SELF-PERCEIVED GRIEF COUNSELING COMPETENCIES OF LICENSED PROFESSIONAL COUNSELORS

DISSERTATION

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ABSTRACT

The purpose of this study was to assess the self-perceived grief counseling competencies of practicing counselors and to explore the relationships between the participants’ demographic characteristics and their competencies. The study used descriptive and multiple regression analyses to examine the data gathered from the completion of the Death Counseling Survey (DCS), the Grief Counseling Experience and Training Survey (GCETS), the Texas Revised Inventory of Grief (TRIG), and a demographic questionnaire. The sample consisted of practicing counselors from the state of Ohio (n = 369) who completed the survey. The predictor variables included: gender, years experience as a licensed counselor, experience and training on grief (as measured by the GCETS), and personal experiences with grief (as measured by the TRIG). The criterion variables included grief counseling competencies as defined by the five scales of the DCS: Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills.

With respect to training and experience with grief counseling, a little over half the sample reported they had not completed any courses on grief and about one quarter of respondents stated they had not completed a course with grief content significantly infused into the course. A little over a quarter of the sample (30.6%) reported they had
not completed any training beyond their graduate program. Surprisingly, almost half of this sample (45.2%) reported completing at least one course on grief as part of their graduate training and 69.4% reported they completed professional development hours. In addition, 91% believed training on grief to be necessary or should be required for counselors and 87% reported they would participate in such training. The data from the GCETS indicated participants believed they have the general experience and training to work with clients on concerns related to grief, however, they reported on average lower scores for specific training and experience components, including knowledge related to theories, definitions related to grief counseling, and identifying effective and ineffective coping skills.

In terms of professional experience, an unexpected finding was discovered. Master Practitioners, those counselors who have practiced for more than 20 years, reported statistically significant lower scores than counselors with less experience on two of the DCS scales, Conceptual Knowledge and Skills and Assessment Competencies. Possible explanations for this decrease in reported competencies found in the group with most years experience include: previous training standards being less stringent than more recent standards, almost half of these counselors completed graduate programs other than counselor education and were grand-parented into licensure, possible burnout and reduced investment in professional interests, and finally completion of previous training on grief which now may be outdated.

This study found counselors’ average scores on the Personal Competencies scale were higher than those scores on all other competencies scales including: Conceptual
Skills and Knowledge, Assessment Skills, Treatment Skills and Professional Skills, concurrent with Charkow’s (2002) findings. The lowest mean scores were found in the Conceptual Skills and Knowledge and Professional Skills scales. However, the average score for each competency scale was at or above the midpoint value (3 or “some confidence”) in their grief counseling skills and knowledge as measured on the Conceptual Skills and Knowledge, Assessment, Treatment, and Professional Skills scales. The sample also reported, on average, values between “this describes me” (4) and “this describes me very well” (5) to statements on the Personal Competencies scale.

The multiple regression analyses found experience and training with grief contributed significantly to the variance in the scores for each of the DCS scales. Gender was found to contribute significantly to the variance in the Personal Competencies, Assessment Competencies, and Treatment Competencies scales. The variable of years of experience as counselor, specifically the category of counselors who have practiced for more than 20 years (Master Practitioner), was found to contribute significantly to the variance in the Conceptual Skills and Knowledge and Assessment Skills scales. The variable of personal experience with grief was not found to be a statistically significant contributor in any of the regression models. The reduced model for the Personal Competencies scale accounted for 17% of the variance in scores and included the predictor variables of gender and experience and training in grief counseling. For the Conceptual Skills and Knowledge scale, the model which contained years experience (Master Practitioner) and experience and training in grief counseling, accounted for 69% of the variance in scores. The reduced model for the Assessment Competencies
accounted for 55% of the total variance in scores and included the predictor variables of gender, years experience (Master Practitioner), and experience and training in grief counseling. For the Treatment Competencies scale, the model which contained gender, years experience (Master Practitioner) and experience and training in grief counseling, accounted for 71% of the variance in scores. The reduced model for the Professional Competencies accounted for 60% of the total variance in scores and the model included the predictor variable of experience and training in grief counseling.

In each of the regression models, experience and training had the largest beta value in comparison with the other predictor variables. This variable was further explored by completing ANOVA analyses to compare differences among groups who reported no, some, and a large quantity of training on grief counseling, either through a course focused specifically on grief, a course with grief significantly infused into the content, or professional development hours. The analyses indicated a statistically significant difference in mean scores for all the competencies scales (except Personal Competencies) between the participants which completed no courses and participants who completed at least one course in which grief had been infused in a significant manner. Similar results were found in the analysis of participants who completed 1-10 professional development hours versus those participants who had not completed any professional development hours on grief. The differences between participants who complete one specific course on grief versus those who had not completed a course on grief showed a statistically significant difference between the two groups across all five scales of the DCS. Specifically, the mean scores of those who completed a course were significantly higher
than the scores of participants who did not take a course on grief on the following scales: Conceptual Skills and Knowledge, Treatment Skills, and Professional Skills. A statistically significant difference in means scores was found on the Personal Competencies scale between those participants who completed one course and those that completed two or more courses on grief. These results indicate those persons who had training on grief counseling, either in course work or professional development hours, reported on average higher self-perceived grief counseling competencies across the DCS scales.

The findings suggest counselors perceived themselves to have stronger grief counseling competencies if they have received training on the subject and the majority of the sample believed this training is necessary for all counselors. Specifically, counselors rated themselves highest in Personal Competencies and lowest on competencies related to Conceptual Skills and Knowledge and Professional Skills. The demographic variables of gender and years experience as a counselor had statistically significant relationships with the scales, but the variable of experience and training on grief accounted for a substantial amount of variance in the average scores of each DCS scale. The variable of personal experience with grief was not found to have significant relationship with any of the competencies scales. Years of experience had a negative relationship with two of the DCS scales (Conceptual Skills and Knowledge and Assessment Skills), as demonstrated by those practitioners with more than 20 years experiencing scoring on average lower than their less-experienced colleagues on both of these scales. This study helped to identify those specific content areas in which training is needed, including: Personal
Competencies (i.e. personal understanding of death, self-care, and sense of humor), theories, definitions of grief, bereavement, and complicated grief, identification of effective and ineffective coping skills, and seeking support from professional peers to manage reactions to working with grieving clients. The findings suggest the importance of training on the topic of grief across the counselor’s career, regardless of years of experience in the profession, to improve self-perceived grief counseling competencies.
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CHAPTER 1

INTRODUCTION

Every person will experience the loss of a loved one, and each person’s response to that loss will be unique. Although all incidents of loss will not result in the bereaved seeking mental health services to manage their grief, the demand for such services is likely to increase for a variety of reasons. First, the Baby Boomer generation is aging, with the estimates of persons who will be 65 or older in the year 2030 at 70 million people. In turn, the percentage of persons dying will increase (Hooyman & Kiyak, 2005). Furthermore, researchers are investigating the use of mental health services by older adults, a population who traditionally underutilize counseling. Recent findings suggest an increase in older adults’ current use of mental health services, based on similar attitudes in older adults (ages 65 and over) and younger adults (ages 21-65) regarding the likelihood of seeking mental health treatment, importance of mental health, and concerns about resources available to them (Robb, Haley, Becker, Polivka, & Chwa, 2003). In addition to the increase in the older adult population, and thus the potential increase in demand for grief counseling services, legislation is pending to extend Medicare reimbursement to counselors (American Counseling Association, 2006a).
Recent military involvement overseas results in a significant number of veterans returning from war in Iraq and the Middle East with a variety of mental health concerns, including grief and loss (Marshall, 2006). In addition, the recent changes in legislature will allow counselors greater opportunity to serve this population within the Department of Veterans’ Affairs clinics, giving counselors the same pay as clinical social workers and allowing counselors to apply for supervisory positions (American Counseling Association, 2007b).

With the likely increase in public demand for grief counseling services and previous research indicating the minimal effectiveness of grief counseling (Allumbaugh & Hoyt, 1999; Kato & Mann, 1999), counselors need to be better prepared to provide effective and appropriate grief counseling to their clients. Currently, several challenges exist in assuring counselors are prepared to meet the pending increase in demand for grief counseling. A lack of professional standards for training and practice, limited training within counselor education programs, a need for definition of competence in grief counseling, and few research studies all contribute to the uncertainty surrounding counselors’ ability to provide effective grief counseling.

1.1 Grief Counseling Competencies

The establishment of counseling competencies is an important development for promoting self-regulation and training within the profession. Recent examples of competencies proposed by the American Counseling Association (ACA) include: Multicultural and Career Counseling Competencies as well as Advocacy Competencies (ACA, 2007c). Leaders in the counseling profession asserted the need and developed a
listing which later became the Multicultural Counseling Competencies, and professional organizations endorsed the listing in response to changing demographics and the recognition of the social/cultural dynamics within therapeutic relationships (Sue, Arredondo, & McDavis, 1992). These competencies exist within three general categories – Awareness, Knowledge and Skills – professional counselors need to possess to provide appropriate care for their clients.

The development of grief counseling competencies is in progress and as such, the framework of the established Multicultural Counseling Competencies is helpful to delineate areas of content. Translating the Multicultural Counseling model to a grief counseling model allows for both counselors’ personal attitudes and self-awareness related to grief and loss and objective content to be included in the competencies. As with multicultural counseling, counselors approach grief with their own biases and preferences based on their experiences, thus requiring competencies to encompass the counselors’ worldview and effectively manage their personal responses to the subject of grief.

Although the previous studies focused on grief counseling competencies have not implicitly identified their framework as including Awareness, Knowledge, and Skills, the researchers focused on either personal coping in response to death and dying, skills related to grief counseling, and/or knowledge about death and grief. Charkow’s Death Counseling Survey (DCS) includes the following five scales: Personal Competencies, Conceptual Knowledge and Skills, Assessment Skills, Treatment Skills and Professional Skills. These scales link to and in a sense parallel the Multicultural Counseling model in
the following manner: Awareness (Personal Competencies), Knowledge (Conceptual Knowledge and Skills) and Skills (Assessment, Treatment, and Professional Skills).

Two recent doctoral dissertations investigated grief counseling competencies including measurements of personal attributes and attitudes as well as knowledge and skills related to grief, death and dying. The researchers used licensed counselors (Smith, 2003) and marriage and family therapists (Charkow, 2002) as their samples. Smith (2003) explored counselors’ abilities to cope with death as measured by the Bugen’s Coping with Death Scale (BCDS) (Bugen, 1980-81) and proposed the variables of counseling self-efficacy, previous personal experience with loss, and training on end-of-life issues predicted counselors’ abilities to better cope with loss, both personally and helping others manage loss. Smith found that the predictor variables partially explained the variance in counselors’ abilities to cope with death, both personally and professionally, as measured by the BCDS (Smith, 2003).

Charkow (2002) administered the BCDS along with an instrument she previously created, the Death Counseling Survey (DCS) to measure specific skills related to grief counseling. She analyzed the possible impact of personal experiences and attitudes, as identified by scales of the BCDS and her instrument, on the knowledge and skills scales of each of the instruments. Charkow found the majority of counselors surveyed believed they possessed the personal competencies necessary for grief counseling, such as their attitudes, self-care, a sense of humor, spirituality, and an ability to articulate their own philosophy about death. But, the counselors reported themselves lower on scales related to knowledge and skills of grief counseling, such as theories about grief, definitions of
normal and pathological grief, and assessment and treatment of persons experiencing grief. The relationship between the counselor’s personal attitudes and their knowledge and skills was explored and as expected, personal experience with death (as measured by the BCDS) had positive relationships with grief counseling skills (Charkow, 2002).

With the limited amount of research directed towards grief counseling competencies in the profession of counseling, studies with other care givers provide additional data. Research completed with hospice volunteers investigated variables possibly related to grief counseling competence, including personal experience, personality characteristics (such as frustration tolerance, self-confidence, compassion, and self-awareness), age, and gender (Amenta, 1984; Caty & Tamlyn, 1983; Lafer, 1989; Paradis & Usui, 1987; Robbins, 1992). Some of these studies operationalized competency as including the variable of the length of time volunteering in addition to scores on standardized assessments. Length of time as a volunteer may be a faulty way to operationalize efficacy in volunteering, as it assumes that the longer one does something (i.e. volunteer with hospice), the better one is at providing effective care. Within the studies exploring the relationship of personal and professional competencies, the researchers found personal experience with death was positively related to death competency in hospice volunteers (Paradis & Usui, 1987; Robbins, 1992). Age was a variable that produced contradictory findings among the studies. Paradis & Usui (1987) found a positive relationship among age and length of time serving as a hospice volunteer, but Mastrogianis (1999) found no relationship between age and competence.
reported by counselors in training. Robbins (1992) determined from research with hospice volunteers that gender was not related to competency.

1.2 Training on Grief Counseling

The training on grief counseling and/or death education within Master’s counseling courses is minimal for mental health and school counselors, a fact that contrasts with many counselor educators’ expressed views about the importance of the subject matter (Freeman & Ward, 1998; Humphrey, 1993). Surveys of psychology, counseling and other health professional programs found that training requirements did not include death and dying issues (Dickinson, Sumner, & Frederick, 1992; Duggan, 2000; Hunt & Rosenthal, 1997; Rosenthal, 1981; Rosenthal & Terkelson, 1978; Stephenson, 1981) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) does not include grief counseling content as part of its core content (CACREP, 2001 Standards).

Investigations that sampled students’ and professionals’ opinions on their grief counseling training illustrated the respondents’ desire for further formal training. Respondents reported their programs included no or one course with grief/death content infused into the course (Allen & Miller, 1988; Charkow, 2002; Stephenson, 1981) and less than 10 hours of professional development on the topic (Charkow, 2002). The majority of respondents reported their training within their counselor education programs was inadequate and/or they believed they needed more training to work with clients effectively. The amount, content, and manner of training counselors receive on grief
and/or death education seems to vary depending upon the program (Allen & Miller, 1988; Charkow, 2002; Stephenson, 1981).

1.2.1 Content and Effectiveness of Training Programs

Grief counseling and/or death education training typically include both didactic and experiential learning experiences. Different models have been developed within the field of counseling, all of which include some integration of personal experience and/or self-reflection on attitudes with lecture and discussion (Dunlop, 1980; Rosenthal, 1978; Worden, 2002). Wass (2004) argued that the multidisciplinary study of grief and death has a central humanistic goal of acquiring knowledge and development of self-understanding that includes clarifying values and attitudes toward death. Authors have asserted the need for trainings to include both personal awareness and cognitive components (Papadatou, 1997; Rando, 1984; Worden, 2002).

The research completed on grief counseling training demonstrated the effectiveness of preparation programs which include a combination of personal reflection/exploration and teaching of content related to death and grief. Kees (1987) found students who completed a training program scored higher on assessments of diagnosis skills and treatment planning, two components requiring knowledge and skills related to grief counseling and furthermore students reported feeling more prepared and comfortable with grief clients. Mastrogianis (1999) compared trainings that focused solely on either experiential or skills-based training for grief counseling. The researcher found both training groups showed higher levels of comfort and competency, as
measured by the BCDS, and lower levels of anxiety after the trainings, regardless of the type of training.

1.3 Statement of the Problem

Although the need for grief counseling services is likely to increase in order to respond to the aging Baby Boomer generation and veterans returning from combat, little training is provided to counselors within Master’s programs (Allen & Miller, 1988; Charkow, 2002; Stephenson, 1981). The profession of counseling has sparse knowledge about the training counselors complete post-graduation through continuing education programs, but one study found the marriage and family therapists acquired less than 10 hours of training on the topic (Charkow, 2002). In addition, many unanswered questions exist as to counselors’ competencies to work with clients presenting with grief including personal awareness, knowledge, and skills related to death and dying.

Currently, grief counseling competencies have yet to be established and standards for training have not been defined by professional organizations and/or an accreditation council. The few studies which have been conducted on grief counseling competencies are further limited by the small sample sizes consisting of members of professional organizations and low return rate (Charkow, 2002), samples including other professionals such as hospice volunteers (Amenta, 1984; Caty & Tamlyn, 1983; Lafer, 1989; Paradis & Usui, 1987; Robbins, 1992) and a study focused primarily on personal attributes and attitudes with little data gathered about skills and knowledge related directly to grief counseling (Smith, 2003). Although authors have initiated the exploration of factors that may contribute to skills and knowledge competencies of grief counseling, the findings are
limited by small data sets (Charkow, 2002; Smith, 2003). Finally, demographic variables of gender, age, professional experience (i.e. years in practice), professional training and experience with grief, personal experience with grief, and practice setting have not been thoroughly explored as potential factors related to grief counseling competencies. Further research is warranted to explore the competencies of practicing counselors to work with clients presenting with issues of grief and loss.

1.4 Purpose of the Study

The purpose of this study was to provide additional data for the purpose of moving toward the creation of grief counseling competencies and the training and experience of licensed counselors on grief and/or death education. This study investigated three areas of competencies including awareness, knowledge, and skills, based on the model provided by the multicultural competencies and further investigated the only assessment developed specifically for grief counseling competencies, Charkow’s Death Counseling Survey (DCS) (Charkow, 2002). The study completed the following goals: describe licensed counselors’ grief counseling competencies as indicated by the five scales of the DCS (Personal Competencies, Conceptual Skills & Knowledge, Assessment Skills, Treatment Skills, and Professional Skills); describe personal and professional demographic variables of licensed counselors including age, gender, professional experience (years in practice), professional training and experience with grief, personal experience with grief, and practice setting; and explore relationships between grief counseling competencies and the counselors’ personal and professional demographic variables.
This study provided significant knowledge related to the competencies and training of licensed counselors on the subject of grief counseling. As there is limited understanding of what counselors know about grief counseling and the source of this knowledge and skills, this study offered information that may be used to argue for additional training, both in Master’s and continuing education programs, and specific training criteria related to death and grief.

1.5 Research Questions

The intent of this study is to provide answers to the following research questions:

Research Question 1. What are the demographic characteristics of the licensed counselors including the following: age, gender, years of practice since obtaining LPC, practice setting in which counselor has had most years of experience, race/ethnicity, highest degree earned, field of study, licensure, supervisor status, current work setting, certifications, religion, number of professional development hours on grief, and number of grief courses completed?;

Research Question 2. What is the extent of professional experience and training with grief as measured by the Grief Counseling Experience and Training Survey (GCETS) and personal experience with grief as measured by the Texas Revised Inventory of Grief (TRIG) (Faschingbauer, DeVaul, & Zisook, 1987) of licensed counselors?;

Research Question 3. What are the levels of grief counseling competencies of licensed counselors as measured by their responses to the Death Counseling Survey (Charkow, 2002), as indicated by scores on the assessment scales of Personal
Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills;

*Research Question 4.* What is the relationship between grief counseling competencies and the following selected demographic variables of age, gender, professional experience as a licensed counselor (years practicing since obtaining initial licensure), training and experiences in grief counseling (as measured by the GCETS), personal experience with grief (as measured by the TRIG scales of Past Behaviors and Present Feelings), and practice setting in which counselors worked for majority of years?

1.6 Definition of Terms

The following are definitions of terms used throughout this investigation.

1.6.1 Licensed Professional Counselor

The sample for this study was drawn from licensed counselors in the state of Ohio and therefore these professionals are governed by the Ohio Counselor, Social Worker, Marriage and Family Therapist (CSWMFT) Board. Within the state of Ohio, counselors are able to achieve two levels of licensure, Licensed Professional Counselor (LPC) and Licensed Professional Clinical Counselor (LPCC). Prior to taking the examination to receive their LPC, the trainee must earn a Master’s degree in Counseling from an accredited institution, with at least 60 semester hours of graduate courses and at least 20 semester (or 30 quarter hours) focused on clinical content. In addition to courses, trainees must complete and document a 100-hour practicum with 40 hours of direct service and a 600-hour internship with at least 240 of those hours spent in direct service. The trainees must complete practicum and internship under the supervision of a counselor who holds a
supervisory credential from the CSWMFT Board. Trainees must pass the National Counselor Examination for Certification and Licensure (NCE) (CSWMFT, n.d.).

1.6.2 Licensed Professional Clinical Counselor

The Licensed Professional Clinical Counselor (LPCC) must complete the requirements mentioned above for the LPC, in addition to the following items. After receiving the LPC, the applicant for LPCC must complete 3000 hours of post LPC experience over at least a two year time period under the supervision of an LPCC who holds a supervisory credential. The clinical experience must include at least 50% of the LPC’s time spent in the diagnosis and treatment of mental and emotional disorders. As of 2006, the LPCC candidate must have previously passed the Professional Counselor Licensure Exam (PCLE) and pass the National Clinical Mental Health Counseling Examination (NCMHCE) (CSWMFT, n.d). Prior to this time, the LPCC candidate was not required to pass any exams other than the original licensure exam completed for obtaining the LPC.

1.6.3 Grief Counseling

Grief counseling refers to therapeutic work with clients who present with concerns related to the death of a person. Grief counseling may occur in different modes of counseling (individual, group, and/or couples/family). Within the definition of grief counseling are the interventions and theoretical approaches counselors employ to help the bereaved manage their emotional, mental, physical, and/or spiritual responses to the loss of the person. Grief counseling includes those therapeutic relationships in which client(s) and counselor explore the death of the person, regardless of whether a bereavement
diagnosis is given to the client upon entering counseling. As many clients may present with symptoms of depression and anxiety who later disclose the death of a significant person in their life, it is important to allow for a broad definition of grief counseling which does not require identifying grief at the initial diagnosis (Worden, 2002).

1.6.4 Grief Counseling Competencies

The grief counseling competencies in this study were based on the assessment developed by Charkow (2002). These competencies included five scales: Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills. The instrument was self-report and asked respondents to report level of agreement on statements about their abilities and characteristics as well as demographic information.

1.7 Limitations of Study

This study had several limitations. Primarily, the data gathered was provided by the licensed professionals themselves about their grief counseling competencies. Self-report may not be the most accurate or objective form of evaluation; however, the profession has yet to develop assessments for clients, supervisors, or third-party evaluators to determine counselors’ grief counseling competencies. The second limitation of the study was the use of the Death Counseling Survey (Charkow, 2002), an assessment that has yet to be standardized. Again, as the research in this area of counseling is at its initial stages, this instrument was the sole method of evaluating competencies in the manner asserted in this study. Finally, the researcher will be able to generalize the results to the larger population of licensed counselors in the state of Ohio. Further generalization
to all licensed counselors within the United States was limited by the sample of Ohio licensed counselors being representative of licensed counselors nationally.

1.8 Summary

Grief counseling is a task most licensed counselors will perform at some time during their career and more than likely, more often than just once. The changing demographics within the United States and recent military involvement overseas will likely increase the need of such services. The counseling profession has completed minimal research on the competencies related to grief counseling and in turn, training standards are deficient throughout Masters and continuing education programs. This study intended to gather an adequate and representative sample of licensed counselors to complete an assessment on their grief counseling competencies in the areas of awareness, skills and knowledge. The data gathered will be explored to determine possible relationships among the areas of competencies (awareness, skills, and knowledge) and between demographic variables and competencies.
CHAPTER 2

REVIEW OF THE LITERATURE

2.1 Introduction

The death of a significant person is something all people will experience at some point in their life. As the Baby Boomer generation ages, estimates of persons who will be 65 or older in the year 2030 are expected to be 70 million, and, in turn, the percentage of persons dying will increase (Hooyman & Kiyak, 2005). Not all people who experience loss will seek mental health services, but it is likely that the demand for grief/bereavement counseling will increase. In addition to an increase in the older adult population, and thus the potential increase in demand for grief counseling services, legislation is pending to extend Medicare reimbursement to counselors, thus extending the numbers of older persons counselors will treat (American Counseling Association, 2006a). Additionally, a significant number of veterans are returning from war in Iraq and the Middle East with a variety of mental health concerns, including grief and loss (Marshall, 2006). Given these factors, counselors need to be prepared to provide effective and appropriate grief counseling to their clients.

Several challenges exist in assuring counselors are prepared to meet the pending increase in demand for grief counseling. A lack of professional standards for training and
practice, little training within counselor education programs, a need for definition of competencies with few researchers attempting to establish a comprehensive list of attitudes and characteristics, skills and knowledge, and limited research all contribute to an uncertainty about the ability of counselors to provide grief counseling.

Not only do the aforementioned challenges exist, but additionally researchers investigated the effectiveness of grief counseling, resulting in further concern about the therapeutic services provided to the public. These studies challenged the effectiveness of grief counseling and in turn give further incentive to examine the training counselors receive on grief counseling (Allumbaugh & Hoyt, 1999; Kato & Mann, 1999). Recent studies have begun to investigate the training and competence of counselors working with clients who present with grief; however, much work remains to be done in order to better understand the process of grief and how counselors can best be prepared for helping bereaved persons who seek assistance.

2.2 Empirical Studies on the Effectiveness of Grief Counseling

The effectiveness of grief counseling has been investigated with conflicting results. These findings necessitate a narrowing of the investigation to determine when and for whom grief counseling works. The following is an overview of the studies completed, focusing on recently completed meta-analyses and more rigorously designed studies.

Two different meta-analyses were completed in 1999, one by Kato and Mann and the other by Allumbaugh and Hoyt. Kato and Mann (1999) reviewed 11 quantitative studies, completed between the years of 1975-1992, including only those studies which
required random assignment to treatment and control groups and similar recruitment procedures. The studies included individual, family, and group modes of counseling and compared the measurements of depressive, somatic, and other psychological symptoms across the studies before and after treatment. The meta-analysis found a global effect size coefficient of .114, a significantly low number in comparison to standards for effect sizes for therapeutic treatments. The authors defined standard effect sizes as .20 for small effect size and .50 and .80 for medium and large effect size respectively (Cohen, 1997 as cited in Kato & Mann, 1999). When the investigators compared the specific measurements used in the studies, they found the effect size coefficients for depressive and other psychological symptoms to be even lower than the global value (.052 and .095), but increased for physical symptoms (.272) (Kato & Mann, 1999).

Regardless of different methods of analysis, all of the effect sizes for these studies are significantly low. The authors suggested three reasons for these low values including: the possibility that grief counseling does not work, the limited number of sessions in the studies prevented detection of a stronger result in the studies, and methodological problems such as small samples, unreliable and invalid measures, high drop-out rates, and lack of control for variables such as gender and the expectedness of the loss. Kato and Mann (1999) suggested that without controlling for these variables, any gains that may have been experienced for one group may be cancelled out by another. Despite the results of the statistical analyses, the authors reported both the control and treatment groups showed improvement in a majority of the studies.
Another explanation for the low effect size scores is the assessments measured a variety of symptoms, but were not developed specifically for grief. The assessments used had been developed to measure improvements in depressive, somatic and psychological symptoms, but did not investigate the domains of relationships and coping skills. Emotions such as loneliness, yearning, shock and guilt or self-blame (specifically associated with the relationship with the deceased) may exist along with other more typical depressive symptoms such as anhedonia, despair, or anger (Hansson & Stroebe, 2007). But, without the appropriate measures to assess for these emotions and other possible grief reactions (ruminations about the deceased, withdrawing from social support system, sleep disturbance, loss of appetite, and somatic problems etc.), researchers may only be measuring depression and anxiety symptoms as evaluated by assessments designed for these disorders. Additionally, these measures do not allow for the possibility of an increase in resiliency or positive personal changes and several authors have called for a shift in methodology to measure a broader range of possible responses to grief (Bonanno, 2004; Carr, 2004, 2006; Frantz, Farrell, & Trolley, 2001; Nolen-Hoeksema & Davis, 2001; Wortman, 2004). Investigators are attempting to distinguish grief as a unique experience which impacts an individual’s emotions, thoughts, actions, relationships and physical health (Boelen, van den Bout, & de Keijser, 2003; Prigerson & Jacobs, 2001). Researchers explored grief and depression in parents who had lost a child and found different predictor variables exist for both grief and depression as do distinctions between these two concepts once thought to be synonymous.
(Wijngaards-de Meij, Stroebe, M., Schut, Stroebe, W., van den Bout, Heijmans, & Dijkstra, 2005).

Allumbaugh and Hoyt (1999) reviewed 35 studies including 2,284 participants and analyzed the treatment and control groups individually to determine the standardized mean-change scores. The majority of the participants was female (84%) with a mean age of 52 years old, who had lost their loved one two years previous and participated in an average 8-week treatment period. The studies reviewed assessed general psychological distress (depressive and anxiety symptoms) in the participants. The resulting effect size coefficient for this meta-analysis was .43, a relatively low number for social science research, but still higher than the other meta-analysis. The authors investigated two variables thought to impact the effectiveness of grief counseling: the length of time since death before beginning treatment and recruitment versus self-referred treatment. The results suggested that those persons who started therapy closer to the time of death and completed more sessions displayed more significant results than those who completed fewer sessions and started counseling later after the loss. Additionally, those who were recruited showed less improvement than those persons who were self-referred to counseling. This difference possibly resulted because people who seek counseling may have more severe symptoms and could be more invested in the process of counseling and its outcomes than those participants who were recruited (Allumbaugh & Hoyt, 1999).

Like Kato and Mann (1999), the authors suggested low effect size values may have resulted from a lack of effectiveness of grief counseling, the low statistical power of many of the studies, the measurement of outcomes using assessments developed for
depression and/or anxiety rather than grief, or the possibility of intervening variables that hid the effect of treatment for specific modes of counseling. One possible confounding variable is that for some of the studies reviewed, professionals completed the counseling while in others, volunteers facilitated the groups. A methodological problem with Allumbaugh and Hoyt’s meta-analysis (1999) was that it included studies that did not require random assignment to treatment and control groups, thus reducing the internal validity of the individual studies and in turn, the results of the meta-analysis.

Neimeyer and Fortner completed a meta-analysis of 23 studies (Fortner’s unpublished dissertation study) and found that grief counseling not only had little positive impact on participants, but that in some cases the treatment actually resulted in an increase in negative symptoms. The studies reviewed included those completed with adults and children with random assignment and control groups. The investigations measured the difference between treated and untreated groups across a range of outcome assessments but also investigated the “treatment induced deterioration” to determine those persons who would have been better off not receiving counseling. A few of the studies used assessments specific to grief, while others used generic measures of health and psychological distress, such as assessments for depressive and anxiety symptoms (Fortner, 2000; Neimeyer, 2000).

