ABSTRACT

Title of Thesis:	BEREAVED COLLEGE STUDENTS: EXAMINING PREDICTORS OF GRIEF COUNSELING SKILLS AMONG UNIVERSITY COUNSELING CENTER THERAPISTS
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Between 22% to 30% of college students are grieving a death of a close friend or family member, and nearly 60% of college seniors report experiencing at least one loss in the last three years of college (Balk, 2011; Cox, Dean, & Kowalski, 2015). The university counseling center often is the primary resource for bereaved students, yet centers have limited resources and some psychologists reported inadequate training for working with grieving students (Kim, 2016). This study examined predictors of grief counseling skills in a sample of university counseling center therapists. Grounded in the death competence model (Gamino & Ritter, 2012), results indicated that cognitive competence and emotional competence predicted grief counseling skills, with training/experience being the most robust predictor. Future directions for research and clinical implications are discussed.

BEREAVED COLLEGE STUDENTS: EXAMINING PREDICTORS OF GRIEF COUNSELING SKILLS AMONG UNIVERSITY COUNSELING CENTER THERAPISTS

by

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Thesis submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
of the requirements for the degree of
Master of Science
2019

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Table of Contents

Table of Contents ii
List of Tables iii
List of Figures iv
Chapter 1: Introduction 1
Chapter 2: Method 18
Chapter 3: Results 38
Chapter 4: Discussion 43
Appendices 61
References 129

List of Tables

Table 1: Demographics

Table 2: Professional Background and Education

Table 3: Means, Standard Deviations, Reliability Estimates, and Intercorrelations

Table 4: Hierarchical Regression Analysis Predicting Grief Counseling Skills as Measured by Death Counseling Survey

Table 5: Hierarchical Regression Analysis Predicting Grief Counseling Skill as Measured by Vignette Rating

Table 6: Hierarchical Regression Analysis Predicting Therapist Comfort

Table 7: Grief-Related Assessment and Treatment Principles/Themes as Measured by Vignette Responses

Table 8: Therapist Self-Reported Issues as Measured by Vignette Responses

List of Figures

Figure 1: Hierarchical Model of Death Competence

Figure 2: Proposed Model of Death Competence Predicting Grief Counseling Skills

Figure 3: Final sample

Chapter 1: Introduction

Bereaved College Students: Examining Predictors of Grief Counseling Skills Among University Counseling Center Therapists

Many college students (22% to 30%) are in the first 12 months of grieving a death of a close friend or family member (Balk, 2011); nearly 60% of college seniors report experiencing at least one loss in the last three years of college (Cox, Dean, & Kowalski, 2015). Following loss, young adults may experience intense and prolonged grief, resulting in depression, physical problems, sleep difficulties, and increased alcohol, drug, and tobacco use (Creighton, Oliffe, Matthews, & Saewyc, 2016; Hardison, Neimeyer, & Lichstein, 2005; Herberman Mash, Fullerton, & Ursano, 2013). Bereaved college students are particularly vulnerable to adverse outcomes after loss due to academic pressures and because they are away from home and often lack strong support from those closest to them (Balk, 2011). The college counseling center often is the primary resource for bereaved students, yet many centers have limited resources and some psychologists reported inadequate training for working with grieving college students (Kim, 2016). Thus, the main purpose of this study was to examine the predictors of grief counseling skills in working with bereaved college students with a sample of university counseling center therapists.

Grieving College Students

College students (typically between 18 to 23 years old) experience various losses such as violent campus incidents, peer suicides, and more commonly, deaths of family members and friends. Approximately 35% to 48% of college students are within two years of grieving the death of a family member or close friend (Balk, 2011; Hardison,

Neimeyer, & Lichstein, 2005). In addition, more than half (60%) of graduating seniors reported experiencing at least one loss and around 23% reported multiple deaths in their last three years in college (Cox et al., 2015). These numbers may seem surprising to some, especially since death, dying, and bereavement are rarely discussed in the context of college life.

College students experience both expected and sudden losses. Expected losses occur when family members or friends have struggled with prolonged illness or disease, while sudden losses comprise unexpected and often traumatic deaths such as motor vehicle accidents, drug overdose, and suicide. A study on the prevalence of grieving college students using a convenience sample of 994 students found that the majority of participants (81.8%) reported deaths of grandparents, and around 20% reported the deaths of immediate family members (Balk, 1997). College students also were more likely to experience an anticipated death of a family member due to illness or old age (83% of all those who reported a family member loss). Furthermore, around 60% of bereaved students reported that they experienced a death of a friend. Unlike family losses, most of the friend losses were sudden (e.g., accident, suicide or murder), accounting for around 80% of all those who reported a friend loss (Balk, 2011). Sudden deaths of peers may be particularly relevant to the college-aged population, as it is shown that suicide is the second leading cause of death among college students, resulting in an average of 1,100 deaths per year (Wilcox et al., 2010). Thus, unexpected peer loss as well as anticipated family loss becomes an all too common experience for young adults.

Death of a close family member or friend is an inevitable and universal human experience and most people cope and adapt in a normative way. Normative grief or

uncomplicated grief is what most would consider an expected grief trajectory (Bonanno, 2004). Those grieving in a normative way recognize that their feelings of loss often are accompanied by sadness, confusion, yearning for the deceased, and emotional numbness. Nonetheless, these feelings gradually subside and the bereaved often begin to slowly make sense of their loss and integrate it into their "new normal" (Holland, Currier, & Neimeyer, 2006; Humphrey, 2009).

Although the majority of grieving individuals are expected to cope with loss in adaptive ways, a subset of grievers (7% to 15%; Kersting, Brähler, Glaesmer, & Wagner, 2011; Zisook & Shear, 2009) can develop complex, more intensified grief, which is known as prolonged grief disorder (Cox et al., 2015; Hardison et al., 2005; Herberman Mash et al., 2013; Prigerson, Vanderwerker, & Maciejewski, 2008) or complicated grief (Shear et al., 2011). While uncomplicated grief often is resolved within six months to a year, prolonged grief disorder is diagnosed when severe grief symptoms persist beyond one year and functioning is impaired (Cozza et al., 2016). Prolonged grief disorder or complicated grief can be distinguished from normative grief in that it manifests in difficulty accepting the death or feeling extreme disbelief that the death has occurred, intense yearning and longing for the deceased, anger, painful and intrusive thoughts related to the death, and avoidance of reminders of the loss or the deceased (Zisook & Shear, 2009). Furthermore, unlike normative grief that does not always require professional support (Jordan & Neimeyer, 2003), prolonged grief disorder may require intervention (Herberman Mash et al., 2013).

Most of bereavement research has been conducted with grieving middle-to-late adults, particularly with widows and widowers (Hardison et al., 2005), while research

with bereaved younger adult populations is lacking. This raises concerns as bereaved young adults (e.g., college students) are at risk for experiencing physical and psychological difficulties as well as impaired academic performance (e.g., Balk, 2011; Hardison et al., 2005; Neimeyer et al., 2008; Servaty-Seib & Taub, 2010). For example, some bereaved college students experience physical problems, insomnia, and increased alcohol, drug, and tobacco use (Creighton et al., 2016; Hardison et al., 2005; Herberman Mash et al., 2013).

These difficulties may further be exacerbated by the fact that college students often are geographically removed from their usual support systems and are adjusting to a new environment and lifestyle (Arnett, 2000; Balk, 2011). Also, many peers of grieving college students may not know how to talk or behave around their bereaved friends and often inadvertently distance themselves from them, which results in poor peer support (Balk & Vesta, 1998). Yet another factor that makes bereaved college students vulnerable is that they often do not seek support for grief, but present with issues related to sleep difficulties (Hardison et al., 2005) and academic struggles including lack of motivation and difficulty concentrating (Janowiak, Mei-tal, & Drapkin, 1995). Thus, bereaved college students face unique challenges and may turn to university counseling centers for assistance.

Campus Resources For Grieving College Students

The most common services available for bereaved college students on college campuses are found in university counseling centers and often include counseling, support groups, and workshops. However, little is known about the preparedness of clinicians at the counseling centers to perform grief counseling. Counseling psychologists

are commonly employed as university counseling center staff and likely are the first responders to student grief issues (Servaty-Seib & Taub, 2010). However, research suggests that many have limited knowledge, training, and skills in providing grief counseling (Charkow, 2001; Ober et al., 2012). This raises concerns as to the degree to which university counseling center therapists are adequately prepared, confident, and competent to work with bereaved college students.

A recent qualitative study of university counseling center therapists revealed mixed findings about the readiness of the therapists as well as the preparedness of the corresponding sites where they worked (Kim, 2016). Most participants cited a lack of resources and limited staff availability as the primary barriers in providing adequate grief support to students. In addition, many participants highlighted the need for improved grief counseling training, starting or expanding grief support groups, and improving outreach and grief workshops to educate the college community (Kim, 2016).

Another important issue related to the preparedness of university counseling center therapists to work with bereaved students is that most therapists do not have prior education and experience in working with bereaved populations. Grief counseling is not an accredited core counseling curricula requirement (Council for Accreditation of Counseling and Related Educational Programs, 2016). Also, the APA accreditation guidelines for psychology programs (American Psychological Association, Commission on Accreditation, 2015) do not include competencies related to dying, death, or end-of-life issues, and there is no mention of these topics in the APA Code of Ethics (although APA has expressed a commitment to improve the field's investment in these topics; American Psychological Association, 2017). It has been suggested that given the general

training that psychologists receive in addressing mental health issues, they should be well suited to work with patients at the end-of-life. However, there is a visible lack of psychologist involvement in palliative care (Kasl-Godley, King, & Quill, 2014). Training programs in counseling psychology also do not provide education about end-of-life issues (Werth, & Crow, 2009) and thanatology as a whole (Servaty-Seib & Taub, 2010). Thus, the overall training and education of therapists who work with bereaved college students seemed inadequate, and research focused on their grief counseling skills was needed.

Theoretical Foundation and Construct Definitions

Gamino and Ritter (2012) coined the term death competence, which is a therapist's "specialized skill in tolerating and managing clients' problems related to dying, death, and bereavement" (p. 23). According to the authors, death competence not only captures the skills necessary to work with the bereaved, but also highlights the necessity for ethical practice in grief counseling (Gamino & Ritter, 2009, 2012). To advance understanding regarding death competence, Gamino and Ritter proposed a model of death competence, which is based on previous theories and the competencies put forth by the Code of Ethics of the Association for Death Education and Counseling (ADEC; 2006), which is the largest professional thanatology association in the United States.

The death competence model, shown in Figure 1, is hierarchical and consists of two primary building blocks – cognitive and emotional competences, which together comprise the overall death competence construct. According to this model, cognitive competence refers to the "consolidation of sound academic training and supervised field experience culminating in proven proficiencies that constitute the counselor's expert

knowledge and skill set" (Gamino & Ritter, 2012, p. 30). In other words, cognitive competence is essentially what the therapist knows about the grief counseling process and outcomes. Moreover, emotional competence refers to a therapist's capacity to work with bereaved individuals and "to endure the emotional rigors of the therapy process, with its attendant graphic discussions of conflict, trauma, loss, anguish and suffering" (Gamino & Ritter, 2009, p. 35). Thus, emotional competence consists of psychological resilience, awareness and integration of one's personal loss history, and utilization of self-care and support from colleagues (Gamino & Ritter, 2012).

Further support for the emotional competence construct comes from what some researchers referred to as the therapist's self-competence when working with end-of-life or bereaved individuals (Chan & Tin, 2012; Chan, Tin, & Wong, 2015; 2017). They defined self-competence as the therapist's personal characteristics required to cope with the emotional and existential challenges that arise within grief counseling. The authors argued that although knowledge and professional skills have been cited as the most important factors in preparing professionals to work with the bereaved, the focus on the therapist self has been neglected (Chan et al., 2015). Building on their previous research studies, Chan and colleagues (2015) developed and tested a measure that focused on therapist self-competence. They found that therapists who possessed more positive qualities related to life and death topics (e.g., acceptance of death, higher meaning in life, and increased emotional well-being) were more likely to score high on self-competence. Overall, they concluded that professionals who possess high self-competence were comfortable working with dying and bereaved individuals (Chan et al., 2015). Thus, these

findings further supported the notion that emotional competence is an integral part of being an effective therapist when working with grieving clients.

Overall, the death competence model (Gamino & Ritter, 2009; 2012) provides a foundational framework to assess grief counseling skills in this study. However, in addition to cognitive and emotional competence, attitudes toward death (Kirchberg, Neimeyer, & James, 1998) may affect the therapists' skills in working with clients who present with grief issues. In the current study, we sought to extend the existing death competence model by including a third component – death attitudes (see Figure 2). Thus, the degree to which cognitive competence, emotional competence, and death attitudes were predictive of grief counseling skills was examined in a sample of university counseling center therapists.

Cognitive competence. Our theoretical model suggested that cognitive competence, defined as knowledge and training/experience regarding death, dying, and grieving would be related to grief counseling skills in working with bereaved individuals. We expected knowledge and training/experience to be closely related, as knowledge in death education and grief counseling may be related to the amount of training and experience received. Knowledge and training/experience may include death education received in graduate school, continuing education related to grief counseling, and other elective professional activities related to the topics of death and dying.

The operationalization of foundational knowledge topics in understanding death, dying, and bereavement in this study was informed by the guidelines provided by ADEC (Meagher & Balk, 2013). Two members of the research team reviewed ADEC's proposed body of knowledge matrix and identified the most salient knowledge components that are

relevant to grief counseling. Furthermore, two clinicians knowledgeable in thanatology and who have experience in working with bereaved clients were asked to rate the importance of each knowledge theme and suggest any additional important themes. After incorporating their feedback, the themes identified included grief models and theories, grief styles, knowledge about normative grief, knowledge about complicated grief, current evidence-based therapeutic strategies, risk factors associated with poor bereavement outcomes, and multicultural considerations in bereavement.

In addition, participation in grief counseling training may be related to skills in providing grief counseling (Ober et al., 2012). A recent systemic review of literature on bereavement that focused particularly on complicated grief reported that training for mental health professionals working with bereaved individuals was lacking (Dodd, Guerin, Delaney, & Dodd, 2017). The authors highlighted that training focused on enhancing knowledge, attitudes, and skills for those working with the bereaved was especially needed.

Relatedly, another study examined family counselors' specialized training and competence in grief counseling (Charkow, 2001). Overall, participants who had more specialized training in death education were more likely to cope well with personal issues related to death and dying, and possessed stronger skills in working with grieving individuals. Another influential study in the field assessed therapists' comfort in working with clients who presented with issues related to death and dying, and found that practitioners with multiple years of experience expressed less distress than novice practitioners (Terry, Bivens, & Neimeyer, 1996). This supported the notion that more

training and experience translated into the therapist feeling more comfortable and ready to address issues experienced by the bereaved.

In addition, Ober et al. (2012) found more support for this proposition. Their exploratory study examined the level of training in grief counseling, personal and professional experiences of grief, and grief counseling competence of 369 licensed professional counselors. Approximately half of the participants (54.8%) reported that they had not completed any specific courses on grief, yet a significant majority (91%) stated that training in grief counseling was needed or should be required part of one's professional training. Furthermore, the results suggested that training and experience in grief counseling were the predictors of death competence. Thus, this study provided further support for cognitive competence consisting of knowledge and training domains that may be closely related to each other.

Grief counseling training and competencies also were assessed in a sample of masters-level counseling students in CACREP-accredited institutions (Imhoff, 2015). Professional training and experience in grief counseling were associated strongly with perceived competencies. This study also demonstrated that students rated themselves higher on the general counseling abilities, but less competent on grief specific skills and knowledge (Imhoff, 2015). Thus, overall these studies suggested that therapists who have more exposure and knowledge in death-related topics and direct experience and training in working with grieving clients may be more prepared and confident to provide grief counseling.

Emotional competence. Building on the death competence model proposed by Gamino and Ritter (2009; 2012) and informed by previous work on self-competence

(Chan & Tin, 2012; Chan et al., 2015; 2017), emotional competence was defined as the therapist's ability to effectively cope with issues of death and dying. Emotional competence consists of psychological resilience, awareness and integration of one's personal loss history and utilization of self-care (Gamino & Ritter, 2012). Emotional competence as it relates to grief work is similar to the general concept of emotional intelligence/competence (Brasseur, Grégoire, Bourdu, & Mikolajczak, 2013; Saarni, 1999), yet one distinct differentiating factor is the necessity to be aware of one's personal loss history and its possible influence on the therapeutic relationship when working with grieving clients.

Research suggested that mental health providers who experienced a personal loss may be more empathetic to clients presenting with grief issues (Martin, 2011; Rappaport, 2000), and counselors who are able to cope with their grief might provide better support for bereaved clients (Worden, 2008). However, therapists' unresolved grief may negatively affect the therapeutic work. One study with a sample of 69 therapist-client dyads found that the therapists were perceived as less empathetic by their clients when the therapists were still coping with their loss and more empathic when the therapists had resolved their grief (Hayes, Yeh, & Eisenberg, 2007). Last, in addition to examining personal loss history, grief counselors were encouraged to identify what drew them into working with end-of-life issues and grieving clients and examine their ongoing interest in death and dying to be effective providers of care (Katz, 2006). Thus, emotional competence became important to assess in addition to therapist skills in providing grief counseling, because there was a positive association between how one approaches and

copes with death-related feelings and overall confidence in providing bereavement care (Chan & Tin, 2012; Chan et al., 2015; 2017; Gamino & Ritter, 2009; 2012).

