms of predictive value, it is possible that other factors, such as general counseling skill or something of that nature, would contribute more to the explained variance, whereas professional training and experience with grief and these other variables did not explain quite as much. Conversely, these variables accounted for much more variance in overall competencies and the subscales of Treatment Skills, Conceptual Skills/Knowledge, and Professional Skills – scales which included more grief-specific items and may rely more heavily on professional training and experience.

Professional training and experience with grief (GCETS) was the strongest predictor of all the variables and contributed significantly to the model for all five subscales and overall competencies. Correlations between GCETS and the criterion
variables were also quite high, suggesting a strong relationship between training and competencies: Overall Grief Counseling Competencies ($r = .67$), Personal Competencies ($r = .19$), Conceptual Skills/Knowledge ($r = .68$), Assessment Skills ($r = .48$), Treatment Skills ($r = .70$), and Professional Skills ($r = .56$).

Standardized beta values ($\beta$) were also examined to look at the unique contribution professional training and experience provided to each equation. The values were consistent with the amount of variance in the criterion variables the models explained. That is, professional training and experience offered the most unique contribution to Treatment Skills ($\beta = .70$), Overall Grief Counseling Competencies ($\beta = .67$), Conceptual Skills/Knowledge ($\beta = .66$), and Professional Skills ($\beta = .59$). These, again, are the scales which included the most grief-specific items, so it is logical that professional training and experience in grief would be a strong predictor of scores on the scales. That is, individuals who had higher levels of grief training and experience were more likely to rate themselves higher on these competencies.

The unique contribution provided by professional training and experience with grief was lower in the equation for Personal Competencies ($\beta = .22$), and was only slightly higher than the other significant predictor in that model, which was age ($\beta = .19$). Given that older individuals reported higher scores on this scale, it may suggest these skills are accumulated or acquired throughout one’s life as they mature and likely experience more personal loss. So, Personal Competencies, like articulating one’s philosophy and beliefs about death, experiencing loss and describing one’s personal
grieving process, having a sense of humor, and things of this nature, may be as much a factor of life experience as they are professional training or experience.

Another noteworthy point arising out of this data is that age did not significantly predict scores on any other subscale. This suggests that more grief-specific skills are not simply acquired over time, but instead require training and professional experience. With this in mind, and recognizing the lower scores on more grief-specific subscales, it may suggest that individuals are confident in their personal awareness and beliefs as they pertain to grief, but much less confident when it comes to actual knowledge and skills about grief theories, processes, and treatment. Simply stated, age and personal familiarity with grief are not a replacement for professional training (Ober et al., 2012). Having personal familiarity with grief or being able to articulate one’s beliefs about it are not enough when it comes to helping a client who is experiencing complicated grief. Nor does it help a clinician be able to discuss developmentally appropriate responses to grief with a parent whose child is grieving. These are skills that come with training.

Gender was a significant predictor with women scoring significantly higher than men on Overall Grief Counseling Competencies and three of the five subscales (Conceptual Skills/Knowledge, Treatment Skills, and Professional Skills). The standardized beta scores for each of these were relatively low ($\beta = .12 - .17$) and, upon further examination, the actual differences in mean scores were limited. The largest difference in means was on Professional Skills (.15), while the others were between .06 and .09 – all on a five-point scale. Given the limited difference, there may be little practical application as gender relates to grief counseling competencies.
That said, some research suggests differences in the way men and women are socialized and how they respond to grief, which could potentially influence comfort and confidence in grief counseling as well. Women are generally encouraged to be more expressive emotionally, while men are socialized to remain stoic, strong, and to generally hide their feelings. As a result, in response to losses, women are more likely to focus on the emotions involved, while men focus more on problem-solving behavioral changes such as completing tasks the deceased used to do, staying busy, and managing the reduction in financial resources (Bennett, 2007; Cochran, 2006; Schut, Stroebe, & van den Bout, 1997). These tendencies, or approaches to grief, may play out in a professional setting when addressing grief issues and could help explain the higher perceived competencies in that women may be more comfortable sitting with difficult emotions and exploring the strong emotional reactions clients may have. Women also tend to be recognized as more nurturing and those in this study may have had more life experiences helping grieving friends and family. This could account for some of their greater perceived competencies when it comes to dealing with grief issues.

The regression results of this study are consistent with those found in Ober et al. (2012) with professional counselors. In both studies, the regression models explained a great deal of the variance in the criterion variables – in this one between 25% and 51.7% on all but one scale, and in Ober et al. (2012) between 18% and 71%. In both studies, professional training and experience was also the strongest predictor of the dependent variables with standardized beta scores ranging from .19 -.70 in this study and .35 -.84 in Ober et al. (2012). Also similar to this study, both age and gender were found to be
significant predictors, albeit to a limited extent, on a number of the scales. The consistency between the two studies further supports the notion that professional training and experience with grief is an important component to one’s perceived competency in dealing with grief issues.

**Implications for practitioners.** The findings in this study have a number of implications for practitioners – those working as professionals as well as students entering the field. There is continued evidence for the lack of grief counseling focus in graduate level counseling training programs (cf. Allen & Miller, 1998; Charkow, 2002; Humphrey, 1993; Ober et al., 2012; Stephenson, 1981), which was noted in the present study as well. This is the case despite clear evidence in this study and others that practitioners are often expected to work with clients on grief issues (Allen & Miller, 1988, Charkow, 2002, Ober et al., 2012).

In some programs, elective courses are available, but many students are only being introduced to grief counseling concepts through information infused into other courses. It appears students have very limited opportunities to acquire the knowledge and skills necessary for grief counseling and may have to more intentionally pursue such training. Students and professionals alike may have to rely on professional development opportunities like conference sessions and workshops to bolster their knowledge and skills of grief counseling.

It is important for practitioners to advance their understanding and knowledge of grief beyond their own personal experiences and familiarity. While the present study and others (Charkow, 2002; Ober et al., 2012) suggest high perceived competency with
personal attributes and awareness related to grief and loss, there is a sharp decline in perceived competency with more grief-specific professional knowledge and skills. This is especially true when it comes to understanding grief theories, developmentally appropriate responses and interventions, understanding complicated and uncomplicated grief symptoms, and providing different modes of grief counseling (e.g., in groups, with families, etc.).

Clinicians, especially school counselors who work daily with children, would do well to find training or educate themselves on the interaction of grief and developmental levels. A focus of this training might include developmentally appropriate understanding of death, so helpers can grasp how children are viewing and comprehending loss. Another may be to learn how grief manifests itself at various developmental levels, so as to recognize what is adaptive, maladaptive, and when intervention is necessary. For example, knowing that in adolescents there is often an ebb and flow of strong emotional reaction and returns to normalcy (Christ, Siegel, & Christ, 2002) could help a high school counselor more perceptively monitor students who have experienced a loss.