The researchers found the effect size value was .13, with 38% of the participants who received treatment actually deteriorated as a result of the treatment. This percentage is high compared to other psychotherapy interventions that have an average of about a 5% rate of participants who fare worse after treatment (Anderson, 1999 as cited in
Neimeyer, 2000). The findings suggest counseling was more effective for those participants who were younger in age and had higher levels of risk, defined by experiencing a sudden or violent death and/or the presence of chronic grief. The authors suggested the low effect size values resulted from assessments that measure psychiatric and physical problems rather than specific variables of grief (such as yearning or guilt related to loss) and the relationship of the participant with the deceased (Fortner, 2000; Neimeyer, 2000).

A significant confounding variable in this study, as well as other research, was the type of treatments, specifically those studies which used treatments that are based on stage or task theories of grief. Therefore, treatments for grief may not be effective because of the treatments’ conceptualization of grief, its symptomology, and the resolutions of grief are inaccurate (Corr, 1993). Researchers have questioned the lack of evidence for these task/stage theories (Bonanno & Kaltman, 1999; Hansson & Stroebe, 2007; Stroebe & Schut, 1999; Wortman & Silver, 1989) and more recently have examined the validity of the sequenced stage theory (Maciejewski, Zhang, Block, & Prigerson, 2007). The study of bereavement has undergone significant change initiated by investigators questioning long-held beliefs about grief that had not been substantiated by empirical studies. As these stage theories provide the basis for the research mentioned, it is necessary to present a brief overview of the emerging theories of grief and the evolution of the field of bereavement studies. However, it is important to recognize that despite the progress of research, there exists a disparity between the bereavement theories which are showing evidence in the most recent research (such as Stroebe & Schut’s Dual
Process and Neimeyer’s Meaning Making theories) and those stage/task theories which currently are being taught in counseling programs (Lindstrom, 2002; Maciejewski et. al, 2007; Payne, Jarrett, Wiles & Field, 2002). The gap between research and practice is particularly evident in grief counseling and further complicates investigations into its effectiveness.

The following is a brief review of the major theories developed about an individual’s experience of grief and grief counseling as discussed in the counseling literature, including Psychodynamic, Continuing Bond, Stage/Task theories, Meaning Making theories, and the Dual-Process Model of Grief. Freud’s *Mourning and Melancholia* (1917) defined the normal reaction to death as the bereaved withdrawing their attention and emotions from the deceased and reinvesting this energy in a new person. Freud conceptualized pathological grief as the person’s focus on the absence of the loved one; either resulting from ambivalence about the death or the bereaved blaming themselves for the loss (Freud, 1957).

Parkes collaborated with Bowlby, using Bowlby’s Attachment Theory, to develop a theory about adults’ responses to the death of loved ones. They defined phases of response to the loss, including: numbness, yearning and searching, disorganization and despair, and reorganization (Bowlby, 1980; Bowlby & Parkes, 1970; Parkes, 2001). Similar to Freud’s concept of grief, Bowlby and Parkes theorized a process of responding to loss that progressed from the bereaved experiencing strong emotional response to the loss to an eventual emotional detachment from the deceased.
Klass, Silverman and Nickman (1996) countered this theory by suggesting that some people may not disengage from the deceased completely, but rather maintain a strong connection with them. The Continuing Bond theory suggests that although the relationship between the deceased and survivor is altered, a relationship remains between the two people, and/or the deceased and their family or community (Klass, 2001). A recent study completed by Field, Gal-Oz, and Bonanno (2003) suggested a Continuing Bond with the deceased may not result in positively adapting to the loss, generating others to expand upon this theory. Field, Gao, and Paderna (2005) investigated the Continuing Bond theory adding an Attachment Theory perspective, including the relationship with the deceased, culture, and religion of the bereaved as factors in the grieving process. As with the field of bereavement research in general, the Continuing Bonds theory continues to evolve.

Stage or task theories are prevalent in grief counseling literature, with the most familiar theorist being psychiatrist Elisabeth Kubler-Ross. Kubler-Ross (1969) wrote *On Death and Dying* based on her experiences working with persons with terminal illnesses. She outlined her stages of grief as having five steps: denial, anger, bargaining, depression, and acceptance. Although her theory was developed with people facing their own impending death, the stages have been applied to the bereaved in counseling texts and in course content (Humphrey, 1993; Kees, 1987). In her last book, *On Grief and Grieving*, Kubler-Ross stated that her original theory had often been applied in a rigid manner as practitioners and laypersons conceptualized the stages as distinct and sequential steps to be completed to achieve a healthy resolution of their loss. Kubler-Ross
argued the stages are a general guide to the experience of grief and are flexible to allow for overlap and individuality within the stages (Kubler-Ross & Kessler, 2005).

Other theorists developed their interpretations of the stages and/or tasks of grief (Rando, 1995; Westberg, 1971; Worden, 2002) and as with Kubler-Ross’ theory, these stage/task theories have been criticized for the rigid application of the stages to clients, limiting the counselor’s ability to understand and accept the individual’s experience of grief (Servaty-Seib, 2004). Researchers have provided evidence that depression is not an inevitable response to loss and have suggested a resolution to the loss may not be achieved (Bonanno & Kaltman, 1999; Wortman & Silver, 1989; Wortman & Silver, 2001). Richardson (2007) asserted that the phases/stages are not exclusive, and the intensity of feelings in response to grief can fluctuate within individuals, as well as among them in various stages. Thus, the strict application of the sequential stage or task theories limits the understanding of grief, both among different people and within an individual. Stroebe (1992-93) questioned the ability to distinguish the “work” of processing the loss from ruminating on it, a fundamental challenge to the necessity of focusing on the emotional impact of the death of a loved one.

In contrast to stage or task theories, Neimeyer’s concept of Meaning Making through grief is a highly individualized process through which a person determines meaning out of their grief and relationship with the deceased. “Meaning Making” theory is an approach that conceptualizes the bereaved as being changed, both inter-personally in their relationships, and intra-personally. The processing of the grief is continual and does not terminate with the achievement of a specific stage or list of tasks. Finally, the
meaning one makes out of their loss is a product of their experiences, personality, gender, age, and context of the death (Gillies & Neimeyer, 2006; Davis, Wortman, Lehman & Silver, 2000; Neimeyer, 2001).

Strobe & Schut (1999) proposed their Dual Process Model or Stress-Coping Model to help understand how people manage grief. Using trauma/stress, attachment, and grief theories, the authors conceptualized loss as resulting in multiple stressors on the individual and categorized these stressors as either loss-oriented or restoration-oriented. Loss-oriented stressors include the end of a physical relationship with the deceased and an inability to experience future events with the deceased. Restoration-oriented stressors are those that impact the bereaved at a later time, such as a decrease in financial resources and an increase in household responsibilities. The theory posits that people who had developed secure attachments with the deceased either process the loss emotionally or work on problem solving, and this moving back and forth between emotional and action-oriented processes is termed Oscillation. This back and forth movement is thought to be healthy coping in that it allows for the person to experience different aspects of the loss at different times (Hansson & Stroebe, 2007).

The Dual Process Model is currently being applied to existing data on older adults and their experiences of grief. Studies suggest widows and widowers do participate in loss and restoration-oriented activities throughout bereavement. Older adults completed loss-restoration activities initially after the death, such as visiting the gravesite and later used more restoration-orientated coping skills, like learning to complete household tasks for which the deceased had been responsible. The bereaved that used both modes of
coping in balance were found to experience higher levels of well-being (Hogan & Schmidt, 2002; Richardson, 2007; Richardson & Balaswamy, 2001). The research suggests gender differences exist in the coping styles. Women tend to cope using more loss-oriented strategies while men use more restoration-oriented coping styles. This difference is particularly useful in the context of grief counseling and helping clients to achieve a balance between the two types of coping (Schut, Stroebe, de Keijser & van den Bout, 1997). Initial findings suggest this theory is valid and can be used to explain pathological grieving as resulting from difficulty in moving between loss and restoration-oriented coping, resulting in the bereaved being restricted to either problem solving or emotional responses to the loss (Hogan & Schmidt, 2002; Stroebe, Stroebe, & Schut, 2005).

Another criticism of the research on the effectiveness of grief counseling, in addition to fact that many investigations are based on the unfounded stage/task theories, is the use of meta-analysis. Primarily, the studies measure differences or improvements in symptoms to determine effect size. However, the participants in the studies, particularly participants who have been recruited, may not have severe symptoms and therefore will only be able to improve a slight amount in comparison to those participants who have more significant psychological and/or physical levels of distress. This ceiling-effect limits the amount of improvement a person with an average amount of distress can make after the intervention (Neimeyer, 2000). Another concern with these meta-analyses is that the symptoms being measured are mostly negative emotions or physical problems. Bonanno and Kaltman (1999) suggested that studies on bereavement should assess for
changes in a full range of emotions and behaviors to investigate the possible adaptive function in response to the stress of loss. Others have questioned the ability to complete meta-analyses on grief counseling effectiveness because of the limited number of studies that have been completed with rigorous design, large numbers of participants, and adequate levels of adherence to intervention protocols across studies (Schut, Stroebe, van den Bout & Terheggen, 2001).

The most recent analysis, completed by Jordan and Neimeyer (2003), of several qualitative and quantitative studies resulted in the authors stating that weak methodology and limited measurements of negative effects of grief are not the only problems with previous research on bereavement. Primarily, the authors asserted that grief counseling may work, but within a specific time frame for particular types of clients. By reviewing the effectiveness of grief counseling across the variables of time elapsed since death and beginning of counseling and the manner in which treatment was initiated, either through recruitment in a study or self-referral, the authors determined guidelines for future research. They suggested a window of time, between 6-18 months after the death, in which the interventions for grief have shown to be most effective. By adding the variable of time, researchers could investigate the effectiveness of different interventions within specific time intervals. Jordan and Neimeyer also argued for assessments that measure both positive and negative responses to grief, such as the Hogan Grief Reaction Checklist (HGRC) rather than using global measures of depression and anxiety that focus on levels of only negative emotions (Jordan & Neimeyer, 2003).
Schut, Stroebe, van den Bout & Terheggen (2001) investigated the effectiveness of studies through grouping those studies that provided interventions to persons as a preventative measure, studies that provided interventions to those who were at risk (defined as parents of children who died or persons who lost a loved one to a violent and/or sudden death), and finally those people who had already developed symptoms of complicated or pathological grieving. The overall analysis of these studies found that little to no difference was found for those persons at risk for developing complicated grief symptoms and for those persons who did not experience a loss defined as placing them at high risk for difficulties adjusting. But, the review did show that interventions for those people who had complicated grief symptoms were overall successful at reducing symptoms and distress in comparison to the control groups. These findings supported a study completed four years earlier in which persons with complicated grief were assigned to one of three groups: emotion-focused counseling, problem-focused counseling, and a wait list (control group). At the time of follow up, both counseling groups were doing better than the control group as measured by the General Health Questionnaire (Schut, Stroebe, de Keijser & van den Bout, 1997).

The variables of self-referral versus recruitment, time at which intervention begins after the death, context of the loss, expected versus unexpected, the interventions used and at what time, and the characteristics of the bereaved (i.e. gender and age) all potentially impact the effectiveness of grief counseling. Prior studies have used limited sample sizes, assessments that measure global symptoms of anxiety and depression as the indications of grief and coping, and have not controlled for variables that may
significantly impact the client’s response to counseling. Taken as a whole, the literature suggests grief counseling is not effective. But when the data is critically analyzed and categorized into specific groups – such as children, adults that self-refer to counseling and persons who maintain high levels of distress after at least six months after the death – grief counseling has shown to be effective.

2.3 Training for Providers of Grief Counseling

Researchers who investigated the effectiveness of grief counseling acknowledge the possibility of the counseling itself, rather than the methodological shortcomings of the studies, was the cause of the low effect size values. As this area of counseling contains many unknowns, it is necessary to investigate the current state of training and competence in grief counseling as a possible contributing cause to the limited effectiveness of interventions. The training on grief counseling and/or death education within Master’s counseling courses is minimal for mental health and school counselors. Surveys of psychology, counseling and other health professional programs found that training requirements did not include death and dying issues (CACREP, 2001 Standards; Dickinson, Sumner, & Frederick, 1992; Duggan, 2000; Hunt & Rosenthal, 1997; Rosenthal, 1981; Rosenthal & Terkelson, 1978; Stephenson, 1981). Freeman and Ward (1998) reported that most counseling programs did not typically include a specific course on death and dying, but argued that counselors should learn the basics of grief counseling, including normal and abnormal grief, phases of grief, and how to help clients move through the phases/stages of grief. The Association for Death Education and Counseling (ADEC) is an organization through which persons can obtain a special
credential in grief counseling, but the majority of clinical and school counselors do not complete the additional course work and exam to obtain a Certification in Thanatology (CT) (http://www.adec.org/certification/CT_info.cfm).

Humphrey (1993) surveyed chairs of counselor education departments on the importance of teaching grief counseling, reasons for including or excluding grief counseling in their curriculum, and the ways in which the topic of grief counseling was addressed in their programs. With a return rate of 36.3% (135 respondents), the author reported that the majority of the respondents (70.4%) considered grief counseling to be an important topic for training and that most (81.5%) address grief counseling within their curriculum in one way or another. The primary method of integrating the content was through one lecture within a course (73.3%). Twenty-five programs reported not addressing grief counseling at all and the majority of these respondents (23) provided one or more of the following reasons: lack of funding, lack of room within the curriculum, lack of a mandate for such curriculum by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), lack of interest/demand, determination that it is not an important topic, and finally a lack of qualified faculty to serve as instructors.

It is interesting to note the discrepancy between the percentage of respondents who considered grief counseling an important topic (70.4%) and those that reported it is included in their curriculum (81.5%). The difference suggests that despite some chairs’ views that this topic is not important; they reported it is included in their curriculum. It is possible that social desirability impacted the chairs’ responses, resulting in some
reporting inclusion of grief counseling within their curriculum when in reality, this may not be the case. This highlights one of the shortcomings of this study in that the investigation relied upon self-report of program heads rather than an analysis of course requirement listings and/or course syllabi.

Charkow (2002) surveyed members of marriage and family professional organizations (both trainees and professionals) and respondents reported few specialized trainings on grief were included within their programs. Half of the surveyed participants reported having no or one course with grief/death content infused into the course. The majority of practicing counselors stated they had less than 10 hours of professional development on the topic of death and dying, but 98% reported working with at least one client who had a presenting concern of grief. Further, the majority of respondents judged their training within their graduate program as less than adequate.

Allen and Miller (1988) surveyed rehabilitation counselors and discovered the majority of participants had experience working with clients on concerns related to grief and loss, but reported feeling unprepared for this work. Sixty-one percent (61%) stated they had experienced at least one client death in the past year and 40% reported counseling at least one client who was terminally ill at the time of the survey. Most (54%) reported having no training on death and dying and almost all (98%) stated that they needed more training on grief and death to effectively counsel clients.

Stephenson (1981) asked a random sample of members of the American Association of Marriage and Family Therapists about their experiences, both personally and professionally, with death and dying and their training and perceived competency. Of
the 119 returned surveys, 60% reported they felt competent to provide grief counseling and of this group, 90% reported little or no emphasis on death and dying in their formal education. Ninety-seven percent (97%) of the respondents stated there was a need for formal training on death and dying. Thirty percent (30%) reported they had counseled dying persons for their grief, yet additionally reported believing themselves to be incompetent in such counseling. Of the counselors who reported having worked with grieving families, over 80% reported they were not competent to provide this service. These responses are disturbing because counselors are claiming competency based on experience in the field without formal training or they are stating the significant need for education on a common issue in counseling. Counselors are providing grief counseling services without formal training on effective means or practices and it is ambiguous as to how they are determining their competence.

The amount of training counselors receive related to grief and death education appears to vary depending upon who is reporting on the programs, either the professors or the students. Furthermore, the manner in which the topic is integrated into training (lecture, course, workshop, and/or professional development), content, and time dedicated to the training varies from program to program.

2.3.1 Content of Training Programs

Grief counseling and/or death education training typically include both didactic and experiential learning experiences. Different models have been developed within the field of counseling, all of which include some integration of personal experience and/or self-reflection on attitudes with lecture and discussion (Dunlop, 1980; Rosenthal, 1978;
Worden, 2002). The task/stage theories are the concepts predominantly taught in counselor education programs (Humphrey, 1993; Kees, 1987). Wass (2004) argued the multidisciplinary study of grief and death has a central humanistic goal of acquiring knowledge and development of self-understanding that includes clarifying values and attitudes toward death. Authors have argued for trainings to include both personal awareness and cognitive components (Papdatou, 1997; Rando, 1984; Worden, 2002).

2.3.2 Research on the Effectiveness of Grief Training

Few researchers have investigated the effectiveness of training on grief counseling. Kees (1987) developed two instruments to determine the trainees’ comfort level and the effectiveness of a grief course on counseling students’ abilities to diagnose, treat, and respond to grief and loss concerns with clients. The course consisted of three 5-hour class sessions that included lectures, discussions, videos, and role-plays. Students were encouraged to disclose their personal experiences with loss and grief, as appropriate during discussions and role plays. At the end of the last session, the 62 students completed two instruments that had been created by Kees, the Counselor Response Questionnaire (CRQ) and Grief Comfort and Preparedness Index (GCPI).

The researcher completed pilot studies on the instruments prior to administering them to the participants to determine their reliability and validity. The reliability of the CRQ was calculated by using Cronbach’s alpha and was determined to be .78. The validity for this instrument was established through three counselor educators’ review of the items and their subsequent agreement upon the content. Content validity for the GCPI was established through two professional counselors’ review of the instrument. Cronbach
alpha was calculated for the subscales of comfort and preparedness, yielding coefficients of .95 and .93 respectively (Kees, 1987). Thus, both of the instruments were determined to have internal reliability and content validity.

Kees (1987) implemented independent sample t-tests to analyze the data. The findings revealed that the treatment group scored higher on the diagnosis (t = -3.66, p < .0005) and treatment planning (t = -3.01, p < .0037) components of the assessments and also felt more prepared (t = -3.10, p <.0029) and comfortable with grief clients (t = 2.43, p < .0225). This study did not implement random assignment of participants to the control and treatment groups, used a small sample, collected data on both groups at one time, and tested only one model of training. These methodological concerns challenge the internal and external validity of the results. In addition, the lack of pre-test scores does not allow for certain conclusions to be drawn about the effectiveness of the training, as the participants could have obtained knowledge from prior experiences and/or programs.

Mastrogianis (1999) investigated different modes of grief training and the possible interaction with personal variables of race and gender. She recruited and randomly assigned 60 counselors in training to either an experiential or skills-based training for grief counseling. All the participants completed assessments related to death anxiety, the Revised Death Anxiety Scale (RDAS) and the Bugen’s Coping with Death Scale (BCDS), to measure a person’s response to death-related situations despite feelings of discomfort (Bugen, 1980-81). Participants also completed a modified version of the Counseling Situations Questionnaire (CSQ) to measure the comfort level of the trainees when working with clients experiencing grief. Mastrogianis provided grief education
manuals to each of the two instructors of the 3-hour training sessions for either the experiential or skills-based groups. The researcher completed an Analysis of Covariance to analyze differences in pre-training and post-training scores for death anxiety, death competency, and comfort scores. Both training groups showed higher levels of comfort and competency and lower levels of anxiety after the trainings. Men demonstrated higher levels of comfort after participating in the skills-based training than the experiential based training. African-Americans had greater levels of competency and comfort after participating in the experiential training, than after participation in the skills-based training.

As with the amount of training provided, the effectiveness of the grief training provided to counselors has yet to be determined with certainty. Grief counseling suffers from a lack of clarity of competence to help define training standards, and in turn requirements for counseling programs to implement. Small samples, weak methodologies, and newly developed instruments that have not been standardized complicate the findings of the small number of studies that have attempted to begin studying the status of the counseling profession on the topic of grief.

2.4 Competence in Grief Counseling

The profession of counseling does not have a standard for competence or training guidelines for grief counseling and/or death education. Professional organizations, such as the American Counseling Association (ACA) and the American School Counselor Association (ASCA), as well as CACREP, give no direction as to standards for training or practice for grief counseling, as are provided for broad topics such as multicultural,
career, and group counseling (ACA, 2007c; ASCA, n.d.; CACREP, n.d.). The establishment of counseling competencies in the areas of multicultural and career counseling was forerunners for other areas of counseling to establish competencies (ACA, 2007c; Sue, Arredondo, & McDavis, 1992). Specifically, the Multicultural Counseling Competencies provide a framework for the content areas of a broad range of competencies. These competencies exist within three general categories – Awareness, Knowledge, and Skills – professional counselors need to possess to provide appropriate care for their clients. The limited research thus far completed regarding grief counseling competence has been accomplished by doctoral candidates who developed instruments and/or studies based on the literature to assess counselors’ abilities to counsel the bereaved (Charkow, 2002; Smith, 2003).

Smith (2003) completed her dissertation on the topic of counselors’ ability to cope with death, thus focusing on personal competencies of managing loss. She asserted counseling self-efficacy, previous personal experience with death, and training on end-of-life issues predicted the counselor’s ability to cope with death as measured by Bugen Coping with Death Scale (BCDS). Smith sent surveys to a representative sample of counselors licensed in the state of Ohio (n = 500) and received completed and usable surveys from 258 respondents, resulting in a 52% response rate. Smith found that these practicing counselors reported coping well with death as evidenced by the mean score of 160.96 out of a total possible score of 210 and a standard deviation of 21.79 on the 30-item BCDS assessment. Smith performed a factor analysis on the BCDS scale to verify the assumed factors of Coping with Self and Coping with Others asserted by a previous
author (Robbins, 1991, 1992, 1994). She found four factors included in the assessment: Expressing Personal Feelings and Preparedness for Own Death or Dying (Coping with Self) and Counseling Skills and Practical Knowledge (Coping with Others) (Smith, 2003).

Smith (2003) explored predictor variables related to coping with death using multiple regression analysis. The researcher measured counseling self-efficacy with the Counselor Self-Estimate Survey (COSE) created by Larson, Suzuki, Gillespie, Potenza, Bechtel, and Toulouse in 1992. The COSE scale includes five factors which Smith used as separate predictor variables: Microskills, Process, Difficult Client Behavior, Cultural Competence, and Awareness of Values. Previous experience with death was a dichotomous variable with respondents indicating “yes” or “no” to question about the occurrence of a loss of a loved one. Training in end-of-life issues was measured by clock hours in a class, continuing education seminar, professional meeting presentation, or volunteer training on death education or counseling. Smith converted the clock hours into graduate credit hours with three clock hours equaling one graduate credit. Smith gathered demographic information on the participants in addition to their completing the BCDS and COSE assessments.

Smith (2003) developed three regression models in an attempt to explain counselors’ skills related to death and dying, expression of personal feelings towards death and dying, and practical knowledge about death and dying. Each of the models was constructed using select predictor variables and the criterion variable of coping from the BCDS, as categorized by either coping with self or coping with others. The first model
included the following predictor variables: Microskills and Process factors of the COSE and training on end of life issues. This model explained about 35% of the variance in counselors’ skills related to death and dying (coping with others). These findings make intuitive sense in that counselors who have basic counseling skills in working with clients use those skills regardless of the specific presentation or context of the client.

The second model explained approximately 18% of the variance in counselors’ expression of personal feelings regarding death and dying (coping with self), using two predictor variables of Microskills and Values from the COSE. The author interpreted these findings as counselors’ confidence in their abilities and awareness of their own values predicting their ability to express emotions related to death, thus self-awareness contributing to effective expression of personal feelings on the topic of death and dying.

The third model explained 10% of the variance in practical knowledge about death and dying with training and Difficult Client Behaviors factor of the COSE as the predictor variables (Smith, 2003). The relatively small variance may result from many factors. The measurement of the training variable included only quantity of hours spent (translated into graduate credits) and the variety of training options (class, workshop, professional presentations, volunteer experiences) and thus did not account for standardization of material within the trainings. The variable assumes “training” would translate into the information and concepts included in the BCDS however, there is no way of knowing if the training experiences align with the content of the BCDS. Smith’s study investigated the factors which related to counselors’ personal and professional
coping in response to death and dying including counseling self-efficacy, training on death/dying, and personal experience with death/dying.

The most extensive study on grief counseling competencies, including skills, knowledge, and awareness of personal feelings, was completed by Charkow. Her unpublished dissertation (2002) documented the study of grief counseling competence and training of a sample of members from the International Association of Marriage and Family Counselors (IAMFC) and the American Association of Marriage and Family Therapy (AAMFT). Using internet surveys, the researcher asked participants to complete several instruments; including the BCDS, a demographic questionnaire, and the Death Counseling Survey, an instrument developed by Charkow to assess grief counseling competence. Charkow attempted to identify variables that could predict competency in grief counseling; therefore, she gathered data on a variety of personal and professional characteristics, including: general professional experience, specific grief counseling experience, training, personal experience with death/grief, attitudes and values related to grief and loss, and knowledge about grief counseling.

Charkow developed her instrument, the Death Counseling Survey, based on the standards she discerned from both the literature and grief counseling experts. In a prior study, Charkow attempted to identify relevant personality characteristics, attitudes, knowledge, and skills related to grief counseling. Thirty-four experts, defined by persons who had at least five years experience in grief counseling, completed three individual surveys regarding characteristics important for grief counselors to possess, content to be included in courses/lectures on grief, and general competence. This study resulted in the
instrument which was used in a pilot study and further refined to be implemented as part of her dissertation research. Charkow determined the Death Counseling Survey to be a reliable instrument as indicated by an overall Cronbach alpha of .97, with subscales ranging from .72-.95. She reported a correlation between her instrument and the Burgen’s Coping with Death Scale (BCDS) of r = .73, suggesting concurrent validity (Charkow, 2002).

The findings suggested the majority of counselors surveyed believed they possessed the personal competencies necessary for grief counseling, such as their attitudes, self-care, a sense of humor, spirituality, and an ability to articulate their own philosophy about death. But, the counselors reported themselves lower on scales related to knowledge and skills of grief counseling, such as theories about grief, definitions of normal and pathological grief, and assessment and treatment of persons experiencing grief. As part of the data analysis, Charkow implemented Structural Equation Modeling to help better understand the possible relationships between various personal characteristics and competencies. The results suggested the following relationships: personal death experience positively impacted personal grief counseling competence, personal competence positively impacted personal death competence and personal death competence positively impacted knowledge and skills of grief counseling. As expected, personal experience with death and self-awareness had positive relationships with grief counseling competence (Charkow, 2002).

Charkow’s study of counselors’ competencies is the most extensive to date and the development of an instrument to assess competence was a significant accomplishment.
to the study of grief counseling. However, several criticisms of the methodology need to be included to cautiously interpret the findings. First, the grief counseling literature referenced by Charkow to develop the standards of competence was based on theories that have not been verified in empirical research, such as Worden’s concept of “grief work” and the conceptualization that grief counselors are to facilitate the client’s accomplishment of specific “tasks of grief.” Finally, the combination of the low return rate (7.54%), a limited sample (n = 147) consisting only of members of professional counseling associations, and self-report instruments challenge the validity and ability to generalize the results to other counselors.

Other researchers have investigated possible variables thought to be related to grief counseling competencies, including personal experience, personality characteristics (such as frustration tolerance, self-confidence, compassion, and self-awareness), age, and gender. However, the majority of these investigations used hospice volunteers (Amenta, 1984; Caty & Tamlyn, 1983; Lafer, 1989; Mastrogiannis, 1998; Paradis & Usui, 1987; Robbins, 1992). Further, the construct of competency was determined by including variables such as length of experience volunteering in addition to scores on standardized assessments. As previously mentioned, experience does not automatically or necessarily equate competence. Although a counselor’s scope of practice is different than hospice volunteers, it is worthwhile to note that for the volunteer samples, personal experience with death was positively related to death competency (Paradis & Usui, 1987; Robbins, 1992). Age was a variable that produced contradictory findings amongst the studies. Paradis & Usui (1987) found a positive relationship among age and length of time
serving as a hospice volunteer, but Mastrogiannis (1999) found no relationship between age and competence reported by counselors in training. Robbins (1992) determined from research with hospice volunteers that gender was not related to competence.

These studies give some direction for further exploration of the possible relationships between personal characteristics and competence in dealing with death and dying, but the small samples and minimal diversity of the participants limit the confidence placed in the results. Additionally, the majority of these studies did not focus on counselors, but rather hospice volunteers. In contrast to volunteers, counselors are required to provide documentation of assessments, treatment plans and goals, as well as provide treatment for other mental health and emotional concerns the client may present with during the session. These different requirements would likely result in different competence for grief counselors. To date, standards for grief counseling competencies have not been established or rigorously investigated.

2.5 Summary

Research has been completed on the effectiveness of grief counseling and the training and competencies of counselors on the topic of grief. Specifically, the empirical studies on the overall effectiveness of grief counseling lacks conclusive evidence, but do suggest that grief counseling for specific groups (i.e. children, those who experienced a traumatic loss, and those who are experiencing pathological grief symptoms) results in the reduction of negative symptoms. Given the small samples for which data exists about grief counseling competencies, the scarcity of training, and the few investigations about grief counseling competence, the dearth of conclusive evidence to support grief
counseling as an effective treatment is not surprising. Furthermore, the profession has an obligation to prepare professionals to effectively care for an increasing number of clients presenting with grief concerns.
CHAPTER 3

METHODS

3.1 Introduction

This study used descriptive and regression methods to explore the relationships between demographic characteristics and self-perceived Grief Counseling Competencies (comprised of the following five scales: Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills) of licensed counselors using the Death Counseling Survey (DCS) (Charkow, 2002), the Texas Revised Inventory of Grief (TRIG) (Faschingbauer, DeVaul, & Zisook, 1987), the Grief Counseling Experience and Training Survey (GCETS), and a demographic survey. Self-perceived grief counseling competencies are in progress of being defined and as such, the framework of Multicultural Counseling Competencies (Awareness, Knowledge, and Skills) was adapted to structure and further investigate the areas of grief counseling competencies. The variables investigated in relationship to competencies in previous research include: professional training and experience in grief counseling, personal experience with grief, education, and the attribute variables of age and gender. Additional variables introduced in this study included: professional experience as a licensed...
counselor and practice setting in which counselor had the most years experience. A limited number of studies previously investigated counselors’ personal competencies, skills, and knowledge competencies related to grief counseling. However, little is known about the relationships between these variables, specifically among practicing counselors. The present study was an initial step toward understanding the relationship between counselors’ personal experiences with grief and their counseling competencies and provided valuable information about the training of counselors to respond to clients’ needs.