Death attitudes. Although much of the early research on attitudes toward death and dying focused on negative reactions to death (e.g., Collett, & Lester, 1969; Templer, 1970), death attitudes now are operationalized more comprehensively as views on death and dying, including negative as well as more neutral and even positive reactions (Neimeyer, Wittkowski & Moser, 2004). Death attitudes often have been studied as a multidimensional construct that includes various dimensions of death-related views. For example, one of the most widely used measures of death attitudes, the Death Attitudes Profile – Revised (DAP-R; Wong, Reker, & Gesser, 1994), assesses death attitudes on five separate dimensions. This measure consists of negative attitudes including fear of death, death avoidance, and escape approach attitudes (e.g., death will end a miserable existence), as well as neutral approach attitudes (e.g., death is a part of life), and positive approach attitudes (e.g., death is a gateway to a happy afterlife; Wong et al., 1994). Death attitudes are important for therapists, because they reflect overall views on death and dying, which in turn could have an effect on working with the bereaved.

In fact, one of the first studies that directly assessed mental health providers' death attitudes was conducted by Kirchberg and colleagues (1998). They explored masters-level counselors' attitudes toward working with clients presenting with death-related issues and their ability to respond to them in an empathic manner. Participants viewed videotape vignettes depicting clients with death-related (e.g., grief, AIDS) and non-death-related problems (e.g., marital discord, physical disability). They found that counselors reported higher levels of discomfort in responding to client situations

involving death and dying compared to other presenting issues. Importantly, personal fear of death predicted counselors' distress in grief counseling. Interestingly, the counselors were slightly more empathic in responding to grief and loss than other conditions, which was not anticipated by the authors (Kirchberg et al., 1998).

Another study examined the relationship between professional and personal characteristics when responding to clients presenting with suicide issues in samples of undergraduates, suicide hotline volunteers, and graduate students in clinical and counseling psychology (Neimeyer, Fortner, & Melby, 2001). Overall, participants who reported strong levels of death acceptance and who also had more training and experience were more responsive to clients who presented with suicidal ideation or intent. These results further highlighted that the death attitudes of the counselor may relate to their effectiveness in working with clients facing issues related to death and dying. Thus, overall, death attitudes and ability to tolerate and cope with the topic of death may be crucial when working with bereaved clients.

Whereas death attitudes encompass general reactions to death and dying, fear of death is a specific dimension of death attitudes that denotes a negative feeling of dread that is caused by thoughts of the death, dying, or ceasing to be of one's self or others (Lehto, & Stein, 2009). Fear of death is an important dimension of death attitudes, as it may affect comfort in working with bereaved individuals. For example, novice counselors with greater personal fear of death reported more distress in working with clients who present with bereavement, life-threatening illness, or suicide risk (Kirchberg, Neimeyer, & James, 1998). On the other hand, crisis counselors who reported strong levels of death acceptance were more responsive to clients who presented with suicidal

ideation or intent (Neimeyer et al., 2001). Thus, death attitudes and ability to cope with the topic of death may be crucial when working with bereaved clients.

Grief counseling skills. In the current literature, there was no unifying definition of grief counseling skills. However, the death competence model (Gamino & Ritter, 2009; 2012) provided a useful framework for conceptualizing the characteristics of an effective grief counselor. According to this model, a counselor who is skilled to provide grief counseling is someone who has the knowledge and training to do the work, and is emotionally prepared, self-aware of their emotions and personal loss history, and able to tolerate and cope with the distress that often accompanies working with the bereaved (Gamino & Ritter, 2009; 2012). Furthermore, the ADEC comprehensive handbook of thanatology (Meagher & Balk, 2013) provides insight into important aspects of working with bereaved individuals and skills needed to be an effective grief counselor. Similarly to therapeutic care broadly construed, in grief counseling, clinical assessment and utilization of various treatment interventions emerge as crucial components in providing effective grief counseling. Furthermore, both assessment and treatment need to be understood through the lens of the client's cultural background and views (Meagher & Balk, 2013). Building upon the death competence model and ADEC guidelines, in this study, we define grief counseling skills as the therapist's ability to provide effective grief counseling that is based on knowledge of core components of grief assessment and treatment, which includes acute awareness of contextual factors (e.g., client's cultural background and beliefs), and the ability to emotionally tolerate working with a bereaved individual.

Research assessing grief counseling skills in mental health professionals is extremely limited. Most studies focus on overall competence, which more often highlights the counselor's knowledge, training, or comfort in working with bereaved clients rather than their skills. For example, competence in grief counseling was assessed in a sample of family and marriage therapists (Charkow, 2001). Participants who had more specialized training in death education were more likely to cope well with personal issues related to death and dying, and possessed stronger skills in working with grieving individuals. Not surprisingly, training in death education may predict effective grief counseling skills. Similarly, counselors' training, experience, and competencies in grief counseling were studied in a sample of 369 licensed professional counselors (Ober et al., 2012); training and experience in grief counseling were related to death competence. Interestingly, no studies assessed grief counseling skills among university counseling center therapists.

Current Study

In summary, although a large number of university students experience the deaths of loved ones (Balk, 2011; Cox et al., 2015), research related to counseling bereaved college students was lacking. Importantly, university counseling center therapists are at the forefront of providing resources and support to bereaved students, yet their grief counseling skills have not been examined thoroughly. Thus, the purpose of this study was to examine the predictors of grief counseling skills in a sample of university counseling center therapists. Specifically, the degree to which cognitive competence, emotional competence, and death attitudes predicted grief counseling skills was examined (see Appendix A for more information regarding the constructs of interest in this study).

It was hypothesized that collectively, cognitive competence, emotional competence, and death attitudes would predict grief counseling skills (see Appendix B for an outline of study constructs and measures). Specifically, cognitive competence and emotional competence were expected to correlate positively with grief counseling skills. Last, we hypothesized that death attitudes would be related to grief counseling skills with more negative death attitudes such as fear of death and death avoidance being correlated negatively with grief counseling skills. More neutral death attitudes (neutral acceptance) were expected to correlate positively with grief counseling skills.

Implications

The current study has important research and clinical implications. First, a very large number of college students experience the death of a loved one, yet grief counseling for this young adult population is grossly understudied (Servaty-Seib & Taub, 2010) and received little attention in the counseling world. Given that many health-related and psychological risks were associated with grief (Creighton et al., 2016; Hardison et al., 2005; Herberman Mash et al., 2013), particularly prolonged or complicated grief, and the fact that college students often are removed from their usual support systems (e.g., living away from home; Balk, 2011), more research was needed that focused on the bereaved college population.

Furthermore, we know very little about the preparedness and skills of the university counseling center therapists who work with bereaved college students. Considering that grief counseling is not an accredited core counseling curricula requirement (Council for Accreditation of Counseling and Related Educational Programs, 2016), and that APA has no established standards and requirements regarding this

domain, the state of the therapists' preparedness and competency working with bereaved individuals is unknown. Thus, since many counseling psychologists working at university counseling centers will likely work with bereaved clients, it was critically important to study their current levels of knowledge, training/experience, attitudes, and skills.

Thus, the current study examined a proposed model of several components of grief counseling skills (i.e., cognitive competence, emotional competence and death attitudes) using a sample of university counseling center therapists. In addition to advancing research focused on the bereaved college student population, the results of this study advanced knowledge regarding the predictors of grieving counseling skills of professionals who work with bereaved college students. This information could inform the future development of grief counseling training for university counseling center therapists and graduate programs and may ultimately improve the counseling services provided to bereaved college students.

Chapter 2: Method

Design

The purpose of this descriptive, cross-sectional design was to examine the contributions of cognitive competence, emotional competence, and death attitudes to the prediction of one criterion variable, which was measured in two ways. First, the study sought to determine if cognitive competence, emotional competence, and death attitudes would predict university counseling center therapists' grief counseling skills as measured by a self-report quantitative scale. Additionally, this study aimed to determine the degree to which cognitive competence, emotional competence, and death attitudes could predict university counseling center therapists' grief counseling skills as measured by a case vignette response ratings.

Procedures

An *a priori* statistical power analysis, using the G*POWER v3 software (Faul, Erdfelder, Lang, & Buchner, 2007), was used to calculate the total number of participants needed to achieve statistical power of 0.90, a medium effect size ($f^2 = 0.15$), with an overall $\alpha = 0.05$. The results indicated a suggested total sample size of 116 participants. Due to the utilization of two hierarchical multiple regressions, we aimed to obtain a sample of 150 therapists and pre-doctoral interns working in university counseling centers located in the United States.

Several recruitment methods were used. First, we identified university counseling centers that housed APA-accredited internships (a total of 139). We sent email messages to 131 counseling center directors and asked them to forward a study recruitment email to the therapists and the pre-doctoral interns who were completing internships at their site.

We also sent recruitment email messages to 8 training directors instead of the counseling center directors, because we could not locate email addresses for seven directors and one director was away on an extended vacation and did not have access to email. Thus, all 139 identified APA-accredited internship sites were contacted. In addition, email messages were sent to the APA Division 17 (Counseling Psychology) email listserv as well as the Division 17 University Counseling Center section listserv. The recruitment email contained information about the study, IRB approval, and a link to an online survey.

All individuals who accessed the link to the survey were asked to answer inclusion criteria questions about whether they were employed or on internship at a university counseling center in the United States (see Appendix C). Those who confirmed that they were currently working as a therapist or pre-doctoral intern at a university counseling center in the United States were eligible to participate and were provided with the informed consent form. Individuals who did not meet the inclusion requirements received a message informing them that they did not meet the criteria to participate.

After indicating consent, eligible participants were presented with the study measures using online Qualtrics software. All measures were counterbalanced in their presentation order except for the grief knowledge assessment and demographics surveys, which were included last. At the conclusion of the study, contact information for the researchers and resources related to grief counseling were provided. As a small incentive, participants were offered the opportunity to receive an Amazon.com gift card worth $10 upon completion of the study. Those interested in receiving the gift card were prompted to click on a link that took them to another survey where they were asked to provide their

name and contact information. No identifiable information was collected on the main survey. Participation in the study took approximately 20 minutes.

Participants

Two hundred sixty-four individuals met the inclusion criteria and provided consent to participate. Forty-one participants did not start the survey after consenting, and thus, were removed from analyses. In addition, eight participants failed to provide a correct answer to at least one of the two validity checks and were removed. Then, data from participants who failed to complete at least 85% of the items on the survey were deleted (n = 43). Also, it became clear that one participant was a current student-trainee (and not an intern) and their data were removed from the study. Thus, the final sample consisted of 171 participants who completed the quantitative measures (see Figure 3). However, out of the 171 participants, 16 (9.3%) participants did not complete the vignette question assessing comfort in working with the bereaved client, and 15 (8.8%) participants did not respond to the other qualitative vignette questions and were removed from the analyses. Thus, the final sample for the qualitative analyses consisted of 155 participants for the vignette question assessing therapist's comfort, and 156 participants for the other three vignette questions (see Figure 3). All 171 participants met the inclusion criteria and were either practicing therapists or interns working in a university counseling center in the United States.

With regard to the characteristics of the sample, between 10.5% to 12.9% of the sample did not respond to the demographic questions and thus were missing responses (see Table 1 for full demographics and Table 2 for full professional background and education information). The participants ranged in age from 24 to 68 years old (*M* =

36.57, *SD* = 9.25). The gender identity of the participants was female (68.4%), male (19.3%), trans male/trans man (0.6%), genderqueer/gender non-conforming (0.6%), and other (prefer to self-describe, 0.6%). In terms of racial identity/ethnicity, majority of the sample (62.0%) identified as White, Hispanic/Latinx (7.6%), Asian (6.4%), Biracial/Multiracial (6.4%), Black/African American (4.7%), Native American (1.2%), and other (prefer to self-describe, 1.2%). Furthermore, the most commonly endorsed sexual orientation was straight/heterosexual (66.7%). Most of the participants were married (52.0%) or were single and never married (21.1%).

The participants endorsed a range of religious/spiritual identities with Christian (34.5%), agnostic (15.8%), and spiritual, but not religious (14.6%) being the most common ones; and some participants endorsed more than one religious/spiritual identity. When asked about the importance of their religious/spiritual identity, vast majority reported it being important to some degree, with only 7.0% endorsing it as not at all important. In addition, participants rated the importance of their spiritual/religious identity or views in the way they approach clinical work with grieving clients. There was a range of responses, yet majority endorsed some level of importance, with 21.2% of the sample reporting not at all important.

With regard to their profession, the majority of participants (83%) were working as a therapist (post-training and not a student-trainee), while 17% identified as interns. Many participants held doctorate degrees (38.6% Ph.D., 16.4% Psy.D.), while 34.5% of participants reported having M.A. or M.S. degrees. The fairly high percentage of those holding M.A. or M.S. degrees was likely due to the fact that our sample included interns who have yet to complete their doctoral degrees. The most common degrees were in

counseling (37.4%) or clinical psychology (31%). Others reported having their highest degree in mental health counseling (11.1%), social work (7.6%), family and marriage counseling (1.8%), or art therapy (0.6%). The majority of participants were employed at a 4-year public college/university (74.3%).

The average number of years of clinical experience of the therapists and interns was 8.81 (*SD* = 7.50). Most participants were licensed to provide mental health care (67.8%). A number of theoretical orientations were reported with Integrative (56.9%), Cognitive-Behavioral (28.1%), and Humanistic (26.8%) being the most common. A little over a quarter of the sample stated a combination of a few theoretical orientations or identified with another theoretical approach that was not listed (e.g., Feminist, Interpersonal, Acceptance and Commitment Therapy, Relational Cultural Therapy). When asked about the degree to which their typical caseload consists of clients who present with grief issues/bereavement, all but one participant endorsed seeing bereaved clients. About a third of the sample reported their caseload containing 6 to 10% bereaved clients, while another third indicated 1 to 5%. Furthermore, when considering all the years that they had done therapy, most participants (44.4%) reported having worked with bereaved clients fairly often.

Information also was collected regarding the training, education, or other experiences that participants received related to death, dying, and grief counseling. Only a small percentage of participants (18.3%) completed grief counseling or death education coursework in their graduate training. However, approximately half of the sample (52.9%) obtained grief counseling experience/training in their practica, externships, or internships. Some participants (34.6%) completed continuing education courses in grief

counseling or death education, and majority (73.8%) had read books or other educational material on grief counseling. Only a small number of participants (12.4%) attended professional conferences that focused on grief counseling or death education, and only one participant (0.6%) received a certification in grief counseling. Some participants (19.6%) were or currently are primary caregivers to someone who is critically ill, worked with terminally-ill clients (7.8%), or volunteered/worked in hospice (7.2%).

Participants also rated their grief counseling knowledge. Over half of the sample (55.6%) stated that they still have much to learn to call themselves knowledgeable, while only 1.8% claimed feeling highly knowledgeable. When asked whether they would be interested in learning more about grief counseling, most participants expressed being very interested (42.1%) or interested (28.1%). Also, when asked about the importance of ongoing/continuing education in grief counseling for university counseling center therapists, the vast majority thought it important (40.9%) or very important (30.4%), with no participants reporting it as not important at all. Finally, the majority of participants (74.9%) had experienced significant deaths in their life. For those who answered positively to this question, they were asked to what degree any of these losses feel unresolved or unfinished. The responses varied, yet majority (60.1%) endorsed them as mostly resolved.

Measures

Cognitive competence. Using ADEC's Body of Knowledge Matrix (Meagher & Balk, 2013) as a foundation, the authors developed a grief knowledge assessment (see Appendix D). First, themes were identified that represented salient knowledge related to grieving and grief counseling. The principal investigator (a doctoral student in counseling

psychology with three years of experience working with caregivers of terminally-ill patients and bereaved individuals, and conducting research on death and grieving) reviewed the ADEC Body of Knowledge Matrix (Meagher & Balk, 2013) and selected the most salient themes for working with bereaved college students. Her advisor, a doctoral level counseling psychologist who completed a graduate certificate program in applied thanatology, reviewed the ADEC matrix and selected themes. After discussion, the themes were finalized (influential grief models and theories, grief styles, normative grief, complicated grief, risk factors associated with poor bereavement outcomes, and multicultural considerations in bereavement).

Second, the items were sent (via a Qualtrics survey) to two clinicians who were knowledgeable in thanatology and who had experience working with the bereaved (one doctoral level counseling center staff psychologist who facilitates therapy groups related to death and grieving and one doctoral candidate who completed hospice training, provides end-of-life assistance to dying patients, and conducts research on disenfranchised grief). The clinicians were asked to assess each item's degree of importance when assessing therapist knowledge of grief counseling on a 5-point Likert scale from "*extremely important*" to "*not at all important*." They also were asked to indicate any additional categories related to knowledge about grief that are critically important when assessing therapist knowledge of grief counseling. Both clinicians responded that all six categories were either very important or extremely important. Furthermore, one clinician suggested that an additional theme be included that centered on current, evidence-based therapeutic strategies. The feedback was incorporated and this

additional theme was added. Thus, seven grief-related themes were deemed as foundational in assessing therapist's knowledge regarding death, dying, and bereavement.