Practitioners may also benefit from getting training or reading up on theoretical foundations on grief and grief counseling. Grief theory has come a long way in the past several decades (Humphrey, 2010) and theories have evolved significantly since Kubler-Ross first proposed her stages in 1969. The results from the present study and Ober et al. (2012) suggest that practitioners are vastly more familiar with this stage theory than they are with more contemporary models like meaning making and dual process approaches to grief counseling. This is concerning in that these latter two theories have empirical
support, while stage theories do not. Much like in counseling as a whole, evidence-based treatment should be a focus for practitioners. Sadly, however, there is clearly a general unawareness of these more modern theories. By only being familiar with stage theories, practitioners run the risk of having, and conveying, certain expectations for grief processes that may simply be unfounded. Grief does not necessarily progress linearly through stages, but is a personal, unique, and individualized process; it is hard to communicate this idea to clients if it is also unknown to the practitioner.

The literature also suggests a great deal of discomfort for students and beginning counselors when it comes to death and grief-related issues (Kirchberg & Neimeyer, 1991; Kirchberg et al., 1998), but this discomfort is not as present in experienced clinicians (Terry et al., 1995). This may highlight the value of counselors intentionally seeking training on how to work with grief issues. They may be coming into the field unprepared and uncomfortable with death-related work, but with more training and experience may develop confidence and competency to work more effectively with grief issues.

**Implications for counselor education programs and educators.** The findings in this study have implications for counselor educators and counseling education programs as well. Professional standards like those provided by CACREP and ASCA call for students to have knowledge and skills in grief-related areas. Yet, this study and others suggest there has been, and continues to be, a lack of focus on grief-related training in the helping professions (Allen & Miller, 1998; Charkow, 2002; Humphrey, 1993; Ober et al., 2012; Stephenson, 1981).
It may not be feasible for programs to implement entire courses on grief counseling, but there are specific areas of focus that could very much benefit beginning counselors. While some authors note the importance of a personal focus in grief training (Ho Chan & Tin, 2012; Watts, 2007), the results from this study and others (Charkow, 2002; Ober et al., 2012) show that individuals generally rate themselves high when it comes to personal attributes and awareness about loss and death. The shortcomings appear to be with grief-specific knowledge and skills. Therefore, there are a few areas on which counselor educators could direct focus to better prepare students to work with grief issues.

First, students would benefit from being introduced to the variety of grief counseling theories that have been developed throughout the past decade or two. Whereas older theories focused on stages and detaching emotionally from the deceased (Bowlby, 1980; Kubler-Ross, 1969; Freud, 1957), more contemporary theories have strayed from these notions. Now there is a greater focus on meaning making and reconstruction (Neimeyer, 2000b), implementing one’s relationship with the deceased into life via a continuing bond (Klass et al., 1996), and recognizing the multitude of stressors that come with loss and oscillating between facing and avoiding them (Stroebe & Schut, 1999). Students overwhelmingly responded that they were unfamiliar with these modern theories, despite their efficacy in practice. Counselor educators would do well to introduce these theories to students, so they can operate from a sound theoretical approach, as they would with general counseling theory.
Second, counselor educators may consider implementing into their training assessment techniques that address grief-related issues. Students could benefit from understanding how complicated and uncomplicated grief manifest and the symptoms they might recognize as a result. With awareness to these issues, practitioners can better assess how adaptive a client’s grieving process is, and whether or not there are unresolved or complicated grief issues at play. Furthermore, Neimeyer (2000b) suggested grief counseling may be most appropriate for complicated grief and that many individuals navigate the grieving process successfully on their own within their social support systems. When students are trained to more effectively assess for adaptive and maladaptive patterns of grief, they can better determine when intervention is necessary, if at all.

Third, given that grief counseling training has been lacking for a number of years, counselor educators may consider providing professional development opportunities on the topic. Whether within specific counseling agencies, at professional conferences, or through workshops, educators have opportunities to provide grief training to practitioners who likely missed it in their own training programs. Foci for these trainings could include effective assessment as it pertains to grief, theoretical foundations for grief counseling, contemporary understanding of grief and what it means for grief counseling, and understanding grief at various developmental levels. These training ideas target specific grief counseling skills and knowledge that seem to presently be a shortcoming for students and professionals.
In summary, educators have an opportunity to provide better grief training to students via the classroom and to practitioners via continuing education trainings. Individuals may benefit from educators placing a more intentional focus on grief counseling concepts, especially those that focus on increased theoretical knowledge, assessment and conceptualization, and skill building. The results of this study suggest students are being expected to work with grieving clients very early in their field experience and would likely benefit from grief-specific training, so as to provide the best possible care for their clients.

**Limitations and implications for future research.** There are a few limitations in the present study worth addressing, which may also inform future research. First, the instruments used in this study were self-report surveys. They relied on honest, accurate reporting from the respondents as opposed to more objective assessments of grief counseling competencies. That said, the instruments used are currently the only ones available to assess for grief counseling competency and training and are relatively new in their development and use. Future research using the instruments across different populations would help further examine their psychometric properties and validate their usefulness. Future research could also focus on developing more ways to assess for grief counseling competencies. For example, developing instruments on which supervisors can assess the skills of supervisees may offer additional insight into grief counseling competency. Another option would be to assess, from the client’s perspective, the effectiveness of grief counseling received, so as to further our understanding of what skills and approaches are found to be helpful.
A second limitation involves the sample of this study. There was limited diversity within the sample as 79.2% were white, 75.3% were female, and all respondents were from Ohio. These findings may be representative of Ohio, as they were similar to those found in Ober et al. (2012), which surveyed professional counselors in Ohio. However, the general lack of diversity limits the overall generalizability of the study. Future studies may focus on exploring grief counseling competencies within more diverse populations to improve upon this. Researchers may also continue exploring the influence of gender on grief counseling, as this study and Ober et al. (2012) found it to be a predictor, albeit minimally, of competencies. A more balanced sample of male counselors may offer additional information about the differences between genders. Also related to the sample, a more balanced ratio of school counseling students to mental health counseling students would be useful in future studies to better compare differences across degree tracks.

Another focus of future research relates to grief counseling theories. The present study and Ober et al. (2012) suggested a lack of knowledge in students and practitioners about different grief theories. Neimeyer (2000b) suggested some of the inconsistency in the literature about grief counseling effectiveness may be due to practitioners counseling from ineffective theoretical foundations, which are not accounted for in the studies. Much like studies on general counseling efficacy focus on the theoretical approach, this may be an approach to take with future grief counseling research as well. For example, are outcomes in grief counseling different based on the theoretical foundation of the practitioner?
A final suggestion for future research is to investigate more closely the details of current grief training practices. In this study, 60.1% of respondents identified having taken at least one course in which grief topics were infused significantly. In light of this, students were still very unfamiliar with modern grief theory and rated themselves low on a variety of grief-specific skill sets. It would be worthwhile to better understand the quality of training received and what topics and issues pertaining to grief are being addressed in the classroom, so as to identify weaknesses and improve the training received.

**Conclusion.** The purpose of this study was to explore the grief counseling training, experience, and self-perceived grief counseling competencies of master’s level counseling students. The extent and type of training received and how prepared students thought they were to work with grief-related issues was explored. Additionally, the self-perceived grief counseling competencies were explored in relationship to a number of variables. These included age, gender, professional training and experience with grief (GCETS), degree track, and type of grief counseling training received.