3.2 Research Design and Methodology

This study explored the relationship between demographic characteristics, personal experience with grief, professional experience and training with grief, and grief counseling competencies (Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills) of practicing counselors using the DCS (Charkow, 2002), the TRIG (Faschingbauer et. al., 1987), the GCETS, and a demographic questionnaire. The researcher used descriptive and regression methods to analyze data gathered from a representative sample randomly selected and a mail survey design (Fink & Kosecoff, 1998; Heppner, Kivlighan & Wampold, 1992).

3.3 Research Questions

*Research Question 1.* What are the demographic characteristics of the licensed counselors including the following: age, gender, years of practice since obtaining LPC, practice setting in which counselor has had most years of experience, race/ethnicity, highest degree earned, field of study, licensure, supervisor status, current work setting,
certifications, religion, number of professional development hours on grief, and number of grief courses completed?;

*Research Question 2.* What is the extent of professional experience and training with grief as measured by the Grief Counseling Experience and Training Survey (GCETS) and personal experience with grief as measured by the Texas Revised Inventory of Grief (TRIG) (Faschingbauer, DeVaul, & Zisook, 1987) of licensed counselors?;

*Research Question 3.* What are the levels of grief counseling competencies of licensed counselors as measured by their responses to the Death Counseling Survey (Charkow, 2002), as indicated by scores on the assessment scales of Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills?;

*Research Question 4.* What is the relationship between grief counseling competencies and the following selected demographic variables of age, gender, professional experience as a licensed counselor (years practicing since obtaining initial licensure), training and experiences in grief counseling (as measured by the GCETS), personal experience with grief (as measured by the TRIG scales of Past Behaviors and Present Feelings), and practice setting in which counselors worked for majority of years?

3.4 Participants

3.4.1 Population

To effectively study grief counseling competencies of counselors, it was important to use a representative population of practicing counselors. The researcher
obtained a listing of currently licensed counselors in the State of Ohio from the State of Ohio Counselor, Social Worker and Marriage and Family Therapist (CSWMFT) Board. Licensed counselors in the state of Ohio were an accessible population for this researcher. Demographic characteristics were gathered to provide comparisons between this sample and the larger population of licensed counselors who practice nationally.

3.4.2 Subject Description

The presumed description of participants was a mixed gender sample, with mostly female licensed counselors as was found in the population. It was expected that the sample respondents would have at least a Master’s degree and would be a minimum of 22 years old. This researcher expected the majority of the sample to be of Caucasian background. The total number of licensed counselors in the state of Ohio at the time of the study was obtained from the CSWMFT Board, including a designation of those counselors who hold an LPC license (typically counselors with less than three years of experience working towards independent licensure), those who hold an LPCC license (counselors who have completed requirements for independent licensure with a minimum of two years experience), and those counselors who were grand-parented into LPC licensure (counselors with more than twenty-one years experience who were grand-parented into counselor licensure before 1986) (CSWMFT, n.d.).
3.4.3 Sample Size

The necessary sample size was determined prior to collecting data. The researcher considered the alpha level, otherwise defined as the risk of Type I error, falsely rejecting the null hypothesis when in reality there is no relationship between variables. This level was set at $\alpha = .05$, a standard level in the social sciences research (Gay & Airaisan, 2003; Newton & Rudestam, 1999). This alpha level translated into the acceptance of the risk that 5% of the time or less, the researcher may falsely identify a relationship between the variables. Two different references were consulted to determine the necessary respondents needed to complete a multiple regression analysis. First, the researcher used two equations to compute the sample sizes with multiple correlation and individual predictor variables ($N \geq 50 + 8k$ and $N \geq 104 + k$ where $k =$ number of independent variables). With seven independent variables, the equations became $50 + 8(7) = 106$ and $104 + 7 = 111$ and therefore the largest value, 111 was the necessary number of respondents required for the multiple regression with an alpha level of .05, a power of 0.8 and a medium effect size (Newton & Rudestam, 1999). The second reference was the table provided by Kraemer and Thiemann (1987). This table suggested a sample size of 257 for the same alpha level, power and effect size.

The overall number of licensed counselors was assessed as to determine appropriate sample size for the study. After the total number of licensed counselors was identified, the researcher consulted several sample size tables and selected the largest number of participants needed for a 95% confidence interval and $\pm .05$ margin of error (Rea & Parker, 1997; Salant & Dillman, 1994). The estimated return rate of mail surveys
was approximately 30% from one wave of distribution, thus the total number of surveys sent to the simple random sample needed to be at least 857 to provide the necessary completed surveys for data analysis (257) (Dillman, 2000). A second distribution wave was completed to obtain additional data.

3.4.4 Sampling Method

After the instrument was prepared for the potential respondents, the researcher used a simple random sampling method to ensure each member had an equal and independent chance of participating in the study. The researcher used the Statistical Package for the Social Sciences (SPSS, version 15) software to complete the random sampling from the population. By using this software to randomly identify potential participants, the possibility for researcher bias towards potentially known participants was eliminated.

3.5 Predictor Variables

The following were the predictor variables: age, gender, professional experience as a licensed counselor (as measured in years), training and experience with grief counseling (as measured by the GCETS), personal experience with grief, both Past Behaviors and Present Feelings (as measured by the TRIG) and practice setting in which counselor had the majority of experience in years.
3.5.1 Age

Age was a continuous ratio variable. Participants were asked to report, in an open-ended format, their age in years.

3.5.2 Gender

Gender was a categorical variable (male or female) which was dummy coded for data analysis. Women were coded as 1, men as 0. Men were the reference group as the number of women practicing as licensed counselors was assumed to be larger than the number of male counselors.

3.5.3 Professional Experience as a Counselor

Professional experience as a counselor was a continuous ratio variable. Participants were asked to report, in an open-ended format, the amount of time since receiving their status of Licensed Professional Counselor (the number of years they have been a licensed counselor).

3.5.4 Professional Training and Experience in Grief Counseling

Professional training and experience in grief counseling was assessed through a twelve-item Likert scale survey, the Grief Counseling Experience and Training Survey (GCETS). The mean value for the total survey was calculated and resulted in an interval level variable. Participants indicated on a scale from one (“Not True at All”) to five (“Totally True”) their response to statements about their clinical training, supervision, experience, and formal education (workshops, conferences, and in-services) on grief counseling.
3.5.5 Personal Experience with Grief

Personal experience with grief was measured by using the Texas Revised Inventory of Grief (TRIG) (Faschingbauer et al., 1987) which provided two scales, Past Behavior and Present Feelings, to measure responses to the death of a loved one the participant identifies as their most significant loss. The mean total value for each scale was calculated (eight items for Past Behavior scale and 13 items for Present Feelings scale respectively) to produce two interval level variables. Participants were asked to report on a scale from one (“Completely True”) to five (“Completely False”) their response to statements about thoughts, feelings, and behaviors both after the death and currently.

3.5.6 Practice Setting

Practice setting was a discrete nominal scale variable with ten levels including the following: community agency, employee assistance program, school (elementary, middle or high school), college counseling center, private practice, career counseling, corrections, hospital, hospice, and other. Participants were asked to identify the setting in which they have the most experience as measured in years.

3.6 Criterion Variables

The following were the criterion variables: Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills.

3.6.1 Grief Counseling Competencies

Grief Counseling Competencies assessment was comprised of five scales – Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment
Skills, and Professional Skills. The overall Grief Counseling Competencies score was calculated by totaling the score and determining the mean for all items on the Death Counseling Survey (DCS). The DCS contained 58 items on a five-point Likert scale, with possible scores ranging from 58-290. This total score was calculated for comparison to the reported scores from the first administration of this measure by Charkow (2002), however the mean scores for the individual scales were used for data analysis as each scale measured specific competencies.

3.6.2 Personal Competencies Scale

Personal Competencies was a criterion variable calculated from items on the Death Counseling Survey. Personal Competencies was an interval level variable assessed by calculating the mean scores to specific items of the Death Counseling Survey. Eleven (11) items comprised this scale with a five-point Likert scale participants used to indicate responses to statements of (1) “this does not describe me at all” to (5) “this describes me very well.” The possible mean score for this scale ranged from 1-5. Items in this scale asked respondents to report on self-care, self-awareness related to grief issues, spirituality, humor and personal beliefs/philosophies about death and loss (Charkow, 2002).

3.6.3 Conceptual Skills and Knowledge Scale

The Conceptual Skills and Knowledge scale consisted of nine items with a range of mean scores between the values of 1-5. Items on this scale asked respondents to identify their confidence level in completing tasks such as defining “normal grief” and other terms related to death and dying, describing effective and ineffective coping skills,
applying counseling theories to case conceptualizations, and articulating children’s
developmental stages of understanding death (Charkow, 2002).

3.6.4 Assessment Skills Scale

The Assessment Skills scale also consisted of nine items with a range of mean scores from 1-5. This scale assessed on participants’ ability to assess clients for unresolved losses, complete suicide assessments, assess spirituality, recognize cultural influences on assessments, and use assessment to make appropriate referrals for client to receive medical treatment (Charkow, 2002).

3.6.5 Treatment Skills Scale

Treatment Skills included 22 items with a range of mean scores from 1-5. The content assessed by this scale included: belief in ability to provide psycho-education on grief and loss issues, facilitating individual, group and family counseling sessions focused on grief, establishing rapport with clients, using active listening skills, ability to reframe loss experience, use of creative arts in counseling, co-creating and participating in mourning rituals and identifying cultural influences affecting treatment (Charkow, 2002).

3.6.6 Professional Skills Scale

Professional Skills scale included seven items with possible mean scores ranging from 1-5. This scale asked participants to identify their confidence in tasks such as providing grief-related community and school activities, providing crisis intervention, working on a inter-disciplinary team, maintaining current literature on grief and participating in professional support groups (Charkow, 2002).
3.7 Instruments

3.7.1 Death Counseling Survey (DCS)

One assessment has been developed to measure grief counseling competence. Charkow developed an instrument in 2000 and implemented this instrument in her unpublished dissertation (2002) on grief counseling competence with a sample of members from the International Association of Marriage and Family Counselors (IAMFC) and the American Association of Marriage and Family Therapy (AAMFT). The internet survey contained several instruments including: Bugen’s Coping with Death Scale (BCDS), a demographic questionnaire, and the Death Counseling Survey, a 58-item Likert scaled assessment to assess personal and skills/knowledge grief counseling competencies. Although Charkow developed the assessment to focus on competence related to family grief counseling, the content used to develop the assessment and the items were applicable to counselors working with grief concerns, either with families or individuals.

Charkow (2002) attempted to identify variables that could predict competence in grief counseling; therefore, she gathered data on a variety of personal and professional characteristics, including: general professional experience, specific grief counseling experience and training, personal experience with death/grief, attitudes and values related to grief and loss, and knowledge about grief counseling. She defined her competence scales based on the standards she discerned from both the literature and grief counseling experts.
The Death Counseling Scale had five areas of measurement: Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills. The Personal Competence scale was composed of 11 items and the respondent had the option of indicating a number from 1 to 5 to suggest either “this does not describe me at all” or “this describes me very well” respectively. Charkow provided the cut-off scores which indicated competency, but did not indicate these cut-off points were established for each of the scales, therefore these arbitrary cut-off points were not referenced when reviewing the data in this current study. The psychometric properties of the Death Counseling Survey can be found in the Internal Validity section below.

3.7.2 Grief Counseling Experience and Training Survey

The Grief Counseling Experience and Training Survey (GCETS) is an twelve-item survey that was modified from the Sexual Orientation Counselor Competency Scale (SOCC) (Bidell, 2005), which was originally developed to assess counseling competencies in working with gay, lesbian, and bisexual clients. As no other instrument existed to assess for experience and training related to working with clients who present with grief, the researcher modified the assessment by replacing the term “Lesbian, Gay, and Bisexual Clients” with “Clients who present with grief.” The researcher then piloted this survey with a group of twenty-one practicing mental health providers (counselors, social workers, psychologists and psychiatrists) to assess the instrument’s reliability and validity. Information on the survey’s psychometric properties can be found in the Internal Validity section below.
Participants indicated on a scale from one (“Not True at All”) to five (“Totally True”) their response to statements about their clinical training, supervision, experience, and formal education (workshops, conferences, and in-services) on grief counseling. The researcher included additional text to clarify the meaning of one statement in the survey (“I have experience counseling survivors of suicide.”). Some participants in the pilot study provided feedback that they were uncertain about the meaning of the term “survivor of suicide” and thus the researcher included the definition, (“clients who have experienced the completed suicide of a loved one”). The mean score for the total survey was calculated as well as the mean values for each individual item.

3.7.3 Texas Revised Inventory of Grief (TRIG)

The Texas Revised Inventory of Grief (TRIG) was an assessment used to measure a person’s response to grief, both at the time of the death and currently. The TRIG had two scales, Past Behavior and Present Feelings, which were scored individually by totaling the responses to each of the eight and thirteen items on each scale, respectively and then the mean score for each scale was calculated. The measure was developed by Faschingbauer, DeVaul, and Zisook and asked participants to respond to each statement and accompanying Likert scale ranging from “Completely True” (one) to “Completely False” (five). The TRIG identified the intensity levels of response to the death of a significant person and the impact or level of disruption the death had on them at the time of the loss (1987).

Researchers administered the TRIG in studies investigating counselors’ experience of loss and the relationship with professional practice. Most recently, Hayes,
Yeh, & Eisenberg (2007) used the TRIG along with assessments of therapeutic empathy, counselor effectiveness, and working alliance to explore the relationship between counselors’ grief and clients’ perceptions of grief counseling. The researchers administered the assessments to 69 client-counselor pairs, all of which had experienced the death of a loved one and who had been working together for an average of 24 counseling sessions. The counselors ranged in age from 32 to 83 years and their average number of years practicing was 15.8 years. The average number of years since significant loss experienced by the counselor was 15.3 years prior to collection of data.

The majority of clients were women (90%) and white (92%) with a mean age of 46.5 years. The percentage of respondents who had experienced the death in the previous three months was 15%, 15% experienced loss in three to six months since completing assessments, 19% experienced loss six to nine months previous, and finally 52% experienced loss more than nine months prior to completing assessments. Hayes et al. found the counselors with higher scores on the TRIG were perceived to be less empathetic by their clients and those counselors who had lower scores on the TRIG were perceived by their clients to be more empathetic. The researchers did not find a significant relationship between counselors’ response to loss and clients’ ratings of alliance, session depth or counselors’ credibility (Hayes et al., 2007).

Boyer and Hoffman (1993) implemented the TRIG in their study of counselors’ reactions to terminations and counselors’ perceived client sensitivity to loss. A total of 117 psychologists participated in the study, with an almost even representation of men and women (61 men and 56 women) and the majority were white (96.6%). The
participants ranged in age from 30 to 82 years old with an average age of 45.2 years with an average of 13.2 years of clinical experience. The researchers found the counselors’ loss experience (age at time of most significant loss, past grief reactions and present grief reactions) was a significant predictor of counselors’ emotional response (depression and anxiety) during termination with their clients. Counselor loss history was a significant predictor of counselor anxiety, $F(3, 103) = 4.94, p < .01$ and accounted for 13% variance. Counselor loss history was a significant predictor of depression, $F(3, 103) = 4.18, p < .01$ and accounted for 11% of the variance.

In addition to these studies with counselors, researchers have administered the TRIG to various groups who experienced grief, such as men and women living with HIV (Summers, Zisook, Sciolla, Patterson, Atkinson, & HNRC Group, 2004), participants of group grief counseling (Piper, Ogrodniczuk, McCallum, Joyce, & Rosie, 2003), persons experiencing conjugal bereavement (Field, Gal-Oz, Bonanno, 2003), parents experiencing grief after the loss of a child (Seecharan, Andresen, Norris, & Toce, 2004), and family members of persons who died of cancer (Ringdal, G.I., Jordhoy, Ringdal, K., & Kaasa, 2001). The psychometric properties of the TRIG can be found in the Internal Validity section below.

3.7.4 Demographic Questionnaire

The author created a demographic questionnaire based on previous research (Boyer & Hoffman, 1993; Charkow, 2002; Hayes, Yeh, & Eisenberg, 2007). The questionnaire included items to obtain demographic information about participants including: race, age, and gender. Information about the professional experience of the
participants was gathered by asking questions about the number of years experience as a licensed professional counselor, highest degree obtained, license(s) held (ie. LPC, LPCC), current practice setting and practice setting in which participant has had most experience in years (i.e. community agency, school, hospital, etc.), supervisory status, and the primary work participants engaged in currently (practicing counselor, administrator, professor, etc.). The questionnaire asked participants to indicate the number of courses completed which focused specifically on death and/or grief; the number of courses completed which included or infused death and/or grief content in the course in a significant way; and the number of professional development hours earned (aside from courses completed) on the subject of death and/or grief. The questionnaire asked participants to identify their level of familiarity with different grief counseling theories, including Dual-Process Theory, Meaning Making Theory, and Task, and Stages theories. The questionnaire provides space for respondents to provide any additional comments or feedback to the researcher about the demographic questionnaire and/or the other assessments used in this study.

3.8 Data Collection

The method of data collection was cross-sectional survey administered to a simple random sample of licensed counselors in the State of Ohio (Campbell & Stanley, 1963). Prior to collecting the data, the appropriate number of participants required to complete the analysis was calculated. In addition, the researcher contacted and obtained permission from Charkow and Bidell to use (and in the case of Bidell, slightly modify) their assessments in this investigation.
3.8.1 Procedures for Data Collection

The initial contact with the sample included a letter to introduce the study, the survey packet (consisting of the demographic questionnaire, the Grief Counseling Experience and Training Survey, the TRIG and the DCS, see Appendix A) a stamped and addressed envelope to return the survey, and a stamped and addressed postcard with their name. The cover letter included instructions, information about the researcher, the purpose of the study, informed consent description, and the importance of respondents’ participation. The letter explained the importance of anonymity and confidentiality in the research with an explanation of steps taken to protect participants’ anonymity, an estimate of time to complete the survey to encourage participation, and a due date for the surveys to be completed and mailed to researcher (Dillman, 2000; Fink & Kosecoff, 1998).

To encourage participation in the study and maintain anonymity, the postcard with the participants name was returned to the researcher separate from the research materials and was included in a drawing for one of five prizes, a gift certificate to a national retailer. The researcher resent the survey packet to those participants who did not return a postcard by the original due date. The survey itself was formatted into a booklet with text on both sides of each 8½ x 11 sheet. The font size was standard (Times New Roman, 12) and items were spaced for clarity and ease of reading and completion of items, based on instructions related to the importance of the appearance of surveys. Finally, the researcher asked a small number of people to review the booklet, cover letter, and post cards for editing of text, layout, and clarity of instructions prior to the final
distribution to participants (Edwards, Roberts, Clarke, DiGuiseppi, Pratap, Wentz, &
Kwan, 2002; Fink & Kosecoff, 1998; Fowler, 2002; Gray & Nguyen, 2003).

3.8.2 Advantages and Disadvantages of Procedure for Data Collection

The advantages of the mail survey procedure using a simple random sample were
the relative ease of gathering data from a diverse and representative sample of licensed
counselors across the state (Fink & Kosecoff, 1998; Fowler, 2002). The respondent was
able to complete the survey within a setting and time of their choice, and therefore could
have privacy, confidentiality, and anonymity. These points were counterbalanced by the
potential for low response rate and therefore inability to perform the data analyses with
sufficient statistical power and the potential for a biased sample (Fowler, 2002). The
other potential problems with mail surveys were the uncertainty of the person who
actually completed the survey, the possible problems with misunderstandings of the
questions/items, and the inability of the researcher to follow-up with specific participants.
The inclusion of the researcher’s contact information on instructions and the use of a
second mailing of the survey and post-card increased survey response rate to meet the
expected level of 30-40% from the initial mailing and an additional 10-20% after the
follow-up mailing (Fowler, 2002; Heppner et al, 1992; Moore & Tarnai, 2002).

3.9 Validity

3.9.1 Threats to Internal Validity

The research design had possible internal and external threats to validity. Where
possible these threats were reduced and the researcher included clear descriptions of steps
taken for both review of methods and possible future replication. Measurement error was
present within the survey through the lack of clarity of questions and/or instructions, the assumption that respondents interpreted items in a consistent manner, and non-response to the surveys or deliberately lying, possibly because of lack of motivation or the desire to provide socially appropriate responses (Gliem 2006; Heppner et al., 1992). The survey was administered in a manner to protect respondents’ anonymity and thus encourage true responses on the part of the participants. Finally, events may have occurred within the respondents’ personal and/or professional lives, work setting, or community that impacted their response to a survey questions about death and dying and their competence in grief counseling (Gliem, 2006). This potential threat to validity could not be controlled for in the study; however, the researcher provided space for the respondents to include comments at the end of the survey to allow for additional information to be gathered, as participants’ deemed necessary.

Validity and Reliability of Death Counseling Survey. In a prior study, Charkow (2002) developed the DCS by surveying grief counseling experts. Thirty-four experts, defined as persons who had at least five years experience in grief counseling, completed three individual surveys regarding characteristics important for grief counselors to possess, content to be included in courses/lectures on grief, and general competence. The resulting instrument was used in a pilot study and further refined to be implemented as part of her dissertation research. Charkow determined the DCS to be a reliable instrument as indicated by an overall Cronbach alpha of .87, with subscales ranging from .79 - .94. The following were the Cronbach alpha values for the scales and subscales: Personal Competencies scale (.79); Conceptual Skills and Knowledge subscale (.92); Assessment
Skills subscale (.87); Treatment Skills Subscale (.94); and Professional Skills subscale (.83). She reported a correlation between her instrument and the Burgen’s Coping with Death Scale (BCDS) of $r = .73$, suggesting concurrent validity (Charkow, 2002).

Validity and Reliability of Grief Counseling Experience and Training Survey. The GCETS was piloted with twenty-one practicing mental health providers (counselors, social workers, psychologists and psychiatrists). The researcher used statements with high face validity. The researcher asked participants to give feedback on the twelve-item survey regarding whether the survey adequately assessed for counselors’ experience, training, and self-perceived competency in providing grief counseling and 13 responded “yes,” zero participants responded “no,” and seven did not respond to the question. The researcher calculated the Cronbach alpha to assess for the survey’s reliability. The researcher found the reliability to be 0.86.

Validity and Reliability of TRIG. The TRIG was used with several different populations and its validity and reliability are evident through previous studies. The authors of the TRIG assessed the reliability of each of the scales, Past Behaviors and Present Feelings, and found the alpha coefficients to be .77 and .86 respectively and split-half reliability to be .74 (Past Behaviors) and .88 (Present Feelings). The authors reported construct validity for both scales by testing hypotheses about different groups’ responses to death both at the time of death and currently. These tests found respondents whose loved one who was active and important in the respondents’ day-to-day life reported higher levels of disruption in behaviors than those respondents whose loved one was less active in the respondents’ day-to-day life. The construct validity of the Present Feelings
Scale was tested by comparing emotional responses of females to males, based on assumption that women would score higher on this scale, and those respondents who had lost a spouse in comparison to those who did not lose a spouse, based on the assumption that these persons would score higher. The authors found that women and spouses did score higher on the Present Feelings Scale (Faschingbauer et al., 1987). Other researchers found the alpha coefficients to be within an acceptable range for both scales, .79-.82 for Past Behaviors and .82-.91 for Present Feelings (Boyer & Hoffman, 1993; Hayes et al., 2007; Ringdal, et al., 2001; Seecharan et al., 2004).

3.9.2 Threats to External Validity

The challenges to generalizing the findings of this study to the population were related to the sample and the methods of the sample selection. The four sources of error include: (a) sampling error, (b) frame error, (c) selection error, and (d) nonresponse error (Gliem, 2006). The use of an up-to-date and complete list of licensed counselors in the State of Ohio and implementing simple random sampling helped reduce these potential errors. The researcher reviewed the frame for possible duplicates of names. The nonresponse rate could have produced error, therefore steps were taken (as described above) to increase response rate. The researcher reported the total number of surveys sent to respondents and the number of returned and completed surveys. The researcher separated the late respondents’ surveys from those returned on-time. Demographic data was collected for both groups of early and late respondents and compared to determine similarities between the groups. As the two groups were similar across demographics and responses to the items, the researcher assumed the respondents were a representative
sample of the population and therefore results were generalized to licensed counselors in the State of Ohio (Ary, Jacobs, Razavieh, & Sorensen, 2006).

3.10 Data Analysis

The method of data analysis for this research study was a descriptive and multiple regression analysis. The analyses provided the opportunity for the simultaneous analysis of several predictor variables to determine possible relationships with each of the five criterion variables of grief counseling competencies (Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills). The analyses provided for the exploration of possible relationships among the predictor variables and between the predictor and criterion variables. The researcher analyzed which variables had a significant correlation with the grief counseling competencies using five separate regression equations. The following predictor variables were entered into each of the multiple regression equations: age, gender, professional experience as a counselor, professional training and experience in grief counseling, personal experience with grief and practice setting (Lewis-Beck, 1980; Newton & Rudestam, 1999).

The first step in the data analysis was the development of a codebook. This document contained the variable description, the variable name, the value labels with the possible numbers and/or codes and the cell/column numbers (Newton & Rudestam, 1999). This document was used as a reference during the process of inputting data and later for the interpretation of SPSS readouts and interpretation of the data analysis. The next step was the scoring of the DCS, the GCETS and the TRIG and entering this data into SPPS. The researcher completed frequency distributions to review the data for
missing values, outliers, and to verify data entry (Newton & Rudestam, 1999). Descriptive statistics (range, frequency, mean, median, modes and standard deviations) were calculated for the scales of the DCS, the GCETS and the TRIG, and for each of the predictor variables.

The multiple regression analysis was based upon a variety of assumptions that cannot be violated if the statistical results were to be deemed valid, therefore the researcher tested for these assumptions before completing further statistical analysis. Primarily, the relationship between predictor and criterion variables was assumed to be linear and additive, with the effect of one predictor variable remaining constant for all other values for the other predictor variables. This analysis also assumed the values of the criterion variable existed along a normal distribution. Box-plots were used to investigate the distribution of the data and scatter plots were completed to preliminarily determine if the relationship between the predictor and criterion variables was linear, as it was assumed to be (Lewis-Beck, 1980; McClendon, 1994). The model was assumed to have homoscedasticity; therefore the variance of error in predicting the criterion variable value was the same at all values of a given predictor variable. Residual plots were completed to test the assumption of homoscedasticity. Finally, it was assumed that the predictor variables were not highly correlated. Multicollinearity, the sizeable correlations among predictor variables, may have been present but would not necessarily present a problem for the data analysis. The problem that could occur from multicollinearity was the inflation of standard error values, therefore there would be a greater risk of concluding a variable was non-significant when in reality it did have a significant effect (Type II error).
Collinearity diagnostics were completed on the data by investigating the values of the condition indices and the variance proportions as specified by Belsley, Kuh, and Welsch (1980). As multicollinearity was not found to present a problem in each of the regression equations, no further modifications were required such as the removal of problem variables from the regression model.

After the appropriate steps were taken to ensure normality, linearity, homoscedasticity and a lack of problem caused by multicollinearity, Pearson product moment correlations were computed to establish the strength of relationships between predictor variables and between predictor and criterion variables as indicated by the correlation index ($r$ and $r^2$) for each multiple regression equation (Heppner et al, 1992; Newton & Rudestam, 1999).

For each of the multiple regression equations, the coefficient value that describes variance in the criterion variable ($R^2$) was reviewed for significance. The Adjusted $R^2$ value was reviewed to determine the strength of the relationship among the predictor and criterion variables in the regression equation, taking into account the number of predictor variables and the sample size. The $b$ and specifically the Beta ($\beta$) coefficients were used to describe the relationship between individual predictor variables and the criterion variable (Vogt, 2005). The Standard Error of the Estimate (SEE) values was compared between models, with the lower SEE values indicating the better fit for the linear relationship (Lewis-Beck, 1980; McClendon, 1994).
3.11 Summary

Taking into consideration the expected increase in demand for grief counseling and the previous research suggesting counselors’ feelings about being ill-equipped to provide such services, it is important for the profession to assess the current level of preparedness of practicing counselors to provide grief counseling. This exploratory investigation provided data that is needed to better understand the possible factors impacting counselors’ grief counseling competencies and to suggest possible changes to training on grief counseling for licensed counselors and trainees.
CHAPTER 4

RESULTS

4.1 Introduction

This chapter contains the results of the descriptive and statistical analyses completed for each of the research questions. The statistical analyses conducted and their significant findings are discussed. The following research questions were examined:

Research Question 1. What are the demographic characteristics of the licensed counselors including the following: age, gender, years of practice since obtaining LPC, practice setting in which counselor has had most years of experience, race/ethnicity, highest degree earned, field of study, licensure, supervisor status, current work setting, certifications, religion, number of professional development hours on grief, and number of grief courses completed?;

Research Question 2. What is the extent of professional experience and training with grief as measured by the Grief Counseling Experience and Training Survey (GCETS) and personal experience with grief as measured by the Texas Revised Inventory of Grief (TRIG) (Faschingbauer, DeVaul, & Zisook, 1987) of licensed counselors?;
Research Question 3. What are the levels of grief counseling competencies of licensed counselors as measured by their responses to the Death Counseling Survey (Charkow, 2002), as indicated by scores on the assessment scales of Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills?