Next, an item was generated for each of the six, originally-proposed knowledge themes identified by the study authors: influential grief models and theories (e.g., question testing therapist's knowledge about continuing bonds theory), grief styles (e.g., question testing therapist's knowledge in identifying instrumental grieving style), normative grief (e.g., question testing therapist's common normative grief expressions), complicated grief (e.g., question testing therapist's knowledge about complicated grief symptoms), risk factors associated with poor bereavement outcomes (e.g., therapist's knowledge about important risk factors associated with poor bereavement adjustment), and multicultural considerations in bereavement (e.g., knowledge of important multicultural considerations in grief). The clinicians were given the seven knowledge assessment items (on a Qualtrics survey) and asked to match each item to one of the six grief-related themes (one theme had more than one item). The match rate was 100%, therefore all proposed items were retained for the assessment of knowledge regarding death, dying, and bereavement. Furthermore, an additional eighth item was generated for the knowledge theme (empirically supported therapeutic strategies) that was added after receipt of expert feedback. After receiving additional feedback from two licensed counseling psychologists, the one item assessing knowledge of normative and complicated grief was separated into two distinct items.

The final grief knowledge assessment (see Appendix D) contained nine items. Eight out of nine questions contained one correct answer, and one question was a multiple-choice question that allowed for six possible answers, with only four being

counted as correct. The correct answers from each grief knowledge assessment question were summed, which produced a total possible knowledge score ranging from 0 to 12 (M = 8.82, SD = 1.39).

In addition, the Grief Counseling Experience and Training Survey (GCETS) was created by Ober et al. (2012) by modifying the Sexual Orientation Counselor Competency Scale (SOCC; Bidell, 2005), which assesses counseling competencies in working with gay, lesbian, and bisexual clients. The original GCETS consists of 12 items that assess counselor's clinical training, supervision, experience, and formal education on grief counseling. For the purpose of the current study, researchers removed one item and edited the language of another item (item 7; see Appendix E). Example items included: "I have received adequate clinical training and supervision to counsel clients who present with grief" and "I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling." Participants responded to these items using a 5-point Likert scale ranging from 1 (*not at all true*) to 5 (*totally true*). High scores on GCETS meant considerable level of experience and training in grief counseling.

The GCETS was first piloted with 21 practicing mental health providers and found to have an acceptable reliability (α = .86; Deffenbaugh, 2008). The reliability estimate for the GCETS was .97, and scores on the GCETS were correlated positively with measures of grief counseling competence (Ober et al., 2012). In the current sample, reliability was .87.

Emotional competence. The Death Counseling Survey (DCS; Charkow, 2000) was developed to assess grief counseling competencies among family counselors and consists of 58 items on five subscales (i.e., Personal Competencies, Conceptual Skills and

Knowledge, Assessment Skills, Treatment Skills, and Professional Skills). The Personal Grief Counseling Competencies subscale (e.g., "I have self-awareness related to my own grief issues and history") was used to measure emotional competence in this study (see Appendix F). One item assessing personal loss history was edited by replacing "family member" with "significant person." This change was made to capture possible personal loss other than a family member. Participants responded to 11 items using a 5-point Likert scale ranging from 1 (*this does not describe me*) to 5 (*this describes me very well*). High scores on the DCS indicated strong levels of personal grief counseling competencies.

Support for the reliability of the scale was demonstrated with a sample of 369 licensed professional counselors: Personal Grief Counseling Competencies ($\alpha = .80$; Ober et al., 2012). Validity support was found by positive relationships among DCS subscale scores and scores on a scale measuring coping with death in a sample of 147 family counselors (Charkow, 2001). With the current sample, the reliability estimate was .74.

In addition to the Personal Grief Counseling Competencies subscale on the DCS, the Self-Competence in Death Work Scale (SC-DWS; Chan et al., 2015) was utilized to measure emotional competence. The SC-DWS is a 16-item measure that was developed to assess professionals' ability to cope with the emotional and existential challenges to self when working with dying individuals or those grieving a loss. The SC-DWS has two subscales: Emotional and Existential coping. In this study, we used the Emotional coping subscale (e.g., "I can effectively cope with my emotions induced by work"; see Appendix G) to assess emotional competence in working with the bereaved. The items were edited slightly to clarify that "work" in the items refers to "grief/bereavement work," which is

described in the instructions. Also, one sentence was removed from the instructions of the measure ("The word "work" in the following statements refers to death work"), and the response options were edited. In this final edited version, participants were asked to rate the extent to which the item described them. The scale consisted of 5-scale Likert scale ranging from 1 (*this does not describe me*) to 5 (*this describes me very well*). High scores on the subscale represented high levels of emotional competence.

The SC-DWS scale was developed by generating qualitative feedback from 176 palliative professionals on what competencies they viewed as important in working with dying and bereaved individuals (Chan & Tin, 2012). Then, the scale items were developed by two expert thanatologists, and then refined by additional professionals working in the death and dying field. The refined scale was pilot tested with 45 undergraduate and graduate social work students. Last, the final scale was assessed for reliability and validity with a sample of 151 helping professionals working with dying and bereaved individuals in Hong Kong. The total scale and the Emotional subscale showed adequate internal consistency, with Cronbach alphas of 0.88 and 0.78, respectively (Chan et al., 2015). Construct validity was supported by correlations with scores on measures of death attitudes, meaning in life, depression and burnout (Chan et al., 2015). It is important to note that to date, the SC-DWS was administered in Chinese, and no data was available on the translated English version. In the current study, the reliability estimate for the four-item Emotional coping subscale was .63. After one item was removed ("I do not bring grief/bereavement work-induced emotions into my life and do not bring life-induced emotions into my grief/bereavement work"), the reliability of

the SC-DWS Emotional subscale was improved (α = .80). This three-item scale was used in all data analyses.

Death attitudes. The Death Attitude Profile-Revised (DAP-R; Wong, Reker, & Gesser, 1994; see Appendix H) is a 32-item scale that assesses attitudes toward death using five subscales. In this study, three of the DAP-R subscales were used including Fear of Death (e.g., "I am disturbed by the finality of death"), Death Avoidance (e.g., "Whenever the thought of death my mind, I try to push it away"), and Neutral Acceptance (e.g., "Death should be viewed as a natural, undeniable, and unavoidable event").

The original DAP-R measure used response options ranging from *strongly agree* to *strongly disagree*, but these reversed order multiple times throughout the measure. In this study, all response options for the items ranged from *strongly disagree* to *strongly agree* to reduce confusion. Thus, participants indicated their agreement with the items using a 7-point Likert scale ranging from 1 (*strongly disagree)* to 7 (*strongly agree).* Additionally, two response options were edited: *"moderately disagree"* and *"moderately agree"* were changed to *"slightly disagree"* and *"slightly agree,"* respectively. High scores on the Fear of Death subscale indicated a strong fear of death. High Death Avoidance subscale scores were indicative of avoidance of death-related thoughts and associations. Last, high scores on the Neutral Acceptance subscale indicated belief that death is a reality that is neither good nor bad.

Overall, in a study with a sample of 403 hospital and hospice nurses, subscales on the DAP-R had a range of reliability estimates: Fear of Death (α = .82); Death Avoidance (α = .87); and Neutral Acceptance (α = .60; Clements & Rooda, 2000). In the same study,

support for the convergent validity was found, as DAP-R subscales correlated in expected direction with another scale measuring attitudes toward care for the dying (Clements & Rooda, 2000). Furthermore, subscales were identified as stable on the DAP-R (Wong et al., 1994), although more recent research proposed that the Neutral Acceptance subscale might consist of two dimensions (Clements & Rooda, 2000). Overall, the DAP-R subscales had strong psychometric properties and were considered to adequately measure multidimensional death attitudes (Clements & Rooda, 2000). In the current study, the reliability estimates for the Fear of Death subscale and Death Avoidance subscales were $\alpha = .82$ and $\alpha = .89$, respectively. However, consistent with previous findings, the Neutral Acceptance subscale had a lower reliability ($\alpha = .62$). Two out of five items were found to be problematic and were removed ("I would neither fear death nor welcome it" and "Death is neither good nor bad"). The reliability estimate from the remaining three items was improved ($\alpha = .82$).

Grief counseling skills. As noted previously, the DCS (Charkow, 2000) consists of 58 items assessing grief counseling competence on five subscales (i.e., Personal Competencies, Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills). Given the focus of the current study on assessing grief counseling skills, a thorough review of the items on the DCS was conducted and two of the subscales that most closely related to the construct of grief counseling skills were selected for inclusion in this study (see Appendix I): Assessment Skills (e.g., "Articulate the diagnostic criteria for Bereavement, according to the DSM-V and how to distinguish this Diagnosis from related diagnoses") and Treatment Skills (e.g., "Facilitate individual grief counseling sessions").

In this study, the DCS measure items and scales were edited. Because the original DCS was developed to measure grief counseling competencies among family counselors, slight edits were made to the items by removing the words that were associated with "family," so that items would refer to the therapists more broadly. Also, some items were edited to specify that the questions relate to working "with a grieving client." One item was changed from "children" to "college students" and another item was updated (i.e., "DSM-IV" was updated to "DSM-V" to reflect the current version of the manual). Furthermore, one item was changed from "creative arts" to "creative arts and activities." Also, the response scale was edited from the original DCS measure (Charkow, 2001). The scale originally assessed confidence (e.g., *very low confidence* to *very high confidence*) in the ability to perform grief-related tasks. However, for the purpose of this study (to assess skills, not confidence), the scale was changed to indicate the extent to which the item describes the participant. In the current study, participants responded to 31 items using a 5-point Likert scale ranging from 1 (*this does not describe me*) to 5 (*this describes me very well*). The items from the two subscales were summed and the mean of the composite was calculated. High scores on the DCS indicated the ability to perform tasks associated with grief counseling.

Support for the reliability of the scale was demonstrated previously with a sample of 369 licensed professional counselors: Assessment Skills ($\alpha = .86$) and Treatment Skills ($\alpha = .94$; Ober et al., 2012). Validity support was found by positive relationships among DCS subscale scores and scores on a scale measuring coping with death in a sample of 147 family counselors (Charkow, 2001). In the current study, the reliability estimates were .93 for the Treatment Skills subscale and .81 for the Assessment Skills subscale.

The coefficient alpha for the composite scale (mean of the summed two subscales) was .94.

In addition to the DCS, a case vignette was used to assess participants' skills in grief counseling. Modeled after a measure from a prior study that used vignettes to assess mental health professionals' reactions and comfort in working with clients presenting with end-of-life issues (Parent, O'Brien, & Jankauskaite, 2018), a vignette depicting a bereaved college student seeing a university counseling center therapist was developed by the authors (see Appendix J). The purpose of this vignette was to evaluate therapist responses to a grieving client, what they identified as the most salient grief-related assessment and treatment principles or themes in their therapeutic work, their overall comfort, and any possible issues they anticipated to emerge while working with this bereaved client.

Participants were asked to read the vignette and give brief, written responses about their reactions and approach to working with this client. Two coders independently rated the quality of the responses provided by the participants with regard to how they would initially respond to the client, what grief-related assessment and treatment principles or themes they would focus on during their work, their reactions and comfort in working with the bereaved college student, and any potential issues they may encounter while working with the bereaved client.

The first vignette question assessed quality of the initial response to the bereaved client (i.e., "Write exactly what you would say to Mary about what she has told you as if you were speaking directly to her") and was rated on a scale from (0) *not at all helpful*,

(1) *slightly helpful*, (2) *moderately helpful*, to (3) *very helpful,* or (9) *missing data*. This scale was used to reflect the overall quality of the therapist's initial response.

Furthermore, the second question assessed the therapist's skills in being able to identify four assessment and/or treatment principles or themes relevant to grief counseling (i.e., "What are four salient grief-related assessment and/or treatment principles or themes that you would want to focus on with this client over the next few sessions?"). The raters independently reviewed participant responses and, using the rating rubric, coded the grief-related assessment and/or treatment principles or themes that were provided by the participants. The initial rubric consisted of topics that were deemed important in grief counseling as outlined by ADEC. Guidelines provided by ADEC (Meagher & Balk, 2013) highlighted the most salient themes that included examining the client's closeness to the deceased, previous loss history, existing support system, assessing client's grief style, assessing client's functioning, multicultural considerations (e.g., family cultural background, spiritual and religious beliefs, beliefs in the afterlife), and ways to maintain a continuing bond with the deceased or explore ways to reconstruct meaning of the loss. However, participant responses included other themes that were not originally included in the rubric. Thus, the list was expanded, and all grief-related assessment and/or treatment principles or themes that emerged can be found in Table 7.

The third question assessed the therapist's comfort in working with the bereaved client (i.e., "How comfortable do you feel about working with Mary regarding the sudden death of her friend?"). Raters individually rated the reactions and comfort of the participants on a scale from (0) *uncomfortable*, (1) *slightly comfortable*, (2) *moderately/fairly/pretty/mostly comfortable* to (3) *quite*/*very comfortable,* or (9) *missing*

data. This scale was used to reflect the therapist's overall comfort in working with a bereaved client.

Last, the fourth question assessed the probable issues that may come up for the therapist while working with a bereaved client (i.e., "What issues might come up for you with this bereaved client?"). Two raters individually coded each issue mentioned by the participant by its general theme (see Table 8).

Demographics. Participants provided information regarding their age, gender, race, ethnicity, spiritual/religious identification and its importance, educational level, death education and training received (including professional grief counseling certifications), years in counseling practice, and bereaved client caseload. In addition, the questionnaire contained questions on the therapist's personal loss history and the degree to which any of the losses felt unresolved or unfinished (see Appendix K).

Data Analyses

Quantitative data analysis. Data were entered into SPSS 25. Missing data were addressed first using the Expectation Maximization algorithm. Then, the means, standard deviations, and reliabilities of scores on the measures were calculated. Also, Pearson *r* correlations were calculated among the scores on all measures. Grounded in the existing theoretical model of death competence (see Gamino & Ritter, 2009; 2012), two hierarchical multiple regression analyses were calculated to investigate the total and unique contributions of cognitive competence, emotional competence, and death attitudes to the prediction of grief counseling skills (operationalized as a composite measure of the DCS Assessment and Treatment Skills subscales and as measured by the quality of the therapist's initial response to the bereaved client).

Specifically, the variables were entered in three steps. Cognitive competence (consisting of knowledge and training/experience in death and grief-related topics) was entered in the first step because previous research consistently found that knowledge, training, and experience account for the greatest variance in competence in providing grief counseling (see Ober et al., 2012). Then, consistent with the death competence model, emotional competence (consisting of personal grief counseling competencies and emotional coping) was entered in the second step of the analysis, as the ability to handle feelings that emerge surrounding death and one's personal loss history is hypothesized to explain variance in grief counseling skills over and above cognitive competence. Finally, based on prior research indicating that the personal beliefs about death and dying may impact work with clients presenting with grief issues (e.g., Harrawood, Doughty, & Wilde, 2011; Neimeyer et al., 2001), the three subscales of the death attitudes measures were entered in the third and final step of the hierarchical regressions predicting grief counseling skills.

Qualitative data analysis. A comprehensive rating rubric was developed for each vignette question and was used by two independent coders to provide individual ratings for each response. This rubric was also edited to include additional themes as they emerged throughout the coding process. Both coders were graduate counseling psychology students with experience in the death, dying, and end-of-life research domains, as well as clinical experience conducting therapy. After coding responses individually, the coders met and discussed their codes for each vignette question in consensus meetings. If the primary two coders in the consensus meetings did not resolve code incongruences, then a third coder was employed. This third coder was a licensed

psychologist with extensive research and clinical experience. For all four questions the inter-rater reliability was calculated and is provided below.

This first vignette question rating was used to reflect the overall quality of the therapist's initial response. After the two primary coders compared their initial ratings, there was a high degree of congruence in their ratings (86.0%), with disagreement on only 14.0% (24) codes. The opinion from the third rater was sought to resolve all 24 incongruent ratings. The third coder independently looked at the responses and provided the final code for this question.

The second vignette question assessed the therapist's skills in being able to identify assessment and/or treatment principles or themes relevant to grief counseling. After the two coders compared their initial ratings, there was a high degree of congruence in their ratings (89.7%), with disagreement on only 10.3% (353) codes. Then, 351 discrepancies were discussed and resolved by the primary two coders. The third rater was asked to resolve the remaining 2 incongruent ratings. The third coder independently looked at the responses and provided the final code.

The third question assessed the therapist's comfort in working with the bereaved client. After the two coders compared their initial ratings, there was a very high degree of initial congruence in their ratings (94.9%), with disagreement on only 5.1% (8) codes. The opinion from the third rater was sought to resolve all eight incongruent ratings. The third coder independently looked at the responses and provided the final code.

Finally, the fourth question assessed the probable issues that may come up for the therapist while working with a bereaved client. After the two coders compared their initial ratings, there was a very high degree of congruence in their ratings (96.1%), with

disagreement on only 3.9% (96) of codes. Then, 83 discrepancies were discussed and resolved by the primary two coders. The third rater resolved the remaining 13 incongruent ratings, by independently looking at the responses and providing the final code.

Initially, we planned to calculate a composite score (a sum of the scores from all four vignette ratings) to use as a measure of grief counseling skills outcome. However, many participants did not follow the directions and provided more than four grief-related assessment and/or treatment principles or themes for the second vignette question. Thus, a score for this vignette question could not be calculated. Similarly, the fourth vignette question asked participants to list any issues that may come up while working with a bereaved client. The responses that we received did not lend themselves to an index of skills so we did not include responses to this item in the outcome score. Instead, the most common themes provided by the participants were reported. Last, the third vignette question assessed therapist's comfort in working with a bereaved client. Researchers decided that therapist's self-reported comfort may not necessarily reflect their skills, and thus, this item was not used as part of the grief counseling skills outcome variable. Instead, therapist's comfort was analyzed independently as part of a post-hoc analysis. Therefore, of the four vignette questions, only the first question that assessed the quality of the initial response to the bereaved client ("Write exactly what you would say to Mary about what she has told you as if you were speaking directly to her") was used to create a score for use as an outcome variable in the second regression analysis.