The respondents indicated specific grief counseling training was limited, as evidenced by 79.7% of respondents reporting they had never taken a course focused specifically on grief and 61% indicating grief counseling courses were not available to them in their training programs. However, 60.1% of students noted they had taken a course that infused grief topics in a considerable way. Most respondents were unfamiliar with grief theories outside of Kubler-Ross’s stage theory, which may indicate a lack of sound theoretical foundation from which they conduct grief counseling. This is of
concern especially considering 73.4% of respondents indicated having already worked with clients on grief issues.

The data collected about professional training and experience, using the GCETS, indicated respondents did not have very much professional training or experience with grief issues. The mean score reported on this instrument was 2.11 on a five-point scale with higher scores representing more training and experience with grief. Upon closer examination, the data revealed respondents reported higher scores on items relevant to grief, but more general in focus (e.g., receiving supervision and consultation, assessing mental health needs of grieving individuals, etc.). They reported much less experience with grief-specific items like conducting grief counseling with families, counseling children experiencing grief, etc. One explanation was that students in their field experience may simply lack varied clinical experience. A second explanation was that the language in the survey (i.e., “I have a great deal of experience...”) did not lend toward students rating themselves higher. However, they also rated themselves low on items more specific to training instead of clinical experience (e.g., participating in grief role plays and having sufficient knowledge of grief theories and models). This suggests they not only lacked varied clinical experience, but also had limited training on grief.

Similar findings were discovered with the perceived grief counseling competencies as well. Students rated themselves far more competent with general counseling abilities relevant to grief than on grief-specific items. This was evident across the scales in that Personal Competencies had a mean score of 4.26, while Conceptual Skills/Knowledge has a mean score of 2.82. Students appear to be comfortable with their
self-awareness and personal attitudes about grief, but report much less competence with grief specific skills like applying theoretical models, understanding and assessing for complicated grief, and recognizing developmentally appropriate grief reactions and interventions. These results suggest that respondents have personal experience and familiarity with loss and grief, but lack the necessary professional skills that come into play when counseling grieving clients.

Given that professional standards (e.g., CACREP and ASCA) differ slightly in their attention to grief counseling, scores across degree tracks were explored as well. There were no significant differences in the training, experience, and competencies between clinical mental health counseling students, school counseling students, and those pursuing both degrees. However, there was an imbalance in the number of representatives for each group and, thus, could be a focus of future research.

Regression analyses were conducted to explore the relationship between the competency scales on the DCS and the variables of age, gender, professional training and experience with grief (GCETS), and type of grief training received. The type of training received (having taken a grief-specific class versus being in classes grief material was infused) was not a significant predictor of any of the competencies. Age was a significant predictor of Personal Competencies, which may indicate that some general skills and personal beliefs about loss are acquired and developed over time, outside of the classroom, throughout one’s life. Gender was a significant predictor of Overall Grief Counseling Competencies and three of the four subscales (Conceptual Knowledge/Skills, Treatment Skills, and Professional Skills). The unique contribution of gender to the
equations was limited, but females reported higher scores on these scales. This might be explained by some literature that suggests women are socialized to experience and express emotions more so than men; thus, may feel more confident and competent to work with the challenging emotions that arise with grief. Professional training and experience was the strongest predictor within all the regression equations, which suggests that training and professional experience are pivotal in viewing oneself as competent to work with grief issues.

There are implications for both practitioners and counselor educators that arise from this study. First, more emphasis on quality grief counseling training may be necessary. Practitioners appear to lack in their grief-specific knowledge and skills and may benefit from pursuing professional development opportunities related to grief, so as to provide appropriate care to grieving clients. Educators could help in the process by providing current, specific, grief training in their classes. They may also recognize the dearth of understanding and skill in grief counseling and work to develop grief-related continuing education opportunities for practitioners. Ideas for both the classroom and continuing education could include focusing on contemporary grief theories, assessing for and recognizing complicated grief symptoms, and understanding grief as it applies to various developmental levels.

The present study was not without limitations, such as a sample that had limited diversity and the use of self-report instruments. The sample came from a single state and was made up of predominantly white females. The use of self-report instruments rely on subjective responses from those being assessed, but were the only available instruments
to study grief counseling competencies. Future research could include more and varied samples, so as to improve the generalizability of findings. Additionally, the continued use of these instruments will help in the understanding of their psychometric properties and their usefulness in grief research. Researchers may also consider developing other ways of assessing grief counseling competencies, whether via client report, supervisor assessment, or other possible methods. Finally, it would also be worthwhile to explore the details of current grief counseling training – looking at the quality and type of information that is being taught in training programs. Doing so may provide better understanding of the weaknesses within training practices and ultimately lead to ways to improve grief counseling competency.
References


Appendix A: Demographic Questionnaire

Please take the time to answer the following questions. Please understand that your responses will remain anonymous and will only be used collectively for data analysis.

1. What is your age? _______ years

2. What is your gender?
   ______ Male    ______ Female
   ______ Transgender    ______ Other (Please identify) ______________

3. What is your race/ethnicity?
   ______ Black/African-American    ______ White/Caucasian
   ______ Asian-American    ______ Hispanic/Latino
   ______ Native American    ______ Pacific Islander
   ______ Multiracial
   ______ Other (Please list) ______________________

4. Please indicate your religious/spiritual background:
   ______ Jewish    ______ Protestant    ______ Hindu
   ______ Muslim    ______ Catholic    ______ Buddhist
   ______ Atheist    ______ Agnostic
   ______ Other (Please list) ______________________

5. Do you believe your religious or spiritual background is helpful to you personally in processing grief?
   ______ Yes    ______ No    ______ Undecided

6. How many close relatives or friends have you lost to death?
   ______ friend(s)/relative(s)

7. Please rate your overall counseling competence by circling a statement below:
   a. I need to learn a great deal more before I would call myself competent.
   b. I have much to learn in order to call myself competent.
   c. I am comfortable with my knowledge and skill level.
   d. I am highly competent.
Education/Training Items

8. In which discipline(s) are you pursuing a degree?
   ______ School Counseling   ______ Clinical Mental Health Counseling
   ______ Both

8a. If both, which is your primary degree track?
   ______ School Counseling   ______ Clinical Mental Health Counseling

9. How many courses focused specifically on death or grief are offered in your program?
   ______ required course(s)   ______ elective/optional course(s)

10. How many courses focused specifically on death or grief have you completed?
    ______ course(s)

11. How many courses have you completed that have incorporated or included information on death or grief in a significant way?
    ______ course(s)

12. Approximately how many hours of professional development (e.g., conference sessions, workshops) have you earned on the subject of death and grief?
    ______ hour(s)

13. Approximately how many hours of your field experience have you completed?
    ______ hour(s)

14. In your field experience, have you served clients or students for whom grief issues were part of counseling?
    ______ Yes   ______ No

13a. If yes, approximately how many adults and how many children?
    ______ adult(s)   ______ child/children
15. Please indicate your level of familiarity with the following theories of grief counseling by circling the appropriate response to each below. (Authors of the models have been included for your reference.)

   a. Stage Theories (e.g., Kubler-Ross, Bowlby, Parkes)  
      None    Very Little    Some    A lot
   b. Task Theories (e.g., Worden)  
      None    Very Little    Some    A lot
   c. Dual-process Theories (e.g., Stroebe & Schut)  
      None    Very Little    Some    A lot
   d. Meaning-making Theories (e.g., Neimeyer)  
      None    Very Little    Some    A lot
   e. Continuing Bonds Theories (e.g., Bonanno & Klass)  
      None    Very Little    Some    A lot