Research Question 4. What is the relationship between grief counseling competencies and the following selected demographic variables of age, gender, professional experience as a licensed counselor (years practicing since obtaining initial licensure), training and experiences in grief counseling (as measured by the GCETS), personal experience with grief (as measured by the TRIG scales of Past Behaviors and Present Feelings), and practice setting in which counselors worked for majority of years?

4.2 Participants

The accessible population for this study consisted of 6,919 licensed counselors in the state of Ohio (Ohio Office of Information Technology, personal communication, May 22, 2007). The sample frame included 3,358 LPCs and 3,561 LPCCs. The sample size was determined to be 1,000 subjects. The researcher used a simple random sampling procedure to select subjects from the sampling frame, specifically using SPSS 15.0 program to randomly select subjects. The first mailing was sent to all 1,000 members of the sample. A total of 318 surveys were returned completed, 87 post-cards were returned which indicated non-participation in the study, and 36 survey packages were returned to sender because of incorrect/outdated addresses of recipients. A second copy of the survey and post-card were sent to those 559 subjects who had not returned the postcard.
indicating non-participation in the study. The second mailing resulted in 56 returned surveys, 25 post-cards which indicated non-participation in the study, and three undeliverable survey packets due to incorrect/outdated addresses. The final tally of returned surveys from both mailings was 374, representing a 37.4% return rate. This return rate is within the expected range for mail survey response (30-40%) (Heppner et al., 1992).

The researcher reviewed the surveys and determined 369 surveys provided usable data. The researcher removed the surveys which had three or more missing responses from the TRIG, the GCETS, or the DCS assessments. The remaining surveys which had two or less missing responses were included in the analysis. The mean scores for the items of the TRIG, the GCETS, and DCS were calculated to allow for accurate comparisons between surveys. The elimination of incomplete surveys resulted in a final sample size of 369 subjects, or a 36.9% response rate.

4.3 Data Analysis

4.3.1 Research Question One

What are the demographic characteristics of the licensed counselors including the following: age, gender, years of practice since obtaining LPC, practice setting in which counselor has had most years of experience, race/ethnicity, highest degree earned, field of study, licensure, supervisor status, current work setting, certifications, religion, number of professional development hours on grief, and number of grief courses completed?
Gender was collected as a categorical variable in which respondents self-identified as female, male, transgender or other. The majority of the sample (77%) identified as female (see Table 4.1). The gender of the sample could not be compared with the population as this demographic data was not provided with the listing of licensed counselors.

<table>
<thead>
<tr>
<th>Gender (n=369)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>284</td>
<td>77.0</td>
</tr>
<tr>
<td>Men</td>
<td>83</td>
<td>22.5</td>
</tr>
<tr>
<td>Transgender</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Table 4.1: Frequency Distributions for Gender

The average age for the sample was 47.7 years ($SD = 12.81$) with a range of 25 to 78 ($n = 363$). Race/ethnicity was a close-ended question to which respondents selected the race/ethnicity to which they identified. The majority of the sample identified as White/Caucasian (92.7%) with the remaining respondents identifying as Native American, Multiracial, Asian-American, Hispanic/Latino, Black/African-American, or Other (see Table 4.2). As with gender, the researcher was unable to compare the sample to the population as the demographic characteristic of race is not recorded in the state records of licensed counselors. The majority of the population, 73.8%, reported Christian (either Protestant or Catholic) when surveyed about their religious/spiritual background.
(n = 267). The researcher provided the following categories from which the respondents could indicate their religious/spiritual background: Jewish, Protestant, Catholic, Muslim, Buddhist, Hindu, None, or Other (see Table 4.3). Those respondents who indicated “Other” reported spiritual/religious backgrounds including: Mormon, a combination of various spiritual practices, and general spirituality.

<table>
<thead>
<tr>
<th>Race/Ethnicity (n=369)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>342</td>
<td>92.7</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>14</td>
<td>3.8</td>
</tr>
<tr>
<td>Multiracial</td>
<td>6</td>
<td>1.6</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>3</td>
<td>0.8</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Asian-American</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Table 4.2: Frequency Distributions for Race/Ethnicity
<table>
<thead>
<tr>
<th>Religion/Spiritual Background</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>153</td>
<td>42.3</td>
</tr>
<tr>
<td>Catholic</td>
<td>114</td>
<td>31.5</td>
</tr>
<tr>
<td>Other</td>
<td>60</td>
<td>16.6</td>
</tr>
<tr>
<td>None</td>
<td>18</td>
<td>5.0</td>
</tr>
<tr>
<td>Jewish</td>
<td>8</td>
<td>2.2</td>
</tr>
<tr>
<td>Buddhist</td>
<td>7</td>
<td>1.9</td>
</tr>
<tr>
<td>Muslim</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Hindu</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Table 4.3: Frequency Distributions for Religion/Spiritual Background

**Professional Experience, Education, and Certification**

The years of experience as practicing counselors after obtaining the LPC (initial licensure) was another predictor variable for which data was collected. The open-ended question prompted participants to indicate the years of practice since obtaining the LPC. The respondents reported on average working 11 years ($SD = 8.3$) with a range of 6 months to 39 years (see Table 4.4).

After reviewing the data for years experience and completing initial data analyses (correlations), the researcher determined the one year unit for experience may not provide the optimal measure for this variable. For example, counselors practicing for four years
may not demonstrate a qualitative difference in competencies with those counselors practicing for five years. It was hypothesized that experience would provide a more meaningful factor in the analyses if it were converted into an ordinal variable.

The categories for this variable were determined by the distribution of the sample and guidelines for achieving independent licensure. The categories included: new practitioners (0-3 years); skilled practitioners (4-9 years); experienced practitioners (10-20 years); and master practitioners (more than 20 years). The categories were determined by the quartiles of the sample distribution and the independent licensure requirements. The new practitioners were defined as those with three or fewer years of experience, including the minimum two years of post-LPC practice required to complete the 3,000 clinical hours to obtain independent licensure in the state of Ohio. The new practitioners were identified as the reference group (and therefore coded as zero) and this categorical variable was dummy coded prior to being entered into the regression analyses. The nominal variable resulted in three dummy variables. The frequency distribution for the ordinal variable of years experience as a counselor can be found in Table 4.5.

<table>
<thead>
<tr>
<th>Years of Experience (n = 361)</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>Standard Deviation</th>
<th>Range (0.5-39)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11.1</td>
<td>9.0</td>
<td>1.0</td>
<td>8.3</td>
<td>38.5</td>
</tr>
</tbody>
</table>

Table 4.4: Descriptive Statistics for Years of Counseling Experience
Table 4.5: Frequency Distributions for Categorical Variable: Years of Experience

<table>
<thead>
<tr>
<th>Experience (n=361)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Practitioner (0-3 years)</td>
<td>76</td>
<td>21.1</td>
</tr>
<tr>
<td>Skilled Practitioner (4-9 years)</td>
<td>105</td>
<td>29.1</td>
</tr>
<tr>
<td>Experienced Practitioner (10-20 years)</td>
<td>94</td>
<td>26.0</td>
</tr>
<tr>
<td>Master Practitioner (more than 20 years)</td>
<td>86</td>
<td>23.8</td>
</tr>
</tbody>
</table>

The setting in which counselors had the most years experience was another predictor variable for which the researcher gathered data. This was a categorical variable to which respondents indicated the number of years working in various settings. Thirty-nine percent (39%) of the sample reported most years working in community agencies. Smaller percentages of the sample reported working in private practice for the most years and working in multiple settings for an equal number of years, approximately 11% for both categories (see Table 4.6). The original thirteen levels of this variable were combined into five categories: community, hospital/hospice, school, private practice and multiple settings, and other settings (professor, administrator, employee assistance program, career counselor, college counselor, corrections and other). The categories were combined based on similarities in the settings, i.e. hospice and hospital settings, or overlap between settings, i.e. typically counselors work in at least one other setting prior to entering private practice based on requirements of independent licensure to obtain reimbursement from insurance companies in their private practice (see Table 4.7). (The
independent licensure requires completion of 3,000 supervised hours post-LPC licensure). The five categories were dummy coded to add four variables into the multiple regression equations with community being the reference group. The variables were found to have no correlation with the dependent variables and therefore were removed from the regression analysis.
<table>
<thead>
<tr>
<th>Practice Setting with Most Years Experience (n=353)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Agency</td>
<td>144</td>
<td>39.0</td>
</tr>
<tr>
<td>Private Practice</td>
<td>41</td>
<td>11.1</td>
</tr>
<tr>
<td>Multiple Settings</td>
<td>39</td>
<td>10.6</td>
</tr>
<tr>
<td>School</td>
<td>31</td>
<td>8.4</td>
</tr>
<tr>
<td>Hospital</td>
<td>22</td>
<td>6.0</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>5.7</td>
</tr>
<tr>
<td>Administrative</td>
<td>13</td>
<td>3.5</td>
</tr>
<tr>
<td>Professor</td>
<td>10</td>
<td>2.7</td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td>10</td>
<td>2.7</td>
</tr>
<tr>
<td>Corrections</td>
<td>9</td>
<td>2.4</td>
</tr>
<tr>
<td>Career</td>
<td>8</td>
<td>2.2</td>
</tr>
<tr>
<td>College/University</td>
<td>4</td>
<td>1.1</td>
</tr>
<tr>
<td>Hospice</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Table 4.6: Frequency Distributions for Practice Setting in which Counselor had most Years Experience
<table>
<thead>
<tr>
<th>Practice Setting with Most Years Experience - Recoded ($n=353$)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>144</td>
<td>40.8</td>
</tr>
<tr>
<td>Hospital/Hospice</td>
<td>23</td>
<td>6.5</td>
</tr>
<tr>
<td>School</td>
<td>31</td>
<td>8.8</td>
</tr>
<tr>
<td>Private and Multiple Settings</td>
<td>80</td>
<td>22.7</td>
</tr>
<tr>
<td>Others</td>
<td>75</td>
<td>21.2</td>
</tr>
</tbody>
</table>

Table 4.7: Frequency Distributions for Recoded Categorical Variable: Practice Setting in which Counselor had most Years Experience

The majority of the sample, 99.2% ($n = 366$), reported acquiring a master’s degree or higher (see Table 4.8) and the majority, 70.6% ($n = 257$), reported counseling as their major field of study (see Table 4.9). Of the 369 respondents, most participants identified themselves as LPCCs, 56.1% ($n = 207$), and the remaining identified as LPCs, 43.9% ($n = 162$). The majority of respondents (61.8%) reported they held supervisory credentials ($n = 228$) (see Table 4.10). Respondents identified if they held any of the following certifications: National Certified Counselor (NCC), Licensed Independent Chemical Dependency Counselor (LICDC), Certified Grief Therapist (CGT), Certified Grief Counselor (CGC), or Other. The majority of the sample did not hold certifications and only three participants identified as holding either a CGT or CGC (see Table 4.11).
<table>
<thead>
<tr>
<th>Highest Degree Earned ($n = 368$)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masters</td>
<td>322</td>
<td>87.3</td>
</tr>
<tr>
<td>Doctorate</td>
<td>44</td>
<td>11.9</td>
</tr>
<tr>
<td>Bachelors</td>
<td>2</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Table 4.8: Frequency Distributions for Highest Degree Earned

<table>
<thead>
<tr>
<th>Major Field of Study ($n = 364$)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>257</td>
<td>70.6</td>
</tr>
<tr>
<td>Pastoral Counseling</td>
<td>23</td>
<td>6.3</td>
</tr>
<tr>
<td>Psychology</td>
<td>23</td>
<td>6.3</td>
</tr>
<tr>
<td>Rehabilitation Counseling</td>
<td>20</td>
<td>5.5</td>
</tr>
<tr>
<td>Education</td>
<td>8</td>
<td>2.2</td>
</tr>
<tr>
<td>Social Work</td>
<td>8</td>
<td>2.2</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>2.2</td>
</tr>
<tr>
<td>Marriage and Family Therapy</td>
<td>6</td>
<td>1.6</td>
</tr>
<tr>
<td>Counseling/Art Therapy</td>
<td>5</td>
<td>1.4</td>
</tr>
<tr>
<td>School Psychology</td>
<td>4</td>
<td>1.1</td>
</tr>
<tr>
<td>School Counseling</td>
<td>2</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Table 4.9: Frequency Distributions for Major Field of Study
<table>
<thead>
<tr>
<th>Licensure (n = 369) and Supervisor Credential (n = 366)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPCC</td>
<td>207</td>
<td>56.1</td>
</tr>
<tr>
<td>LPC</td>
<td>162</td>
<td>43.9</td>
</tr>
<tr>
<td></td>
<td>369</td>
<td>100</td>
</tr>
<tr>
<td>Supervisor Credential</td>
<td>228</td>
<td>61.8</td>
</tr>
<tr>
<td>Without Supervisor Credential</td>
<td>138</td>
<td>37.4</td>
</tr>
<tr>
<td></td>
<td>366</td>
<td>99.2</td>
</tr>
</tbody>
</table>

Table 4.10: Frequency Distributions for Licensure and Supervisor Credential
<table>
<thead>
<tr>
<th>Certifications ((n = 367))</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCC Certified</td>
<td>56</td>
<td>15.2</td>
</tr>
<tr>
<td>Not NCC Certified</td>
<td>311</td>
<td>84.3</td>
</tr>
<tr>
<td></td>
<td><strong>367</strong></td>
<td><strong>99.5</strong></td>
</tr>
<tr>
<td>LICDC Certified</td>
<td>44</td>
<td>11.9</td>
</tr>
<tr>
<td>Not LICDC Certified</td>
<td>321</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td><strong>365</strong></td>
<td><strong>98.9</strong></td>
</tr>
<tr>
<td>CGT Certified</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Not CGT Certified</td>
<td>364</td>
<td>98.6</td>
</tr>
<tr>
<td></td>
<td><strong>365</strong></td>
<td><strong>98.9</strong></td>
</tr>
<tr>
<td>CGC Certified</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Not CGC Certified</td>
<td>365</td>
<td>98.9</td>
</tr>
<tr>
<td></td>
<td><strong>367</strong></td>
<td><strong>99.4</strong></td>
</tr>
<tr>
<td>Other</td>
<td>87</td>
<td>23.6</td>
</tr>
<tr>
<td>Not Other Certified</td>
<td>278</td>
<td>75.3</td>
</tr>
<tr>
<td></td>
<td><strong>365</strong></td>
<td><strong>98.9</strong></td>
</tr>
</tbody>
</table>

Table 4.11: Frequency Distributions for Certifications

Data was collected regarding the current work setting of the participants. As was found with the variable of practice setting in which counselor has had the most experience, the category of community mental health was the most frequent response (28.5%, \(n = 105\)). Most of the respondents indicated currently working in one of the following three categories: private practice (16.6%), multiple settings (16.3%), and other.
(16.6%). The respondents who indicated they worked in other settings provided specific locations such as nursing homes, church or religious settings, or drug and alcohol programs (see Table 4.12).

<table>
<thead>
<tr>
<th>Current Practice Setting (n = 368)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Agency</td>
<td>105</td>
<td>28.5</td>
</tr>
<tr>
<td>Private Practice</td>
<td>61</td>
<td>16.6</td>
</tr>
<tr>
<td>Other</td>
<td>61</td>
<td>16.5</td>
</tr>
<tr>
<td>Multiple Settings</td>
<td>60</td>
<td>16.3</td>
</tr>
<tr>
<td>School</td>
<td>19</td>
<td>5.1</td>
</tr>
<tr>
<td>Hospital</td>
<td>19</td>
<td>5.1</td>
</tr>
<tr>
<td>Administrative</td>
<td>11</td>
<td>3.0</td>
</tr>
<tr>
<td>Professor</td>
<td>7</td>
<td>1.9</td>
</tr>
<tr>
<td>Corrections</td>
<td>7</td>
<td>1.9</td>
</tr>
<tr>
<td>College/University</td>
<td>6</td>
<td>1.6</td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>6</td>
<td>1.6</td>
</tr>
<tr>
<td>Hospice</td>
<td>4</td>
<td>1.1</td>
</tr>
<tr>
<td>Career</td>
<td>2</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Table 4.12: Frequency Distributions for Current Practice Setting
Training on Grief and/or Death Education

Training on grief and/or death was collected as three variables. The survey prompted respondents to identify courses taken which focused specifically on grief and/or death, courses taken in which grief and/or death content was infused or included in a significant way, and number of professional development hours earned on the topic of grief and/or death. The researcher converted the continuous variables into categorical variables to explore the differences between categories as a large number of respondents stated they had “zero” or “no” courses or professional development hours on grief and/or death (see Table 4.13). Courses completed which focused specifically on grief/death was a continuous variable converted into the categories of none (zero courses), one, and more than one classes. Courses completed which infused death and/or grief in a significant way was a continuous variable converted into the three categories of none (zero courses), one or two courses, and three or more courses. Professional development hours completed on death and/or grief was converted into four categories of none (zero hours), 1-10 hours, 11-30 hours, and more than 30 hours. The majority of the sample, 54.8%, reported not taking a course specifically on grief and/or death ($n = 190$). In contrast, the majority of respondents, 50.1%, reported they completed one or two courses which included or infused content on grief and/or death in a significant way ($n = 174$).

The data collected for the professional development hours completed demonstrated a wide range within the sample. A total of 109 of the 356 persons (30.6%) who responded to the question indicated they had earned zero professional development
hours on grief and/or death. In contrast, 22 participants (6.2%) reported completing 30 or more professional development hours on the topic (see Table 4.13).

<table>
<thead>
<tr>
<th>Training</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Courses specifically about Grief and/or Death <em>(n = 347)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No courses</td>
<td>190</td>
<td>54.8</td>
</tr>
<tr>
<td>One Course</td>
<td>107</td>
<td>30.8</td>
</tr>
<tr>
<td>Two or More Courses</td>
<td>50</td>
<td>14.4</td>
</tr>
<tr>
<td>Courses which included Grief and/or Death Content in a Significant Way <em>(n = 347)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No courses</td>
<td>93</td>
<td>26.8</td>
</tr>
<tr>
<td>One to Two Courses</td>
<td>174</td>
<td>50.1</td>
</tr>
<tr>
<td>Three or More Courses</td>
<td>80</td>
<td>23.1</td>
</tr>
<tr>
<td>Professional Development Hours <em>(n = 356)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Hours Earned</td>
<td>109</td>
<td>30.6</td>
</tr>
<tr>
<td>1 to 10 Hours Earned</td>
<td>125</td>
<td>35.1</td>
</tr>
<tr>
<td>11 to 30 Hours Earned</td>
<td>100</td>
<td>28.1</td>
</tr>
<tr>
<td>More than 30 Hours Earned</td>
<td>22</td>
<td>6.2</td>
</tr>
</tbody>
</table>

Table 4.13: Frequency Distributions for Training on Grief and/or Death
The researcher asked participants to indicate their familiarity with various grief counseling theories included in the literature. Participants indicated their familiarity as being “none,” “very little,” “some,” or “a lot” to the following grief counseling theories: Stage Theories, Task Theories, Dual Process Theory, Meaning Making Theory, and Continuing Bonds Theory. As expected, the majority of the sample (92.4%) indicated at least “some” or “a lot” of familiarity with the Stage Theories (often associated with Kubler-Ross) (see Table 4.14). The majority of the sample (65.8%) reported having “none” or “very little” familiarity with Task Theories (see Table 4.15). A small number of participants reported “some” or “a lot” of familiarity with Dual Process Theory (15.4%) (see Table 4.16). As compared to the Dual Process Theory, a slightly larger percentage of the sample reported “some” or “a lot” of familiarity with Meaning Making Theory (25.5%), and an almost equal percentage reported the same level of familiarity with the Continuing Bonds Theory (14.9%) (see Tables 4.17 and 4.18 respectively).

<table>
<thead>
<tr>
<th>Familiarity with Stage Theories (n = 366)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>7</td>
<td>1.9</td>
</tr>
<tr>
<td>Very Little</td>
<td>18</td>
<td>4.9</td>
</tr>
<tr>
<td>Some</td>
<td>158</td>
<td>42.8</td>
</tr>
<tr>
<td>A Lot</td>
<td>183</td>
<td>49.6</td>
</tr>
</tbody>
</table>

Table 4.14: Frequency Distributions for Familiarity with Stage Theories
### Familiarity with Task Theories ($n = 347$)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>148</td>
</tr>
<tr>
<td>Very Little</td>
<td>95</td>
</tr>
<tr>
<td>Some</td>
<td>73</td>
</tr>
<tr>
<td>A Lot</td>
<td>31</td>
</tr>
</tbody>
</table>

Table 4.15: Frequency Distributions for Familiarity with Task Theories

### Familiarity with Dual Process Theory ($n = 343$)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>177</td>
</tr>
<tr>
<td>Very Little</td>
<td>109</td>
</tr>
<tr>
<td>Some</td>
<td>48</td>
</tr>
<tr>
<td>A Lot</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 4.16: Frequency Distributions for Familiarity with Dual Process Theory
<table>
<thead>
<tr>
<th>Familiarity with Meaning Making Theory (n = 348)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>159</td>
<td>43.1</td>
</tr>
<tr>
<td>Very Little</td>
<td>95</td>
<td>25.7</td>
</tr>
<tr>
<td>Some</td>
<td>77</td>
<td>20.9</td>
</tr>
<tr>
<td>A Lot</td>
<td>17</td>
<td>4.6</td>
</tr>
</tbody>
</table>

Table 4.17: Frequency Distributions for Familiarity with Meaning Making Theory

<table>
<thead>
<tr>
<th>Familiarity with Continuing Bonds Theory (n = 346)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>195</td>
<td>52.8</td>
</tr>
<tr>
<td>Very Little</td>
<td>96</td>
<td>26</td>
</tr>
<tr>
<td>Some</td>
<td>49</td>
<td>13.3</td>
</tr>
<tr>
<td>A Lot</td>
<td>6</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Table 4.18: Frequency Distributions for Familiarity with Continuing Bonds Theory
4.3.2 Research Question Two: Professional Experience and Training and Personal Experience

What is the extent of professional experience and training with grief as measured by the Grief Counseling Experience and Training Survey (GCETS) and personal experience with grief as measured by the Texas Revised Inventory of Grief (TRIG) (Faschingbauer, DeVaul, & Zisook, 1987) of licensed counselors?

Grief Counseling Experience and Training Survey (GCETS)

To answer the second research question, mean scores, standard deviations, and median scores were calculated for the GCETS ($M = 2.7$, $SD = 0.9$) (see Table 4.19). The 12-item survey had a range of potential mean scores from 1 to 5. For all of the questions except for one which was reverse scored (number 10), “1” indicated no experience or training and “5” indicated significant training or experience. The researcher investigated the reliability of this assessment and found the Cronbach’s Alpha to be .93. This instrument was developed from a subscale of another instrument, the Sexual Orientation Counselor Competency Scale (SOCCS). The coefficient alpha for the SOCCS subscale was .91 (Bidell, 2005). Many questions remained the same from the SOCCS scale to the GCETS, with the substitution of the term “client presenting with grief” for “gay, lesbian, bisexual or transgender client.” One additional question was added to the GCETS, “I have sufficient knowledge of grief counseling theories and models.”
Table 4.19: Descriptive Statistics for Grief Counseling Experience and Training Survey

<table>
<thead>
<tr>
<th>GCETS (n = 368)</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>Standard Deviation</th>
<th>Range (1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.7</td>
<td>2.7</td>
<td>2.8</td>
<td>0.9</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Texas Revised Inventory of Grief (TRIG)

The counselors’ personal experiences with grief were measured by the TRIG. This instrument provided two continuous, interval level variables, past behaviors and present feelings. Respondents answered the survey about the death of a loved one to which they had the most significant response. The researcher calculated the mean scores, standard deviations, median and mode scores for each variable related to personal experience with grief (see Table 4.20).

TRIG: Past Behaviors. The 8-item scale on past behaviors had a potential mean score from 1 to 5 (M = 3.8, SD = 0.8). Lower numbers on the past behaviors scale indicated more intense behavioral responses to the death (such as irritability, difficulty sleeping, anhedonia, and problems working) and higher numbers indicated less intense behavioral responses.

TRIG: Present Feelings. The 13-item scale on present feelings had a potential mean score from 1 to 5 (M = 3.7, SD = 0.7). Lower numbers on the present feelings scale indicated currently the respondent experiences more intense feelings about the death (such as crying, preoccupied thoughts about and yearning for the deceased) and higher numbers indicated less intense feelings about the death.
Previous researchers found that higher scores on the TRIG (scores which indicated less intense responses to death) were related to counselors being perceived as less empathetic and lower scores (which indicated more intense responses to death) were related to counselors being perceived as more empathetic in the counseling sessions by their clients (Hayes et al., 2007). The researcher hypothesized that personal experience with grief, both past behavior and present feelings variables, would provide more meaningful factors in the analyses if they were converted into a categorical variables with three levels: high, middle and low scores.

The categories for this variable were determined by the distribution of the sample. The categories for the past behaviors variable included: low scores (1.00 to 3.38); middle scores (3.50 to 4.30); and high scores (4.40 and above). The categories for the present feelings variable included: low scores (1.00 to 3.46); middle scores (3.50 to 3.90); and high scores (4.00 and above). The categories were determined by the values of the 33rd and 67th percentiles of the sample distribution. The middle scores were identified as the reference groups (and therefore coded as zero) for both the past behaviors and present feelings variables. The frequency distribution for the categorical variables of personal

<table>
<thead>
<tr>
<th>TRIG: Past Behaviors and Present Feelings</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>Standard Deviation</th>
<th>Range (1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Behaviors (n = 369)</td>
<td>3.8</td>
<td>3.9</td>
<td>3.8</td>
<td>0.8</td>
<td>4.0</td>
</tr>
<tr>
<td>Present Feelings (n = 369)</td>
<td>3.7</td>
<td>3.8</td>
<td>3.9</td>
<td>0.7</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Table 4.20: Descriptive Statistics for TRIG: Past Behaviors and Present Feelings
experience with grief, both past behaviors and present feelings, can be found in Tables 4.21 and 4.22.

<table>
<thead>
<tr>
<th>TRIG: Past Behaviors (n=369)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Scores (1.00 to 3.38)</td>
<td>113</td>
<td>30.6</td>
</tr>
<tr>
<td>Middle Scores (3.50 to 4.30)</td>
<td>160</td>
<td>43.4</td>
</tr>
<tr>
<td>High Scores (4.40 and above)</td>
<td>96</td>
<td>26.0</td>
</tr>
</tbody>
</table>

Table 4.21: Frequency Distributions for Categorical Variable: TRIG: Past Behaviors

<table>
<thead>
<tr>
<th>TRIG: Present Feelings (n=369)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Scores (1.00 to 3.46)</td>
<td>120</td>
<td>32.5</td>
</tr>
<tr>
<td>Middle Scores (3.50 to 3.92)</td>
<td>114</td>
<td>30.9</td>
</tr>
<tr>
<td>High Scores (4.00 and above)</td>
<td>135</td>
<td>36.6</td>
</tr>
</tbody>
</table>

Table 4.22: Frequency Distributions for Categorical Variable: TRIG: Present Feelings

4.3.3 Research Question Three

What are the levels of grief counseling competencies of licensed counselors as measured by their responses to the Death Counseling Survey (DCS) (Charkow, 2002), as
indicated by scores on the assessment scales of Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills?

The DCS includes a scale from 1 to 5, with a midpoint of three. The scores of “1” indicated no confidence on four of the scales (Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills and Professional Skills). The same score of “1” indicated “This does not describe me” in response to questions on the Personal Competencies scale. The score of “5” indicated “This describes me very well on the Personal Competencies scale and “Very high confidence” on the other four scales (Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills and Professional Skills). To answer the third research question, the researcher calculated the mean scores, standard deviations, median scores and ranges for each of the five scales in the Death Counseling Survey (see Table 4.23). The mean scores for the current study were similar to those scores obtained from the previous administration of the Death Counseling Survey (Charkow, 2002). The respondents in the current study indicated mean scores at or above the midpoint for each scale. Respondents reported scores > 3.0 (“This Somewhat Describes Me,” “This Describes Me,” or “This Describes Me Very Well”) for the Personal Competencies Scale. Respondents reported scores > 3.0 (“Some Confidence,” “Confidence,” or “Very High Confidence”) for the Conceptual, Assessment, Treatment, and Professional Skills scales. Similar to Charkow’s results (2002), this sample had the highest mean scores for Personal Competencies ($M = 4.41, SD = .43$) and the lowest mean scores for Conceptual Skills and Knowledge ($M = 3.07, SD = .91$). Assessment Skills ($M = 3.56, SD = .73$) and Treatment Skills ($M = 3.47, SD =
.71) were the second and third highest scores followed by Professional Skills ($M = 3.19$, $SD = .83$).

<table>
<thead>
<tr>
<th>Death Counseling Survey ($n = 369$)</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Median</th>
<th>Range (1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Competencies</td>
<td>4.41</td>
<td>0.43</td>
<td>4.45</td>
<td>2.73</td>
</tr>
<tr>
<td>Conceptual Skills and Knowledge</td>
<td>3.07</td>
<td>0.91</td>
<td>3.11</td>
<td>4.00</td>
</tr>
<tr>
<td>Assessment Skills</td>
<td>3.56</td>
<td>0.73</td>
<td>3.67</td>
<td>3.89</td>
</tr>
<tr>
<td>Treatment Skills</td>
<td>3.47</td>
<td>0.71</td>
<td>3.41</td>
<td>3.55</td>
</tr>
<tr>
<td>Professional Skills</td>
<td>3.19</td>
<td>0.83</td>
<td>3.14</td>
<td>3.86</td>
</tr>
</tbody>
</table>

Table 4.23: Descriptive Statistics for Death Counseling Survey Scales

4.3.4 Research Question Four

What is the relationship between grief counseling competencies and the following selected demographic variables of age, gender, professional experience as a licensed counselor (years), training and experiences in grief counseling (GCETS), personal experience with grief (TRIG), and practice setting in which counselors worked for majority of years?