Chapter 3: Results

Quantitative Results

Descriptive statistics and correlations. The means, standard deviations, reliabilities, ranges, and correlations among the measures are reported in Table 3. Overall, therapists reported having average amounts of grief education and training experience, and above average grief knowledge. Participants endorsed having fairly high personal grief competencies and emotional coping. Moreover, participants indicated an average level of fear of death, low average death avoidance, and fairly high neutral acceptance of death. Last, therapists reported having above average grief counseling treatment skills and assessment skills. Overall, as measured by the quantitative survey, participants rated themselves as having above average grief counseling skills.

Regression analyses. Prior to conducting the regression analyses, the four assumptions of multiple linear regressions were examined: normality, linearity, reliability, and homoscedasticity. Homoscedasticity and linearity were evaluated using plots of the standardized residuals. Cronbach alphas were calculated for each scale to address reliability, and the skew and kurtosis of each variable were used to assess normality. All assumptions were met, allowing the data to be analyzed using regressions.

The first hierarchical regression analysis was conducted and investigated the degree to which cognitive competence (consisting of knowledge and training/experience in death and grief-related topics), emotional competence (consisting of personal grief counseling competencies and emotional coping), and death attitudes (three subscales consisting of fear of death, death avoidance, and neutral acceptance) were predictive of grief counseling skills (measured by the composite of DCS Assessment and Treatment

Skills subscales; see Table 4). Collectively, the predictor variables accounted for 62% of the variance in grief counseling skills, with cognitive competence explaining 55% and the personal competencies variables accounting for an additional 7% of the variance. When all of the variables were entered in the regression equation, training/experience, personal competencies and emotional coping accounted for variance in grief counseling skills, and all related positively to the outcome variable.

A second hierarchical multiple regression investigated the degree to which cognitive competence (consisting of knowledge and training/experience in death and grief-related topics), emotional competence (consisting of personal grief counseling competencies and emotional coping), and death attitudes (three subscales consisting of fear of death, death avoidance, and neutral acceptance) were predictive of the grief counseling skill as measured by scores on the first vignette question (see Table 5). None of the constructs accounted for variance in the prediction of grief counseling skills.

Post-hoc analysis. We decided to further examine the third vignette question responses that indicated therapist's self-reported comfort in working with a bereaved client. Similarly to the other two hierarchical regressions previously conducted with grief counseling skill outcome variables (quantitatively derived and vignette-generated), one hierarchical regression was conducted to investigate the degree to which cognitive competence (consisting of knowledge and training/experience in death and grief-related topics), emotional competence (consisting of personal grief counseling competencies and emotional coping), and death attitudes (three subscales consisting of fear of death, death avoidance, and neutral acceptance) were predictive of the therapist's self-reported comfort in working with the bereaved client (see Table 6). Collectively, the predictor

variables accounted for 19% of the variance in therapists' comfort level, with cognitive competence explaining 14% and the personal competencies variables accounting for an additional 4% of the variance. When all of the variables were entered in the regression equation, only training/experience accounted for variance in therapist's comfort and related positively to the outcome variable.

Qualitative Results

Response quality vignette question. Overall, the average quality of the therapists' initial response to the bereaved client, as rated by two coders, was found to be slightly helpful and corresponded to a score of 1 on the four-point scale ranging from 0 to 3 (M = 1.06, SD = 0.06). Specifically, 51.3% of the sample who completed this question (n = 156) received a quality rating of 1 (e.g., *"I am sad about your loss," "I am so sorry to hear this, Mary. I cannot imagine what you are going through. When you feel ready, please tell me how I can best support you"*), 23.7% received a score of 0 (e.g., *"This sucks," "I'm so sorry to hear about your friend, what is their name? What happened? How did you find out about it? Tell me about your friend"*), 19.9% received a score of 2 (e.g., *"I am so sorry to hear about the accident and your loss. I can see that it has really affected you," "I'm sorry to hear about your loss. It must be very difficult and sudden dealing with this"*), and only 4.7% received the highest rating of 3 (e.g., "*Oh Mary, that sounds devastating. How are you feeling?,*" "*I'm so very sorry for your loss, Mary. Would you like to take some time to process how you're feeling?").*

Grief-related assessment and/or treatment vignette question. The full list of grief-related assessment and/or treatment principles or themes can be found in Table 7. Participants endorsed on average around four salient grief-related assessment and/or

treatment principles or themes. The most common themes included: Process loss/grief (60.2%), Explore client's feelings and/or reactions (57. 7%), Existing support system (35.2%), Assess suicidal ideation/intent (31.4%), and Provide grief psycho-education (30.8%). Notably, only 18.6% of the sample highlighted multicultural considerations (e.g., client's cultural background, spiritual views) as one of the most salient assessment and/or treatment approaches. Also, almost a quarter (23.7%) of the sample reported using outdated stage or task grief models (i.e., Kubler-Ross model), and 3.8% referenced the need to assess for complicated grief or prolonged grief disorder in a recently bereaved vignette client. Interestingly, more recent grief models were not commonly suggested, with meaning making or meaning reconstruction cited by 13.5%, and exploration of the continuing bond mentioned by 3.2% of the sample. Lastly, the number of participants who suggested exploring the client's relationship with the deceased (13.5%), their previous loss history (14.1%), and their grief style (0.6%) was fairly low.

Comfort vignette question. Overall, therapists' comfort level, as rated by two coders, was found to be above average on a four-point scale ranging from 0 to 3 (M = 2.41, SD = 0.05). Specifically, 51.6% of the sample who responded to this question (n = 155) received a comfort rating of 2 (e.g., *"Fairly comfortable," "Average comfort level. I have experienced similar situations that I can draw on," "I feel comfortable doing so, although it would be difficult, given the sudden nature of the death"*), 45.2% received a score of 3 (e.g., *"I would feel sympathetic and react emotionally to her loss, but I would feel entirely comfortable working with Mary. She is very similar to many clients I have already worked with," "Very comfortable"*), 2.6% received a score of 1 (e.g., *"I would be okay," "Some initial discomfort due to the sudden nature of the loss and change in*

treatment direction, but likely would become comfortable quickly"), and only 0.6% received the lowest comfort rating (e.g., *"Fairly uncomfortable - grief is difficult for me and can be an intense emotional experience. I sometimes feel stuck in the hopelessness and feel a desire to "make it better," which is impossible"*).

Issues vignette question. The full list of issues mentioned by therapists can be found in Table 8. On average therapists reported fewer than two possible issues that they may encounter while working with a bereaved client. The most commonly cited issues were coded as: Issues related to personal loss history (recent and older losses; 29.5%), Intense sadness/emotional difficulty (11.5%), Death anxiety (own or someone else's; 9.6%), Countertransference due to similar loss circumstances (e.g., unexpected loss of a friend; 8.3%), and other (28.8%). Interestingly, only a small number of participants cited lack of training in grief counseling (1.9%) as a possible obstacle. Further, 7.7% of the sample reported no possible issues that may come up while working with the bereaved client, while 12.8% did not answer this question – they talked about the client and not their issues.

Chapter 4: Discussion

The current study advanced knowledge regarding the grief counseling skills of university counseling center therapists. In this study, support was found for the existing theoretical model of death competence (Gamino & Ritter, 2009, 2012) as cognitive competence and emotional competence predicted grief counseling skills. Our findings provided additional support and were consistent with previous research that suggested that training and experience in grief counseling predicted death competence in a sample of licensed professional counselors (Ober et al., 2012). The results also confirmed that therapist's personal grief experiences and ability to cope with emotional distress associated with grief work might influence therapist's self-perceived competence in grief counseling (Chan & Tin, 2012; Chan, Tin, & Wong, 2015; 2017).

Sample Characteristics

Before interpreting the results, it is important to situate the current sample in relation to the findings. The sample consisted of 171 therapists who were either employed or completing their pre-doctoral internships at the university counseling centers located in the United States. The majority of the sample were white, heterosexual, married females who were working at four-year public universities. All participants were highly educated and held at least a Masters degree, with the majority holding doctoral degrees in counseling or clinical psychology. Moreover, an overwhelming majority reported having experienced a significant loss in their lives, and indicated that these losses felt mostly or completely resolved. Nonetheless, a small minority shared that their losses were slightly, very, or extremely unresolved or unfinished. Furthermore, all but one participant reported having worked with bereaved clients at some point in their careers, and the majority

reported that bereaved clients accounted for between 1 to 10% of their typical caseload. The participants reported participating in a variety of activities related to death, dying, and grief counseling; the most common being having read books or other educational material on grief counseling, having received some grief counseling training in clinical practica, externships, or externships, or having taken continuing education courses in grief counseling. Nonetheless, regardless these reported experiences, the majority of participants reported their grief counseling knowledge as insufficient to some degree, and only less than a quarter of the sample felt comfortable with their knowledge level. Last, everyone in the sample agreed that continuing education in grief counseling for university counseling center therapists was important to varying degrees, and all expressed some interest in learning more about grief counseling.

Death Competence Model: Cognitive Competence

Consistent with previous research findings and our hypotheses, training and experience in death, dying, and grief counseling topics were predictive of grief counseling skills.

As evidenced from previous studies, therapists who received specialized training in death education were better equipped to cope with personal issues related to death and dying, and reported more skills in working effectively with grieving clients (Charkow, 2001; Ober et al., 2012). Therapist experience also related to less distress in working with clients who presented with issues related to death and dying (Terry, Bivens, & Neimeyer, 1996). The connection between training and experience seems to go hand in hand, as more training in grief counseling could translate into more experience. Thus, the findings of the current study provided additional support that training and experience in grief

counseling may in fact predict better skills in working with grieving clients. This is significant, because it underlies the importance of receiving training and gaining experience in grief counseling to be an effective helper. However, these results need to be interpreted with caution, as scores on the self-report measures might represent inflated experience and skill levels.

Although we conceptualized cognitive competence as consisting of knowledge and training/experience in grief counseling, only training/experience emerged as a predictor. This finding may have occurred because of the grief knowledge assessment, which likely produced inflated results. As previously described, the grief knowledge assessment consisted of multiple choice questions that assessed knowledge about grief models and theories, grief styles, normative grief, complicated grief, evidence-based therapeutic strategies, risk factors associated with poor bereavement outcomes, and multicultural considerations in bereavement. Most participants did very well on this assessment; the scores obtained lacked variance, perhaps because the questions were obvious or participants may have looked up the needed information to answer the questions. The responses to this scale contradicted participants' self-reported low knowledge in the demographics section of the survey.

Furthermore, only a small minority (16.4%) of all participants reported having taken a grief counseling or death education course in their graduate program, and less than half of the sample (47.4%) received grief counseling training/experience in practica, externship, or internship. Perhaps to reconcile their lack of formal preparation to work with grieving clients, the majority of therapists reported having read books or other educational material on grief counseling, while about a third of the sample had completed

continuing education courses in grief counseling or death education. These results underlie previously reported lacking curricula in grief counseling among graduate programs in the United States (Eckerd, 2009), and point to the need of increased training in this area (Dodd, Guerin, Delaney, & Dodd, 2017).

Death Competence Model: Emotional Competence

Emotional competence also was predictive of grief counseling skills, although the percentage of variance accounted for was low. Overall, this finding aligned with previous data that stressed the importance of therapists' personal and emotional competencies in working with bereaved clients. According to the death competence model (Gamino & Ritter, 2009, 2012), emotional competence is the second most important dimension of therapist's competence in working with bereaved clients. It was suggested that a skilled therapist is someone who is resilient and able to regulate their distress, emotions, and integrate personal loss history, while utilizing self-care and support from colleagues while working with clients who present with issues related to death and dying. Emotional competence underscores the importance of recognizing and responding empathically to others' emotions, while simultaneously being aware and regulating emotional reactions that may arise from reminders of the therapist's losses or from emotionally-taxing grief work. In fact, therapists who experienced personal loss and were able to effectively cope and resolve their personal grief were seen as more empathic towards their clients (Martin, 2011; Rappaport, 2000). Overall, as suggested by the death competence model and previous and current findings, emotional competence might indeed play an important role in ability to be an effective grief counselor.

Nonetheless, it is important to interpret these results with caution, as they were self-reported and may reflect a bias to report higher competencies. In fact, scores on the personal grief competencies were fairly high, although aligned with previous studies that showed similar results (Ober et al., 2012). Also, the personal grief competencies measure included a few questions that were general and not specific to grief counseling (i.e., self-care, using humor, spirituality), although they represented aspects related to emotional competence construct.

Interestingly, both emotional competence constructs – personal death competencies and emotional coping, were correlated weakly and negatively with fear of death and death avoidance subscales. Although not substantial, this finding was not surprising, as those who had more personal experiences with loss and feel more emotionally prepared to talk about death and grief, may feel less fear and less avoidance regarding the topic of death. Last, the emotional competence constructs also were correlated positively with the comfort in working with a bereaved client, as measured by the vignette. Even though this relationship was not very strong, one's emotional preparedness and comfort in working with bereaved clients were related.

Furthermore, the vast majority of therapists reported having experienced a significant death in their life, and majority claimed that their loss was either mostly or completely resolved. As previously stated, individuals who had personal loss experience and who feel that their loss was somewhat resolved, might have increased emotional competence, which was proposed by the death competence model (Gamino & Ritter, 2009, 2012). Additionally, a sizeable majority reported that they read books or other educational materials on grief counseling, and close to a third of the sample attended

continuing education courses on these topics, which might indicate that the sample was generally more self-aware, interested, and open to the death and dying topics and working with bereaved individuals. It is possible that self-selection bias might had contributed to this, as therapists who felt more interested and comfortable with death and dying may have elected to participate in this study.

Death Attitudes

Our proposed addition to the death competence model, death attitudes, did not predict grief counseling skills. There might be a few potential explanations for these findings. First, it is possible that the personal death attitudes one holds may not relate to their skills in working with bereaved clients. For example, even if one holds some fearful or avoidant attitudes regarding death and dying, the therapist might work hard to not let their attitudes affect their work with clients. Perhaps training and experience on death and grieving-related topics may compensate for internal negative attitudes about death. Alternatively, therapists with the highest negative death attitudes such as high fear of death and death avoidance likely did not participate in the study, which had a clear, stated focus on death, dying, and grieving. Furthermore, the therapists who participated in the study may have underreported their actual level of fear and death avoidance.

Therapists' Grief Counseling Skill

To further explore grief counseling skills, quantitative and qualitative analyses of the vignette-based responses were conducted. Overall, the quality of the participants' initial responses to the bereaved client was rated as only *"slightly helpful"* and seemed to contradict the high level of therapists' self-rated grief counseling skills, as reported by the quantitative measure. First, the qualitative vignette rating rubric employed by the

independent raters may have been conservative, which could have resulted in lower average response ratings. However, the rubric was developed, discussed, and revised by three coders who had knowledge and experience in death and dying research and possessed clinical grief counseling experience. In addition, given that most participants did not report substantial training and education in grief counseling, and that most claimed insufficient knowledge in this area, the participants may have inflated their self-reported grief counseling skills. Again, self-selection bias might also be at play, in that the therapists who decided to partake in this study may have felt confident in their ability to work with grieving clients, yet this might not necessarily mean that they were highly skilled in this work.

Furthermore, none of the variables of interest in this study explained variance in grief counseling skills as measured by the quality of the therapist's initial response to the bereaved client. This likely occurred because of the quality of the assessment, which measured grief counseling skills by a using single item measure and showed low variability. Nonetheless, the quality ratings correlated with a few variables, although in the opposite direction that one might expect. Specifically, response quality correlated negatively with treatment, assessment, and overall grief counseling skills as measured by the quantitative DCS measure. Even though the relationship was not strong, this finding was interesting, as it suggested some possible incongruence between quantitative and qualitative grief counseling measures and participant responses. As previously noted, the rubric employed by the independent raters could have been overly stringent. However, it is also possible that the discrepancy existed due to participants reporting inflated skills that contradicted with observer ratings of their grief counseling skills. These findings are

interesting in light of previous research that indicated that therapists tend to overestimate their competence. For example, it was previously shown that around 25% of clinicians rated themselves as being in the top 10% with regard to skills, while no clinicians placed themselves in the below average category (Walfish, McAlister, O'Donnell, & Lambert, 2012), suggesting that therapists may overestimate their skills. Even though the current findings need to be interpreted cautiously, a similar kind of inflation may have occurred in the present study which may explain the discrepancy between the self-reported grief counseling skills and those rated by independent observers.

Therapists' Comfort

Overall, the sample reported feeling mostly comfortable working with a recently bereaved client. All participants indicated that they had worked with bereaved clients at some point in their careers, which might contributed to them reporting being fairly comfortable. Yet, again, it is possible that participants may have inflated their level of comfort. This could be the case, as therapists often are expected to be open and comfortable in working clients who present with a variety of issues, and an indication of personal discomfort may signal lack of self-efficacy or competence.

Moreover, as evidenced by the post hoc analysis, training/experience was predictive of comfort in working with a bereaved client. Once again, this further suggested that mental health professionals who have more professional training and experience in death and dying topics might feel the most comfortable in providing grief counseling to bereaved individuals. Even though emotional competence did not emerge as predictor of comfort, there were notable positive associations between personal grief competencies, emotional coping, and comfort in working with bereaved client. Although

the correlations were not strong, these findings provided additional support for the possible link between cognitive competence and emotional competence, as suggested by the death competence model. However, based on the correlational data, we could not infer the directionality of this relationship.