16. How adequately prepared by your graduate training do you think you are to work with grief-related issues?
   a. Very inadequately  
   b. Somewhat inadequately  
   c. Somewhat adequately  
   d. Adequately  
   e. Very adequately

17. Do you think education and training in grief counseling:

   _____ is not necessary     _____ is necessary     _____ should be required
# Appendix B: Grief Counseling Experience and Training Survey

Anne Deffenbaugh (2008)

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale</th>
</tr>
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<tbody>
<tr>
<td>I have received adequate clinical training and supervision to counsel clients who present with grief.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>I consistently check my grief counseling counseling skills by monitoring my functioning and competency via consultation, supervision, and continuing education.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>I have a great deal of experience counseling clients who present with grief.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>At this point in my professional development, I feel competent, skilled and qualified to counsel clients who present with grief.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>I have a great deal of experience counseling persons who experienced loss of a loved one to suicide.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>I have a great deal of experience counseling children who present with grief.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>I feel competent to assess the mental health needs of a person who presents with grief in a therapeutic setting.</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

*Using the scale, rate the truth of each item as it applies to you by circling the appropriate number.*
9. I have a great deal of experience with facilitating group counseling focused on grief concerns.

10. Currently, I do not have sufficient skills or training to work with a client who presents with grief.

11. I have done many counseling role-plays (as either the client or counselor) involving grief concerns.

12. I have sufficient knowledge of grief counseling theories and models.
Appendix C: Death Counseling Survey (DCS)

(Wendy Charkow, 2002)

Part I: Personal Grief Counseling Competencies

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<td>5</td>
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</table>

Using the scale above, please rate how well the following items describe you.

1. I practice personal wellness and self-care. 1 2 3 4 5
2. I have experienced the death(s) of a family member and can verbalize my own grief process. 1 2 3 4 5
3. I have self-awareness related to my own grief issues and history. 1 2 3 4 5
4. I view death as a natural part of the experience of living. 1 2 3 4 5
5. I believe that grief is a result of a variety of loss experiences, to include but not limited to death. 1 2 3 4 5
6. I display therapeutic attributes of empathy, unconditional positive regard, and genuineness in interactions with others. 1 2 3 4 5
7. I view grief as a systemic as well as an individual experience. 1 2 3 4 5
8. I have a strong sense of spirituality defined as separate from religious beliefs and practices. 1 2 3 4 5
9. I believe that there is no one right way to deal with grief. 1 2 3 4 5
10. I have a sense of humor. 1 2 3 4 5
11. I can articulate my own philosophy and attitudes regarding death. 1 2 3 4 5
Part II: Skills and Knowledge Grief Counseling Competencies

<table>
<thead>
<tr>
<th></th>
<th>1 This does not describe me.</th>
<th>2 This barely describes me.</th>
<th>3 This somewhat describes me.</th>
<th>4 This describes me.</th>
<th>5 This describes me very well.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I can assess for unresolved losses that may not be stated as a presenting problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>I can provide psycho-education to clients related to the grief experience for themselves and others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>I can facilitate family grief counseling sessions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>I can provide educational workshops and activities to community members about grief.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I can define and articulate the nature of “normal” bereavement and grief as detailed by theoretical models.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>I can articulate the diagnostic criteria for Bereavement, according to the DSM-IV and how to distinguish this Diagnosis from related diagnoses.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>I can facilitate individual grief counseling sessions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>I can use concrete terms regarding death to address the reality of death and convey the ability to discuss death-related issues.</td>
<td>1</td>
<td>2</td>
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<td>9.</td>
<td>I can provide developmentally appropriate programs about grief and loss issues in schools.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>10.</td>
<td>I can facilitate group grief counseling sessions.</td>
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<td></td>
<td>This does not describe me.</td>
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<td>11.</td>
<td>I can describe general differences in the grief experience as determined by different status and process variables (i.e. personality, relationship to the deceased).</td>
<td>1 2 3 4 5</td>
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<tr>
<td>12.</td>
<td>I can conduct suicide assessments.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>13.</td>
<td>I can facilitate multi-family group grief counseling sessions.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>14.</td>
<td>I can articulate a grief consultation model for parents, teachers, and other adults about how to talk to children about death, grief, and loss.</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>15.</td>
<td>I can provide crisis intervention services to schools and/or community settings.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>16.</td>
<td>I can define and articulate the nature and symptoms of complicated/unresolved grief situations.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>17.</td>
<td>I can teach clients how to obtain support and resources in the community.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>18.</td>
<td>I can assess a client's sense of spirituality.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>19.</td>
<td>I can establish rapport with clients of all ages.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>20.</td>
<td>I can work on an interdisciplinary team by interacting with staff from different professions.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>21.</td>
<td>I can identify cultural differences that affect treatment.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>22.</td>
<td>I can describe common functional coping styles of bereaved persons.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>23.</td>
<td>I can utilize family assessment techniques to examine interaction patterns and roles.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>24.</td>
<td>I can provide appropriate crisis debriefing services.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>25.</td>
<td>I can exhibit effective active listening skills.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>26.</td>
<td>I can read and apply current research and literature related to grief and effective treatment interventions.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>27.</td>
<td>I can facilitate a reframe of loss experience and grief reactions for client empowerment.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>28.</td>
<td>I can describe common dysfunctional coping styles of bereaved persons.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>29.</td>
<td>I can assess individuals’ progress on theoretically defined grief tasks.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>30.</td>
<td>I can facilitate reconnection between a dying client and distant/estranged family members.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>31.</td>
<td>I can use the creative arts in counseling to facilitate grief expression.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>32.</td>
<td>I can appropriately self-disclose related to own grief and loss experiences.</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>33.</td>
<td>I maintain an updated library of grief and loss resources for clients.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>34.</td>
<td>I can articulate appropriate developmental levels of death understanding for children.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>35.</td>
<td>I can identify cultural differences that affect assessment.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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<tr>
<td>36.</td>
<td>I can recognize and work with grief-related client resistance and denial.</td>
<td>1 2 3 4 5</td>
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<td></td>
<td>1 This does not describe me.</td>
<td>2 This barely describes me.</td>
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<td>5 This describes me very well.</td>
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<tr>
<td>37.</td>
<td>I can participate in informal or formal support groups for professionals who work with issues of grief and loss to prevent burnout and vicarious traumatization.</td>
<td></td>
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<td>$\text{1 2 3 4 5}$</td>
</tr>
<tr>
<td>38.</td>
<td>I can describe how various individual counseling theories can be applied to grief counseling with individuals and families.</td>
<td></td>
<td></td>
<td></td>
<td>$\text{1 2 3 4 5}$</td>
</tr>
<tr>
<td>39.</td>
<td>I can recommend helpful articles and books for grieving individuals and families.</td>
<td></td>
<td></td>
<td></td>
<td>$\text{1 2 3 4 5}$</td>
</tr>
<tr>
<td>40.</td>
<td>I can identify symptoms that warrant medical evaluation and refer to a physician.</td>
<td></td>
<td></td>
<td></td>
<td>$\text{1 2 3 4 5}$</td>
</tr>
<tr>
<td>41.</td>
<td>I can describe how various family counseling theories can be applied to grief counseling with individuals and/or families.</td>
<td></td>
<td></td>
<td></td>
<td>$\text{1 2 3 4 5}$</td>
</tr>
<tr>
<td>42.</td>
<td>I can advocate for the needs of the dying client and the family.</td>
<td></td>
<td></td>
<td></td>
<td>$\text{1 2 3 4 5}$</td>
</tr>
<tr>
<td>43.</td>
<td>I can define and differentiate between the terms of grief, bereavement, and mourning.</td>
<td></td>
<td></td>
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<td>$\text{1 2 3 4 5}$</td>
</tr>
<tr>
<td>44.</td>
<td>I can determine appropriate treatment modality (i.e. individual or group) for a grieving client as a result of assessment.</td>
<td></td>
<td></td>
<td></td>
<td>$\text{1 2 3 4 5}$</td>
</tr>
<tr>
<td>45.</td>
<td>I can co-create and participate in mourning rituals for individuals and/or families.</td>
<td></td>
<td></td>
<td></td>
<td>$\text{1 2 3 4 5}$</td>
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<tr>
<td>46.</td>
<td>I can provide a supportive presence for client(s) in difficult times.</td>
<td></td>
<td></td>
<td></td>
<td>$\text{1 2 3 4 5}$</td>
</tr>
<tr>
<td>47.</td>
<td>I can provide hope without giving false reassurance.</td>
<td></td>
<td></td>
<td></td>
<td>$\text{1 2 3 4 5}$</td>
</tr>
</tbody>
</table>
Appendix D: Relevant Sections of 2009 CACREP Standards