Prior completing the multiple regression analysis to explore the relationships between grief counseling competencies and the predictor variables, the researcher examined the data and tested the assumptions of the multiple regression analysis. The assumptions of normality, linearity, homoscedasticity, and multicollinearity must not be
violated in order for the statistical analysis to be valid (Lewis-Beck, 1980; McClendon, 1994).

Normality

The assumption of normality dictates values for criterion variables exist along a normal distribution. The researcher used a P-P Plot for each of the five criterion variables to display the assumption of normality was maintained (see Figures 4.1-4.5).

![Dependent Variable: Mean Personal Competencies Score](image)

Figure 4.1: Normal P-P Plot for Mean Personal Competencies Scores ($n = 369$)
Figure 4.2: Normal P-P Plot for Conceptual Skills and Knowledge Scores ($n = 369$)
Figure 4.3: Normal P-P Plot for Mean Assessment Skills Scores ($n = 369$)
Figure 4.4: Normal P-P Plot for Mean Treatment Skills Scores ($n = 369$)
Figure 4.5: Normal P-P Plot for Mean Professional Skills Scores ($n = 369$)

**Linearity**

Linearity assumes the relationship between predictor and criterion variables is linear and additive, with the effect of a predictor variable remaining constant for all other values of other predictor variables. Scatterplots were used to investigate the relationships between continuous predictor variables (age, years practicing as a counselor, professional
experience and training with grief, and personal experience with grief) and the criterion variable of the overall score on the DCS (combined scores of Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills). Figures 4.6 through 4.10 demonstrate the relationships between five predictor variables and the criterion variable of the DCS total score (all five scales combined). The scatter plots demonstrate weak and positive relationships between age, years practicing as a counselor, and personal experience with grief (past behaviors and present feelings) with the overall DCS scores. In contrast, the scatter plot representing the relationship between experience and training with grief and the overall DCS scores demonstrates a positive, strong, and linear relationship between these variables. This relationship suggests the variable of experience and training with grief is a better predictor of overall DCS scores than the other variables of age, years practicing as a counselor, and personal experience with grief.
Figure 4.6: Scatterplot of Age and Mean Death Counseling Survey (DCS) Total Score
Figure 4.7: Scatterplot of Years of Practice and Mean Death Counseling Survey (DCS) Total Score
Figure 4.8: Scatterplot of Professional Experience and Training and Mean Death Counseling Survey (DCS) Total Score
Figure 4.9: Scatterplot of Past Behaviors and Mean Death Counseling Survey (DCS) Total Score
Homoscedasticity

Homoscedasticity is assumed to be present, meaning the variance of error in predicting the criterion variable value is the same at all values of any given predictor variable. A residual plot was created for each of the criterion variables (Personal Experience with Grief (Present Feelings) and Mean Death Counseling Survey (DCS) Total Score).
Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills) to verify this assumption (see Figures 4.11-4.15).

Figure 4.11: Residual Plot of Mean Personal Competencies Scores ($n = 369$)
Scatterplot

Dependent Variable: Conceptual Skills and Knowledge Score

Figure 4.12: Residual Plot of Mean Conceptual Skills and Knowledge Scores ($n = 369$)
Figure 4.13: Residual Plot of Mean Assessment Skills Scores ($n = 369$)
Figure 4.14: Residual Plot of Mean Treatment Skills Scores ($n = 369$)
Multicollinearity

Multicollinearity is the sizeable correlations among predictor variables. Multicollinearity may be present in the regression model; however the presence of multicollinearity does not guarantee a problem with data analysis. Therefore, collinearity diagnostics must be completed for each regression model (Lewis-Beck, 1980). An initial analysis of the data was completed to explore correlations between predictor variables. The correlation matrix suggests none of the independent variables are highly correlated.

Figure 4.15: Residual Plot of Mean Professional Skills Scores (n = 369)
(Tables 4.24). Additional, collinearity diagnostics were completed for each regression equation to verify multicollinearity did not cause a problem in the analyses by reviewing the Collinearity Diagnostics and Condition Indices provided by the SPSS program for each regression equation (Tabachnick & Fidell, 2001).

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Years Experience</th>
<th>GCETS</th>
<th>TRIG: Past Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years Experience (n = 361)</td>
<td></td>
<td>0.14*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCETS (n = 368)</td>
<td>0.03</td>
<td>0.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRIG: Past Behavior (n = 369)</td>
<td>0.12*</td>
<td>0.13</td>
<td>0.15</td>
<td></td>
</tr>
<tr>
<td>TRIG: Present Feelings (n = 369)</td>
<td>0.05</td>
<td>0.09</td>
<td>0.09</td>
<td>0.22**</td>
</tr>
</tbody>
</table>

Table 4.24: Intercorrelations of Independent Variables

**Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

Reliability and Intercorrelation Values of the DCS

The researcher investigated the internal reliability of the five scales of the DCS. Table 4.25 includes the Cronbach’s alpha values for each of the scales and the intercorrelations among the criterion variables. Cronbach’s alpha for Personal, Conceptual and Knowledge, Assessment, Treatment, and Professional scales were .74, .93, .87, .94, and .81 respectively. The Cronbach’s alpha for Personal, Conceptual and
Knowledge, Assessment, Treatment, and Professional scales are consistent with the values found by Charkow (2002). The intercorrelation values for the criterion variables ranged from .33 to .89. Those correlations suggest a moderate relationship between Personal Competencies and the other scales (Conceptual Skills and Knowledge, Assessment, Treatment, and Professional Competencies). The correlation values suggest a strong relationship among Conceptual Skills and Knowledge, Assessment, Treatment and Professional Competencies.

<table>
<thead>
<tr>
<th></th>
<th>Personal (361)</th>
<th>Conceptual Skills and Knowledge (366)</th>
<th>Assessment (364)</th>
<th>Treatment (362)</th>
<th>Professional (361)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal (361)</td>
<td>.74</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conceptual Skills</td>
<td>.35**</td>
<td>.93</td>
<td>.86**</td>
<td>.84**</td>
<td>.88**</td>
</tr>
<tr>
<td>and Knowledge (366)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment (364)</td>
<td>.38**</td>
<td>.86**</td>
<td>.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment (362)</td>
<td>.45**</td>
<td>.89**</td>
<td>.84**</td>
<td>.94</td>
<td></td>
</tr>
<tr>
<td>Professional (361)</td>
<td>.33**</td>
<td>.84**</td>
<td>.74**</td>
<td>.88**</td>
<td>.81</td>
</tr>
</tbody>
</table>

Table 4.25: Intercorrelations and Alpha Coefficients for Death Counseling Survey (DCS) 

(n = 360 for correlations; n for reliability is in parentheses) 

**Correlation is significant at the 0.01 level (2-tailed) 

Cronbach Alpha coefficients are written on the diagonal
Linear Regression Analyses

The researcher completed a forced entry linear regression analysis to examine the relationships between the independent variables and the dependent variable. Five regression equations were developed, one for each of the scales of the DCS. Each of the scales was investigated separately as they are conceptually independent and can provide specific data on the strength and weakness of the sample in these training areas. Before completing the linear regression analyses, correlations were determined to identify the independent variables which were statistically related to the dependent variables (see Table 4.26). The variables of age and practice setting in which counselor had the most years experience were not found to be correlated with any of the dependent variables and therefore were not included in the regression analyses. The categorical variables for the TRIG scales (Past Behavior and Present Feelings) were dummy coded prior to being entered into the regression analyses. The two nominal variables (past behavior and present feelings) resulted in a total of two dummy variables for each scale.
Table 4.26: Correlations for Independent and Dependent Variables \((n = 361)\)

*Correlation is significant at the 0.05 level (2-tailed)

**Correlation is significant at the 0.01 level (2-tailed)
<table>
<thead>
<tr>
<th></th>
<th>Personal</th>
<th>(SD)</th>
<th>Conceptual Skills and Knowledge</th>
<th>(SD)</th>
<th>Assessment</th>
<th>(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>men (83)</td>
<td>4.26</td>
<td>(0.47)</td>
<td>2.94</td>
<td>(0.97)</td>
<td>3.36</td>
<td>(0.81)</td>
</tr>
<tr>
<td>women (284)</td>
<td>4.46</td>
<td>(0.41)</td>
<td>3.11</td>
<td>(0.88)</td>
<td>3.62</td>
<td>(0.70)</td>
</tr>
<tr>
<td><strong>Years of Experience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Practitioner (61)</td>
<td>4.36</td>
<td>(0.40)</td>
<td>2.87</td>
<td>(0.72)</td>
<td>3.43</td>
<td>(0.60)</td>
</tr>
<tr>
<td>Skilled Practitioner (120)</td>
<td>4.39</td>
<td>(0.40)</td>
<td>3.06</td>
<td>(0.89)</td>
<td>3.59</td>
<td>(0.64)</td>
</tr>
<tr>
<td>Experienced Practitioner (109)</td>
<td>4.43</td>
<td>(0.49)</td>
<td>3.26</td>
<td>(0.89)</td>
<td>3.74</td>
<td>(0.70)</td>
</tr>
<tr>
<td>Master Practitioner (71)</td>
<td>4.46</td>
<td>(0.43)</td>
<td>3.04</td>
<td>(1.01)</td>
<td>3.42</td>
<td>(0.91)</td>
</tr>
<tr>
<td><strong>TRIG: Past Behavior</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores (160)</td>
<td>4.35</td>
<td>(0.42)</td>
<td>3.05</td>
<td>(0.86)</td>
<td>3.52</td>
<td>(0.68)</td>
</tr>
<tr>
<td>Middle Scores (113)</td>
<td>4.51</td>
<td>(0.45)</td>
<td>3.26</td>
<td>(0.84)</td>
<td>3.73</td>
<td>(0.67)</td>
</tr>
<tr>
<td>High Scores (96)</td>
<td>4.40</td>
<td>(0.41)</td>
<td>2.89</td>
<td>(1.01)</td>
<td>3.43</td>
<td>(0.83)</td>
</tr>
<tr>
<td><strong>TRIG: Present Feelings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores (114)</td>
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<td>(0.40)</td>
<td>3.18</td>
<td>(0.91)</td>
<td>3.63</td>
<td>(0.75)</td>
</tr>
<tr>
<td>Middle Scores (120)</td>
<td>4.37</td>
<td>(0.45)</td>
<td>3.02</td>
<td>(0.86)</td>
<td>3.49</td>
<td>(0.68)</td>
</tr>
<tr>
<td>High Scores (135)</td>
<td>4.40</td>
<td>(0.45)</td>
<td>3.03</td>
<td>(0.94)</td>
<td>3.57</td>
<td>(0.75)</td>
</tr>
</tbody>
</table>

Table 4.27: Table of Means and Standard Deviations for Personal Competencies, Conceptual Skills and Knowledge, and Assessment Competencies
<table>
<thead>
<tr>
<th></th>
<th>Treatment</th>
<th>(SD)</th>
<th>Professional</th>
<th>(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>men (83)</td>
<td>3.35</td>
<td>(0.76)</td>
<td>3.07</td>
<td>(0.90)</td>
</tr>
<tr>
<td>women (284)</td>
<td>3.50</td>
<td>(0.69)</td>
<td>3.22</td>
<td>(0.80)</td>
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<tr>
<td><strong>Years of Counseling Experience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Practitioner (61)</td>
<td>3.29</td>
<td>(0.54)</td>
<td>2.99</td>
<td>(0.62)</td>
</tr>
<tr>
<td>Skilled Practitioner (120)</td>
<td>3.43</td>
<td>(0.68)</td>
<td>3.11</td>
<td>(0.78)</td>
</tr>
<tr>
<td>Experienced Practitioner (109)</td>
<td>3.64</td>
<td>(0.68)</td>
<td>3.37</td>
<td>(0.81)</td>
</tr>
<tr>
<td>Master Practitioner (71)</td>
<td>3.48</td>
<td>(0.86)</td>
<td>3.22</td>
<td>(1.02)</td>
</tr>
<tr>
<td><strong>TRIG: Past Behavior</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores (160)</td>
<td>3.43</td>
<td>(0.72)</td>
<td>3.15</td>
<td>(0.82)</td>
</tr>
<tr>
<td>Middle Scores (113)</td>
<td>3.61</td>
<td>(0.66)</td>
<td>3.30</td>
<td>(0.80)</td>
</tr>
<tr>
<td>High Scores (96)</td>
<td>3.38</td>
<td>(0.73)</td>
<td>3.12</td>
<td>(0.86)</td>
</tr>
<tr>
<td><strong>TRIG: Present Feelings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores (114)</td>
<td>3.60</td>
<td>(0.72)</td>
<td>3.28</td>
<td>(0.86)</td>
</tr>
<tr>
<td>Middle Scores (120)</td>
<td>3.41</td>
<td>(0.65)</td>
<td>3.11</td>
<td>(0.75)</td>
</tr>
<tr>
<td>High Scores (135)</td>
<td>3.41</td>
<td>(0.74)</td>
<td>3.17</td>
<td>(0.86)</td>
</tr>
</tbody>
</table>

Table 4.28: Table of Means and Standard Deviations for Treatment and Professional Competencies
Personal Competencies Regression Analysis. Prior to completing the regression analysis, the means for Personal Competencies (and all other dependent variables) were calculated for each of the independent variables (see Tables 4.27 and 4.28).

A forced entry regression which included all of the independent variables (gender, years as counselor – recoded, GCETS, TRIG: past behavior – recoded, and TRIG: present feeling - recoded) was completed. This model was statistically significant \( F(9, 348) = 8.99, p < .00 \). This model accounted for 17% of the total variance in Personal Competencies scores (adjusted \( R^2 = .168 \)) (see Table 4.29).

The correlation analysis completed as part of the regression determined three independent variables were statistically related to Personal Competencies scores. The three variables were: gender, GCETS, and TRIG: past behavior (low scores). A forced entry regression with a reduced number of independent variables was used to explore the relationship between Personal Competencies and gender, GCETS, and TRIG: past behavior (low scores). The reduced model was also statistically significant \( F(3, 362) = 25.59, p < .00 \). This model accounted for 17% of the total variance in Personal Competencies scores (adjusted \( R^2 = .168 \)) (see Table 4.30).
<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>(SE)</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.18</td>
<td>(0.05)</td>
<td>0.17**</td>
</tr>
<tr>
<td>GCETS</td>
<td>0.17</td>
<td>(0.02)</td>
<td>0.35**</td>
</tr>
<tr>
<td><strong>Years of Experience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Practitioner</td>
<td>-0.03</td>
<td>(0.06)</td>
<td>-0.03</td>
</tr>
<tr>
<td>Experienced Practitioner</td>
<td>-0.03</td>
<td>(0.07)</td>
<td>-0.04</td>
</tr>
<tr>
<td>Master Practitioner</td>
<td>0.03</td>
<td>(0.07)</td>
<td>0.03</td>
</tr>
<tr>
<td>TRIG: Past Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>0.12</td>
<td>(0.05)</td>
<td>0.13*</td>
</tr>
<tr>
<td>High Scores</td>
<td>0.06</td>
<td>(0.05)</td>
<td>0.06</td>
</tr>
<tr>
<td>TRIG: Present Feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>-0.07</td>
<td>(0.05)</td>
<td>-0.08</td>
</tr>
<tr>
<td>High Scores</td>
<td>-0.03</td>
<td>(0.05)</td>
<td>-0.03</td>
</tr>
<tr>
<td>Adjusted R²</td>
<td></td>
<td></td>
<td>0.17</td>
</tr>
<tr>
<td>S.E.E.</td>
<td></td>
<td></td>
<td>0.40</td>
</tr>
<tr>
<td>N</td>
<td></td>
<td></td>
<td>358</td>
</tr>
</tbody>
</table>

Table 4.29: Forced Entry Regression for Personal Competencies (Full Model)

Note: The reference category for Years of Counseling Experience was Novice (0-3 Years)

Note: The reference category for TRIG: Personal Experience - Past Behavior was Middle Scores (3.5-4.4)

Note: The reference category for TRIG: Personal Experience - Present Feelings was Middle Scores (3.5-4.0)

**p < .00
<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>(SE)</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.18</td>
<td>(0.05)</td>
<td>0.17**</td>
</tr>
<tr>
<td>GCETS</td>
<td>0.17</td>
<td>(0.02)</td>
<td>0.35**</td>
</tr>
<tr>
<td>TRIG: Past Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>0.07</td>
<td>(0.05)</td>
<td>0.08</td>
</tr>
<tr>
<td>Adjusted R²</td>
<td></td>
<td></td>
<td>0.17</td>
</tr>
<tr>
<td>S.E.E.</td>
<td></td>
<td></td>
<td>0.40</td>
</tr>
<tr>
<td>N</td>
<td></td>
<td></td>
<td>366</td>
</tr>
</tbody>
</table>

Table 4.30: Forced Entry Regression for Personal Competencies (Reduced Model)

Note: The reference category for TRIG: Past Behavior was Middle Scores (3.5-4.4)

Note: The reference category for TRIG: Present Feelings was Middle Scores (3.5-4.0)

**p < .00

Conceptual Knowledge and Skills Competencies Regression Analysis. Prior to completing the regression analysis, the means for Conceptual Knowledge and Skills Competencies were calculated for each of the independent variables (see Table 4.28). A forced entry regression model which included all of the independent variables (gender, years as counselor - recoded, GCETS, TRIG: past behavior – recoded, and TRIG: present feeling - recoded) was completed. This model was statistically significant ($F(9, 348) =$
87.92, $p < .00$). This model accounted for 69% of the total variance in Conceptual Knowledge and Skills Competencies (adjusted $R^2 = .687$) (see Table 4.31).

The correlation analysis completed as part of the regression determined two independent variables were statistically related to Conceptual Knowledge and Skills Competencies scores. The two variables were: years practicing (Master Practitioner) and GCETS. A forced entry regression was used to explore the relationship between Conceptual Knowledge and Skills Competencies and the independent variables of years practicing (Master Practitioner) and GCETS. The model was statistically significant ($F (2, 357) = 397.25, p < .00$). This model accounted for 69% of the total variance in Conceptual Knowledge and Skills Competencies scores (adjusted $R^2 = .688$) (see Table 4.32).
<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>(SE)</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.12</td>
<td>(0.06)</td>
<td>0.06</td>
</tr>
<tr>
<td>GCETS</td>
<td>0.82</td>
<td>(0.03)</td>
<td>0.84**</td>
</tr>
<tr>
<td>Years of Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Practitioner</td>
<td>-0.12</td>
<td>(0.08)</td>
<td>-0.06</td>
</tr>
<tr>
<td>Experienced Practitioner</td>
<td>-0.11</td>
<td>(0.08)</td>
<td>-0.06</td>
</tr>
<tr>
<td>Master Practitioner</td>
<td>-0.25</td>
<td>(0.09)</td>
<td>-0.11**</td>
</tr>
<tr>
<td>TRIG: Past Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>0.05</td>
<td>(0.06)</td>
<td>0.02</td>
</tr>
<tr>
<td>High Scores</td>
<td>0.01</td>
<td>(0.07)</td>
<td>0.00</td>
</tr>
<tr>
<td>TRIG: Present Feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>0.00</td>
<td>(0.07)</td>
<td>0.00</td>
</tr>
<tr>
<td>High Scores</td>
<td>0.00</td>
<td>(0.07)</td>
<td>0.00</td>
</tr>
<tr>
<td>Adjusted $R^2$</td>
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</tr>
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<td>S.E.E.</td>
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<td></td>
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<tr>
<td>N</td>
<td>358</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.31: Forced Entry Regression for Conceptual Knowledge and Skills (Full Model)

Note: The reference category for Years of Experience was Novice (0-3 Years)
Note: The reference category for TRIG: Past Behavior was Middle Scores (3.5-4.4)

Note: The reference category for TRIG: Present Feelings was Middle Scores (3.5-4.0)

**$p < .00$
Table 4.32: Forced Entry Regression for Conceptual Knowledge and Skills (Reduced Model)

Note: The reference category for Years of Counseling Experience was the combined categories of Novice, Skilled and Experienced Practitioners

**p < .00

Assessment Competencies Regression Analysis. The means for Assessment Competencies were calculated for each of the independent variables before the regression analysis was completed (see Table 4.28). A forced entry regression model which included all of the independent variables (gender, years as counselor - recoded, GCETS, TRIG: past behavior – recoded, and TRIG: present feeling - recoded) was completed. This model was statistically significant as well ($F$ (9, 348) = 48.09, $p < .00$). This model accounted for 54% of the total variance in Assessment Competencies scores (adjusted $R^2$ = .543) (see Table 4.33).
The correlation analysis completed as part of the regression determined three independent variables were statistically related to Assessment Competencies scores. The three variables were: gender, GCETS, and years practicing (Master Practitioner). A forced entry regression was used to explore the reduced model of Assessment Competencies and the independent variables. The model was statistically significant \( F(3, 354) = 143.58, p < .00 \). This model accounted for 55% of the total variance in Assessment Competencies scores (adjusted \( R^2 = .545 \)) (see Table 4.34).
<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>(SE)</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.22</td>
<td>(0.06)</td>
<td>0.13**</td>
</tr>
<tr>
<td>GCETS</td>
<td>0.57</td>
<td>(0.03)</td>
<td>0.72**</td>
</tr>
<tr>
<td>Years of Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Practitioner</td>
<td>-0.06</td>
<td>(0.08)</td>
<td>-0.04</td>
</tr>
<tr>
<td>Experienced Practitioner</td>
<td>-0.04</td>
<td>(0.08)</td>
<td>-0.03</td>
</tr>
<tr>
<td>Master Practitioner</td>
<td>-0.28</td>
<td>(0.09)</td>
<td>-0.15**</td>
</tr>
<tr>
<td>TRIG: Past Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>0.09</td>
<td>(0.06)</td>
<td>0.06</td>
</tr>
<tr>
<td>High Scores</td>
<td>0.00</td>
<td>(0.07)</td>
<td>0.00</td>
</tr>
<tr>
<td>TRIG: Present Feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>-0.03</td>
<td>(0.07)</td>
<td>-0.02</td>
</tr>
<tr>
<td>High Scores</td>
<td>0.05</td>
<td>(0.06)</td>
<td>0.04</td>
</tr>
<tr>
<td>Adjusted $R^2$</td>
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</tr>
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<td>S.E.E.</td>
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<td></td>
</tr>
<tr>
<td>$N$</td>
<td>358</td>
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<td></td>
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</tbody>
</table>

Table 4.33: Forced Entry Regression for Assessment Skills (Full Model)

Note: The reference category for Years of Experience was Novice (0-3 Years)

Note: The reference category for TRIG: Past Behavior was Middle Scores (3.5-4.4)

Note: The reference category for TRIG: Present Feelings was Middle Scores (3.5-4.0)

**$p < .00$
Table 4.34: Forced Entry Regression for Assessment Skills (Reduced Model)

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>(SE)</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.22</td>
<td>(0.06)</td>
<td>0.13**</td>
</tr>
<tr>
<td>GCETS</td>
<td>0.57</td>
<td>(0.03)</td>
<td>0.72**</td>
</tr>
<tr>
<td>Years of Counseling Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master Practitioner</td>
<td>-0.25</td>
<td>(0.07)</td>
<td>-0.14**</td>
</tr>
<tr>
<td>Adjusted $R^2$</td>
<td>0.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S.E.E.</td>
<td>0.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>358</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The reference category for Years of Counseling Experience was the combined categories of Novice, Skilled and Experienced Practitioners

**p < .00

Treatment Competencies Regression Analysis. The means for the Treatment Competencies were calculated for each of the independent variables before the regression analysis was completed (see Table 4.28). A forced entry regression model which included all of the independent variables (gender, years as counselor - recoded, GCETS, TRIG: past behavior – recoded, and TRIG: present feeling - recoded) was completed. This model was statistically significant ($F (9, 348) = 97.20, p < .00$). This model accounted for 71% of the total variance in Treatment Competencies scores (adjusted $R^2 = .708$) (see Table 4.35).
The correlation analysis completed as part of the regression determined three independent variables were statistically related to Treatment Competencies scores. The three variables were: gender, GCETS, and years practicing (Master Practitioner). A reduced model regression was completed to explore the relationship between Treatment Competencies and the independent variables. The model was statistically significant ($F(3, 354) = 285.91, p < .00$). This model accounted for 71% of the total variance in Treatment Competencies scores (adjusted $R^2 = .705$) (see Table 4.36).
<table>
<thead>
<tr>
<th>Variable</th>
<th>Full Model</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$B$</td>
<td>(SE)</td>
<td>$\beta$</td>
</tr>
<tr>
<td>Gender</td>
<td>0.11</td>
<td>(0.05)</td>
<td>0.07*</td>
</tr>
<tr>
<td>GCETS</td>
<td>0.65</td>
<td>(0.02)</td>
<td>0.84**</td>
</tr>
<tr>
<td>Years of Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Practitioner</td>
<td>-0.10</td>
<td>(0.06)</td>
<td>-0.07</td>
</tr>
<tr>
<td>Experienced Practitioner</td>
<td>-0.05</td>
<td>(0.06)</td>
<td>-0.03</td>
</tr>
<tr>
<td>Master Practitioner</td>
<td>-0.14</td>
<td>(0.07)</td>
<td>-0.08*</td>
</tr>
<tr>
<td>TRIG: Past Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>0.06</td>
<td>(0.05)</td>
<td>0.04</td>
</tr>
<tr>
<td>High Scores</td>
<td>0.08</td>
<td>(0.05)</td>
<td>0.05</td>
</tr>
<tr>
<td>TRIG: Present Feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>-0.06</td>
<td>(0.05)</td>
<td>-0.04</td>
</tr>
<tr>
<td>High Scores</td>
<td>-0.09</td>
<td>(0.05)</td>
<td>-0.06</td>
</tr>
<tr>
<td>Adjusted R2</td>
<td>0.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S.E.E.</td>
<td>0.38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>358</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.35: Forced Entry Regression for Treatment Skills (Full Model)

Note: The reference category for Years of Experience was Novice (0-3 Years)
Note: The reference category for TRIG: Past Behavior was Middle Scores (3.5-4.4)
Note: The reference category for TRIG: Present Feelings was Middle Scores (3.5-4.0)

**p < .00, *p < .05
<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>(SE)</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.11</td>
<td>(0.05)</td>
<td>0.07*</td>
</tr>
<tr>
<td>Grief Counseling Experience and Training</td>
<td>0.65</td>
<td>(0.02)</td>
<td>0.84**</td>
</tr>
<tr>
<td>Years of Counseling Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master Practitioner</td>
<td>-0.08</td>
<td>(0.05)</td>
<td>-0.04</td>
</tr>
<tr>
<td>Adjusted R2</td>
<td>0.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S.E.E.</td>
<td>0.38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>358</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.36: Forced Entry Regression for Treatment Skills (Reduced Model)

Note: The reference category for Years of Counseling Experience was the combined categories of Novice, Skilled and Experienced Practitioners

**$p < .00$**

*p $< .05$

*Professional Competencies Regression Analysis.* Before the regression analysis was completed, the means for the Professional Competencies were calculated for each of the independent variables (see Table 4.28). A forced entry regression model which included all of the independent variables (gender, years as counselor - recoded, GCETS, TRIG: past behavior – recoded, and TRIG: present feeling - recoded) was completed. This model was statistically significant ($F(9, 348) = 59.03, p < .00$). This model
accounted for 59% of the total variance in Professional Competencies scores (adjusted $R^2 = .594$) (see Table 4.37).

The correlation analysis completed as part of the regression determined only one independent variable was statistically related to Professional Competencies scores, GCETS. A forced entry regression was used to explore the relationship between Professional Competencies and GCETS. The model was statistically significant ($F(1, 366) = 546.86, p < .00$). This model accounted for 60% of the total variance in Professional Competencies scores (adjusted $R^2 = .598$) (see Table 4.38).
<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>(SE)</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.12</td>
<td>0.07</td>
<td>0.06</td>
</tr>
<tr>
<td>GCETS</td>
<td>0.71</td>
<td>0.03</td>
<td>0.78**</td>
</tr>
<tr>
<td>Years of Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Practitioner</td>
<td>-0.15</td>
<td>0.08</td>
<td>-0.08</td>
</tr>
<tr>
<td>Experienced Practitioner</td>
<td>-0.06</td>
<td>0.09</td>
<td>-0.03</td>
</tr>
<tr>
<td>Master Practitioner</td>
<td>-0.14</td>
<td>0.10</td>
<td>-0.07</td>
</tr>
<tr>
<td>TRIG: Past Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>0.01</td>
<td>0.07</td>
<td>0.01</td>
</tr>
<tr>
<td>High Scores</td>
<td>0.11</td>
<td>0.07</td>
<td>0.06</td>
</tr>
<tr>
<td>TRIG: Present Feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Scores</td>
<td>-0.02</td>
<td>0.07</td>
<td>-0.01</td>
</tr>
<tr>
<td>High Scores</td>
<td>0.00</td>
<td>0.07</td>
<td>0.00</td>
</tr>
<tr>
<td>Adjusted R2</td>
<td>0.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S.E.E.</td>
<td>0.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>358</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.37: Forced Entry Regression for Professional Competencies (Full Model)

Note: The reference category for Years of Experience was Novice (0-3 Years)

Note: The reference category for TRIG: Past Behavior was Middle Scores (3.5-4.4)
Note: The reference category for TRIG: Present Feelings was Middle Scores (3.5-4.0)
**p < .00, *p < .05
4.3.6 Further Exploration of Training Variable

The regression analyses indicated the variable of Grief Counseling Experience and Training as being a statistically significant factor in all five scales of grief counseling competencies (Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills). Additional data had been gathered regarding training, specifically the courses completed which focused on death/grief, courses completed which had content on death/grief significantly included, and professional development hours completed on death/grief. The researcher compared the groups (levels) within the three training variables (specific courses, courses with significant focus on death/grief, and professional development hours) by their mean scores on the dependent variables of grief counseling competencies. The groups were determined by the distribution of the data for each variable. The three levels for the
variable of courses specifically about grief and/or death were “no courses,” “one course,” and “two or more courses.” The three levels for the variable of courses which infused death and/or grief content in a significant manner were “no courses,” “one or two courses,” and “three or more courses.” The levels for the variable of professional development hours completed were “no hours earned,” “1-10 hours earned,” “11-30 hours earned,” and “31 or more hours earned” (see Table 4.12 for frequencies). The following are the results of One-Way between Subjects Analysis of Variance (ANOVA) for each dependent variable, comparing the groups which reported different levels of training in courses specifically on death and/or grief, courses with grief/death content significantly infused into course, and professional development hours.