Grief-related Assessment and/or Treatment Principles/Themes

The participants suggested an array of possible treatment and assessment principles that they may use while working with a bereaved college student. Not surprisingly, the majority of therapists highlighted the need to process the loss and explore client's feelings. Some therapists also suggested exploring client's support system and assessing their functioning, especially the suicidal ideation or intent. Furthermore, many therapists underlined the importance of providing psycho-education to the client about the grief process, which seemed appropriate given that many students might experience their first death loss in college (Balk, 2011) or simply not know much about bereavement. Also, providing psycho-education seemed particularly important to this vignette case, as it was a sudden loss, and sudden losses had been found to potentially result in more intense grief process (Frazier et al., 2009; Herberman Mash et al., 2013).

However, some responses were lacking. For example, close to a quarter of the participants proposed to use a stage grief model (i.e., Kuber-Ross model), which has been widely criticized for its validity, while more recent grief theories were rarely mentioned. Nonetheless, these findings were consistent with prior research, which indicated that mental health professionals were much more familiar with the older grief models and knew little about the more recently supported grief models, such as the continuing bonds

or meaning-making theories (Ober et al., 2012). This pointed to the need for improved education and training in grief counseling.

Furthermore, only a small percentage of participants suggested exploring multicultural considerations, such as the impact of bereaved client's culture, spiritual beliefs, mourning rituals, in grief counseling. This was extremely concerning, as multicultural factors are paramount to effective grief counseling (Meagher & Balk, 2013). It is imperative to think about the impact of the client's background, their identities, families, and the larger communities they come from that would affect their grief process. Also, another striking finding was that only a small minority of participants suggested exploring client's closeness with the deceased friend, or assessing their previous loss history and its potential impacts on current grief process. All of these factors have been deemed salient to most grieving clients (Meagher & Balk, 2013). Given these results, the lack of current training in grief counseling might have contributed to the omission of important treatment considerations.

Therapists' Issues

Participants provided a wide array of potential issues that may emerge if they worked with the bereaved client described in the case vignette. The most common response given was issues related to personal loss history. Therapists noted that working with the grieving client may evoke personal memories about their past losses, which potentially could affect their work. Specifically, some participants referred to countertransference based on the similarity between the client's unexpected friend loss and a friend's sudden death when they were younger. As supported by research, the therapist's loss history or lack thereof might influence the grief counseling process, and

affect emotional competence (Gamino & Ritter, 2009, 2012). Thus, it was important to see that many participants referred to their loss history as something to be aware of, especially if there were unresolved issues surrounding the loss. Moreover, other participants cited feeling sadness and potentially having an emotionally difficult time if they were to work with the case vignette client. This was understandable and expected, as witnessing and processing loss with clients may not be easy, especially if the loss is recent and raw to the client.

Interestingly, only a small number of participants cited lack of training in grief counseling as a possible obstacle. This finding contradicted the participants' endorsement of fairly low grief counseling knowledge, as measured by the demographics survey; less than a quarter of all participants reported feeling comfortable with their knowledge level or being highly knowledgeable about grief counseling. Furthermore, only a small minority of participants reported taking graduate courses on death and dying, and less than half of the sample reported receiving training in grief counseling as part of their clinical training. These findings may indicate participant self-report bias or a reluctance to viewing lack of training as an obstacle in working with the bereaved client.

Lastly, many participants did not report any potential issues related to working with this client or misinterpreted the question and talked about the client and not themselves. It is possible that the question was not as clear, or perhaps some therapists were not readily aware or willing to share the obstacles that might emerge while working with a suddenly bereaved client.

Strengths of the Study

This study was the largest study to assess knowledge, training/experience, attitudes, and grief counseling skills among university counseling center therapists in the United States. The current study advanced scientific knowledge in assessing grief counseling skills among university counseling center therapists, and possessed strengths that are important to highlight. First, the current project explored how well prepared therapists felt to work with grieving clients and whether they had the necessary skills to provide grief counseling by using a mixed-methods approach, which was the first study of its kind that employed this design. Second, this study was innovative in that it was based on a theoretical foundation, the death competence model (Gamino & Ritter, 2009, 2012), which included cognitive and emotional competencies. Furthermore, this study added and tested another proposed dimension to the death competence model, death attitudes. This decision was made based on previous research that suggested that internal attitudes about death and dying may have an effect on how therapists approach working with grieving clients. Also, the present study included previously used measures to assess therapists' training/experience, personal grief counseling competencies, emotional coping, death attitudes, and grief counseling skills. Only one quantitative measure was developed by the researchers – the grief knowledge assessment, as there was no such known measure in the literature.

Moreover, another strength of this study was the sample. Therapists were recruited by contacting all university counseling centers in the United States that had an APA-approved internship, ensuring some geographic diversity. Also, the study focused on therapists who provided mental health care to college students, a young adult population that has been historically underrepresented in the bereavement literature. By

focusing our research questions on the skills of therapists employed in colleges and universities, we by extension contributed to the body of literature concerning this understudied group.

Limitations

Although this study had a number of strengths, it also is important to note several limitations. First, the measure that assessed grief counseling skills was used previously in only two studies, and its validity has not been widely supported. In addition, to supplement the measurement of grief counseling skills, an author-developed qualitative case vignette was included in this study. On one hand, this approach enriched the study by providing an additional method for assessing the outcome variable, however the psychometric properties of this assessment have not been established. Many therapists did not follow the vignette question instructions and provided extraneous information, which was difficult to code.

Moreover, two other measures had limitations. Due to no known existing grief knowledge assessments, the authors developed a test to assess therapists' knowledge about death, dying, and grief counseling which did not perform well in this study. Furthermore, this study was conducted online and participants theoretically had opportunities to access online resources to help them answer questions on this test. Thus, this measure potentially did not accurately assess participants' grief knowledge. Lastly, the emotional coping measure (Self-Competence in Death Work Scale; Chan et al., 2015) was researched and validated in Chinese, and current study was the first to use the author-translated version with an English-speaking sample.

Another limitation of this study related to the sample. First, the participants were fairly homogenous – mostly white, straight or heterosexual, female, married, and Christian. Second, it is possible that our sample mostly included therapists who had previous grief work experience. Considering that the topic of the research project was not covert, it is likely that people who felt more familiar and comfortable with the topics of death, dying, and grief counseling participated in the study. This self-selection bias may explain the fairly high ratings of grief counseling skills, high grief knowledge, and high positive death attitudes, and fairly low negative death attitudes. Also, the nature of the therpists' grief-related training and experience were not assessed. Future studies may benefit from including questions regarding the specific type of education, training, and clinical opportunities (and the year in which the training occurred). Specifically, it would be crucial to learn more about the courses, educational opportunities, and extent of clinical experience in working with bereaved clients (i.e., whether they saw one or two clients during practicum or participated in ongoing education and worked with many grieving clients in various clinical settings).

Future Research Directions

Research on therapists' grief counseling skills and overall preparedness to work with bereaved clients is scarce, and additional research needs to be conducted to further explore these topics. In particular, more research is needed to examine university counseling center therapists' knowledge and skills in working with grieving clients. Given the results of this study, training and experience were the best predictors of grief counseling skills. Thus, future studies should employ an experimental, randomized controlled study design to test the efficacy of grief counseling training on therapists' grief

counseling skills. Using this methodologically rigorous method, researchers could assess whether exposing therapists to a training focused on grief counseling may improve their grief counseling skills. Furthermore, to accommodate busy schedules and to minimize burden, this training may be conducted online.

Furthermore, because the current project highlighted the need for multicultural considerations in grief work (only a small number of participants cited the need to consider the bereaved client's cultural background and spiritual views in their bereavement process), future studies may focus on assessing university counseling center therapists' cultural competence in working with bereaved clients. One potential way to study multiculturalism in grief counseling may be to conduct a qualitative analysis of grief for a diverse sample of bereaved students. Using this method, researchers may learn more about the lived experiences of these students and what clients might consider helpful as they grieve and navigate college. Then, these data may serve as a basis for developing culturally-sensitive and responsive training programs focused on the needs of diverse college students for university counseling center therapists .

Clinical Implications

The results indicated that training and experience were the most robust predictors of grief counseling skills. However, many therapists reported minimal training and insufficient knowledge about death, dying, and grief counseling. This study serves as a call to action for increased education and training opportunities for university counseling center therapists to enhance their ability to positively impact clients who present with grief issues. First, exposure to death, dying, and grief counseling topics should start early and ideally during undergraduate, but no later than graduate training. It would be best if

undergraduates interested in careers in mental health (e.g., psychology majors) would be offered courses on death and grieving, or this material would be at least amply represented in core psychology courses. Further, it is crucial that psychology graduate training programs incorporate courses addressing death education. Considering that most programs may be unable to add a separate graduate course on grief counseling, curricula on death, dying, and grief work may be best incorporated into existing clinical practica and program seminars. Even though this method may not offer comprehensive training in grief counseling, it would expose students to grief work and offer foundational knowledge on the most salient topics in grief counseling. In addition, graduate programs may consider partnering with their counseling centers, campus mental health clinics, or qualified outside organizations to offer workshops or webinars on grief counseling facilitated by therapists who are knowledgeable in this clinical domain.

Further, in addition to graduate training, continuing education trainings should be offered for those who work at university counseling centers. Training should address young adult grief and stress the fact that grieving on college campus is difficult. To reduce burden, these trainings may be conducted entirely online or offered as an in-house didactics course. Also, considering that many counseling centers employ externs and interns, it would be beneficial if the grief courses would be required for all trainees. To assist counseling center staff in developing such trainings, collaborations with thanatology organizations may be utilized. For example, the Association for Death Education and Counseling (ADEC) offers regular web-based trainings for mental health professionals, and may be a resource in developing a college campus geared grief counseling course for therapists. Alternatively, if counseling center staff do not feel

adequately prepared to conduct a training at their counseling center, it may be beneficial to request a specialized training organized by an outside organization that focuses on grief counseling.

Considering the findings of this study, it would be important to highlight salient components required for the grief counseling course, practicum, or continuing training. First, it is important that curricula emphasize newer grief models and educate trainees about the lack of empirical support for older grief models. Furthermore, the importance of culture in bereavement should be stressed. Aspects such as client's cultural background, salient identities, and spiritual views should be carefully examined and addressed intersectionally in the context of grief. Furthermore, curricula should incorporate space and allow for exploration of therapists' views on death, dying, as well as examination of personal loss history and its impact on clinical work.

Conclusion

In conclusion, this study revealed that training/experience was the most robust predictor of therapist skills in working with grieving college students – and that therapists-in-training rarely receive education regarding death, dying and grieving in graduate programs. The majority of respondents admitted that their knowledge about grief counseling was insufficient, and their qualitative responses to a case vignette were lacking in many grief-specific domains. Thus, additional training on death, dying, and grief counseling is needed to prepare therapists to meet the needs of grieving college students. University counseling centers could play a pivotal role in providing their staff therapists and interns with ongoing or continuing educational courses on grief counseling. Future research should evaluate the efficacy of such trainings, and based on the findings,

potentially implement them at university counseling centers nationwide. By way of increasing knowledge and awareness of grief-related topics, we hope to ensure that bereaved college students receive effective support during their challenging time of loss and mourning.

Appendices

Appendix A

Review of Literature

The literature review is divided into five subsections. The first section addressed bereavement as a prevalent and serious issue among college students. This section also provided a brief overview of the existing supports available to this population. The second section reviewed the death competence model, which provided the theoretical foundation for the current study. The third section provided the background for the predictor variables of interest: cognitive competence, emotional competence, and death attitudes. The fourth section concluded with the literature review on the outcome variable – grief counseling skills. Finally, the fifth section briefly addressed the current state of the bereavement literature.

Bereaved College Students

The majority of college students (traditionally, individuals between 18 and 23 years old) experience death-related loss at some point throughout the years they are attending an undergraduate institution. In fact, previous studies using convenience samples suggested that approximately 22% to 30% of college students are in the first year of bereavement of a close friend or family member (Balk, 2011). A follow-up study using a random sample confirmed this finding, indicating that 30% of college students were in the first 12 months of bereavement (Balk, Walker, & Baker, 2010). Moreover, 35% to 48% of college students were within two years of grieving the death of a family member or close friend (Balk, 2011; Hardison et al., 2005). Additionally, more than half (60%) of

graduating seniors reported experiencing at least one loss and around 23% reported multiple deaths in their last three years in college (Cox et al., 2015).

Although dated, a longitudinal study assessed the prevalence of college student bereavement over the death of close friends and family members using a large sample of 994 undergraduate students (Balk, 1997). The majority of students (*n* = 813, 81.8%) indicated that they lost a family member, with the grandparent death being the most common, and around 20% reporting an immediate family member death (e.g., parent). In addition, around 20% of students reported multiple deaths: 139 reported two, 30 reported three, eight reported four, and three reported five family deaths. Moreover, more than 60% (*n* = 594) of the sample reported the death of a friend, and almost half (46.6%) of this group indicated that the deceased was a close or very close friend. This study also found that college students were more likely to experience an anticipated death of a family member due to illness or old age (83% of all those who reported a family member death), while most of the friend losses were sudden (e.g., vehicular accident, suicide or homicide), accounting for around 80% of those who reported a friend loss (Balk, 1997).

In a more recent study that used a random sample of students (n = 118) from a Midwestern university, the death of a close friend was the most common loss, accounting for 50% of all losses that occurred within the last 12 months, and 45% of all losses that occurred in the last two years (Balk, Walker, & Baker, 2010). In this study, the death of a grandparent was the second most common (22-24%), followed by other immediate and extended family losses.

Besides the deaths of family members, sudden deaths of peers (e.g., fellow college students) may be particularly relevant to the college-aged population, as it was

shown that suicide was the second leading cause of death among college students, resulting in an average of 1,100 deaths per year (Wilcox et al., 2010). In fact, one epidemiological study found that about 8 per 100,000 students die by suicide each year (Haas, 2004). Unexpected death also was one of the most traumatic events cited by undergraduates (47% of study participants) in a multi-campus assessment of overall exposure to traumatic events in undergraduates (Frazier et al., 2009).

College student bereavement is an important topic to examine because of the negative outcomes often associated with grief. First, there have been non-empirical anecdotal and clinical suggestions that bereaved college students experience declined academic performance and risk dropping out of school or being expelled, and that their overall career development may be negatively affected (Balk, 2001). This general assumption received some empirical research support in a study with 227 bereaved college students (Servaty-Seib & Hamilton, 2006). Bereaved students exhibited lower GPAs than their peers, especially during the semester when the death occurred. In addition, although this study did not find a difference between the frequency of bereaved students who had poor academic standing compared to a matched non-bereaved group, there was support for this expected direction and further research is warranted (Servaty-Seib & Hamilton, 2006).

In addition to academic performance difficulties, bereaved college students are at risk for experiencing physical and psychological difficulties. Hardison and colleagues (2005) examined sleep difficulties and grief symptoms by conducting a study with a sample of 815 (508 bereaved and 307 non-bereaved) college students. As hypothesized, they found the bereaved sample to have a higher rate of insomnia (22%) than the non-

bereaved comparison group (17%) and more difficulty concentrating. Their findings also suggested that bereaved students with insomnia reported higher complicated grief than the bereaved non-insomniacs. Furthermore, the authors also found a higher risk for complicated grief symptoms among students who experienced a violent loss as compared to those who experienced a death to natural causes. Last, the closeness to the deceased was important as it was associated with more complicated grief symptoms. These results are important, as they underscored the fact that for some, a loss of a non-kin, but an emotionally close person might be as difficult and as distressing as losing a family member (Hardison, 2005).

Furthermore, besides sleep difficulties, some studies examined other outcomes related to young adults bereavement. One study looked at 176 youth (ages 7-25) who lost a parent to suicide, accident, or sudden natural death (Brent, Melhem, Donohoe, & Walker, 2009). They found higher rates of major depression and alcohol or substance abuse 21 months after the parent's death in the bereaved youth than among the non-bereaved comparison group. Furthermore, those who lost a parent to suicide or accident had higher rates of depression than the comparison subjects who experienced sudden natural death. Youth with parental suicide had a higher incidence of depression and higher rates of alcohol or substance abuse. In this study, losing a mother, low self-esteem, blaming of others, negative coping, and complicated grief were associated with higher depression in the second year following the death of a parent (Brent et al., 2009).

Another study examined the association between types of loss and relationship quality with complicated grief, depression, somatic symptoms, and world assumptions in bereaved young adults (Herberman Mash et al., 2013). Their sample consisted of 107

young adults (aged 17-29) who lost either a close friend (n = 66), a sibling (n = 7), or had never experienced a loss (n = 34). Young adults with a deceased sibling reported greater depth in the relationship as compared to those who lost a friend. They also were more likely to have complicated grief (57% versus 15%) and report higher levels of grief, depression, and somatic symptoms than those who lost a close friend. Additionally, those who lost a sibling reported lower self-worth and a lower sense of meaningfulness and benevolence of the world as compared with those who lost a close friend or had not previously experienced a loss (Herberman Mash et al., 2013).