(CACREP, 2009)

(Relevant Standards in **Bold**)

**CLINICAL MENTAL HEALTH COUNSELING**

Students who are preparing to work as clinical mental health counselors will demonstrate the professional knowledge, skills, and practices necessary to address a wide variety of circumstances within the clinical mental health counseling context. In addition to the common core curricular experiences outlined in Section II.G, programs must provide evidence that student learning has occurred in the following domains:

**FOUNDATIONS**

A. Knowledge

1. Understands the history, philosophy, and trends in clinical mental health counseling.

2. Understands ethical and legal considerations specifically related to the practice of clinical mental health counseling.

3. Understands the roles and functions of clinical mental health counselors in various practice settings and the importance of relationships between counselors and other professionals, including interdisciplinary treatment teams.

4. Knows the professional organizations, preparation standards, and credentials relevant to the practice of clinical mental health counseling.

5. Understands a variety of models and theories related to clinical mental health counseling, including the methods, models, and principles of clinical supervision.

6. Recognizes the potential for substance use disorders to mimic and coexist with a variety of medical and psychological disorders.

7. Is aware of professional issues that affect clinical mental health counselors (e.g., core provider status, expert witness status, access to and practice privileges within managed care systems).

8. Understands the management of mental health services and programs, including areas such as administration, finance, and accountability.
9. **Understands the impact of crises, disasters, and other trauma-causing events on people.**

10. Understands the operation of an emergency management system within clinical mental health agencies and in the community.

**B. Skills and Practices**

1. Demonstrates the ability to apply and adhere to ethical and legal standards in clinical mental health counseling.

2. Applies knowledge of public mental health policy, financing, and regulatory processes to improve service delivery opportunities in clinical mental health counseling.

**COUNSELING, PREVENTION, AND INTERVENTION**

**C. Knowledge**

1. Describes the principles of mental health, including prevention, intervention, consultation, education, and advocacy, as well as the operation of programs and networks that promote mental health in a multicultural society.

2. Knows the etiology, the diagnostic process and nomenclature, treatment, referral, and prevention of mental and emotional disorders.

3. Knows the models, methods, and principles of program development and service delivery (e.g., support groups, peer facilitation training, parent education, self-help).

4. Knows the disease concept and etiology of addiction and co-occurring disorders.

5. Understands the range of mental health service delivery—such as inpatient, outpatient, partial treatment and aftercare—and the clinical mental health counseling services network.

6. **Understands the principles of crisis intervention for people during crises, disasters, and other trauma-causing events.**

7. Knows the principles, models, and documentation formats of biopsychosocial case conceptualization and treatment planning.
8. Recognizes the importance of family, social networks, and community systems in the treatment of mental and emotional disorders.

9. Understands professional issues relevant to the practice of clinical mental health counseling.

D. Skills and Practices

1. Uses the principles and practices of diagnosis, treatment, referral, and prevention of mental and emotional disorders to initiate, maintain, and terminate counseling.

2. Applies multicultural competencies to clinical mental health counseling involving case conceptualization, diagnosis, treatment, referral, and prevention of mental and emotional disorders.

3. Promotes optimal human development, wellness, and mental health through prevention, education, and advocacy activities.

4. Applies effective strategies to promote client understanding of and access to a variety of community resources.

5. Demonstrates appropriate use of culturally responsive individual, couple, family, group, and systems modalities for initiating, maintaining, and terminating counseling.

6. Demonstrates the ability to use procedures for assessing and managing suicide risk.

7. Applies current record-keeping standards related to clinical mental health counseling.

8. Provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders.

9. Demonstrates the ability to recognize his or her own limitations as a clinical mental health counselor and to seek supervision or refer clients when appropriate.
SCHOOL COUNSELING

Students who are preparing to work as school counselors will demonstrate the professional knowledge, skills, and practices necessary to promote the academic, career, and personal/social development of all K–12 students. In addition to the common core curricular experiences outlined in Section II.G, programs must provide evidence that student learning has occurred in the following domains.

FOUNDATIONS

A. Knowledge
   1. Knows history, philosophy, and trends in school counseling and educational systems.
   2. Understands ethical and legal considerations specifically related to the practice of school counseling.
   3. Knows roles, functions, settings, and professional identity of the school counselor in relation to the roles of other professional and support personnel in the school.
   4. Knows professional organizations, preparation standards, and credentials that are relevant to the practice of school counseling.
   5. Understands current models of school counseling programs (e.g., American School Counselor Association [ASCA] National Model) and their integral relationship to the total educational program.
   6. Understands the effects of (a) atypical growth and development, (b) health and wellness, (c) language, (d) ability level, (e) multicultural issues, and (f) factors of resiliency on student learning and development.
   7. Understands the operation of the school emergency management plan and the roles and responsibilities of the school counselor during crises, disasters, and other trauma-causing events.

B. Skills and Practices
   1. Demonstrates the ability to apply and adhere to ethical and legal standards in school counseling.
   2. Demonstrates the ability to articulate, model, and advocate for an appropriate school counselor identity and program.
COUNSELING, PREVENTION, AND INTERVENTION

C. Knowledge
    1. Knows the theories and processes of effective counseling and wellness programs for
       individual students and groups of students.

    2. Knows how to design, implement, manage, and evaluate programs to enhance the
       academic, career, and personal/social development of students.

    3. **Knows strategies for helping students identify strengths and cope with
       environmental and developmental problems.**

    4. Knows how to design, implement, manage, and evaluate transition programs,
       including school-to-work, postsecondary planning, and college admissions
       counseling.