**Personal Competencies**

*Courses Completed on Death and/or Grief.* To compare the three levels of courses completed on death and/or grief (no courses, one course, and two or more courses), a One-Way ANOVA with a post-hoc Tukey test was completed. Because the Levene’s test indicated that the population variance was not equal for the three levels, a second ANOVA with a Brown-Forsythe and a post hoc test that does not assume homogeneity of variances (Dunnett’s T3) was conducted. The ANOVA indicated between group differences, $F(2, 365) = 4.67, p < .05$. The Dunnett’s T3 indicated those participants who completed two or more courses on death and/or grief ($M = 4.55, SD = .39$) scored significantly higher on Personal Competencies than those who completed one ($M = 4.37, SD = .51, p = .03$) or no courses ($M = 4.38, SD = .39, p = .01$). There was no statistically significant difference found between those counselors who completed one course and no courses (see Table 4.39).
Table 4.39: Personal Competencies Score Means and Standard Deviations for Training (Courses on Death and/or Grief)

<table>
<thead>
<tr>
<th>Courses on Death and/or Grief</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Courses (190)</td>
<td>4.38</td>
<td>0.39</td>
</tr>
<tr>
<td>One Course (106)</td>
<td>4.37</td>
<td>0.51</td>
</tr>
<tr>
<td>Two or more Courses (72)</td>
<td>4.55</td>
<td>0.39</td>
</tr>
</tbody>
</table>

Courses with Death/Grief Infused in a Significant Manner. To compare the mean scores on Personal Competencies between the three levels of courses completed which infused content on death and/or grief in a significant manner (no courses, one or two courses, and three or more courses), a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F(2, 366) = 6.38, p < .01$. The post-hoc Tukey indicated those participants who completed three or more courses which had content infused on death and/or grief in a significant way ($M = 4.47, SD = .43$) scored significantly higher on Personal Competencies than those who completed one or two courses ($M = 4.45, SD = .43, p = .00$) or no courses ($M = 4.28, SD = .42, p = .01$). There was no statistically significant difference found between those counselors who completed one or two courses and no courses (see Table 4.40).
Courses with Significant Content of Death and/or Grief | Mean | SD
--- | --- | ---
No Courses (93) | 4.28 | 0.42
One or Two Courses (174) | 4.45 | 0.43
Three or more Courses (102) | 4.47 | 0.43

Table 4.40: Personal Competencies Score Means and Standard Deviations for Training (Courses with Significant Content of Death and/or Grief)

Professional Development Hours. To compare the mean scores on Personal Competencies between the four levels of professional development hours completed on death and/or grief, a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F (3, 365) = 4.64, p < .01$. The post-hoc Tukey indicated those participants who completed more than thirty professional development hours on death and/or grief ($M = 4.60, SD = .40$) scored significantly higher on Personal Competencies than those who completed zero professional development hours ($M = 4.34, SD = .40, p = .01$) or 1-10 professional development hours ($M = 4.36, SD = .47, p = .02$). There was no statistically significant difference found between those counselors who completed more than thirty hours and those who completed 11-30 hours of professional development (see Table 4.41).
Table 4.41: Personal Competencies Score Means and Standard Deviations for Training (Professional Development Hours on Death and/or Grief)

<table>
<thead>
<tr>
<th>Professional Development Hours on Grief and/or Death</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Hours (109)</td>
<td>4.34</td>
<td>0.40</td>
</tr>
<tr>
<td>One - Ten Hours (125)</td>
<td>4.36</td>
<td>0.47</td>
</tr>
<tr>
<td>Eleven - Thirty Hours (100)</td>
<td>4.48</td>
<td>0.42</td>
</tr>
<tr>
<td>More than Thirty Hours (35)</td>
<td>4.60</td>
<td>0.40</td>
</tr>
</tbody>
</table>

*Conceptual Skills and Knowledge*

*Courses Completed on Death and/or Grief.* To compare the mean scores on Conceptual Skills and Knowledge between the three levels of courses completed on death and/or grief (no courses, one course, and two or more courses), a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F(2, 365) = 21.81, p < .01$. The post-hoc Tukey indicated those participants who completed two or more courses on death and/or grief ($M = 3.45, SD = .83$) scored significantly higher on Conceptual Skills and Knowledge than those who completed no courses ($M = 2.79, SD = .90, p = .00$). Those who completed one course ($M = 3.32, SD = .78, p = .00$) scored significantly higher than those who completed no courses. There was no statistically significant difference found between those counselors who completed one course and two or more courses (see Table 4.42).
<table>
<thead>
<tr>
<th>Courses on Death and/or Grief</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Courses (190)</td>
<td>2.79</td>
<td>0.90</td>
</tr>
<tr>
<td>One Course (106)</td>
<td>3.32</td>
<td>0.78</td>
</tr>
<tr>
<td>Two or more Courses (72)</td>
<td>3.45</td>
<td>0.83</td>
</tr>
</tbody>
</table>

Table 4.42: Conceptual Skills and Knowledge Mean Scores and Standard Deviations for Training (Courses on Death and/or Grief)

Courses with Death/Grief Infused in a Significant Manner. To compare the mean scores on Conceptual Skills and Knowledge between the three levels of courses completed which infused content on death and/or grief in a significant manner (no courses, one or two courses, and three or more courses), a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F(2, 366) = 30.63, p < .01$. The post-hoc Tukey indicated those participants who completed three or more courses which had content infused on death and/or grief in a significant way ($M = 3.51, SD = .81$) scored significantly higher on Conceptual Skills and Knowledge than those who completed one or two courses ($M = 3.08, SD = .83, p = .00$) or no courses ($M = 2.57, SD = .89, p = .00$). There was also a statistically significant difference found between those counselors who completed one or two courses ($M = 3.08, SD = .83$) and no courses ($M = 2.57, SD = .89, p = .00$) (see Table 4.43).
<table>
<thead>
<tr>
<th>Courses with Significant Content of Death and/or Grief</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Courses (93)</td>
<td>2.57</td>
<td>0.89</td>
</tr>
<tr>
<td>One or Two Courses (174)</td>
<td>3.08</td>
<td>0.83</td>
</tr>
<tr>
<td>Three or more Courses (102)</td>
<td>3.51</td>
<td>0.81</td>
</tr>
</tbody>
</table>

Table 4.43: Conceptual Skills and Knowledge Mean Scores and Standard Deviations for Training (Courses with Significant Content of Death and/or Grief)

*Professional Development Hours.* To compare the mean scores on Conceptual Skills and Knowledge between the four levels of professional development hours completed on death and/or grief, a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F(3, 365) = 28.94, p < .01$. The post-hoc Tukey indicated those participants who completed more than thirty professional development hours on death and/or grief ($M = 3.71, SD = .86$) scored significantly higher on Conceptual Skills and Knowledge than those who completed zero professional development hours ($M = 2.55, SD = .84, p = .00$) or 1-10 professional development hours ($M = 3.05, SD = .77, p = .00$). There was also a statistically significant difference between the scores of those who completed zero professional development hours and both of the following groups, those who completed 1-10 ($p = .00$) and 11-30 professional development hours ($M = 3.45, SD = .83, p = .00$). There
was a statistically significant difference between the scores of those who completed 1-10 professional development hours and 11-30 professional development hours ($p = .00$). There was no statistically significant difference found between those counselors who completed 11-30 and more than thirty professional development hours (see Table 4.44).

<table>
<thead>
<tr>
<th>Professional Development Hours on Grief and/or Death</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Hours (109)</td>
<td>2.55</td>
<td>0.84</td>
</tr>
<tr>
<td>One - Ten Hours (125)</td>
<td>3.05</td>
<td>0.77</td>
</tr>
<tr>
<td>Eleven - Thirty Hours (100)</td>
<td>3.45</td>
<td>0.83</td>
</tr>
<tr>
<td>More than Thirty Hours (35)</td>
<td>3.71</td>
<td>0.86</td>
</tr>
</tbody>
</table>

Table 4.44: Conceptual Skills and Knowledge Mean Scores and Standard Deviations for Training (Professional Development Hours on Death and/or Grief)

Assessment Skills

Courses Completed on Death and/or Grief. To compare the mean scores on Assessment Skills between the three levels of courses completed on death and/or grief (no courses, one course, and two or more courses), a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences ($F(2, 365) = 12.55, p < .01$). The post-hoc Tukey indicated those participants who completed two or more courses on death and/or grief ($M = 3.74, SD = .74$) scored
significantly higher on Assessment Skills than those who completed no courses ($M = 3.38, SD = .72, p = .00$) or one course ($M = 3.76, SD = .65, p = .00$). There was no statistically significant difference found between those counselors who completed one course and two or more courses (see Table 4.45).

<table>
<thead>
<tr>
<th>Courses on Death and/or Grief</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Courses (190)</td>
<td>3.38</td>
<td>0.72</td>
</tr>
<tr>
<td>One Course (106)</td>
<td>3.76</td>
<td>0.65</td>
</tr>
<tr>
<td>Two or more Courses (72)</td>
<td>3.74</td>
<td>0.74</td>
</tr>
</tbody>
</table>

Table 4.45: Assessment Skills Mean Scores and Standard Deviations for Training (Courses on Death and/or Grief)

Courses with Death/Grief Infused in a Significant Manner. To compare the mean scores on Assessment Skills between the three levels of courses completed which infused content on death and/or grief in a significant manner (no courses, one or two courses, and three or more courses), a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F(2, 366) = 24.27, p < .01$. The post-hoc Tukey indicated those participants who completed three or more courses which had content infused on death and/or grief in a significant way ($M = 3.87, SD = .68$) scored significantly higher on Assessment Skills than those who completed one or two courses ($M = 3.58, SD = .67, p = .00$) or no courses ($M = 3.19, SD = .72, p = .00$). There was also a statistically significant difference found between
those counselors who completed one or two courses and no courses ($p = .00$) (see Table 4.46).

<table>
<thead>
<tr>
<th>Courses with Significant Content of Death and/or Grief</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Courses (93)</td>
<td>3.19</td>
<td>0.72</td>
</tr>
<tr>
<td>One or Two Courses (174)</td>
<td>3.58</td>
<td>0.67</td>
</tr>
<tr>
<td>Three or more Courses (102)</td>
<td>3.87</td>
<td>0.68</td>
</tr>
</tbody>
</table>

Table 4.46: Assessment Skills Mean Scores and Standard Deviations for Training (Courses with Significant Content of Death and/or Grief)

*Professional Development Hours.* To compare the mean scores on Assessment Skills between the four levels of professional development hours completed on death and/or grief, a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F (3, 365) = 9.91, p < .01$. The post-hoc Tukey indicated those participants who completed zero professional development hours ($M = 3.30, SD = .69$) scored significantly lower on Assessment Skills than each of the other three categories including: 1-10 hours ($M = 3.55, SD = .66, p = .04$), 11-30 hours ($M = 3.75, SD = .76, p = .00$), and more than thirty hours ($M = 3.88, SD = .72, p = .00$) of professional development. There was no statistically significant difference found
amongst those counselors who completed 1-10 hours, 11-30 hours, and more than thirty professional development hours (see Table 4.47).

<table>
<thead>
<tr>
<th>Professional Development Hours on Grief and/or Death</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Hours (109)</td>
<td>3.30</td>
<td>0.69</td>
</tr>
<tr>
<td>One - Ten Hours (125)</td>
<td>3.55</td>
<td>0.66</td>
</tr>
<tr>
<td>Eleven - Thirty Hours (100)</td>
<td>3.75</td>
<td>0.76</td>
</tr>
<tr>
<td>More than Thirty Hours (35)</td>
<td>3.88</td>
<td>0.72</td>
</tr>
</tbody>
</table>

Table 4.47: Assessment Skills Mean Scores and Standard Deviations for Training (Professional Development Hours on Death and/or Grief)

**Treatment Skills**

*Courses Completed on Death and/or Grief.* To compare the mean scores on Treatment Skills between the three levels of courses completed on death and/or grief (no courses, one course, and two or more courses), a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F(2, 365) = 13.07, p < .01$. The post-hoc Tukey indicated those participants who completed two or more courses on death and/or grief ($M = 3.71, SD = .72$) scored significantly
higher on Treatment Skills than those who completed no courses \((M = 3.29, SD = .69, p = .00)\). The analysis also indicated that those who completed one course \((M = 3.61, SD = .65)\) scored significantly higher than those who completed zero courses \((M = 3.29, SD = .69, p = .00)\). There was no statistically significant difference found between those counselors who completed one course and two or more courses (see Table 4.48).

<table>
<thead>
<tr>
<th>Courses on Death and/or Grief</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Courses (190)</td>
<td>3.29</td>
<td>0.69</td>
</tr>
<tr>
<td>One Course (106)</td>
<td>3.61</td>
<td>0.65</td>
</tr>
<tr>
<td>Two or more Courses (72)</td>
<td>3.71</td>
<td>0.72</td>
</tr>
</tbody>
</table>

Table 4.48: Treatment Skills Mean Scores and Standard Deviations for Training (Courses on Death and/or Grief)

Courses with Death/Grief Infused in a Significant Manner. To compare the mean scores on Treatment Skills between the three levels of courses completed which infused content on death and/or grief in a significant manner (no courses, one or two courses, and three or more courses), a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences \(F(2, 366) = 22.17, p < .01\). The post-hoc Tukey indicated those participants who completed three or more courses which had content infused on death and/or grief in a significant way \((M = 3.80, SD = .64)\) scored significantly higher on Treatment Skills than those who completed one or two courses \((M = 3.44, SD = .67, p = .00)\) or no courses \((M = 3.16, SD = .70, p =\)
.00). There was also a statistically significant difference found between those counselors who completed one or two courses and no courses ($p = .00$) (see Table 4.49).

<table>
<thead>
<tr>
<th>Courses with Significant Content of Death and/or Grief</th>
<th>Mean</th>
<th>$SD$</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Courses (93)</td>
<td>3.16</td>
<td>0.70</td>
</tr>
<tr>
<td>One or Two Courses (174)</td>
<td>3.44</td>
<td>0.67</td>
</tr>
<tr>
<td>Three or more Courses (102)</td>
<td>3.80</td>
<td>0.64</td>
</tr>
</tbody>
</table>

Table 4.49: Treatment Skills Mean Scores and Standard Deviations for Training (Courses with Significant Content of Death and/or Grief)

*Professional Development Hours.* To compare the mean scores on Treatment Skills between the four levels of professional development hours completed on death and/or grief, a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F(3, 365) = 23.26, p < .01$. The post-hoc Tukey indicated those participants who completed zero professional development hours ($M = 3.12, SD = .62$) scored significantly lower on Treatment Skills than each of the other three categories including: 1-10 hours ($M = 3.44, SD = .62, p = .00$), 11-30 hours ($M = 3.70, SD = .73, p = .00$), and more than thirty hours ($M = 4.04, SD = .64, p = .00$) of professional development. There was a statistically significant difference found between those counselors who completed 1-10 hours and 11-30 hours ($p = .02$). There was also a statistically significant difference found between those counselors who
completed 1-10 hours and more than thirty hours ($p = .00$). Finally, there was a statistically significant difference found between those counselors who completed 11-30 hours and more than thirty professional development hours ($p = .04$) (see Table 4.50).

<table>
<thead>
<tr>
<th>Professional Development Hours on Grief and/or Death</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Hours (109)</td>
<td>3.12</td>
<td>0.62</td>
</tr>
<tr>
<td>One - Ten Hours (125)</td>
<td>3.44</td>
<td>0.62</td>
</tr>
<tr>
<td>Eleven - Thirty Hours (100)</td>
<td>3.70</td>
<td>0.73</td>
</tr>
<tr>
<td>More than Thirty Hours (35)</td>
<td>4.04</td>
<td>0.64</td>
</tr>
</tbody>
</table>

Table 4.50: Treatment Skills Mean Scores and Standard Deviations for Training (Professional Development Hours on Death and/or Grief)

**Professional Skills**

*Courses Completed on Death and/or Grief.* To compare the mean scores on Professional Skills between the three levels of courses completed on death and/or grief (no courses, one course, and two or more courses), a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F(2, 365) = 17.12, p < .01$. The post-hoc Tukey indicated those participants who zero courses on death and/or grief ($M = 2.95, SD = .78$) scored significantly lower on Professional Skills than those who completed one course ($M = 3.38, SD = .75, p = .00$) and those who completed two or more courses ($M = 3.50, SD = .87, p = .00$). There was
no statistically significant difference found between those counselors who completed one course and those who completed two or more courses (see Table 4.51).

<table>
<thead>
<tr>
<th>Courses on Death and/or Grief</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Courses (190)</td>
<td>2.95</td>
<td>0.78</td>
</tr>
<tr>
<td>One Course (106)</td>
<td>3.38</td>
<td>0.75</td>
</tr>
<tr>
<td>Two or more Courses (72)</td>
<td>3.50</td>
<td>0.87</td>
</tr>
</tbody>
</table>

Table 4.51: Professional Skills Mean Scores and Standard Deviations for Training (Courses on Death and/or Grief)

Courses with Death/Grief Infused in a Significant Manner. To compare the mean scores on Professional Skills between the three levels of courses completed which infused content on death and/or grief in a significant manner (no courses, one or two courses, and three or more courses), a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F(2, 366) = 28.89, p < .01$. The post-hoc Tukey indicated those participants who completed three or more courses which had content infused on death and/or grief in a significant way ($M = 3.63, SD = .74$) scored significantly higher on Professional Skills than those who completed one or two courses ($M = 3.14, SD = .78, p = .00$) or no courses ($M = 2.80, SD = .78, p = .00$). There was also a statistically significant difference found between those counselors who completed one or two courses and no courses ($p = .00$) (see Table
Courses with Significant Content of Death and/or Grief  Mean  SD

<table>
<thead>
<tr>
<th>Courses with Significant Content of Death and/or Grief</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Courses (93)</td>
<td>2.80</td>
<td>0.78</td>
</tr>
<tr>
<td>One or Two Courses (174)</td>
<td>3.14</td>
<td>0.78</td>
</tr>
<tr>
<td>Three or more Courses (102)</td>
<td>3.63</td>
<td>0.74</td>
</tr>
</tbody>
</table>

Table 4.52: Professional Skills Mean Scores and Standard Deviations for Training (Courses with Significant Content of Death and/or Grief)

Professional Development Hours. To compare the mean scores on Professional Skills between the four levels of professional development hours completed on death and/or grief, a One-Way ANOVA with a post-hoc Tukey test was completed. The ANOVA indicated between group differences $F(3, 365) = 28.38, p < .01$. The post-hoc Tukey indicated those participants who completed zero professional development hours ($M = 2.74, SD = .67$) scored significantly lower on Professional Skills than each of the other three categories including: 1-10 hours ($M = 3.14, SD = .69, p = .00$), 11-30 hours ($M = 3.48, SD = .85, p = .00$), and more than thirty hours ($M = 3.88, SD = .83, p = .00$) of professional development. There was a statistically significant difference found between those counselors who completed 1-10 hours and 11-30 hours ($p = .00$). There
was also a statistically significant difference found between those counselors who completed 1-10 hours and more than thirty hours ($p = .00$). There was no statistically significant difference found between those counselors who completed 11-30 hours and more than thirty professional development hours (see Table 4.53).

<table>
<thead>
<tr>
<th>Professional Development Hours on Grief and/or Death</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Hours (109)</td>
<td>2.74</td>
<td>0.67</td>
</tr>
<tr>
<td>One - Ten Hours (125)</td>
<td>3.14</td>
<td>0.69</td>
</tr>
<tr>
<td>Eleven - Thirty Hours (100)</td>
<td>3.48</td>
<td>0.85</td>
</tr>
<tr>
<td>More than Thirty Hours (35)</td>
<td>3.88</td>
<td>0.83</td>
</tr>
</tbody>
</table>

Table 4.53: Professional Skills Mean Scores and Standard Deviations for Training (Professional Development Hours on Death and/or Grief)

4.4 Summary

This study explored the grief counseling competencies, experience and training with grief (GCETS), and personal experiences with grief (TRIG) of licensed counselors using descriptive and multiple regression analysis. The majority of the sample was female (77%), white (92.7%) and Christian (73.8%). The average age was 48 years, with a range of 25 to 78 years. On average, the respondents had worked 11 years as licensed counselors, with a range from 6 months to 39 years. The setting in which the majority of counselors had the most experience was community agencies (39%). This was also the setting were most counselors currently worked (28.5%). Almost the entire sample
reported receiving at least a master’s degree (99.2%) with most reporting counseling as their major field of study (70.6%). The sample had fairly equal representation of LPCCs (56.1%) and LPCs (43.9%), with a majority of the sample reporting they held supervisory credentials (61.8%). Of those participants reporting supervisory credentials (n = 228), 140 reported being an LPC and 88 reported being an LPCC. The most frequently reported credential was the National Certified Counselor (NCC), however only 15.2% of participants held this credential. The majority of the sample, 54.8%, reported they had not taken a course on grief/death education; however half (50.1%) had taken one or two courses in which grief/death content was infused in a significant way. The reported hours of professional development by the respondents demonstrated a distribution from no to many hours. Many respondents reported zero professional development hours on grief, death education, or both (30.6%). In contrast, 35.1% reported completing 1-10 hours, 28.1% reported completing 11-30 professional development hours and 6.2% reported completing more than 30 professional development hours.

Respondents provided data about their experience and training on grief by completing the GCETS in addition to questions about courses and professional development hours completed. The mean score on the GCETS was 2.7 and most counselors reported below the scale midpoint (3). The TRIG was used to measure respondents personal experiences with grief. Participants had mean scores of 3.8 and 3.7, respectively, for the TRIG past behaviors and present feelings scales. These scores are greater than the midpoint for the scale (3) and suggest less intense responses to loss both at the time of the death and presently.
The sample reported at or above the midpoint value (3) for each of the scales of the DCS. Personal Competencies was the highest mean score (4.41), and Conceptual Skills and Knowledge was the lowest mean score (3.07). Professional Competencies mean score was (3.19). Assessment and Treatment Competencies were fairly close in mean values, 3.56 and 3.47, respectively.

Five regression analyses were completed to determine which independent variables that contributed to the variance in each of the scales of the DCS in a statistically significant way. Experience and training with grief (GCETS) contributed significantly to the variance in scores for each of the scales. Gender related to Personal, Assessment, and Treatment competencies scores. The variable of years of experience as a counselor (Master Practitioner) was related to Conceptual Skills and Knowledge, and Assessment Skills. Interestingly, those who were Master Practitioners (more than 20 years practicing) had lower scores on these competencies than all the other categories of practitioners (Novice, Skilled, and Experienced Practitioners). TRIG: past behaviors (personal experiences with grief) contributed to the amount of variance in Personal Competencies scores, however when analyzed as part of the reduced model, this variable was no longer statistically significant.

The reduced regression model for the Personal Competencies scale accounted for 17% of the total variance in respondents’ scores. The independent variables included in the reduced model were gender and GCETS. Women scored significantly higher than men on this scale. For each of the competency scales, the GCETS had the largest beta value in comparison with the other independent variables.
The reduced model for Conceptual Skills and Knowledge accounted for 69% of the total variance in the respondents’ scores. This model contained the variables of years experience (Master Practitioner) and GCETS. Master Practitioners scored significantly lower on this scale than all other categories of practitioners.

The reduced model for Assessment Competencies accounted for 55% of the total variance in the respondents’ scores. This model contained the variables of gender, years experience (Master Practitioner) and GCETS. Women scored significantly higher on this scale than men. As stated previously, Master Practitioners scored significantly lower on this scale than all other categories of practitioners.

The reduced model for Treatment Competencies accounted for 71% of the total variance in the respondents’ scores. This model contained the variables of gender, years experience (Master Practitioner) and GCETS. Women scored significantly higher on this scale than men. As stated previously, Master Practitioners scored significantly lower on this scale than all other categories of practitioners.

The reduced model for Professional Competencies accounted for 60% of the total variance in the respondents’ scores. This model contained the variable of GCETS. Unlike the previous dependent variables, there were no statistically significant variables associated with Professional Competencies other than the respondents’ experience and training as measured by the GCETS.

Further exploration on the construct of training and experience was completed by using ANOVAs to compare differences among those who reported no, some, and many courses and professional development hours completed on death/grief. The ANOVAs indicated that a statistically significant difference in scores existed when comparing the
groups who completed zero and at least one course which had been infused with
grief/death content. This result was similar for professional development hours
completed, suggesting a statistically significant difference in competencies for those who
complete 1-10 hours of professional development hours in comparison to those who have
completed zero hours. These differences existed for all of the competency scales except
for Personal Competencies.

Similar results occurred when the researcher explored the differences in groups
related to courses completed which focused specifically on death and/or grief. A
statistically significant difference existed between those who had completed no course
and those who had completed one course on their scores for the Conceptual Skills and
Knowledge, Treatment, and Professional Competencies. When the Personal and
Assessment Competency scales were explored, the ANOVAs indicated a statistically
significant difference existed between those who had completed one course and those
who had completed two or more courses. All of the training modes (course specifically
on grief, course infused with grief content, and professional development hours) seem to
have a positive effect on the grief counseling competencies, increasing the mean scores of
competencies with additional courses and/or professional development hours.
CHAPTER 5

DISCUSSION

5.1 Purpose of the Study

The purpose of this study was to provide information about the grief counseling competencies and the training and experience of licensed counselors on grief and/or death education. This data previously had not been reported for practicing mental health counselors. The study used a simple random sample of practicing counselors in the state of Ohio. This study investigated the three areas of competencies including awareness, knowledge, and skills by administering the only assessment developed specifically for grief counseling competencies, Charkow’s Death Counseling Survey (DCS) (Charkow, 2002). The study had the following goals: describe personal and professional demographic variables of licensed counselors including age, gender, professional experience (years in practice), professional training and experience with grief, personal experience with grief, and practice setting; report licensed counselors’ grief counseling competencies as indicated by the five scales of the DCS (Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills); and explore possible relationships between grief counseling competencies and the counselors’ personal and professional demographic variables.
The target population for this study was licensed professional counselors. The accessible population was comprised of those licensed professional counselors practicing in the state of Ohio. The total number of licensed professional counselors in May 2007 was 6,919, with 3,358 being Licensed Professional Counselors (LPCs) and 3,561 being Licensed Professional Clinical Counselors (LPCCs) (Customer Support Help Desk Staff, personal communication, May 22, 2007). The sample of 1,000 participants was randomly selected from the population frame and 374 respondents returned completed surveys.

5.2 Results and Significant Findings

The following is a discussion of the research study results and a summary of significant findings. Limitations of the research study and suggestions for future research will also be discussed.

5.2.1 Research Question One

What are the demographic characteristics of the licensed counselors including the following: age, gender, years of practice since obtaining LPC, practice setting in which counselor has had most years of experience, race/ethnicity, highest degree earned, field of study, licensure, supervisor status, current work setting, certifications, religion, number of professional development hours on grief, and number of grief courses completed?

The sample was comprised of the 374 returned surveys, of which 369 had usable data. The average age of the participants was 48 years old, with a range of 25 to 78 years. The majority of the sample reported female gender (77%) and 0.5% of the sample (two respondents) identified as transgender. The majority of the participants reported Caucasian/white as their race (92.7%) with African-American/black at 3.8% as the next most frequent response. The majority of the participants indicated a Christian
religious/spiritual background (73.8%) with 16.6% reporting “Other,” including the following religious/spiritual backgrounds: Mormon, a combination of spiritual practices, and general spirituality. The researcher attempted to obtain demographic statistics (specifically age, gender, and race/ethnicity) of practicing counselors in the state of Ohio from the Counselor, Social Worker, and Marriage and Family Therapist Board. However, these demographic statistics are not made available to the public, per the Board representative (Counselor, Social Worker, and Marriage and Family Therapist Board, personal communication, January 5, 2008). As the demographic statistics for the population were unavailable, the researcher was unable to make comparisons between the sample and population.

The average number of years practicing as a licensed counselor was 11 years, with a range of six months to 39 years. Almost all respondents indicated having at least a Master’s degree (99.2%). Most reported their major field of study to be counseling (70.6%). A large percentage (39%) indicated community agencies as the settings in which they had the most work experience, with private practice (11.1%) and multiple settings (10.6%) as the next most frequent responses. A limited percentage (6.5%) reported having most of their counseling experience in a hospital or hospice setting. Many reported their current work setting as a community mental health agency (28.5%) with again private practice (16.6%) and multiple settings (16.5%) being the next most frequent responses in addition to other settings, such as nursing homes, church/religious settings, or drug and alcohol programs (16.5%). The sample included close to equivalent representation of both LPCs (43.9%) and LPCCs (56.1%). The majority of the sample (61.8%) reported having a supervisory credential. A small percentage reported to be a
National Certified Counselor (NCC) (15.2%) and a smaller percentage indicated they were a Licensed Independent Chemical Dependency Counselor (LICDC) (11.9%). Only three respondents indicated they were a Certified Grief Therapist or a Certified Grief Counselor (0.8%).

The data collected on training on grief and/or death education indicated limited preparation for working with clients on issues of grief and loss. Over half of the sample (54.8%) reported they had taken no (zero) courses specifically on grief/death in their graduate training, with 30.8% reporting they had taken one or two courses on grief/death. These combined percentages (85.6%) are almost equal to those obtained by Charkow (2002) where she found the majority of her sample (86.4%) had completed no or one course on the subject of grief and/or death education. The current study’s percentage of participants who reported completing no courses is almost identical to that found by Allen and Miller (1988) who reported 54% of those rehabilitation counselors surveyed indicated they completed no courses on grief and/or death education.