Although most bereaved individuals are expected to cope with loss in resilient ways (Bonanno, 2004), a considerable minority of grievers (7% to 15%; Kersting, Brähler, Glaesmer, & Wagner, 2011; Zisook & Shear, 2009) can develop complex, more intensified grief, which is known as prolonged grief disorder (Cox et al., 2015; Hardison et al., 2005; Herberman Mash et al., 2013; Prigerson, Vanderwerker, & Maciejewski, 2008) or complicated grief (Shear et al., 2011). Prolonged grief disorder or complicated grief can be distinguished from normative or uncomplicated grief in that it manifests in persistent difficulty accepting the death or feeling extreme disbelief that the death has occurred, intense yearning and longing for the deceased, anger, painful and intrusive thoughts related to the death, and avoidance of reminders of the loss or the deceased (Zisook & Shear, 2009). Unlike normative grief that often resolves on its own and does not always require professional support (Jordan & Neimeyer, 2003), prolonged grief disorder may require professional intervention (Herberman Mash et al., 2013).

Research pointed that for approximately 10 to 15% of bereaved individuals, especially those who had other risk factors (e.g., those who had experienced other recent

losses; Neimeyer & Burke, 2013), the prolonged grief disorder could cause severe long-term psychological and physical problems, such as generalized anxiety, depression, and cardiovascular and immune system-related illnesses (Ott, 2003; Prigerson & Maciejewski, 2006). Although there is considerable number of studies that examined complicated grief in a general population (see Crunk, Burke, & Robinson, 2017), research focused on complicated grief among undergraduate college students is lacking. One recent study assessed the prevalence of complicated grief among bereaved college students (n = 117) and found that around 21.4% of grieving students reported "long-term" grief that affected their academic, social, physical, and psychological areas in their lives (Cox et al., 2015). These findings raised questions, because the authors did not use a validated prolonged grief or complicated grief assessment (e.g., PG-13; Prigerson et al., 2008), and thus, it is likely that their findings may be disproportionately high as compared to previous studies that focused on the prevalence of complicated grief in the general population.

Another study (Balk et al., 2010) that used a randomly-selected undergraduate student sample (n = 118) utilized PG-13, which is one of the most popular measures to assess prolonged grief disorder (Prigerson et al., 2008). In this study, only two participants (1.7% of the total sample) met criteria for prolonged grief disorder, which was considerably lower than the estimates in the general population. However, the researchers of this study discussed the challenges of self-report in this population, citing the possibility of underreporting, especially since college students are known not to see themselves as needing support (Balk, 2008). It is likely that students who were in the most severe distress were unwilling to participate in a bereavement study or

underreported their symptoms (Balk et al., 2010). Overall, there seems to be not enough research conducted with college students to fully understand their grief experiences and estimate the prevalence of prolonged grief disorder among this population.

Overall, bereaved students reported more intense and longer grief reactions than originally anticipated, and the friends close to them also expected that the grief should be less intense, involve less sadness, and should not last as long (Balk, 1997). In addition, many bereaved students do not receive adequate support from their friends, who may lack knowledge in how to communicate about death, feel uncomfortable with the topic of death and dying, and possibly shun the grieving friend (Balk, 1997; Balk & Vesta, 1998). Furthermore, college students often are geographically removed (e.g., out of state students) for their usual support systems, which further creates a challenge to their adjustment to the loss (Schnider, Elhai, & Gray, 2007). Many students may turn to their family (e.g., parents) for support, yet some research suggested that bereaved students may experience a lack of communication with their parents regarding their first death experience, despite wanting to discuss this topic further (Knight, Elfenbein, & Capozzi, 2000). Also, many family members may underestimate the impact of the loss experienced by their child, incorrectly assuming that the relationship to the deceased was not that close (Cupit, Servaty-Seib, Parikh, Walker, & Martin, 2016; Liew & Servaty-Seib, 2017). These findings indicated that many bereaved college students might not receive enough social support from those close to them when grieving and may need additional resources on campus. Thus, university counseling centers often become the primary source of support for grieving college students.

University Counseling Centers

University counseling centers are a common resource available to undergraduate college students. According to the 2015 annual report conducted by The Association for University and College Counseling Center Directors (AUCCCD) with 529 training directors, most counseling centers offered various services, including but limited to individual counseling, consultation, workshops, therapy groups, suicide prevention programs, career counseling, and sexual assault prevention (Reetz, Bershad, LeViness, & Whitlock, 2015). Traditionally, university counseling centers were viewed as having the main purpose of providing psychological services to students to help with their personal problems to aid their academic performance (Choi, Buskey, & Johnson, 2010; Cooper & Archer, 2002; Sharkin, 2004). However, today, vocational and academic struggles may no longer be the primary concerns of students seeking support (Benton, Robertson, Tseng, Newton, & Benton, 2003), and facilitating academic performance may not be the main mission of the university counseling centers as a whole.

In fact, university counseling centers have been noting an increase in clients who presented with severe and complex emotional problems and high distress levels (Gallagher, Gill, & Sysco, 2000). In a national study of university counseling center directors, around 77.1% of directors expressed concern for having to provide services to an increasing number of students with severe psychological problems (Gallagher et al., 2000). A more recent study found that 39% of student-clients seen presented with severe psychological problems (Gallagher, 2012). Another study that analyzed counseling center client problems using the perspectives of treating staff across 13 years with a large student-client sample (n = 13257) found an increase in 14 out of 19 client problem areas (Benton et al., 2003). To note, the areas that showed significant steady linear increases

across three time points were depression, developmental problems, academic skills, medication use, situational problems, and grief (Benton et al., 2003). Although an increase in grief issues was noted, many university counseling centers do not offer bereavement-specific therapy groups or workshops (Balk, 200; O'Neill & Fry, 2013).

Given the possible increase in severity of client problems, university counseling centers face high demand for psychological services, yet their resources and a number of staff were found to be limited (Ilagan, Vinson, Sharp, Havice, & Ilagan, 2014). Overall, university counseling centers employ a wide range of providers with varying professional and educational backgrounds. Nonetheless, the most common full time employees at the university counseling centers are clinical and counseling psychologists, professional counselors, and social workers (Reetz et al., 2015). To meet the demands of the students seeking support, many counseling centers employ trainees (e.g., graduate students and interns), and around 60.9% of surveyed counseling centers were found to have an established mental health training program (Reetz et al., 2015). Furthermore, in addition to efforts to increase available staff providing services, many counseling centers use waitlist procedures. In fact, it has been reported that 35.9% of surveyed counseling centers use waitlists (Reetz et al., 2015). Although a considerable amount of research exists on the services provided by the university counseling centers and the therapists who work there, there is no specific research that addresses grief counseling skills in this population. Thus, little is known about the preparation and efficacy of university counseling center therapists who work with bereaved college students.

Theoretical Foundation: The Death Competence Model

The concept of death competence has been coined and proposed by Gamino and Ritter (2012). It refers to a therapist's "specialized skill in tolerating and managing clients' problems related to dying, death, and bereavement" (p. 23). According to the authors, professionals working with dying and bereaved individuals have an ethical imperative to provide appropriate and effective services, and thus, death competence model aimed to capture the skills necessary for this work (Gamino & Ritter, 2009, 2012). Their model was largely based on previous theories and the competencies proposed by the Code of Ethics of ADEC (2006), which is the largest professional thanatology association in the United States. The death competence model that they proposed is hierarchical and consists of two "building blocks" – cognitive competence as the base layer and emotional competence as the top layer, which together comprised the overall death competence construct (see Figure 1).

According to this model, cognitive competence refers to what the counselor or therapist working with bereaved client knows about grief counseling theory, practice, and outcomes. According to the authors, cognitive competence is the "consolidation of sound academic training and supervised field experience culminating in proven proficiencies that constitute the counselor's expert knowledge and skill set" (Gamino & Ritter, 2012, p. 30). The second dimension of the death competence model is emotional competence, which refers to therapist's capacity to work with bereaved individuals and "to endure the emotional rigors of the therapy process, with its attendant graphic discussions of conflict, trauma, loss, anguish and suffering" (Gamino & Ritter, 2009, p. 35). Thus, emotional competence consists of psychological resilience, awareness and integration of one's own

personal loss history, and utilization of self-care and support from colleagues (Gamino & Ritter, 2012).

Although to date there is no validated measure to assess death competence and empirical research examining therapists' death competence as defined by Gamino and Ritter (2009; 2012) is lacking, there were a few older studies that assessed death competence indirectly. For example, one study examined palliative care volunteers (n = 17) by testing the effect of 27-hour long specialized training, and found that participants reported being more able to cope with death and dying after they competed the training (Claxton-Oldfield, Crain, & Claxton-Oldfield, 2007). These findings provided some support for the cognitive competence dimension of death competence.

In addition, another study assessed personality traits and empathy in a sample (n = 99) of hospice palliative care volunteers, and since the sample was majority female (84%), they compared their results to the norms of females in a general population (Claxton-Oldfield & Banzen, 2010). They found that female hospice palliative care volunteers scored higher than the female norms on the traits of agreeableness, extraversion, and openness, and lower on neuroticism. In addition, hospice palliative care volunteers were higher on the empathic concern and perspective taking subscales, and lower on personal distress and fantasy subscales (Claxton-Oldfield & Banzen, 2010). Given the lack of randomization in this study, these findings need to be interpreted with caution. However, they also pointed to the possibility that individuals working with end-of-life issues and bereavement might possess unique characteristics that possibly contributed to their choice to do the work as well as to remain in this field. Thus, this may provide support for the emotional competence dimension of the death competence model.

Furthermore, additional support for the importance of emotional competence came from research on therapist self-competence when working with end-of-life or bereaved individuals (Chan & Tin, 2012; Chan, Tin, & Wong, 2015; 2017). The construct of self-competence referred to the personal characteristics required to cope with the emotional and existential challenges that arise within grief counseling. According to the authors who developed this concept, there has been considerable focus on the therapist's knowledge and professional skills in working with dying and bereaved individuals, yet the focus on the therapist self has been neglected (Chan et al., 2015).

Chan and colleagues (2012) first conducted interviews with 176 helping professionals who were asked what were the most important death competencies in working with dying or bereaved individuals. They found four categories of death competencies: knowledge competence, practice competence, self-competence, and work-environment competence. The most commonly cited competence was self-competence, which they further categorized into: personal resources, existential coping, and emotional coping. Based on these findings, they developed a measure, Self-Competence in Death Work Scale (SC-DWS), to assess self-competence among helping professionals involved in death and dying field (Chan et al., 2015). They examined their scale with a Chinese-speaking sample of 151 helping professionals and found a two-factor structure consisting of emotional and existential coping subscales, and demonstrated adequate reliability and validity of the scale. Therapists who possessed more positive qualities related to life and death topics (e.g., acceptance of death, higher meaning in life, and increased emotional well-being) were more likely to score high on self-competence. Overall, they concluded

that professionals who possessed high self-competence were comfortable working with dying and bereaved individuals (Chan et al., 2015).

Furthermore, in a recent study, the effectiveness of a 3-day workshop on self-competence was examined in a randomized controlled trial with a sample (n = 112) of helping professionals (Chan & Wong, 2017). Following the training, participants in the intervention group (workshop) increased their overall Self-competence score on the SC-DWS, as well as increased scores on both the Emotional and Existential subscales of the SC-DWS. These positive effects also were maintained at a three-month follow-up (Chan & Wong, 2017). Thus, these findings provideed support for the importance of self-competence in working with grieving clients.

Overall, the death competence model is one of the only known models that addressed specific dimensions needed to be an effective grief counselor. Nonetheless, the model may be limited in some ways, as it did not include therapist attitudes about death and dying. The next section will address the cognitive and emotional competence dimensions of the death competence model. In addition, it will propose an additional dimension for inclusion in the death competence model – the death attitudes of the therapist.

Predictors of Grief Counseling Skills

Cognitive Competence

Building on the death competence construct, in this study, cognitive competence referred to the therapist's knowledge and training/experience to conduct grief counseling. Research on the current status of the mental health professionals' knowledge and training/experience is scarce. Although there are no official guidelines as to what

constitutes knowledge in grief counseling, ADEC proposed a Body of Knowledge Matrix, which reflected foundational knowledge in thanatology (Meagher & Balk, 2013). The matrix consisted of six categories: dying; end-of-life decision-making; loss, grief, and mourning; assessment and intervention; traumatic death; and death education. Furthermore, the matrix had six indicators that related to each matrix category just described: cultural/socialization, religious/spiritual, professional issues, historical perspectives, and contemporary perspectives (Meagher & Balk, 2013). To date, there is no known empirical evidence or measures developed to assess the extent of knowledge that professionals working in the death and dying field have, as it relates to each matrix category.

In terms of current training and preparation of counselors to do grief counseling, the field of psychology also is lacking and research on the topic is scarce. Grief counseling is not an accredited core counseling curricula requirement (Council for Accreditation of Counseling and Related Educational Programs, 2016). Also, the APA accreditation guidelines for psychology programs do not include competencies related to dying, death, or end-of-life issues, and there is no mention of these topics in the APA Code of Ethics (although APA has expressed a commitment to improve the field's investment in these topics; American Psychological Association, 2017). Overall, psychologists have general training that prepares them to address mental health issues, and so hypothetically, these skills also should include appropriate knowledge and training to work with issues that arise at the end-of-life or after experiencing a death-related loss. However, psychologists' lack of involvement in palliative care has been openly critiqued (Kasl-Godley, King, & Quill, 2014). Furthermore, counseling psychology has been

lacking in initiatives to provide education and training about end-of-life issues (Werth, & Crow, 2009) and thanatology as a whole (Servaty-Seib & Taub, 2010).

Moreover, studies that examined the current state of death education in graduate school that train mental health professionals are lacking. Nonetheless, some studies that are dated assessed death education and training. For example, fewer than 50% of graduate programs in clinical psychology and related disciplines were found to cover topics related to death and dying, including suicide (Bongar & Harmatz, 1991). A study published a few years later (Humphrey, 1993) revealed that among the 135 counselor preparation programs (both masters and doctoral level) surveyed, most (n = 95, 70.4%) indicated that training in grief counseling was considered important, yet most (n = 90, 66.7%) programs that responded to the survey did not offer a distinct course in grief counseling. Nonetheless, majority of programs (n = 99, 73.3%) indicated that they infuse grief counseling into other foundation courses and practica (Humphrey, 1993).

Lastly, one more recent study assessed death and dying course offerings in the U.S. psychology departments, yet their recruitment was limited only to 9 Midwestern states (Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Missouri, Ohio, and Wisconsin) and consisted of 161 psychology department chairs (Eckerd, 2009). They found that 127 (78.9%) of respondents did not offer a course on death and dying in the last five years. Furthermore, schools that did not offer the course were asked for the reasons why, but only 54 schools (42.5%) responded to this question. The most common reasons by those who responded included: faculty issues (e.g., insufficient expertise, n = 22, 34%); topics covered in another psychology course or by another department (n = 21, 33%); curriculum issues (e.g., not part of curriculum; course is too specific, n = 14, 22%);

and lack of interest or demand (n = 7, 11%). Overall, these findings on the state of death education provided and training are conflicting – many schools seemed to recognize that topics of death and dying and grief counseling were important, yet a small minority of them seemed to offer courses on this topic.

In terms of empirical research that assessed counselors' knowledge and training, only a few studies exist. One recent systemic review of existing literature on bereavement research, particularly complicated grief, was conducted and revealed that training for mental health professionals working with bereaved individuals was lacking (Dodd, Guerin, Delaney, & Dodd, 2017). The authors suggested that special attention needs to be paid to the development of training that focuses on knowledge, skills, and attitudes of those working with the bereaved.

One of the first studies to examine competence in grief counseling among counselors was Charkow's (2001) unpublished dissertation. This study focused on family counselors' (n = 147) specialized training and competence in grief counseling. Most importantly, this study was the first to create a comprehensive and empirical measure, the Death Counseling Survey (DCS) to assess specialized competence in doing grief counseling. The Death Counseling Survey consisted of two parts – Personal Family-based Death and Grief-Related Counseling Competencies (11 items) and Skills-based Family-based Death and Grief-Related Counseling Competencies (47 items). In addition to the DCS measure, personal death and grief-related experience (e.g., number of close friends and relatives lost to death), professional death and grief-related training (e.g., number of courses taken in death education in graduate school) and experience (e.g., number of years in working with dying or grieving clients), personal death competency

(measured by Bugen's Coping with Death Scale; Bugen, 1981), and demographics also were assessed.

Descriptive results of this study revealed that majority of participants rated their perceived personal death competence and family death and grief-related counseling competency as moderate to high, yet they rated their specialized death and grief-related training within their program as less than adequate. Overall, these results demonstrated that participants who had more specialized training in death education were more likely to cope well with personal issues related to death and dying, and possess stronger skills in working with grieving individuals. Thus, these results supported the notion that therapists who had more exposure to death-related topics in graduate school and direct experience and training in working with grieving clients, might be more prepared to provide grief counseling.

Another important study examined counselors' training, experience, and competencies in grief counseling (Ober et al., 2012). This exploratory study examined 369 licensed professional counselors on their level of training in grief counseling, personal and professional experiences of grief, and grief counseling competence. The authors used the Death Counseling Survey (Charkow, 2001) in addition to Texas Revised Inventory of Grief (TRIG; Faschingbauer, DeVaul, & Zisook, 1987) and Grief Counseling Experience and Training Survey (GCETS; Ober, 2007). Around half of the participants (54.8%, n = 190) reported that they had not completed any specific courses on grief, yet many (73.2%, n = 254) took at least one course that incorporated some aspects of grief-related topics. Nonetheless, a significant majority (91%, n = 334) stated

that training in grief counseling was needed or should be required part of professional training.