    5. Understands group dynamics—including counseling, psycho-educational, task, and
       peer helping groups—and the facilitation of teams to enable students to overcome
       barriers and impediments to learning.

    6. **Understands the potential impact of crises, emergencies, and disasters on
       students, educators, and schools, and knows the skills needed for crisis
       intervention.**

D. Skills and Practices

    1. Demonstrates self-awareness, sensitivity to others, and the skills needed to relate to
       diverse individuals, groups, and classrooms.

    2. **Provides individual and group counseling and classroom guidance to promote
       the academic, career, and personal/social development of students.**

    3. **Designs and implements prevention and intervention plans related to the effects
       of (a) atypical growth and development, (b) health and wellness, (c) language, (d)
       ability level, (e) multicultural issues, and (f) factors of resiliency on student
       learning and development.**

    4. Demonstrates the ability to use procedures for assessing and managing suicide
       risk.

    5. Demonstrates the ability to recognize his or her limitations as a school counselor and
       to seek supervision or refer clients when appropriate.
DIVERSITY AND ADVOCACY

E. Knowledge
   1. Understands the cultural, ethical, economic, legal, and political issues surrounding diversity, equity, and excellence in terms of student learning.

   2. **Identifies community, environmental, and institutional opportunities that enhance—as well as barriers that impede—the academic, career, and personal/social development of students.**

   3. Understands the ways in which educational policies, programs, and practices can be developed, adapted, and modified to be culturally congruent with the needs of students and their families.

   4. Understands multicultural counseling issues, as well as the impact of ability levels, stereotyping, family, socioeconomic status, gender, and sexual identity, and their effects on student achievement.

F. Skills and Practices

   1. Demonstrates multicultural competencies in relation to diversity, equity, and opportunity in student learning and development.

   2. Advocates for the learning and academic experiences necessary to promote the academic, career, and personal/social development of students.

   3. Advocates for school policies, programs, and services that enhance a positive school climate and are equitable and responsive to multicultural student populations.

   4. Engages parents, guardians, and families to promote the academic, career, and personal/social development of students.

ASSESSMENT

G. Knowledge

   1. Understands the influence of multiple factors (e.g., abuse, violence, eating disorders, attention deficit hyperactivity disorder, childhood depression) that may affect the personal, social, and academic functioning of students.

   2. Knows the signs and symptoms of substance abuse in children and adolescents, as well as the signs and symptoms of living in a home where substance abuse occurs.
3. Identifies various forms of needs assessments for academic, career, and personal/social development.

H. Skills and Practices

1. Assesses and interprets students’ strengths and needs, recognizing uniqueness in cultures, languages, values, backgrounds, and abilities.

2. Selects appropriate assessment strategies that can be used to evaluate a student’s academic, career, and personal/social development.

3. Analyzes assessment information in a manner that produces valid inferences when evaluating the needs of individual students and assessing the effectiveness of educational programs.

4. Makes appropriate referrals to school and/or community resources.

5. **Assesses barriers that impede students’ academic, career, and personal/social development.**

RESEARCH AND EVALUATION

I. Knowledge

1. Understands how to critically evaluate research relevant to the practice of school counseling.

2. Knows models of program evaluation for school counseling programs.

3. Knows basic strategies for evaluating counseling outcomes in school counseling (e.g., behavioral observation, program evaluation).

4. Knows current methods of using data to inform decision making and accountability (e.g., school improvement plan, school report card).

5. Understands the outcome research data and best practices identified in the school counseling research literature.

J. Skills and Practices

1. Applies relevant research findings to inform the practice of school counseling.

2. Develops measurable outcomes for school counseling programs, activities, interventions, and experiences.
3. Analyzes and uses data to enhance school counseling programs.

ACADEMIC DEVELOPMENT

K. Knowledge

1. Understands the relationship of the school counseling program to the academic mission of the school.

2. Understands the concepts, principles, strategies, programs, and practices designed to close the achievement gap, promote student academic success, and prevent students from dropping out of school.

3. Understands curriculum design, lesson plan development, classroom management strategies, and differentiated instructional strategies for teaching counseling- and guidance-related material.

L. Skills and Practices

1. Conducts programs designed to enhance student academic development.

2. Implements strategies and activities to prepare students for a full range of postsecondary options and opportunities.

3. Implements differentiated instructional strategies that draw on subject matter and pedagogical content knowledge and skills to promote student achievement.

COLLABORATION AND CONSULTATION

M. Knowledge

1. Understands the ways in which student development, well-being, and learning are enhanced by family-school-community collaboration.

2. Knows strategies to promote, develop, and enhance effective teamwork within the school and the larger community.

3. Knows how to build effective working teams of school staff, parents, and community members to promote the academic, career, and personal/social development of students.

4. Understands systems theories, models, and processes of consultation in school system settings.
5. Knows strategies and methods for working with parents, guardians, families, and communities to empower them to act on behalf of their children.

6. Understands the various peer programming interventions (e.g., peer meditation, peer mentoring, peer tutoring) and how to coordinate them.

7. **Knows school and community collaboration models for crisis/disaster preparedness and response.**

N. Skills and Practices

1. **Works with parents, guardians, and families to act on behalf of their children to address problems that affect student success in school.**

2. Locates resources in the community that can be used in the school to improve student achievement and success.

3. Consults with teachers, staff, and community-based organizations to promote student academic, career, and personal/social development.

4. Uses peer helping strategies in the school counseling program.

5. Uses referral procedures with helping agents in the community (e.g., mental health centers, businesses, service groups) to secure assistance for students and their families.

**LEADERSHIP**

O. Knowledge

1. Knows the qualities, principles, skills, and styles of effective leadership.

2. Knows strategies of leadership designed to enhance the learning environment of schools.

3. Knows how to design, implement, manage, and evaluate a comprehensive school counseling program.

4. Understands the important role of the school counselor as a system change agent.

5. Understands the school counselor’s role in student assistance programs, school leadership, curriculum, and advisory meetings.

P. Skills and Practices
1. Participates in the design, implementation, management, and evaluation of a comprehensive developmental school counseling program.

2. Plans and presents school-counseling-related educational programs for use with parents and teachers (e.g., parent education programs, materials used in classroom guidance and advisor/advisee programs for teachers).
Appendix E: Relevant Sections of 2012 ASCA School Counselor Competencies

(ASCA, 2012)

(Relative Standards in Bold)

IV. DELIVERY

School counselors should possess the knowledge, abilities, skills and attitudes necessary to deliver a school counseling program aligning with the ASCA National Model.

IV-A: Knowledge

School counselors should articulate and demonstrate an understanding of:

IV-A-1. The distinction between direct and indirect student services

IV-A-2. The concept of a school counseling core curriculum

IV-A-3. Counseling theories and techniques that work in school, such as rational emotive behavior therapy, reality therapy, cognitive-behavioral therapy, Adlerian, solution-focused brief counseling, person-centered counseling and family systems

IV-A-4. Counseling theories and techniques in different settings, such as individual planning, group counseling and classroom lessons

IV-A-5. Classroom management

IV-A-6. Principles of career planning and college admissions, including financial aid and athletic eligibility

IV-A-7. Principles of working with various student populations based on characteristics such as ethnic and racial background, English language proficiency, special needs, religion, gender and income

IV-A-8. Principles of multi-tiered approaches within the context of a comprehensive school counseling program

IV-A-9. Responsive services (counseling and crisis response) including grief and bereavement

IV-A-10. The differences between counseling, collaboration and consultation, especially the potential for dual roles with parents, guardians and other caretakers
**IV-B: Abilities and Skills**

An effective school counselor is able to accomplish measurable objectives demonstrating the following abilities and skills.