The percentage of respondents who indicated completing at least one course (45.2%) is surprisingly high, especially since grief/death courses are relegated to elective status in counselor education programs as the content is not part of the required eight common core areas as defined by CACREP (CACREP, n.d.). Another factor which contributes to this being an unexpectedly high statistic is the limited number of counselor education programs which offered grief/death education courses, as reported by Freeman and Ward (1998). This high percentage suggests almost half the sample had a previous interest in the topic of grief and/or death education and perhaps influenced their motivation to participate in this research study. Those participants who sought out
training in their counselor education programs on grief may have also sought out informal training (i.e. personal reading and discussion with peers in the profession) and may have rated themselves higher on self-perceived grief counseling competencies than those persons who had not elected to take a course on grief because of their interest in the topic and training.

Half of the respondents (50.1%) indicated they completed one or two courses that included grief/death content in a significant way, while 26.8% reported they did not complete any courses which infused grief/death content in a significant way. Twenty-three percent (23.1%) reported they completed three or more courses that infused grief/death content in a significant way. Previous studies did not ask about courses that may have contained content in a significant way, such as courses on lifespan development, crisis intervention training, practicum and internship courses. The researcher included this question as courses dedicated specifically to grief and/or death education are rare in counselor education programs.

Although the researcher attempted to account for grief content that may have been infused in other courses, this question required the respondent to define the “significant manner” in which the content was infused and thus allowed for variability. This question may have been particularly difficult to answer for those persons who completed schooling several years ago and may not remember which specific courses, assignments, lectures, and/or projects contained content on grief/loss. The question did not ask respondents to define the specific grief content infused in the course and likely the content was dependent upon the course. For example, a lifespan development course may have discussed grief as part of the typical experiences of many older adults while a crisis
intervention course may have included content on symptoms of complicated grief demonstrated by victims of violent crime. The lack of clarity in terms of specific content and amount of time and focus given to death/loss in other courses makes it difficult to determine specific conclusions from this data. It is likely, however, that the content that was significantly infused into the courses represented a specific focus which related to the overall course content and was not a broad or comprehensive approach to grief counseling.

For other modes of training, 30.6% reported they had not completed any professional development hours on the topic of grief/death, while 35.1% reported they had completed 1-10 professional development hours. Almost a third of the sample (28.1%) reported they completed 11-30 professional development hours while 6.2% indicated they had completed more than 30 professional development hours on the subject of grief and/or death education. These percentages of counselors who completed 0-10 professional development hours (65.7%) are similar to Charkow’s (2002) findings in which slightly over half of the marriage and family therapists (56.4%) reported they completed less than 10 hours of professional development on grief and/or death education. In comparison with previous studies completed with mental health professionals on their training related to grief and/or death education (Allen & Miller, 1988; Charkow, 2002), this study found similar results in which approximately half the sample reported completing no courses specifically on death and/or grief education and the majority completing less than 10 professional development hours on the topic.

Again, as with courses completed on grief and/or death education, the percentage of respondents who completed some professional development hours was surprisingly
high (69.4%). The professional development workshops/trainings on grief are not required by state licensure, unlike requirements for continuing education in ethics for all counselors. Therefore, the respondents sought out training on this topic, likely because of an interest in the topic and/or self-identified need for further training. The majority of this sample completed at least some professional development training in grief and therefore may not be representative of the population in their interest in the topic.

5.2.2 Research Question Two

What is the extent of professional experience and training with grief as measured by the Grief Counseling Experience and Training Survey (GCETS) and personal experience with grief as measured by the Texas Revised Inventory of Grief (TRIG) (Faschingbauer, DeVaul, & Zisook, 1987) of licensed counselors?

Grief Counseling Experience and Training Survey (GCETS)

The mean score on the GCETS was 2.7 with a standard deviation of 0.9 and a range of 3.9. The possible mean scores ranged from 1-5, with “1” indicating “not at all true” and “5” indicating “totally true.” The mean score for this study indicated the average response was slightly below the midpoint mean score of “3” or “somewhat true.” The GCETS had not been administered previously as it was developed for this study from the Sexual Orientation Counselor Competency Scale (SOCCS), an assessment originally created by Bidell (2005) to assess experiences and training in working with gay, lesbian, and bisexual clients.

The researcher found the scale to have strong reliability as demonstrated in the Cronbach’s Alpha value of .93, thus a factor analysis was not conducted. However, further exploration of the individual items was conducted to determine which questions
resulted in the higher and lower mean scores. Respondents had the highest mean scores for the following questions: “Currently, I do not have sufficient skills or training to work with a client who presents with grief” \( (M = 3.8) \) (item was reverse scored) and “I feel competent to assess the mental health needs of a person who presents with grief in a therapeutic setting” \( (M = 3.3) \). The lowest mean scores were in response to the following questions: “I have done many counseling role-plays (as either the client or counselor) involving grief concerns,” \( (M = 1.9) \) and “I have a great deal of experience with facilitating group counseling focused on grief concerns” \( (M = 2.0) \). It would seem the respondents believe they have the general skills and experience to work with clients who present with grief, but on average, they lack the specific training (role-plays) and variety of experience (group mode) in working with clients who present with concerns related to grief and loss.

Interestingly, the respondents also indicated lower scores on questions related to knowledge of grief counseling theories and models \( (M = 2.4) \) and regular attendance at in-service, conference sessions, or workshops that focus on grief in counseling \( (M = 2.4) \). Several significant points arise from these responses, such as the apparent disparity between counselors obtaining the general skills and knowledge related to grief counseling and their lack of knowledge of grief theories and models, in addition to their irregularly attending some form of continuing education on grief counseling. It would seem the other options for training would be limited to graduate courses and/or experience on the job. However, half the sample reported they had not completed a course specifically on grief and 27% reporting they did not complete a course which infused grief/death content in a
significant manner; it would seem that many counselors relied upon experience with clients to provide them with training.

The survey included questions about the respondent’s familiarity with specific grief counseling theories (Stage, Task, Dual-Process, Meaning Making, and Continuing Bonds). As expected, respondents indicated the most familiarity with the Stage Theory, with 92.4% reporting “some” or “a lot” of familiarity with this theory. However, the majority of respondents indicated “none” or “very little” familiarity with all the other theories. As theory is the foundation for approaching the assessment, conceptualization and treatment of clients, the lack of knowledge reported by the counselors is of concern. Additionally, the specific knowledge about the Stage Theory was not assessed, thus allowing for the respondents to indicate familiarity without demonstrating specific knowledge about the components of the theory and its application.

Also of concern is the response to the question regarding experience in working with survivors of suicide to which the average score was below the midpoint ($M = 2.4$). Respondents indicated on average an answer between “not at all true” and “somewhat true” to the statement, “I have a great deal of experience counseling persons who experienced loss of a loved one to suicide.” This response is of concern as research has indicated those persons who have lost a loved one to suicide are more likely to seek counseling services as this death can result in complicated grief, including feelings of guilt, shame, and stigmatization, in comparison to those persons who are grieving a loss which was due to illness and/or was expected (Granello & Granello, 2007; Schut et al., 2001). If counselors are not seeking out training on this topic and are not obtaining
experience on the job, they may not be prepared to work effectively with clients who are more likely to seek services and present with more severe symptoms.

The contrast between average scores on general skills and experiences related to grief counseling and the scores on specific experiences and training call attention to a broader set of questions. With what criteria are counselors evaluating their grief counseling competencies? Do counselors understand of grief counseling as being distinct from general counseling? Do counselors conceptualize grief counseling as requiring additional awareness, skills and knowledge specific to this topic beyond the basic counseling skills? Without a professional set of standards for training and/or competencies related to grief counseling, it would seem counselors have little direction to self-assess their competencies.

The respondents understood general/overall counseling competency as different from grief counseling competency as evidenced by the diverse mean values for each of the questions related to these constructs. The mean response to the question of overall counseling competence indicated respondents were comfortable with their knowledge and skills ($M = 3.1$, $SD = .72$), in contrast with the average response to grief counseling competence which suggested respondents believe “I still have much to learn in order to call myself competent,” ($M = 2.2$, $SD = .86$). Additional support for a perceived distinction between these constructs was illustrated by the differences in percentages of respondents who indicated they possessed the lowest level of competence for either grief or general counseling. A quarter of the respondents (25.2%) reported “I feel I need to learn a great deal more before I would call myself competent” with respect to grief
counseling competence in contrast with only a small percentage (2.2%) who reported the same response for overall counseling competence.

*Texas Revised Inventory of Grief (TRIG)*

The TRIG has been used to evaluate persons’ response to grief, in both behavior and affect (Boyer & Hoffman, 1993; Hayes et al., 2007). The sample in this research study indicated average scores above the midpoint value (3) for each of the TRIG scales of Past Behaviors and Present Feelings ($M = 3.8$ and $M = 3.7$ respectively). These scores suggest respondents had on average less intense responses than those persons who scored at the midpoint or lower, both at the time of the loss and presently. In previous research, Hayes et al. (2007) found that lower scores on the TRIG (both scales) predicted clients’ perceptions of their counselors as being more empathetic, and higher scores on the TRIG (both scales) predicted clients’ perceptions of their counselors as less empathetic. Boyer and Hoffman (1993) implemented the TRIG in their study of counselors’ reactions to terminations and counselors’ perceived client sensitivity to loss. The researchers found the more severe grief responses predicted counselors experiencing more depressive and anxious symptoms during termination with their clients. As this sample had higher average scores on both TRIG scales, it is likely clients would view these counselors as less empathetic and likely the counselors would not have more depressive and anxious symptoms during termination with their clients than those counselors whose scores were lower on the TRIG scales.

The multicultural counseling competency theory asserts that awareness of experiences and biases is necessary for development of professional knowledge and skills when working with diverse clients (Sue et al., 1992). This theory has been applied in this
research study to grief counseling competencies, suggesting the counselor’s awareness of his/her experiences about grief and death influence his/her skills and knowledge when working with clients on their losses. Integrating Hayes et al. (2007) and Boyer and Hoffman (1993) studies with this theory, it seems the counselor’s personal experiences with grief impact their professional relationships with clients, specifically the client’s perception of the counselor’s empathy and the counselor’s emotional reaction to terminating with the client. It is speculated that those counselors with a greater awareness of their own grief experiences would in turn have higher levels of grief counseling competencies in the areas of skills and knowledge.

However, the TRIG does not necessarily measure awareness of one’s experience, but the intensity of both emotional and psychological response to the death of a loved one. It could be argued that a person may not respond intensely to the loss of a loved one, either at the time of the event or in the present, but is aware of the loss, its impact and meaning within the person’s life, and the uniqueness of the experience due to individual, cultural and social factors. Therefore, it can not be stated that intensity of responses (lower scores on the TRIG) necessarily relate to greater personal awareness and in turn grief counseling competencies. The subsequent section on Research Question Four discusses the possible relationship between personal experience of grief and grief counseling competencies, including awareness.

5.2.3 Research Question Three

What are the levels of grief counseling competencies of licensed counselors as measured by their responses to the Death Counseling Survey (Charkow, 2002), as
indicated by scores on the assessment scales of Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills?

Consistent with Charkow’s study (2002), this research study found that average scores on the Personal Competencies scales were higher than those scores on all other competencies scales including: Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills and Professional Skills (see Table 5.1). The mean score for Personal Competencies ($M = 4.41$) was almost a point higher than the scores for Assessment ($M = 3.56$) and Treatment ($M = 3.47$) Competencies, and was almost a point and a half higher than the scores for Conceptual Skills and Knowledge ($M = 3.07$) and Professional Skills ($M = 3.19$). However, the average score for each competency scale was at or above midpoint (3) for this research study, as the sample assessed themselves as having “some confidence” in their grief counseling skills and knowledge. The sample also reported, on average, values between “this describes me” and “this describes me very well” to statements about personal grief counseling competencies (awareness and personal characteristics).
## Table 5.1: Comparison of Means and Standard Deviations of the DCS Scales in Current and Previous Study

In comparing the two research studies which have used the DCS, it appears those mental health professionals who are members of the International Association of Marriage and Family Counselors professional organization scored higher than licensed professional counselors in the state of Ohio across all scales. In particular, the respondents in Charkow’s study scored approximately half a point higher on all but one of the scales (Personal Competencies). It is uncertain why these differences in scores exist, but it should be noted that Charkow’s study had a significantly smaller return rate (7.84%), contained a smaller number of respondents (n = 147), and the population consisted of counselors who belonged to a professional organization. The membership in a professional organization may result in this sample having more access to trainings on

<table>
<thead>
<tr>
<th>DCS Scales</th>
<th>Present Study: Licensed Professional Counselors</th>
<th>Charkow, 2001: Members of International Association of Marriage and Family Counselors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Personal Competencies</td>
<td>4.41</td>
<td>0.43</td>
</tr>
<tr>
<td>Conceptual Skills &amp; Knowledge</td>
<td>3.07</td>
<td>0.91</td>
</tr>
<tr>
<td>Assessment Competencies</td>
<td>3.56</td>
<td>0.73</td>
</tr>
<tr>
<td>Treatment Competencies</td>
<td>3.47</td>
<td>0.71</td>
</tr>
<tr>
<td>Professional Competencies</td>
<td>3.19</td>
<td>0.83</td>
</tr>
</tbody>
</table>
various topics, including grief, in comparison to those professionals practicing as counselors who may not belong to professional organizations.

The higher average values on Personal Competencies and lower average values on skills and knowledge competencies are not surprising results for this sample. As the average age is 48 years old, it would be reasonable to expect the sample has experienced at least one significant personal loss prior to completing the survey. Over half of the sample reported limited or no specific training on grief and loss issues; therefore it is logical to conclude the counselors have more personal experience with grief than professional training. Additionally, the Personal Competencies scale included general questions not related to grief, but rather inquired about self-care, sense of humor, and spirituality. The higher Personal Competencies scores suggest these counselors possess the awareness competencies required to work effectively with clients who present with grief.

The results for the other competencies scales, specifically the Assessment Skills scale, were unexpected. The Treatment Skills and Assessment Skills scales were both above the midpoint value (3). The scores for Treatment Skills were expected as this scale included questions which encompass general counseling skills such as establishing rapport, demonstrating active listening skills, and conducting individual and group sessions with clients. As the average response for overall counseling competencies was “comfortable with skills and knowledge,” the average score on Treatment Skills was consistent. Somewhat unexpected was the Assessment Skills average score which was slightly higher than Treatment Skills. This scale included questions on assessing for unresolved loss, spirituality, cultural influences on grief, and ability to conduct suicide
assessments. As these skills require more specific knowledge about grief and its impact on psychological well-being and relationships (with the exception of conducting suicide assessments), it would be reasonable to expect these scores to not be higher than scores which reflect general counseling knowledge and skills as included in the Treatment Skills scale.

Another reason the Assessment Skills average scores were surprising was the average scores on the Conceptual Knowledge and Skills scale were the lowest of all the competencies scales ($M = 3.07, SD = .91$). This scale included questions about theories, definitions of “normal” and “complicated grief,” identifying effective and ineffective coping skills, and applying a developmental understanding of grief in work with clients. To assess a client, the counselor needs to have a conceptual understanding of the client and their cultural background, but additionally knowledge of professional standards for “normal” range of thoughts, feelings, and behaviors. Without the knowledge of grief counseling theories and diagnostic guidelines for assessing difficulties in managing grief and loss, counselors may not have the level of competency they believe themselves to possess in the areas of assessment and treatment.

The respondents reported the second lowest average scores for the Professional Skills scale in both the current study and the previous study completed by Charkow in 2002. The questions for this scale included the topics of providing crisis intervention, working on an interdisciplinary team, finding support within profession to help manage personal responses to working with clients on issues of grief, maintaining current literature on grief, and providing community and/or school activities related to grief. Although all counselors may have these experiences, the frequency of these experiences
may be dependent upon the counselor’s work setting and primary population. For instance, counselors in community agencies and schools may not have frequent opportunity to seek out support from professional peers to help manage reactions to working with clients on issues of grief, partly because of limited time due to productivity standards. In comparison, those counselors who may work with clients who have grief concerns on a day-to-day basis, such as those who work in hospitals and/or hospice, may have professional support meetings (either formal or informal) as part of their team/agency setting. The relatively lower scores on this scale may be a reflection of the limited experiences of the sample based upon their work settings.

5.2.4 Research Question Four

What is the relationship between grief counseling competencies and the following selected demographic variables of age, gender, professional experience as a licensed counselor (years practicing since obtaining initial licensure), training and experiences in grief counseling (as measured by the GCETS), personal experience with grief (as measured by the TRIG scales of Past Behaviors and Present Feelings), and practice setting in which counselors worked for a majority of years?

Statistically Significant Relationships

From the seven variables included in the analysis, only three contributed significant variance to the grief counseling competencies: training and experiences in grief counseling (as measured by the GCETS), gender, and professional experience as a licensed counselor. Age, personal experience with grief (as measured by the TRIG scales of Past Behaviors and Present Feelings) and practice setting did not contribute
significantly to grief counseling competencies. These non-significant findings will be discussed later in the subsequent section.

*Training and Experience in Grief Counseling (GCETS).* The scores on the GCETS which indicated counselors’ training and experience in grief counseling accounted for a significant amount of variance in each of the grief counseling competencies (Personal Competencies, $R^2 = .17$; Conceptual Skills and Knowledge, $R^2 = .69$; Assessment Skills, $R^2 = .55$; Treatment Skills, $R^2 = .71$; and Professional Skills $R^2 = .60$). The training and experience variable was the largest beta weight in each of the regression equations for the grief counseling competencies.

It is reasonable to expect the variable of experience and training to have a statistically significant relationship with the grief counseling competencies, however, the large adjusted $R^2$ values and high correlation values between this variable and competencies are unusual (Personal Competencies, $r = .37$; Conceptual Skills and Knowledge, $r = .83$; Assessment Skills, $r = .72$; Treatment Skills, $r = .84$; and Professional Skills $r = .77$). Based on the correlations between the GCETS and the grief counseling competencies scales, it appears counselors who believe they have received adequate training and experience in grief counseling assess themselves as having grief counseling competencies.

These high correlation values may be due to several factors. It may be that the difference between training and experience (assessed by the GCETS) and counseling competencies (assessed by the DCS) was a subtle distinction for the respondents. Although the majority of the questions on the GCETS ask about specific experiences and training, the assessment does contain three questions which ask specifically about
competence (“At this point in my professional development, I feel competent, skilled and qualified to counsel clients who present with grief,” “I feel competent to assess the mental health needs of a person who presents with grief in a therapeutic setting,” and “I have sufficient knowledge of grief counseling theories and models.”). In contrast, the items on the DCS ask the counselor to define the level of confidence in their specific skills and knowledge related to grief counseling. From the researcher’s perspective, there is a distinction between the construct of experience and training and the construct of competencies, but perhaps the respondents did not interpret the questions in this manner.

Another hypothesis is that the respondents understand experience and training and achieving competencies as being equivalent. In other words, if a counselor obtained experience and/or training in an area (grief counseling), the counselor believed he/she gained competencies in this area. Because grief counseling competencies are not established within the profession, a void exists where professional standards need to define for counselors the specific skills, knowledge and awareness to gain from their trainings and experiences. Without professional guidelines, counselors may likely confuse these two separate concepts, and therefore assume any training or experience provides them the opportunity to gain necessary skills and knowledge competencies.

The training and experience variable was further explored by comparing the mean scores on competencies by the amount of training completed by the respondents, either in courses specifically on grief, courses which infused grief content in a significant manner, or professional development hours. As expected, the more training a counselor completes, the higher the scores on the competencies (see Table 5.2). Of particular interest, an increase in training from no to some training resulted in scores increasing
from below the midpoint to above the midpoint for both Conceptual Skills and Knowledge Competencies and Professional Competencies, for all types of training. As these are the same competencies in which counselors had the lowest mean scores, future training workshops and courses should focus on these areas and include topics included in the DCS scales such as: theories of grief counseling, definitions of “normal” and “complicated grief,” effective coping skills, knowledge about the developmental understanding of death, crisis intervention, currency in the grief literature, and participation in interdisciplinary and professional support groups.

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>Conceptual Skills and Knowledge</th>
<th>Assessment</th>
<th>Treatment</th>
<th>Professional</th>
</tr>
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<tbody>
<tr>
<td>Specific Courses Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Courses</td>
<td>4.38</td>
<td>2.79</td>
<td>3.38</td>
<td>3.29</td>
</tr>
<tr>
<td>One Course</td>
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<td>3.32</td>
<td>3.76</td>
<td>3.61</td>
</tr>
<tr>
<td>Two or more Courses</td>
<td>4.55</td>
<td>3.45</td>
<td>3.74</td>
<td>3.71</td>
</tr>
<tr>
<td>Infused Courses Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Courses</td>
<td>4.28</td>
<td>2.57</td>
<td>3.19</td>
<td>3.16</td>
</tr>
<tr>
<td>One or Two Courses</td>
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<td>4.47</td>
<td>3.51</td>
<td>3.87</td>
<td>3.80</td>
</tr>
<tr>
<td>Professional Development Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Hours</td>
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<td>2.55</td>
<td>3.30</td>
<td>3.12</td>
</tr>
<tr>
<td>1-10 Hours</td>
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<td>3.05</td>
<td>3.55</td>
<td>3.44</td>
</tr>
<tr>
<td>11-30 Hours</td>
<td>4.48</td>
<td>3.45</td>
<td>3.75</td>
<td>3.70</td>
</tr>
<tr>
<td>30 or More Hours</td>
<td>4.60</td>
<td>3.71</td>
<td>3.88</td>
<td>4.04</td>
</tr>
</tbody>
</table>

Table 5.2: Table of Means for DCS Scales by Types of Training
Gender. Through exploration of the independent variable of gender and its relationship with grief counseling competencies, the regression analyses demonstrated that women scored significantly higher than men on three of the scales: Personal Competencies, Assessment Competencies and Treatment Competencies. Review of all mean scores by the independent variable demonstrate that on average, women scored higher than men on the remaining grief counseling competencies subscales (see Tables 4.27 and 4.28). Although statistically significant, the difference in scores between the genders was in a range between .15 and .26 points on a five point scale. This difference seems to have little practical significance.

However, the gender difference in counseling competencies may be a reflection of the distinction which has been identified in previous research on men and women’s responses to grief. Schut et al. (1997) in their study on spousal bereavement found women tended to cope with grief by focusing on the emotional impact of the loss such as end of the physical relationship and inability to share future events with the deceased. Whereas men tended to cope by focusing on problem-solving in response to the loss, such as learning to perform household tasks previously done by the wife and/or managing the decrease in financial resources. Additionally, research has demonstrated a difference in genders in terms of emotional expression and response to grief, with women being encouraged to express themselves more openly than men. In contrast, men are socialized to hide feelings and present a “stiff upper lip” in response to emotional situations such as loss and therefore men may be more uncomfortable than women with the sadness of loss (Bennett, 2007; Cochran, 2006; Williams, Baker, Allman, & Roseman, 2006). One
explanation for the differences in competencies between the genders is that women, in general, respond to grief with more focus on the emotional component of the loss in the professional as well as personal setting in comparison to men. This focus on the emotional aspect of loss may result in an ability to establish a stronger relationship with clients, greater ease in exploring emotional responses and potential unresolved losses with clients, and a greater awareness of the loss as it affects the anticipated future.

Gender is a variable which requires further study. In previous research by Robbins (1992), gender was not found to be related to grief counseling competencies in a sample of hospice volunteers. As gender was not explored in previous research on grief counseling competencies, the differences between the genders’ mean scores are to be noted. Future research may benefit from using a larger and more equally-represented sample in terms of gender to further explore gender differences.

Professional Experience as a Licensed Counselor. Professional experience as a licensed counselor was measured as a continuous variable (years practicing since obtaining initial licensure) and was converted into a categorical variable with four levels: New Practitioner (0-3 years); Skilled Practitioner (4-9 years); Experienced Practitioner (10-20 years); and Master Practitioner (more than 20 years). This study found the level of Master Practitioner had a statistically significant relationship with two of the grief counseling competencies: Conceptual Skills and Knowledge and Assessment Competencies. The full regression model for Treatment Competencies initially indicated Master Practitioner had a statistically significant relationship with the grief counseling competency, but the reduced model indicated the relationship to not be statistically significant. Interestingly, the Master Practitioners scored significantly lower than all other
levels of practitioners on both of these grief counseling competencies scales. Again, this is an area of research which has previously not been explored and the results initially appear counterintuitive. However, one explanation for the lower scores in the grief counseling competencies of Conceptual Skills and Knowledge and Assessment Competencies within the Master Practitioners group may be that these counselors have not maintained current training and/or experience on grief. Another possible explanation may be that these counselors may experience a certain amount of burn-out and or apathy related to their profession, thus resulting in lower scores on grief counseling competencies. (This group and their scores on the DCS scales will be discussed further in the Implication for Practicing Counselors section).

Statistically Non-significant Relationships

Age, personal experience with grief as measured by the TRIG scales of Past Behaviors and Present Feelings, and practice setting did not contribute significantly to any of the regression equations for the grief counseling competencies. The variable of age in prior research studies had contradictory results. Mastrogianis (1998) did not find a relationship between age and grief counseling competence, while Paradis and Usui (1987) found a positive correlation between age and length of time serving as a hospice volunteer, which previously was questioned as a valid measurement of competency. As age was not significantly related to any of the grief counseling competencies in this research study, it was removed from the regression models.

Personal experience with grief, as measured by the TRIG scale of Past Behaviors and Present Feelings, was not found to have a statistically significant relationship with any of the grief counseling competencies. In the full regression model for Personal
Competencies, Past Behavior (low scores) were found to be statistically significant in comparison with Past Behavior (middle scores), but were not found to be statistically significant in the reduced model when compared with both middle and high scores on the Past Behavior scale.

These findings are in contrast with the theoretical model and one of the previous research studies which investigated personal experience with grief and its relationship to counselor’s ability to cope with death when working with clients (Smith, 2003). Smith (2003) found personal experience with death, measured as either having experience or not having experience, to partially explain the variance in counselor’s ability to cope with death, along with the variables of counseling self-efficacy and training on end-of-life issues. The multicultural counseling competency theory which was applied to this research study asserts one’s personal experiences and awareness are the first steps in acquiring knowledge and skills in the area. The theory asserts a counselor’s personal experiences with an individual, group, or event influence the counselor in their professional work. However, the results of this research study do not support the assertion that personal experiences with grief impact the counseling competencies.

One explanation for the lack of relationship between personal experience and grief counseling competencies may be the instrument used. The TRIG measured intensity of response to grief, but did not measure the counselor’s reflection on the experience of grief, how they made sense of the loss (or not), the influence of the loss on their spirituality or beliefs, nor the impact of the loss on other relationships. Additionally, the instrument measured negative emotional or behavioral results to the loss of a loved one, and did not assess for the possibility of positive emotions and results such as relief.
(which may occur during instances when the loved one suffered a long illness) or a new found sense of meaning in life as a result of experiencing death.

Finally, the TRIG may not be able to measure or represent the complexity of personal experiences to grief, especially since the instrument requires respondents to answer questions based upon their one most significant loss. It is reasonable to assume the counselors experienced more than one death and each of these experiences may impact their perspective on grief and death. In addition, the variables of time since the death, age of counselor at the time of most significant loss, their relationship with the loved one, and the circumstances related to the death (i.e. sudden or expected, violent or peaceful), and family and cultural norms regarding the expression of grief may also impact the counselors’ perspective on grief. Although data was gathered about religious/spiritual background, the respondents were not asked to identify their specific beliefs about death or afterlife. Also, there is the possibility that in working with clients on issues of grief, counselors learned new and different ways of approaching loss in their personal lives, thus allowing for not only the personal to impact the professional self, but vice versa. It would seem the multifaceted experience of grief may be best explored through a qualitative approach to allow for depth of disclosure and diversity of expression by participants to speak about their personal experiences of grief and the possible relationship to their work with clients.

Practice setting was not found to be a statistically significant variable in any of the regression equations for the grief counseling competencies. The variable of practice setting had not been included in prior research studies, but was included as it was hypothesized that a counselor’s work setting may influence the amount of experience
gained with grieving clients. However, this study had a minimal representation (6.5%) of counselors who worked primarily in hospice or hospitals ($n = 23$) and thus did not have a large enough sample size to compare this group with others in settings such as community agencies, schools, private practice, or other settings. Another reason this variable may not to be statistically significant is the pervasiveness of grief counseling throughout populations and settings. Although it can be assumed those counselors working in hospice and hospitals will work more frequently with clients on issues of grief, there is no research stating school counselors have more experience with grief than community mental health counselors or those working in private practice. Because of the prevalence of loss, it is likely counselors will work with clients on the issues of grief regardless of practice setting.

5.3 Implications for Counselor Educators

The results of this study indicate that training is effective, as evidenced by the increase in self-perceived grief counseling competencies. The results also help to clarify the content areas in which counselors need the most training. The comparisons of mean scores on the DCS scales of Conceptual Knowledge and Skills and Professional Skills showed a statistically significant difference, in particular between no training and some training for courses and professional development hours. As these are the areas with the average lowest scores, future courses/trainings should focus on these content areas. The training content in these areas includes: theories of grief counseling, definitions of terms related to grief, crisis intervention, providing psycho-educational programs to community on the topic of grief, and identifying clients’ effective and ineffective coping skills.
Interestingly, training did not seem to have the same impact on Personal Competencies as was found in the other scales, additionally a weak correlation was found between experience and training (GCETS) and Personal Competencies. It would seem counselors developed Personal Competencies outside of specific training on the topic of grief/loss. Therefore additional training on grief counseling competencies may contain reflection on the personal experiences and understanding of grief in addition to reinforcement for counselors to practice self-care when working with clients who present with grief concerns.

Other content areas for future training, in addition to increasing Conceptual Knowledge and Skills, Professional Competencies, and Personal Competencies include: knowledge about individuals’ understanding of death based on their developmental phase, facilitating groups and family sessions related to grief, and finally providing community and school services on the subject of grief. Respondents scored lowest on questions related to these topics on the DCS. It is important that counselor education programs integrate this material into courses or professional trainings as general training (i.e. course on death and dying) may increase awareness, but may not help counselors develop skills and knowledge needed to provide the best care for their clients.