In addition, participants were asked about their familiarity with various grief models and theories, yet the results revealed that most respondents had limited knowledge about most widely-recognized theories. Moreover, the most familiar theories were stage and task theories grief (e.g., Kubler-Ross, 1969), though these theories have questionable validity in the field. On the other hand, more validated theories (Richardson, 2007; Schut, Stroebe, van den Bout, & Terheggen, 2001), such as meaning-making and dual-process were known to the lesser extent. These findings are problematic, as it pointed to many counselors not being up-to-date with their knowledge about grief counseling. Counselors rated themselves highest on Personal Competencies ($M = 4.41$, $SD = 0.43$) and lowest on Conceptual Skills and Knowledge ($M = 3.07$, $SD = 0.91$). The authors ran multiple regression analyses and found that training and experience in grief counseling were predictors of death competence. They also suggested that because there was a strong relationship between these two variables, these concepts might be understood as closely related if not synonymous.

Emotional Competence

In addition to cognitive competence, emotional competence was the second dimension of the death competence model. Broadly defined, emotional intelligence referred to characteristics and capacities in managing, understanding, and using emotions (Mayer, Salovey, & Caruso, 2008). Emotional intelligence is a two-dimensional construct, involving both intrapersonal and interpersonal skills and consisting of self-awareness, self-regulation, social skills, ability to identify and reflect one's own feelings,

motivations, and intentions, as well as discerning others' feelings, beliefs, and intentions (Goleman, 2005). More recently, another term for emotional intelligence has evolved to be emotional competence (Brasseur et al., 2013; Saarni, 1999). Some researchers prefered to use emotional competence, as it implies that emotional competence is changeable and can be taught (Kotsou, Nelis, Grégoire, & Mikolajczak, 2011), whereas emotional intelligence may imply a static, unchangeable trait.

There has been considerable support for emotional intelligence being an important characteristic of effective counselors or therapists (e.g., Young, 2013). In a therapeutic world, emotional intelligence or competence becomes essential in the therapist's ability to reflect, restate, and otherwise explore the client's feelings (Goleman, 2005; Young, 2013). Moreover, emotional intelligence has been correlated with counselor self-efficacy (Martin, Easton, Wilson, Takemoto, & Sullivan, 2004) and counselor self-care (Gutierrez & Mullen, 2016). Given that counselors and therapists deal with intense emotions of others and need to regulate their emotional reactions, it is not surprising that their work can be emotionally demanding and draining, and may lead to burnout (Bakker, Van Der Zee, Lewig, & Dollard, 2006). In fact, emotional intelligence was associated with counselor distress (Gutierrez & Mullen, 2016).

As previous research indicated, working with loss-related and dying topics might be distressing to counselors, especially to novices without much prior experience (Kirchberg et al., 1998). Thus, grief counseling and working with dying and bereaved patients (e.g., hospice settings, palliative care settings) could be particularly demanding and might cause burnout in health and mental care providers (Holland & Neimeyer, 2005; Quinn-Lee, Olson-McBride, & Unterberger, 2014). According to the death competence

model (Gamino & Ritter, 2009; 2012), emotional competence as it relates to death competence was defined as the therapist's capacity to work with bereaved individuals and "to endure the emotional rigors of the therapy process, with its attendant graphic discussions of conflict, trauma, loss, anguish and suffering" (Gamino & Ritter, 2009, p. 35). Thus, emotional competence consisted of psychological resilience, awareness and integration of one's own personal loss history, and utilization of self-care and support from colleagues (Gamino & Ritter, 2012). Furthermore, Katz (2006) suggested that is important that grief counselors identify what drew them into working with end-of-life issues and grieving clients in the first place, examine their own personal loss history, and determine what motivates their ongoing interest in death and dying to be effective providers of care.

Gamino and Ritter (2012) also had proposed four common obstacles that grief counselors may encounter while working with bereaved individuals and that relate to their emotional competence dimension of the death competence model. First, they claimed that a counselor should be aware of the reasons why they are drawn to do grief counseling and be mindful of their unfinished business regarding the death of a significant other, as to not take attention away from the client to serve their needs. The second obstacle might be high levels of death anxiety, which would interfere with productive grief counseling. The third obstacle that counselors should overcome is to not generalize from their loss experience to clients, as each loss is unique. The last impediment may be lacking a personal history of loss, and thus needing to be self-aware of their emotional reactions when working with the dying and the bereaved (Gamino & Ritter, 2012).

Overall, emotional competence as defined by the death competence model (Gamino & Ritter, 2009; 2012) was based largely on the general concept of emotional competence (Saarni, 1999). Both constructs emphasized the importance of being self-aware of one's emotions and having the ability to recognize and respond to the emotions and feelings of others. Also, both constructs stressed the importance of regulating one's emotions and recognizing the need for self-care (Gutierrez & Mullen, 2016) to prevent negative consequences of the emotional labor involved in therapy.

Relatedly, some research findings supported the importance of personal loss history in working with dying and grieving clients. For example, one study that assessed hospice volunteers' (n = 52) death attitudes and autobiographical memories of loss found that more experienced hospice volunteers (but not novices) who had more personal death experiences used the memories of these events in an adaptive ways, often citing them as important landmarks that changed the way they think and live their lives (Bluck, Dirk, Mackay, & Hux, 2008). Moreover, other studies found that mental health providers who experienced a personal loss may be more empathetic to clients presenting with grief issues (Martin, 2011; Rappaport, 2000).

Furthermore, some studies noted that therapist unresolved grief might negatively affect the therapeutic work. One study with a sample of 69 therapist-client dyads found that the therapists were perceived as less empathetic by their clients when the therapists were still coping with their loss and more empathic when the therapists resolved their grief (Hayes, Yeh, & Eisenberg, 2007). These findings provided support for one of the four obstacles that Gamino and Ritter (2012) described and that were previously discussed – unfinished or unresolved grief might interfere with effective therapeutic

work. These findings were further bolstered by the case study conducted by Rosenberger and Hayes (2002) that found when therapist's unresolved issues were brought up with the client, ruptures in the working alliance might occur that would possibly impede the therapeutic work. Yet another examined psychologists' (n = 117) loss history (i.e., past and current grief reactions and age of the most significant loss) and how it might relate to their affective reactions to termination of therapy with a client (Boyer & Hoffman, 1993). In this study, loss history was found to be a predictor of counselor anxiety and depression during termination.

Death Attitudes

Although the proposed death competence model only consisted of the cognitive and emotional competencies dimensions, in the current study, we proposed an additional component for the model –death attitudes. Death attitudes are operationalized comprehensively as views on death and dying, including negative (e.g., death anxiety) as well as more neutral and even positive reactions (Neimeyer, Wittkowski & Moser, 2004). Death attitudes often have been measured as a one-dimensional construct (e.g., focusing only on death anxiety or fear of death), yet researchers suggested that measures that are multidimensional in nature and include various dimensions of death-related views might be much more useful (Neimeyer et al., 2003; Neimeyer et al., 2004). Nonetheless, one of the most widely studied death attitudes was the fear of death or a broader concept of death anxiety (e.g., Collett, & Lester, 1969; Feldman, Fischer, & Gressis, 2016; Fortner & Neimeyer, 1999; Templer, 1970). Fear of death is a specific dimension of death attitudes that denotes a negative feeling of dread that is caused by thoughts of the death, dying, or ceasing to be of one's self or others (Lehto, & Stein, 2009). Although the

constructs might be overlapping to some extent, it has been suggested that death anxiety is distinct from fear of death, as it is broader, focuses less on specific events, and encompasses more general vigilance and possible avoidance of death-related things (Cai, Tang, Wu, & Li 2017; Lehto, & Stein, 2009).

Furthermore, death anxiety and fear of death have been widely studied in various populations, including but not limited to the elderly (e.g., Fortner & Neimeyer, 1999), terminally ill individuals (e.g., Yaakobi, E., 2018), medical students (e.g., Thiemann, Quince, Benson, Wood, & Barclay, 2015), health professionals working with dementia patients (e.g., McKenzie, Brown, Mak, & Chamberlain, 2017), and many different Western, other than U.S., and non-Western countries (e.g., Cai et al., 2017; Hoelterhoff & Chung, 2017; Maheshwari & Mukherjee, 2017). Researchers found some evidence to suggest that younger individuals may experience more death anxiety than older counterparts (Burke, Martens, & Faucher, 2010), and noted that death anxiety may vary across individuals' professions, gender, and marital status (Neimeyer & Van Brunt, 1995). People who endorsed higher religiosity and purpose in life also had lower death anxiety (Ardelt, 2003; Cicirelli, 2002).

Furthermore, there were a few conceptual approaches that aimed to explain death attitudes, both more negative and neutral/positive ones. Terror Management Theory (TMT; Greenberg et al., 1990; Rosenblatt, Greenberg, Solomon, Pyszczynski, & Lyon, 1989) was one of the most well-known and most utilized theories that focused on death anxiety. It explained that human beings cannot be constantly aware of the fact that they may die, so they use defenses to manage and minimize this constant dread that is part of human existence. This theory proposed that defenses are strengthened when the mortality

salience is either conscious (proximal defense) or unconscious (distal defense). Proximal defenses may include active suppression or rationalization of death anxiety, while distal defenses target one's worldviews. Since it was first published, the authors of this theory, their colleagues, and other researchers have conducted numerous experimental studies (see Burke et al., 2010) providing evidence that Terror Management Theory is an important way that humans react to situations when death and dying is brought to their attention, either consciously or unconsciously.

Another important conceptual framework that explained death attitudes was based on the work of Wong et al. (1994), who proposed that death attitudes were multidimensional and must include not only negative, but also neutral and positive approaches to death. They created what has been one of the most widely used measures of death attitudes, the Death Attitudes Profile – Revised (DAP-R; Wong et al., 1994). This measure assess death attitudes on five separate dimensions: 1) Fear of Death (e.g., "I have an intense fear of death"), Death Avoidance (e.g., "I always try not to think about death"), 3) Escape Acceptance (e.g., "I see death as a relief from the burden of life"), 4) Neutral Acceptance (e.g., "Death is a natural aspect of life"), and 5) Approach Acceptance ("Death is a union with God and eternal bliss"). The Death Attitudes Profile – Revised has been used in studying death attitudes in health care professionals (nurses, social workers, and physicians), and the results suggested that participants (n = 135) with high fear of death, death avoidance, and escape acceptance were less likely to collaborate with their colleagues regarding advance directives (Black, 2007). Furthermore, those who had higher scores on the approach acceptance (positive death attitude) of the DAP-R were more likely to initiate discussions regarding advance directives, and participants

who had a recent personal experience with terminal illness were more likely to disclose more information regarding this topic (Black, 2007). Another study (Bluck et al., 2008) that used the DAP-R assessed the relationship between one's death experience, death attitudes and autobiographical memory in a sample of hospice volunteers (n = 52). Higher levels of death experience were related to lower levels of death anxiety and death avoidance. Overall, professionals working in the fields where death and dying is a common reality might approach death with less anxiety.

Although there were a number of studies that assessed death attitudes among health care professionals, especially hospice workers and medical professionals, few focused on mental health providers. One of the classic studies was conducted with novice counselors (n = 81; Kirchberg & Neimeyer, 1991). The participants were asked to rate their degree of comfort in working with clients who presented with various issues, five of which related to death and loss, while others focused on other difficult topics (e.g., rape, abuse). They found that counselors rated topics related to death and dying as much more distressing than other scenarios, yet level of experience in counseling and personal death threat were not related to these findings (Kirchberg & Neimeyer, 1991). In a similar follow-up study, Kirchberg and colleagues (1998) further explored counselors' attitudes toward working with clients presenting with death-related issues and their ability to respond to them in an empathic manner. The authors studied 58 masters-level counseling students who viewed videotape vignettes depicting clients with death-related (e.g., grief, AIDS) and non-death-related problems (e.g., marital discord, physical handicap). Counselors reported higher levels of discomfort in responding to client situations involving death and dying. Importantly, counselors' fear of death predicted counselors'

distress in grief counseling. Counselors were slightly more empathic in responding to grief and loss than other conditions (Kirchberg et al., 1998).

Relatedly, a sample consisting of undergraduates, suicide hotline volunteers, and graduate students in clinical and counseling psychology (n = 131) were studied to examine the relationship between professional and personal characteristics in responding to clients presenting with suicide issues (Neimeyer et al., 2001). Overall, participants who reported strong levels of death acceptance, and more training and experience were more responsive to clients who presented with suicidal ideation or intent. Furthermore, yet another study focused on the effect of death attitudes in counselors. An exploratory qualitative study was conducted with 11 graduate counseling students who completed a course in death education that discussed death, dying, grief, and loss (Harrawood et al., 2011). Three distinct themes emerged from the data: openness to examining death and death constructs; increased understanding of death; and reduced negative emotional state, specifically, fear of death. Thus, overall, death attitudes and ability to tolerate and cope with the topic of death might be crucial when working with bereaved clients.

It is important to note that death often is perceived as a somewhat taboo topic in our society at large. Many writings in various disciplines (e.g., sociology, archaeology, psychology) discussed the historical roots and possible shifts in how people experience and approach the topic of death and dying (see Samuel, 2013). Some academics argued that the death taboo has been exaggerated and modern society has redefined its meaning by no longer viewing death as something that cannot be discussed openly (e.g., Lee, 2008; Sayer, 2010). However, others contended that discussions about end-of-life issues and death have been normalized and accepted only in environments that "normalize" or

cannot escape these topics, such as the medical community (Wildfeuer, Schnell, & Schulz, 2015), particularly palliative care. However, the circumstances of the death also might contribute to the degree that the bereaved feels allowed to grieve openly - traumatic deaths may be much more stigmatized (e.g. suicide) than non-traumatic ones (Chapple, Ziebland, & Hawton, 2015).

Furthermore, although the field of thanatology has been growing in the last few decades (see Doka, Heflin-Wells, Martin, Redmond, & Schachter, 2011), and more studies have been published that deal with death, dying, and bereavement (e.g., Doka, Neimeyer, Wittkowski, Vallerga, & Currelley, 2016; Hall, 2014), the extent of this progress and commitment to study these topics in the field of psychology remains questionable (Servaty-Seib & Taub, 2010). For example, death education is not a requirement in psychology training programs (Eckerd, 2009; Wass, 2004) and there is insufficient evidence regarding the current state of preparedness and competence among psychologists for working with dying and the bereaved (Ober et al., 2012). Although APA has expressed commitment to advancing psychology's role in palliative care (American Psychological Association, 2017) and there is encouragement for psychologists to be more involved in working in palliative care (Kasl-Godley et al., 2014), more concrete initiatives are needed to ensure that the next generation of mental health professionals are prepared and competent to provide effective and ethical grief counseling (Wass, 2004).

Grief Counseling Skills

Currently, in the literature, there is no unifying definition of grief counseling skills, yet some propositions exist that attempted to summarize important components of

grief counselor competence. For example, the model of death competence (Gamino & Ritter, 2009; 2012) operationalized death competence using a hierarchical model that consisted of two dimensions or building blocks – cognitive competence and emotional competence. According to this model, a counselor who is skilled to do grief counseling has the knowledge and training to do the work, is emotionally prepared, self-aware of their emotions and personal loss history, and able to tolerate and cope with the distress that often accompanies working with the bereaved (Gamino & Ritter, 2009; 2012). Furthermore, ADEC, which has emerged as the leading authority in the field of thanatology (Doka et al., 2011), developed a Body of Knowledge Matrix (Meagher & Balk, 2013), an important tool in delineating the most crucial knowledge components of thanatology. Although this knowledge matrix did not explicitly list the skills needed to perform grief counseling, it provided an overall summary of the most important aspects of being a knowledgeable provider.

Moreover, ADEC also published a handbook of thanatology (Meagher & Balk, 2013) that discussed important aspects of working with the bereaved and provided a summary of the skills needed to be an effective grief counselor. Similarly to usual psychotherapeutic care, clinical assessment and utilization of evidence-based interventions were cited as crucial in providing effective grief counseling. Clinical assessment of response to bereavement was the first step in working with a grieving client, and it consisted of the evaluation of the mourner's experience, symptomatology, social and family relations, and styles of coping (Meagher & Balk, 2013). Proper assessment was needed before a counselor could determine appropriate treatment.

Moreover, following clinical assessment of the client, appropriate interventions might be provided. However, there has been some debate in the field of thanatology whether grief interventions are effective (Jordan & Neimeyer, 2003; Larson & Hoyt, 2007). In fact, some researchers questioned the utility of prescribing grief counseling to all grieving individuals, given the fact that most bereaved are expected to cope with grief in resilient ways (Bonano, 2004). Nonetheless, although interventions might not be needed by all who experienced normative grief (Currier, Holland, & Neimeyer, 2008), interventions might be helpful for those grieving a traumatic loss or individuals experiencing prolonged or complicated grief (Neimeyer & Currier, 2009). Also, some interventions in grief counseling have been found to be promising as evidenced by research findings: Complicated Grief Treatment (Shear, Frank, Houck, & Reynolds, 2005), Cognitive Behavioral Therapy for complicated grief (Boelen, de Keijser, van den Hout, & van den Bout, 2007), meaning-making approaches (e.g., Lichtenthal & Cruess, 2010), Family-focused Grief Therapy (Kissane & Bloch, 2002), and Family Bereavement Program (Sandler, Tein, Wolchik, & Ayers, 2016).