**Direct Student Services**

**School Counseling Core Curriculum**

- **IV-B-1.** Implements the school counseling core curriculum
- **IV-B-1a.** Identifies appropriate curriculum aligned to ASCA Student Standards
- **IV-B-1b.** Develops and presents a developmental school counseling core curriculum addressing all students’ needs based on student data
- **IV-B-1c.** Demonstrates classroom management and instructional skills
- **IV-B-1d.** Develops materials and instructional strategies to meet student needs and school goals
- **IV-B-1e.** Encourages staff involvement to ensure the effective implementation of the school counseling core curriculum
- **IV-B-1f.** Knows, understands and uses a variety of technology in the delivery of school counseling core curriculum activities
- **IV-B-1g.** Understands multicultural and pluralistic trends when developing and choosing school counseling core curriculum
- **IV-B-1h.** Understands and is able to build effective, high-quality peer helper programs

**Individual Student Planning**

- **IV-B-2.** Facilitates individual student planning
- **IV-B-2a.** Understands individual student planning as a component of a comprehensive program
- **IV-B-2b.** Develops strategies to implement individual student planning, such as strategies for appraisal, advisement, goal-setting, decision-making, social skills, transition or post-secondary planning
- **IV-B-2c.** Helps students establish goals and develops and uses planning skills in collaboration with parents or guardians and school personnel
IV-B-2d. Understands career opportunities, labor market trends and global economics and uses various career assessment techniques to help students understand their abilities and career interests

IV-B-2e. Helps students learn the importance of college and other post-secondary education and helps students navigate the college admissions process

IV-B-2f. Understands the relationship of academic performance to the world of work, family life and community service

IV-B-2g. Understands methods for helping students monitor and direct their own learning and personal/social and career development

Responsive Services

IV-B-3. Provides responsive services

IV-B-3a. Lists and describes interventions used in responsive services, such as individual/small-group counseling and crisis response

IV-B-3b. Understands appropriate individual and small-group counseling theories and techniques such as rational emotive behavior therapy, reality therapy, cognitive-behavioral therapy, Adlerian, solution-focused brief counseling, person-centered counseling and family systems

IV-B-3c. Demonstrates an ability to provide counseling for students during times of transition, separation, heightened stress and critical change

IV-B-3d. Understands what defines a crisis, the appropriate response and a variety of intervention strategies to meet the needs of the individual, group or school community before, during and after crisis response
Appendix F: Item Scores on the Grief Counseling Experience and Training Survey

*(Deffenbaugh, 2008)*

<table>
<thead>
<tr>
<th>GCETS Item</th>
<th>$M$</th>
<th>$SD$</th>
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<tbody>
<tr>
<td>1. I have received adequate clinical training and supervision to counsel clients who present with grief.</td>
<td>2.40</td>
<td>1.00</td>
</tr>
<tr>
<td>2. I consistently check my grief counseling skills by monitoring my functioning and competency via consultation, supervision, and continuing education.</td>
<td>2.45</td>
<td>1.16</td>
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<tr>
<td>3. I have a great deal of experience counseling clients who present with grief.</td>
<td>1.99</td>
<td>0.96</td>
</tr>
<tr>
<td>4. At this point in my professional development, I feel competent, skilled and qualified to counsel clients who present with grief.</td>
<td>2.33</td>
<td>0.89</td>
</tr>
<tr>
<td>5. I have a great deal of experience counseling persons who experienced loss of a loved one to suicide.</td>
<td>1.71</td>
<td>0.90</td>
</tr>
<tr>
<td>6. I have a great deal of experience counseling children who present with grief.</td>
<td>1.79</td>
<td>0.94</td>
</tr>
<tr>
<td>7. I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling.</td>
<td>1.51</td>
<td>0.83</td>
</tr>
<tr>
<td>8. I feel competent to assess the mental health needs of a person who presents with grief in a therapeutic setting.</td>
<td>2.53</td>
<td>1.00</td>
</tr>
<tr>
<td>9. I have a great deal of experience with facilitating group counseling focused on grief concerns.</td>
<td>1.65</td>
<td>0.99</td>
</tr>
<tr>
<td>10. Currently, I do not have sufficient skills or training to work with a client who presents with grief.</td>
<td>3.03</td>
<td>1.28</td>
</tr>
<tr>
<td>11. I have done many counseling role-plays (as either the client or counselor) involving grief concerns.</td>
<td>1.86</td>
<td>0.99</td>
</tr>
<tr>
<td>12. I have sufficient knowledge of grief counseling theories and models.</td>
<td>2.06</td>
<td>0.93</td>
</tr>
</tbody>
</table>
Appendix G: Item Scores on the Death Counseling Survey (Charkow, 2002)