Of special interest is the self-perceived need for more training in grief counseling and the strong desire expressed by the sample to obtain more training, as expressed in the responses to both the closed and open-ended questions included in the survey. The average score on self-rated grief counseling competence indicated counselors “still have much to learn in order to call myself competent.” A majority of the respondents (91.1%) reported they believe education in grief counseling, including assessment and treatment,
is necessary or should be required. A large percentage (87.3%) reported they wanted to
learn more about grief counseling and specifically 78.9% stated they would prefer this
training to be a face-to-face, interactive seminar or presentation. Several respondents
indicated their lack of formal training in counselor education programs and the role of
experience with clients and personal experiences as their main forms of training on grief.
Respondents’ statements included: “Most of what I learned about grief counseling I
learned by reading or by workshop. Very little was provided by the college,” “Very little
of my grief counseling skills were derived from my counseling education, except for
listening skills, etc. Most was obtained through nursing education (i.e. hospice) and
seminars. I also participated in grief support groups,” “Most of what I have learned re:
grief counseling is the result of life experience. I have experienced many loses, starting at
age eight. While I am not well clinically/academically trained, I do feel confident in this
area for the most part. I do think I could be better prepared with more formal training,”
and “I can’t remember specific coursework during my training re: grief counseling. I
think it should be required.” Other participants commented on the role the survey played
in helping them define areas for further training. The following are a selection of
participants’ additional comments provided at the end of the survey: “You really made
me aware of how weak my skills are in this arena” (counselor with nine years
experience), “Wow! I had no idea how little I know. I will make every effort to get
involved in some training as soon as possible” (counselor with 10 years experience),
“Helped me realize strengths and weaknesses. I realize I should have had more training a
long time ago!” (counselor with 29 years experience), “Thought provoking re:
accountability” (counselor with 13 years experience), “Thank you for this self-assessment
opportunity. This in itself has been helpful for me in identifying a need for additional training” (counselor with eight years experience), “The survey enlightened me to how much I don’t know. I definitely need more training.” (counselor with 13 years training), and “…this survey makes me know how very little specific training I’ve had in this area” (counselor with 18 years experience).

One recommendation for counselor educators would be to provide trainings to students and practicing counselors in a variety of settings such as classrooms, agency meetings, schools, and/or professional conferences. Additionally, the profession could work towards the establishment and distribution of grief counseling competencies. These competencies could then be used to help establish training content and objectives for courses and/or workshops. The DCS and GCETS may be used as pre-test/post-test assessments to help counselor educators determine if their trainings are increasing self-perceived grief counseling competencies.

5.4 Implications for Practicing Counselors

5.4.1 Self-Perceived Competencies

The practicing counselors who completed this survey reported higher scores on items related to the general experiences and competencies of grief counseling, but indicated lower scores when responding to items of specific training and experiences related to grief counseling. They indicated an understanding of a difference between overall counseling competence and grief counseling competence. Those that received some training reported higher self-perceived competencies than those who received no training. There existed a strong correlation between counselors’ experience and training and their scores on four of the five grief counseling competencies scales. However, the
average score on the question asking counselors to rate their grief counseling competence suggested they believed they have much to learn in order to call themselves competent, but for each of the competencies scales of the DCS, the counselors reported at least “some confidence”. There seems to be disparities between general grief counseling competency (a specific question asked in the survey) and the specific grief competencies upon which the respondents rated themselves on by answering questions on the DCS. These disparities may be a result of a lack of clarity within the profession as to the definition of grief counseling competencies and therefore a lack of specific training experiences and content. Although the participants ranked their overall counseling competency different than grief counseling competency, the respondents were not asked to define this distinction. Without specific competencies identified by professional organizations or accrediting bodies, the counselors are left to make their own distinctions which may not be based on specifics, but rather a general idea of grief counseling requiring specific competencies. However, it may also be that practicing counselors, when asked specific questions about skills and knowledge related to their profession, may have overestimated their competencies as a result of social desirability or fear to admit a lack of knowledge or skills. In particular with questions which ask counselors to self-evaluate specific skills and knowledge, they may have felt inherent pressure in the question itself that they should at least have some knowledge or skills.

The results of the survey indicate counselors may benefit from additional training in topics of grief counseling theories, definitions of terms such as normal grief and complicated grief, and identifying effective/ineffective coping skills. Practicing counselors may find it advantageous to seek out professional development in grief
counseling, specifically the area of theories as recent research has called into question the validity of the Stage Theories in application with clients and other theories (i.e. Continuing Bonds and Meaning Making Theories) have been applied to culturally diverse populations with some success. Unfortunately, counselors likely do not know the gaps in their grief counseling competencies and therefore may not seek out additional training opportunities. Assessments which ask counselors to demonstrate their knowledge of theories and definitions related to grief may be particularly helpful as these areas seem to require improvement and because the content of theories in particular has changed significantly in the recent past. This is an area where counselor educators and practicing counselors who frequently work with clients presenting with grief may collaborate to provide useful and current trainings to the profession.

5.4.2 Master Practitioners

The group of practicing counselors who have practiced for more than 20 years (Master Practitioners) scored significantly lower than other groups with less experience on two of the DCS scales: Conceptual Knowledge and Skills and Assessment Skills. A closer look at this population may help to understand these results. Master Practitioners ($n = 71$) were mostly female (65.1%) with an average age of 60 years old with a range of ages from 43 to 78 years old. Just under half of this group completed their degree in counselor education (47.6%) with equal percentages that completed degrees in education, psychology, and rehabilitation counseling (8.3% each). A small percentage completed degrees in pastoral counseling as their major field of study. Almost equal percentages held LPC (48.8%) and LPCC (51.2%), which indicates about half obtained licensure prior to 1985 when Ohio adopted laws which established a two-tiered system of licensure.
and required additional hours in graduate training programs. A little over a half of this group reported they held supervisory credentials (54.1%) and 50% reporting currently working full-time, 37.2% reported currently working part-time and 12.8% reported not working. About one quarter of the group reported currently working in community agencies (25.3%) and an almost equal percent reported working in schools (22.8%) and 13.9% reported currently working in private practice.

The majority of this group indicated either comfort with knowledge and skills or being highly competent in terms of overall counseling competence (92.8%). In contrast, 20% reported they need to learn a great deal more before they are competent with respect to grief counseling competence and 30.1% reported they still have much to learn to be competent. About one half (49.4%) reported comfort with knowledge and skills or being highly competent in terms of grief counseling competence. This group included a slightly higher percentage of counselors who had not completed a course on grief (62.3%) in comparison with the overall sample (54.8%). About one fifth of the sample (20.7%) had completed zero professional development hours on grief and only 16.1% reported completing 1-10 professional development hours.

The surprising drop in average scores for the grief counseling competencies for Master Practitioners may be accounted for by a few different variables. One may be that over half of this group completed their formal training in programs other than counselor education and received their licenses prior to the establishment of more demanding and extensive training from counselor education programs to obtain licensure in the state of Ohio. Therefore the difference in formal training and limited completion of professional development hours may account for the decrease in grief counseling competencies.
Another possible cause for the decline in average scores for this group in comparison to others with less experience may be burn out as a result of many years working with clients or reduced investment in professional development as these counselors approach retirement age, as the average age of this group was 60 years old. A final explanation may be that this group overestimated the role of professional experience in their knowledge and skills, in a sense assuming their years of experience are equivalent to knowledge and skills in grief counseling. However, their previous training and experiences may not have provided them with necessary competencies as currently defined and perhaps this previous training is now out of date. If these counselors have not maintained currency with the professional literature and trainings, they may assume they have grief counseling competencies, while in comparison to their less experienced peers they are lacking. These results suggest the importance of continued professional development throughout the counselor’s career, specifically in the area of grief counseling in which significant additions and changes have been made in recent years.

5.5 Limitations

Several limitations exist within this present research study. Because of the lack of previous research on this topic, the available instruments developed to assess grief counseling competencies are few. This study used the DCS, the only instrument developed specifically for measuring grief counseling competencies. Although the instrument has adequate psychometric properties, it had been used with a small sample prior to this administration. The GCETS was developed as part of this study. The instrument was pilot tested in a multidisciplinary counseling center and its psychometric properties have been determined to be acceptable. However, both of these instruments
need to be administered to a variety of populations. Lastly, four of the five scales on the DCS strongly correlated with the GCETS, suggesting perhaps participants did not distinguish between their experience and training and their competencies.

Additionally, the assessment for personal experiences with grief (TRIG), provided data as to intensity of response to death, but this instrument measured only negative responses to death. This instrument also did not incorporate into the two scales (Past Behavior and Present Feelings) information regarding the quality of relationship to the deceased, context of the death (i.e. sudden, violent, after a long illness), the age of the participant when death occurred, and restricted respondents’ answers to one loss. It would seem beneficial to have an instrument developed to measure the complex response to death to better understand how this personal experience may relate to the counselors’ self-perceived competencies.

A second limitation to this study is the sample. Although the necessary return rate was achieved to complete the statistical analyses, the study could have been improved by more respondents. The population was comprised of licensed counselors in the state of Ohio, thus the results of this study can only be generalized to this group. Additionally, those persons who responded to the survey may have a stronger interest in the area of grief counseling and therefore a difference may exist between those who completed the assessment and those who did not. The results can be generalized to the national population of licensed counselors only to the extent that Ohio counselors are representative of those counselors across the nation. The sample contained few persons of color (7.3%) and therefore it is likely the ability to generalize the results of this study to
other areas in the nation may be difficult. Further research should use the DCS and GCETS in studies which include large and diverse samples.

Finally, the last limitation exists due to the self-report nature of both the DCS and GCETS assessments. These assessments require respondents to be objective about their skills, knowledge and awareness and also be able to recall their specific experiences working with clients who present with grief. However, self-report is likely more subjective and therefore respondents could intentionally or unintentionally misrepresent their competencies. Further research would benefit from the development of assessments used to rate the counselors by third-parties and/or clients. By gathering data from a variety of sources (client, counselor, and rater/supervisor), more reliable information about the counselor’s grief counseling competencies could be ascertained.

5.6 Implications for Future Research

Future research has several ways in which to build upon this current study. One suggestion would be for the administration of the DCS and GCETS instruments to be larger and diverse samples to norm these instruments and gather additional information on the psychometric properties. Additional administrations of these instruments and further development instruments may also help researchers to capture information about grief counseling competencies in a more useful and practical manner. Another suggestion would be the development of an assessment to measure personal experience with grief and its complex effect on the counselor and their grief counseling competencies. Finally, these assessments should be administered to a variety of mental health professionals (social workers, psychologists, psychiatrists and counselors) to compare grief counseling
competencies across disciplines. This information could be valuable in determining if certain disciplines provide better training on the topic of grief.

Suggestions for future research include investigation of the content and quality of the training provided to counselors on grief and loss issues. This study collected data on the number of courses and/or professional development hours completed by counselors; however it did not investigate the specific training topics or the perceived benefit of the training. In particular, the area of grief counseling theory is a topic which the sample indicated having lower average competencies in comparison to other topics. Researchers could investigate the prevalence of trainings on grief counseling theories and assess the quality of these trainings, specifically the inclusion of theories beyond the Stage and Task Theories.

Finally, a qualitative inquiry may provide valuable data on counselors’ personal experiences with grief and their understanding of how these experiences may impact their work with clients. With the comments provided by the participants at the end of this survey, it seems some counselors believe they learned about grief counseling through their professional and personal experiences rather than formal training. A qualitative study may provide participants an opportunity to share about their experiences with grief. Specifically, it would be interesting to investigate what and how counselors learn about grief and how they translate this knowledge to their professional work with clients who present with grief.

5.7 Conclusion

With the likely increase in persons seeking grief counseling services, it is important for the profession of counseling to be prepared to effectively work with clients.
The purpose of this study was to gather data on practicing counselors regarding their grief counseling competencies, professional and personal experience with grief, and demographic variables including gender, age, and practice setting in which they gained the most experience in years. This study explored the possible relationships between personal and professional variables and the grief counseling competencies as measured by the DCS (Charkow, 2001).

A little over half the sample reported they had not completed any courses on grief and about one quarter of respondents stated they had not completed a course with grief content significantly infused into the course. In terms of professional development hours, 30.6% reported they had not completed any training beyond their graduate program. Surprisingly, almost half of this sample reported completing at least one course on grief as part of their graduate training and 69.4% reported they completed professional development hours. At least half of this sample seems to have an interest or self-determined need for training on grief and therefore the sample may not have been representative of the population.

The results from the assessment of experience and training related to grief (GCETS) indicated that counselors believed they have the general experience and training in working with clients on issues of grief. However, they rated their specific experience and training lower than self-ratings on general items. This difference between ratings of general and specific experiences and trainings calls into question if counselors have received the training required to effectively work with clients. In reviewing questions related to knowledge of theories and definitions of normal and complicated grief it appeared counselors lack knowledge in these particular content areas.
The results of this study demonstrated experience and training, gender, and professional experience as measured in years were three variables which contributed significant variance to the grief counseling competencies scales (Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills). Specifically, experience and training in grief accounted for a large amount of the variance in all of the DCS scales except for Personal Competencies. Women scored significantly higher than men on three scales of the DCS (Personal Competencies, Assessment Skills and Treatment Skills). These differences may be explained by the ways women and men are socialized to respond to grief and have been found to cope differently to grief, with women focusing more on the emotional response and men focusing more on problem-solving and in turn, suppressing or denying emotional reactions. It may be that women are more comfortable with emotional expression in response to grief and thus are able to establish stronger therapeutic relationships with clients and to better demonstrate empathy when working with grief concerns.

Interestingly, Master Practitioners (counselors who have practiced more than 20 years) demonstrated lower average competencies scores than those counselors with less experience on two of the DCS scales, Conceptual Knowledge and Skills and Assessment Competencies. The decrease in average scores may have been a result of different and less stringent training standards which were in place when this group completed their graduate programs and the fact that over half of this group completed graduate degrees in programs other than counselor education. Burnout and reduced investment in professional interests may be another possible explanation for these lower scores, as the average age for this group was 60 years old and they have provided many years service in
the profession. However, it may also be that the training these counselors received is now outdated. These results stress the importance of continued professional development in grief counseling throughout the career of the counselor, perhaps especially for those who have had many years of professional experience.

The implications for training are significant. The majority of the counselors indicated they believe training on grief counseling is necessary and training was found to have a positive relationship with self-perceived grief counseling competencies based on the self-evaluations. This study helped to identify those specific content areas in which training is needed, including: Personal Competencies, theories, definitions of grief, bereavement, and complicated grief, identification of effective and ineffective coping skills, and seeking support from professional peers to manage reactions to working with grieving clients.

The limitations of this study include the use of instruments which require further administration provide additional data regarding psychometric properties. In particular, the GCETS should be administered to larger and more diverse samples to provide additional reliability and validity. Perhaps the most significant limitation to this study is the use of self-report instruments. Currently, there are no instruments developed for supervisors, clients or third-party raters to assess counselors’ grief counseling competencies. The use of self-report allows for subjective responses which may not accurately represent the awareness, knowledge, and skills of the counselor.

Future research needs to develop assessments to be used by objective raters which can be used along with the DCS to evaluate counselors’ grief counseling competencies. Further study should focus on the personal experience of grief and its possible impact on
professional competencies. This may be best investigated through a qualitative study as it would allow a more extensive review of the possible relationship between the personal and professional lives of counselors. Finally, additional study on the content and quality of grief counseling training needs to be completed. Additional research would help to clarify grief counseling competencies and training standards for the profession and help counselor educators and practicing counselors prepare to meet the pending client need.


APPENDIX A

SURVEY OF GRIEF COUNSELING COMPETENCIES
DEMOGRAPHIC QUESTIONNAIRE

Please take a moment to answer some demographic questions. Remember, these answers will not be used to track you individually, but will be used only in an aggregate fashion.

1. What is your gender? _____ Male _____ Female ____ Transgender __ Other

2. What is your age? ______________

3. What is your race/ethnicity?
   ______ Black/African-American _______ Asian-American
   ______ White/Caucasian _______ Hispanic/Latino
   ______ Native American _______ Pacific Islander
   ______ Multiracial
   ______ Other (please explain) __________________________________________

4. How many years have you been a professional counselor? (i.e. How long ago did you receive your initial licensure/LPC)? ______________

5. What is your highest educational degree? _______________________________________
   Major field of study? ___________________________________________________

6. I am licensed as a ________ Professional Counselor (LPC)
   ____________ Professional Clinical Counselor (LPCC).

7. Do you currently hold a Supervising Counselor Designation? ____Yes  ___No

8. Are you currently working:
   ______ Full-time  ______ Part-time  ______ Not at all

9. How many years have you worked in the following settings? (Place a “0” in the blank if you have not worked in the setting.)
   ______ Employee Assistance Program ______ Community Agency
   ______ College Counseling Center ______ Private Practice
   ______ Professor ______ Hospice
   ______ Administrator ______ Corrections
   ______ Career Counseling ______ Hospital
   ______ School (Elementary, Middle or High School)
   ______ Other (please explain) ___________________________________________
10. In which work setting do you currently work?

- Employee Assistance Program
- Community Agency
- College Counseling Center
- Private Practice
- Professor
- Hospice
- Administrator
- Corrections
- Career Counseling
- Hospital
- School (Elementary, Middle or High School)
- Other (please explain) ________________________

11. Which of the following certifications do you hold?

- National Certified Counselor (NCC)
- Licensed Independent Chemical Dependency Counselor (LICDC)
- ADEC Certified Grief Therapist (CGT)
- ADEC Certified Grief Counselor (CGC)
- Other (please explain) ________________________

12. Please indicate your religious/spiritual background.

- Jewish
- Protestant
- Buddhist
- Catholic
- Muslim
- Hindu
- None
- Other (please explain) ________________________

13. Please rate your overall counseling competence by circling the appropriate answer below.

(1) I feel I need to learn a great deal more before I would call myself competent.
(2) I still have much to learn in order to call myself competent.
(3) I feel comfortable with my knowledge and skill level.
(4) I am highly competent, I could teach others.

**Grief Counseling Questions**

14. How many courses did you complete which focused specifically on death and/or grief? ____________ (quarter or semester - circle one)

15. How many courses did you complete which included or infused death and/or grief content in the course in a significant way? ____________ (quarter or semester - circle one)

16. Approximately, how many professional development hours have you earned on the subject of death and/or grief? ____________________________
17. Please indicate your level of familiarity with the following Grief Counseling Theories by circling the appropriate answer below. [The authors of the models are included for your reference].

(a). Stage Theories (i.e. Kubler-Ross, Bowlby, & Parkes)
    None  Very Little  Some  A Lot
(b.) Task Theories (i.e. Worden)
    None  Very Little  Some  A Lot
(c.) Dual-Process Theory (i.e. Stroebe & Schut)
    None  Very Little  Some  A Lot
(d.) Meaning Making Theory (i.e. Neimeyer)
    None  Very Little  Some  A Lot
(e.) Continuing Bonds (i.e. Bonanno & Klass)
    None  Very Little  Some  A Lot

18. Please rate your grief counseling competence by circling the appropriate answer below.
(1) I feel I need to learn a great deal more before I would call myself competent.
(2) I still have much to learn in order to call myself competent.
(3) I feel comfortable with my knowledge and skill level.
(4) I am highly competent, I could teach others.
# Grief Counseling Experience and Training Survey

Using the scale, rate the truth of each item as it applies to you by circling the appropriate number.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Not at All True</td>
<td>Somewhat True</td>
<td>Totally True</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have received adequate clinical training and supervision to counsel clients who present with grief.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>I consistently check my grief counseling skills by monitoring my functioning and competency via consultation, supervision, and continuing education.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>I have a great deal of experience counseling clients who present with grief.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>At this point in my professional development, I feel competent, skilled and qualified to counsel clients who present with grief.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I have a great deal of experience counseling persons who experienced loss of a loved one to suicide.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>6.</td>
<td>I have a great deal of experience counseling children who present with grief.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>7.</td>
<td>I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>8.</td>
<td>I feel competent to assess the mental health needs of a person who presents with grief in a therapeutic setting.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>I have a great deal of experience with facilitating group counseling focused on grief concerns.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
10. Currently, I do not have sufficient skills or training to work with a client who presents with grief. 1 2 3 4 5

11. I have done many counseling role-plays (as either the client or counselor) involving grief concerns. 1 2 3 4 5

12. I have sufficient knowledge of grief counseling theories and models. 1 2 3 4 5
Texas Revised Inventory of Grief (TRIG)
(Thomas R. Fashingbauer, Sidney Zisook, & Richard DeVaul, 1987)
The following questions ask you to reflect upon your personal experience with death. To complete this survey, please select the death of a loved one to which you had the most significant response (i.e. the death that most affected you).

1. The person who died was my (check only one):
   _____ Mother _____ Sister _____ Friend _____
   Father _____ Spouse/Partner _____ Brother _____ Child _____
   _____ Other

2. Looking back, I would guess that my relationship with this person was (check only one):
   _____ Closer than any relationship I’ve ever had before or since.
   _____ Closer than most relationships I’ve had with other people.
   _____ About as close as most of my relationships with others.
   _____ Not as close as most of my relationships.
   _____ Not very close at all.

3. How old was this person when he or she died? _____

4. How long ago did this person die? _______

5. This person’s death was:
   _____ Expected _____ Unexpected _____ Slow _____ Sudden
### Part I: Past Behavior

Think back when this person died and describe your feelings and actions at that time by putting an X under the best answer.

<table>
<thead>
<tr>
<th></th>
<th>Completely True</th>
<th>Mostly True</th>
<th>Both True &amp; False</th>
<th>Mostly False</th>
<th>Completely False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>After this person died, I found it hard to get along with certain people.</td>
<td></td>
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<tr>
<td>2.</td>
<td>I found it hard to work well after this person died.</td>
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<tr>
<td>3.</td>
<td>After this person’s death, I lost interest in my family, friends, and outside activities.</td>
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<tr>
<td>4.</td>
<td>I felt a needed to do things that the deceased had wanted to do.</td>
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<tr>
<td>5.</td>
<td>I was unusually irritable after this person died.</td>
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<tr>
<td>6.</td>
<td>I couldn’t keep up with my normal activities for the first 3 months after this person died.</td>
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<tr>
<td>7.</td>
<td>I was angry that the person who died left me.</td>
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<tr>
<td>8.</td>
<td>I found it hard to sleep after this person died.</td>
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</tbody>
</table>
Part II: Present Feelings

Now answer all of the following items by checking how you presently feel about this person’s death. Please do not look back at Part I.

<table>
<thead>
<tr>
<th>Item</th>
<th>Completely True</th>
<th>Mostly True</th>
<th>Both True &amp; False</th>
<th>Mostly False</th>
<th>Completely False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I still cry when I think of the person who died.</td>
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<tr>
<td>2. I still get upset when I think about the person who died.</td>
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<tr>
<td>3. I cannot accept this person’s death.</td>
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<td>4. Sometimes I very much miss the person who died.</td>
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<tr>
<td>5. Even now it’s painful to recall memories of the person who died</td>
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<tr>
<td>6. I am preoccupied with thoughts (often think) about the person who died.</td>
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<tr>
<td>7. I hide my tears when I think about the person who died.</td>
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<tr>
<td>8. No one will ever take the place in my life of the person who died.</td>
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<tr>
<td>9. I can’t avoid thinking about the person who died.</td>
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<tr>
<td>10. I feel it is unfair that this person died.</td>
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<tr>
<td>11. Things and people around me still remind me of the person who died.</td>
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<tr>
<td>12. I am unable to accept the death of the person who died.</td>
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<td>13. At times I still feel the need to cry for the person who died.</td>
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</tbody>
</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>This Does Not Describe Me</th>
<th>This Barely Describes Me</th>
<th>This Somewhat Describes Me</th>
<th>This Describes Me</th>
<th>This Describes Me Very Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>5</td>
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</tbody>
</table>

Using the scale above, please rate your confidence in your ability to currently perform the following skills.

1. I can assess for unresolved losses that may not be stated as a presenting problem. 1 2 3 4 5

2. I can provide psycho-education to clients related to the grief experience for themselves and others. 1 2 3 4 5

3. I can facilitate family grief counseling sessions. 1 2 3 4 5

4. I can provide educational workshops and activities to community members about grief. 1 2 3 4 5

5. I can define and articulate the nature of “normal” bereavement and grief as detailed by theoretical models. 1 2 3 4 5

6. I can articulate the diagnostic criteria for Bereavement, according to DSM-IV, and how to distinguish this diagnosis from related diagnoses. 1 2 3 4 5

7. I can facilitate individual grief counseling sessions. 1 2 3 4 5

8. I can use concrete terms regarding death to address the reality of death and convey the ability to discuss death-related issues. 1 2 3 4 5

9. I can provide developmentally appropriate programs about grief and loss issues in schools. 1 2 3 4 5

10. I can facilitate group grief counseling sessions. 1 2 3 4 5
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).

12. I can conduct suicide assessments.

13. I can facilitate multi-family group grief counseling sessions.

14. I can articulate a grief consultation model for parents, teachers, and other adults about how to talk to children about death, grief, and loss.

15. I can provide crisis intervention services to schools and/or community settings.

16. I can define and articulate the nature and symptoms of complicated/unresolved grief situations.

17. I can teach clients how to obtain support and resources in the community.

18. I can assess a client’s sense of spirituality.

19. I can establish rapport with clients of all ages

20. I can work on an interdisciplinary team by interacting with staff from different professions.

21. I can identify cultural differences that affect treatment.

22. I can describe common functional coping styles of bereaved persons.
23. I can utilize family assessment techniques to examine interaction patterns and roles.

24. I can provide appropriate crisis debriefing services.

25. I can exhibit effective active listening skills.

26. I can read and apply current research and literature related to grief and effective treatment interventions.

27. I can facilitate a reframe of loss experience and grief reactions for client empowerment.

28. I can describe common dysfunctional coping styles of bereaved persons.

29. I can assess individuals’ progress on theoretically defined grief tasks.

30. I can facilitate reconnection between a dying client and distant/estranged family members.

31. I can use the creative arts in counseling to facilitate grief expression.

32. I can appropriately self-disclose related to own grief and loss experiences.

33. I maintain an updated library of grief and loss resources for clients.

34. I can articulate appropriate developmental levels of death understanding for children.

35. I can identify cultural differences that affect assessment.
36. I can recognize and work with grief-related client resistance and denial.  
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.  
38. I can describe how various individual counseling theories can be applied to grief counseling with individuals and families.  
39. I can recommend helpful articles and books for grieving individuals and families.  
40. I can identify symptoms that warrant medical evaluation and refer to a physician.  
41. I can describe how various family counseling theories can be applied to grief counseling with individuals and/or families.  
42. I can advocate for the needs of the dying client and the family.  
43. I can define and differentiate between the terms of grief, bereavement, and mourning.  
44. I can determine appropriate treatment modality for grieving client (i.e. individual or group) as a result of assessment.  
45. I can co-create and participate in mourning rituals for individuals and/or families.
46. I can provide supportive presence for client(s) in difficult times.

47. I can provide hope without giving false reassurance.
**Final Questions**

1. For persons in my position, education in grief counseling, including assessment and treatment: (check one)  
   _______Are Not Necessary  _______Are Necessary  _______Should Be Required

2. Personally, I would be willing to participate in and learn more about grief counseling. (check one)  
   _______Yes  _______No  _______Uncertain

3. My preferred educational platform for grief counseling training would be (circle one):  
   a. A face-to-face, interactive seminar or presentation  
   b. Multi-media online tutorial  
   c. Multi-media online tutorial and face-to-face review/Q&A  
   d. Read-only print text  
   e. Other (please provide): _________________________________

Thank you for answering all of the questions. Please elaborate on any item above and/or additional comments regarding this survey:
APPENDIX B

EXEMPTION FROM INTERNAL REVIEW BOARD (IRB)
The above project has been determined to be exempt. The project number is 2007E0428. You may begin your data collection. The signature page of the application is attached to serve as an approval letter.

* You are reminded that you must promptly report any problems to the Office of Responsible Research Practices.
* No procedural changes may be made in exempt research.
* Please note that only OSU employees and students who have completed CITI training and are named on the signature page of this application are approved as OSU investigators in conducting this study.
* Your research has been determined to be exempt in category # 2 Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
  a. information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; AND,
  b. any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

(Note: The exemption under Category 2 DOES NOT APPLY to research involving survey or interview procedures or observation of public behavior when individuals under the age of 18 are subjects of the activity except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.)

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APPENDIX C

PERMISSION TO USE DEATH COUNSELING SURVEY (DCS)
Hello Anne,

You most certainly have my permission to use it. Do you have a copy, or do you need me to send it to you?

Best wishes with the dissertation, please keep me posted as to the study and results...

Wendy Charkow Bordeau, Ph.D., LPC, NCC
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-----Anne Deffenbaugh <amd0514@yahoo.com> wrote: -----
APPENDIX D

PERMISSION TO USE SEXUAL ORIENTATION COUNSELOR COMPETENCY SCALE (SOCCS)
Anne -
You are more than welcome to use the scale and make the changes you describe. Please let me know your final results and how the scale worked for you. My web-link is below and you can access my scale. Good luck and thanks for your interest.
Markus

Quoting Anne Deffenbaugh <amd0514@yahoo.com>:

Dr. Bidell -
My name is Anne Deffenbaugh and I am a doctoral candidate in Counselor Education at The Ohio State University. I am currently working on my dissertation proposal and I am interested in using your instrument, the Sexual Orientation Counselor Competency Scale (SOCCS), in my dissertation. Specifically, I would like to use the Skills Scale and substitute "LGB clients" with "clients who present with grief."

I am exploring the relationship between counselors' personal experience with grief and their professional competencies. In my research, your assessment is one of the few I have found which measures competencies of working with specific populations. I would like your permission to use the assessment with practicing licensed counselors in the state of Ohio. Please let me know what steps I need to take to acquire this permission. Thank you in advance for your consideration.

Sincerely,
Anne Deffenbaugh, LPC

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