<table>
<thead>
<tr>
<th>DCS Items Part I</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I practice personal wellness and self-care.</td>
<td>3.97</td>
<td>0.77</td>
</tr>
<tr>
<td>2. I have experienced the death(s) of a family member and can verbalize my own grief process.</td>
<td>4.03</td>
<td>0.96</td>
</tr>
<tr>
<td>3. I have self-awareness related to own grief issues and history.</td>
<td>4.10</td>
<td>0.92</td>
</tr>
<tr>
<td>4. I view death as a natural part of the experience of living.</td>
<td>4.47</td>
<td>0.76</td>
</tr>
<tr>
<td>5. I believe that grief is a result of a variety of loss experiences, to include but not limited to death.</td>
<td>4.62</td>
<td>0.62</td>
</tr>
<tr>
<td>6. I display therapeutic attributes of empathy, unconditional positive regard, and genuineness in interactions with others.</td>
<td>4.64</td>
<td>0.53</td>
</tr>
<tr>
<td>7. I view grief as a systemic as well as an individual experience.</td>
<td>4.29</td>
<td>0.69</td>
</tr>
<tr>
<td>8. I have a strong sense of spirituality defined as separate from religious beliefs and practices.</td>
<td>3.75</td>
<td>1.25</td>
</tr>
<tr>
<td>9. I believe that there is no one right way to deal with grief.</td>
<td>4.45</td>
<td>0.83</td>
</tr>
<tr>
<td>10. I have a sense of humor.</td>
<td>4.56</td>
<td>0.70</td>
</tr>
<tr>
<td>11. I can articulate my own philosophy and attitudes regarding death.</td>
<td>4.03</td>
<td>0.86</td>
</tr>
<tr>
<td>DCS Items Part II</td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>1. I can assess for unresolved losses that may not be stated as a presenting problem.</td>
<td>3.18</td>
<td>0.87</td>
</tr>
<tr>
<td>2. I can provide psycho-education to clients related to the grief experience for themselves and others.</td>
<td>3.01</td>
<td>1.03</td>
</tr>
<tr>
<td>3. I can facilitate family grief counseling sessions.</td>
<td>2.21</td>
<td>1.01</td>
</tr>
<tr>
<td>4. I can provide educational workshops and activities to community members about grief.</td>
<td>1.82</td>
<td>1.04</td>
</tr>
<tr>
<td>5. I can define and articulate the nature of “normal” bereavement and grief as detailed by theoretical models.</td>
<td>2.48</td>
<td>1.09</td>
</tr>
<tr>
<td>6. I can articulate the diagnostic criteria for Bereavement, according to the DSM-IV and how to distinguish this diagnosis from related diagnoses.</td>
<td>2.81</td>
<td>1.15</td>
</tr>
<tr>
<td>7. I can facilitate individual grief counseling sessions.</td>
<td>2.86</td>
<td>1.14</td>
</tr>
<tr>
<td>8. I can use concrete terms regarding death to address the reality of death and convey the ability to discuss death-related issues.</td>
<td>3.06</td>
<td>1.04</td>
</tr>
<tr>
<td>9. I can provide developmentally appropriate programs about grief and loss issues in schools.</td>
<td>1.99</td>
<td>1.05</td>
</tr>
<tr>
<td>10. I can facilitate group grief counseling sessions.</td>
<td>2.31</td>
<td>1.18</td>
</tr>
<tr>
<td>11. I can describe general differences in the grief experience as determined by different status and process variables (i.e., personality, relationship to the deceased).</td>
<td>2.72</td>
<td>1.07</td>
</tr>
<tr>
<td>12. I can conduct suicide assessments.</td>
<td>3.86</td>
<td>1.09</td>
</tr>
<tr>
<td>DCS Items</td>
<td>( M )</td>
<td>( SD )</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>13. I can facilitate multi-family group grief counseling sessions.</td>
<td>1.97</td>
<td>0.96</td>
</tr>
<tr>
<td>14. I can articulate a grief consultation model for parents, teachers,</td>
<td>2.10</td>
<td>1.06</td>
</tr>
<tr>
<td>and other adults about how to talk to children about death, grief,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and loss.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I can provide crisis intervention services to schools and/or</td>
<td>2.56</td>
<td>1.21</td>
</tr>
<tr>
<td>community settings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I can define and articulate the nature and symptoms of complicated/</td>
<td>2.63</td>
<td>1.02</td>
</tr>
<tr>
<td>unresolved grief situations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. I can teach clients how to obtain support and resources in the</td>
<td>3.71</td>
<td>0.98</td>
</tr>
<tr>
<td>community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. I can assess a client’s sense of spirituality.</td>
<td>3.64</td>
<td>0.91</td>
</tr>
<tr>
<td>19. I can establish rapport with clients of all ages.</td>
<td>4.53</td>
<td>0.63</td>
</tr>
<tr>
<td>20. I can work on an interdisciplinary team by interacting with staff</td>
<td>4.36</td>
<td>0.82</td>
</tr>
<tr>
<td>from different professions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. I can identify cultural differences that affect treatment.</td>
<td>3.95</td>
<td>0.91</td>
</tr>
<tr>
<td>22. I can describe common functional coping styles of bereaved persons.</td>
<td>3.27</td>
<td>1.05</td>
</tr>
<tr>
<td>23. I can utilize family assessment techniques to examine interaction</td>
<td>3.05</td>
<td>1.07</td>
</tr>
<tr>
<td>patterns and roles.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. I can provide appropriate crisis debriefing services.</td>
<td>2.61</td>
<td>1.12</td>
</tr>
<tr>
<td>25. I can exhibit effective active listening skills.</td>
<td>4.71</td>
<td>0.49</td>
</tr>
<tr>
<td>DCS Items</td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>Part II (cont’d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. I can read and apply current research and literature related to grief and effective treatment interventions.</td>
<td>3.71</td>
<td>0.98</td>
</tr>
<tr>
<td>27. I can facilitate a reframe of loss experience and grief reactions for client empowerment.</td>
<td>3.17</td>
<td>1.08</td>
</tr>
<tr>
<td>28. I can describe common dysfunctional coping styles of bereaved persons.</td>
<td>3.14</td>
<td>1.14</td>
</tr>
<tr>
<td>29. I can assess individuals’ progress on theoretically defined grief tasks.</td>
<td>2.67</td>
<td>1.15</td>
</tr>
<tr>
<td>30. I can facilitate reconnection between a dying client and distant/estranged family members.</td>
<td>2.29</td>
<td>1.04</td>
</tr>
<tr>
<td>31. I can use the creative arts in counseling to facilitate grief expression.</td>
<td>2.86</td>
<td>1.24</td>
</tr>
<tr>
<td>32. I can appropriately self-disclosure related to own grief and loss experiences.</td>
<td>3.70</td>
<td>1.05</td>
</tr>
<tr>
<td>33. I maintain an updated library of grief and loss resources for clients.</td>
<td>2.05</td>
<td>1.16</td>
</tr>
<tr>
<td>34. I can articulate appropriate developmental levels of death understanding for children.</td>
<td>2.40</td>
<td>1.17</td>
</tr>
<tr>
<td>35. I can identify cultural differences that affect assessment.</td>
<td>3.42</td>
<td>1.12</td>
</tr>
<tr>
<td>36. I can recognize and work with grief-related client resistance and denial.</td>
<td>2.91</td>
<td>1.10</td>
</tr>
<tr>
<td>37. I can participate in informal or formal support groups for professionals who work with issues of grief and loss to prevent burnout and vicarious traumatization.</td>
<td>2.95</td>
<td>1.14</td>
</tr>
<tr>
<td>38. I can describe how various individual counseling theories can be applied to grief counseling with individuals and families.</td>
<td>2.69</td>
<td>1.10</td>
</tr>
<tr>
<td>DCS Items</td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>39. I can recommend helpful articles and books for grieving individuals and families.</td>
<td>2.81</td>
<td>1.25</td>
</tr>
<tr>
<td>40. I can identify symptoms that warrant medical evaluation and refer to a physician.</td>
<td>3.57</td>
<td>1.04</td>
</tr>
<tr>
<td>41. I can describe how various family counseling theories can be applied to grief counseling with individuals and/or families.</td>
<td>2.47</td>
<td>1.10</td>
</tr>
<tr>
<td>42. I can advocate for the needs of the dying client and the family.</td>
<td>3.36</td>
<td>1.14</td>
</tr>
<tr>
<td>43. I can define and differentiate between the terms of grief, bereavement, and mourning.</td>
<td>3.02</td>
<td>1.19</td>
</tr>
<tr>
<td>44. I can determine appropriate treatment modality (i.e., individual or group) for a grieving client as a result of assessment.</td>
<td>2.70</td>
<td>1.05</td>
</tr>
<tr>
<td>45. I can co-create and participate in mourning rituals for individuals and/or families.</td>
<td>2.54</td>
<td>1.22</td>
</tr>
<tr>
<td>46. I can provide a supportive presence for client(s) in difficult times.</td>
<td>4.40</td>
<td>0.71</td>
</tr>
<tr>
<td>47. I can provide hope without giving false reassurance.</td>
<td>4.24</td>
<td>0.74</td>
</tr>
</tbody>
</table>