Furthermore, consideration of multicultural factors was found to be paramount in providing effective and ethical grief counseling (Meagher & Balk, 2013). In fact, Rosenblatt (2008) poignantly stated, “No knowledge about grief is culture free” (p. 207). Thus, one of the most important skills in grief counseling is the awareness of the impact that culture (e.g., race, ethnicity, country of origin, spiritual and religious beliefs) has on expression of grief. Furthermore, grief is a multifaceted experience that is both individual and relational, often involving families and communities at large (Meagher & Balk, 2013; Rosenblatt, 2017). Thus, it is important to assess the grieving individual in terms of social

support, family involvement and dynamics, and larger community, which includes cultural considerations. Moreover, some researchers have discussed the fact that complicated grief or prolonged grief may not be perceived the same in various cultures, where duration and intensity of grief and mourning are not seen as problematic or warranting any intervention (Rosenblatt, 2017). Overall, culture plays a crucial role in how people understand, respond, and integrate their grief into their lives. Thus, in addition to clinical assessment and intervention skills, a counselor should be aware and responsive to the multicultural considerations in providing effective grief counseling.

Research examining grief counseling skills among mental health clinicians is scarce. However, one of the first studies that attempted to measure grief counseling competence among counselors was conducted by Charkow (2001), which was previously discussed in the discussion on cognitive competence. This study focused on family counselors' specialized training and competence in grief counseling (n = 147). The author created a measure known as the Death Counseling Survey (DCS), which consisted of two parts – Personal Family-based Death and Grief-Related Counseling Competencies (11 items) and Skills-based Family-based Death and Grief-Related Counseling Competencies (47 items). One of the most important findings in this study was that participants who had more specialized training in death education were more likely to cope well with personal issues related to death and dying, and possess stronger skills in working with grieving individuals. Thus, not surprisingly, this implied that training in death education might predict effective grief counseling skills (Charkow, 2001).

Similarly, Ober and colleagues (2012) studied counselors' training, experience, and competencies in grief counseling. This exploratory study examined 369 licensed

professional counselors on their level of training in grief counseling, personal and professional experiences of grief, and grief counseling competence. The authors used the Death Counseling Survey (Charkow, 2001) in addition to Texas Revised Inventory of Grief (TRIG; Faschingbauer, DeVaul, & Zisook, 1987) and Grief Counseling Experience and Training Survey (GCETS; Ober, 2007). Counselors rated themselves highest on Personal Competencies ($M = 4.41$, $SD = 0.43$) and lowest on Conceptual Skills and Knowledge ($M = 3.07$, $SD = 0.91$). The authors ran multiple regression analyses and found that training and experience in grief counseling were predictors of death competence (Ober et al., 2012). Thus, counselors might lack knowledge and training in topics related to death, dying, and bereavement, which in turn affects their preparedness and self-efficacy in doing grief counseling work with bereaved individuals and their families.

State of the Bereavement Literature

It is important to briefly discuss the state of the bereavement literature. Given the review provided above, the bereavement literature was limited and lacked rigor and robustness. Specifically, empirical data were lacking that assessed therapist preparation and comfort in working with bereaved clients. Many sources indicated that it was important to assess therapist's emotional coping and preparation, yet measures that would capture these constructs lacked reliability and validity support. Furthermore, empirical measures focused on assessing therapist competencies and skills in doing grief counseling work were virtually nonexistent. This is problematic given that current training in grief counseling is scarce and we know very little about how therapists feel about working with bereaved clients about their skills.

Moreover, the rigor of the research studies was questionable. Many previous research studies used convenience samples or very small samples, and so the generalizability of these studies was questionable. In addition, much of the bereavement research has focused on adult or older adult populations, and so young adults are a fairly underrepresented group in this field of inquiry. Given that young adults (and particular college students) might face unique challenges in coping with loss, it is important to advance empirical data focused on this population. This further underscored the importance of the current study, which contained an exploratory component and meaningfully contributed to the bereavement literature.

Research Hypotheses

The hypotheses were as follows:

I. GRIEF COUNSELING SKILLS (AS MEASURED BY A COMPOSITE SCORE OF DCS SUBSCALES)

1. Cognitive competence was expected to be predictive of grief counseling skills in university counseling center therapists and interns.

    a) Knowledge about grief was expected to predict grief counseling skills (with high levels of knowledge being associated positively with high levels of grief counseling skills).

    b) Training/experience in grief counseling was thought to predict grief counseling skills (with high levels of training and experience being associated positively with high levels of grief counseling skills).

2. Emotional competence was expected to predict grief counseling skills in university counseling center therapists and interns (with high levels of emotional competence being associated positively with high levels of grief counseling skills).

    a) Personal competence was expected to predict grief counseling skills (with high levels of personal competency being associated positively with high levels of grief counseling skills).

    b) Emotional coping was hypothesized to predict grief counseling skills (with high levels of emotional competence being associated positively with high levels of grief counseling skills).

3. Death attitudes were thought to predict grief counseling skills in university counseling center therapists and interns.

    a) Fear of death and death avoidance were thought to account for variance in grief counseling skills (and correlate negatively with grief counseling skills).

    b) Neutral acceptance death attitudes were hypothesized to account for variance in grief counseling skills (and correlate positively with grief counseling skills).

II. GRIEF COUNSELING SKILLS (AS MEASURED BY VIGNETTE-GENERATED GRIEF COUNSELING SKILLS)

4. Cognitive competence was expected to be predictive of grief counseling skills in university counseling center therapists and interns.

    a) Knowledge about grief was thought to predict grief counseling skills (with high levels of knowledge being associated positively with high levels of grief counseling skills).

b) Training/experience in grief counseling was thought to predict grief counseling skills (with high levels of training and experience being associated positively with high levels of grief counseling skills).

5. Emotional competence was hypothesized to predict grief counseling skills in university counseling center therapists and interns.

   a) Personal competence was expected to predict grief counseling skills (with high levels of personal competency being associated positively with high levels of grief counseling skills).

   b) Emotional coping was expected to predict grief counseling skills (with high levels of emotional competence being associated positively with high levels of grief counseling skills).

6. Death attitudes were hypothesized to predict grief counseling skills in university counseling center therapists and interns.

   a) Fear of death and death avoidance were thought to account for variance in grief counseling skills (and correlate negatively with grief counseling skills).

   b) Neutral acceptance death attitudes were expected to account for variance in grief counseling skills (and correlate positively with grief counseling skills).

Appendix B

Study Constructs and Measures

INDEPENDENT VARIABLES:

I. Cognitive Competence

A. Knowledge
   i. *Grief Knowledge Assessment* (Appendix D)
B. Training/Experience
   ii. *Grief Counseling Experience and Training Survey* (Appendix E)

II. Emotional Competence

i. *Death Counseling Survey*
   a) Part I: Personal Grief Counseling Competencies subscale (Appendix F)
ii. *Self-Competence in Death Work Scale*
   a) Emotional coping subscale (Appendix G)

III. Death Attitudes

i. *Death Attitude Profile-Revised (Appendix H)*
   a) Fear of Death subscale
   b) Death Avoidance subscale
   c) Neutral Acceptance subscale

DEPENDENT VARIABLES:

I. Grief Counseling Skills

(1) Measured by composite measure of DCS subscales

i. *Death Counseling Survey - Part II: Skills and Knowledge Grief Counseling Competencies (Appendix I)*
   a) Assessment Skills subscale
   b) Treatment Skills subscale

(2) Measured by vignette-generated grief counseling skills

ii. *Vignette – Bereaved College Student* (Appendix J)
   a) Helpfulness ratings of participants' initial responses to the bereaved client

Appendix C

Eligibility Checklist

Thank you for your interest in our study. Please answer the following questions:

1. Are you currently working as a therapist at a university counseling center in the United States?

☐ Yes
☐ No

2. Are you currently working as a pre-doctoral intern (your final year of doctoral training) at a university counseling center in the United States?

☐ Yes
☐ No

Appendix D

COGNITIVE COMPETENCE: KNOWLEDGE

Grief Knowledge Assessment

(Correct answer/answers are **bolded**)

Please answer the following questions by choosing the best answer.

1. Which of the following statements is true based on Continuing Bonds theory (i.e., Klass, Silverman, & Nickman)?

(a) Ongoing emotional ties to the deceased need to be discontinued to heal from the loss of a loved one.
(b) Family visits to tomb of the deceased in the cemetery is an expression of maintaining a continuing bond with a deceased.
(c) Wearing the deceased clothes is an indication of unresolved and possibly complicated grief.
(d) A bereaved individual who has conversations with the deceased is likely expressing difficulty accepting and adjusting to loss.
(e) c and d

2. Which of the following statements is true based on the Meaning Making Theory (Neimeyer) as it relates to grief?

(a) Search for meaning is not a very common experience that bereaved individuals engage in following a death of a loved one.
(b) Overall, meaning making was not related to adjustment after the death of a loved one.
(c) Narrative retelling of the loss is an important therapeutic intervention that can aid in meaning making.
(d) Sense making and benefit finding were not related to meaning making following loss.
(e) all of the above

3. Which of the following statements is true based on the Kubler-Ross five stage theory of grief?

(a) Bereaved individuals are expected to experience at least two of the five stages of grief.
(b) Bereaved individuals will resolve their grief by accepting the loss.
(c) The five-stage model of grief has not received adequate empirical support.
(d) Bereaved individuals are always expected to start with the denial stage of the grief model.
(e) a and d

4. According to Doka, which grieving style does the following bereaved client most likely express? *"Two days ago Anna lost her mother to cancer. She hasn't cried following the loss and has been focusing on arranging a funeral service that her mother would have loved."*

(a) Anna is likely expressing Intuitive grieving
(b) Anna is likely expressing Instrumental grieving
(c) Anna is likely expressing Blended grieving
(d) Anna is likely expressing Delayed grieving
(e) Anna is likely expressing Task-Focused grieving

5. Which of the following is NOT a risk factor associated with *poor* bereavement outcomes?

(a) Past history of depression, separation anxiety, or PTSD
(b) History of multiple losses
(c) Relationship to the deceased
(d) Sudden death (e.g., vehicular accident)
(e) All of the above are risk factors associated with poor bereavement outcomes

6. Which of the following characteristics best describes a person who may be experiencing **complicated grief** or **prolonged grief disorder**?

(a) Able to plan for the future
(b) Intense and persistent yearning for the deceased
(c) Feeling that life has no meaning or purpose
(d) All of the above
(e) b and c

7. Which of the following statements best describes a person who is experiencing **normative grief**?

(a) Accepts that the loss has happened
(b) Able to pursue interests
(c) Experiences intense sorrow, pain, and rumination
(d) All of the above
(e) a and b

8. Imagine you are seeing a bereaved client in therapy. Looking at the list below, which four (4) areas would be the <u>most</u> important to focus on during your work together? Please only check four responses below:

☐ **Client's spiritual and/or religious identity and views**
☐ **Client's cultural background**
☐ Client's educational level
☐ **Client's race and ethnicity**

☐ Client's occupation
☐ **Client's age**

9. Which of the following grief-specific therapies/interventions have been empirically supported?

(a) Complicated Grief Treatment
(b) Meaning-Making Therapy
(c) Family-Focused Grief Therapy
(d) Cognitive Behavioral Therapy for Complicated Grief
(e) All of the above have received empirical support for their effectiveness with grieving clients.

Appendix E

COGNITIVE COMPETENCE: TRAINING/EXPERIENCE

Grief Counseling Experience and Training Survey (Ober, 2012)

(This measure was edited by the authors for the purpose of this study. See the Method section.)

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

1 = Not at all true
2
3 = Somewhat true
4
5 = Totally true

1. I have received adequate clinical training and supervision to counsel clients who present with grief.
2. I consistently check my grief counseling skills by monitoring my functioning and competency via consultation, supervision, and continuing education.
3. I have a great deal of experience counseling clients who present with grief.
4. I have a great deal of experience counseling persons who experienced loss of a loved one to suicide.
5. I have a great deal of experience counseling children who present with grief.
6. I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling.
7. I have received adequate clinical training to assess the mental health needs of a person who presents with grief in a therapeutic setting.
8. I have a great deal of experience with facilitating group counseling focused on grief concerns.
9. Currently, I do not have sufficient skills or training to work with a client who presents with grief.
10. I have done many counseling role-plays (as either the client or counselor) involving grief concerns.
11. I have sufficient knowledge of grief counseling theories and models.

Appendix F

EMOTIONAL COMPETENCE

Death Counseling Survey (Charkow, 2000)

Part I: Personal Grief Counseling Competencies

(This measure was edited by the authors for the purpose of this study. See the Method section.)

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

1 = This Does Not Describe Me
2 = This Barely Describes Me
3 = This Somewhat Describes Me
4 = This Describes Me
5 = This Describes Me Very Well

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

Appendix G

EMOTIONAL COMPETENCE

Self-Competence in Death Work Scale (Chan et al., 2015)

(This measure was edited by the authors for the purpose of this study. See the Methods section.)

Grief/bereavement work is defined as any supportive, therapeutic or remedial work related to death provided by professionals; for example, physicians, nurses and social workers who work in palliative care, and counselors who provide bereavement counseling.

Please read each statement carefully. Choose the answer that best describes you.

1 = This Does Not Describe Me
2 = This Barely Describes Me
3 = This Somewhat Describes Me
4 = This Describes Me
5 = This Describes Me Very Well

1. I can effectively cope with my emotions induced by grief/bereavement work.
2. I have coped with my bereavement experience or experience related to grief/bereavement work.
3. When I feel stressed by grief/bereavement work, I can take care of my needs properly.
4. I do not bring grief/bereavement work-induced emotions into my life and do not bring life-induced emotions into my grief/bereavement work.

Appendix H

DEATH ATTITUDES

Death Attitude Profile-Revised (DAP-R; Wong, Reker, & Gesser, 1994)

(This measure was edited by the authors for the purpose of this study. See the Methods section.)

This questionnaire contains a number of statements related to different attitudes toward death. Read each statement carefully, and then decide the extent to which you agree or disagree. For example, an item might read: "Death is a friend." Indicate how well you agree or disagree by choosing one of the following:

1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Undecided
5 = Slightly Agree
6 = Agree
7 = Strongly Agree

If you strongly agreed with the statement, you would choose "7." If you strongly disagreed you would choose "1." If you are undecided, choose "4". However, try to use the undecided category sparingly.

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

1. Death is no doubt a grim experience.
2. The prospects of my own death arouses anxiety in me.
3. I avoid death thoughts at all costs.
4. Death should be viewed as a natural, undeniable, and unavoidable event.
5. I am disturbed by the finality of death.
6. Whenever the thought of death enters my mind, I try to push it away.
7. I always try not to think about death.
8. Death is a natural aspect of life.
9. I would neither fear death nor welcome it.
10. I have an intense fear of death.
11. I avoid thinking about death altogether.
12. The subject of life after death troubles me greatly.
13. The fact that death will mean the end of everything as I know it frightens me.
14. Death is simply a part of the process of life.
15. I try to have nothing to do with the subject of death.
16. Death is neither good nor bad.
17. The uncertainty of not knowing what happens after death worries me.

DAP-R Subscale	Corresponding items
Fear of Death (7 items)	1, 2, 5, 10, 12, 13, 17
Death Avoidance (5 items)	3, 6, 7, 11, 15
Neutral Acceptance (5 items)	4, 8, 9, 14, 16
Items that need to be reverse-scored	2, 3, 4, 5, 7, 8, 9, 12, 13, 14, 16

Appendix I

GRIEF COUNSELING SKILLS

Death Counseling Survey (2000)

(This measure was edited by the authors for the purpose of this study. See the Methods section.)

Part II: Skills and Knowledge Grief Counseling Competencies

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

1 = This Does Not Describe Me
2 = This Barely Describes Me
3 = This Somewhat Describes Me
4 = This Describes Me
5 = This Describes Me Very Well

Assessment Skills Subscale
1. I can assess for unresolved losses that may not be stated as a presenting problem with a grieving client.
2. I can articulate the diagnostic criteria for Bereavement, according to the DSM-V and how to distinguish this Diagnosis from related diagnoses.
3. I can conduct suicide assessments with a grieving client.
4. I can assess a grieving client's sense of spirituality.
5. I can utilize assessment techniques to examine interaction patterns and roles with a grieving client.
6. I can assess a grieving client's progress on theoretically defined grief tasks.
7. I can identify cultural differences that affect assessment with a grieving client.
8. I can identify a grieving client's symptoms that warrant medical evaluation and refer to a physician.
9. I can determine appropriate treatment modality for a grieving client (i.e., individual or group) as a result of assessment.
Treatment Skills Subscale
10. I can provide psycho-education to grieving clients related to the grief experience for themselves and others.
11. I can facilitate family grief counseling sessions.
12. I can facilitate individual grief counseling sessions.
13. I can use concrete terms regarding death to address reality of death and convey ability to discuss death-related issues.
14. I can facilitate group grief counseling sessions.
15. I can facilitate multi-family group grief counseling sessions.
16. I can articulate a grief consultation model for parents, teachers, and other adults

about how to talk to college students about death, grief, and loss.
17. I can teach grieving clients how to obtain support and resources in the community.
18. I can establish rapport with grieving clients of all ages.
19. I can identify cultural differences that affect treatment with a grieving client.
20. I can provide appropriate crisis debriefing services to a grieving client.
21. I can exhibit effective active listening skills with a grieving client.
22. I can facilitate a reframe of the loss experience and grief reactions for grieving clients' empowerment.
23. I can facilitate reconnection between a grieving client and distant/estranged family members.
24. I can use the creative arts or activities in counseling to facilitate grief expression.
25. I can appropriately self-disclose related to my own grief and loss experiences.
26. I can recognize and work with grief-related client resistance and denial.
27. I can recommend helpful articles and books for grieving individuals and families.
28. I can provide hope without giving false reassurance to a grieving client.
29. I can advocate for the needs of the grieving client and the family.
30. I can co-create and participate in mourning rituals for grieving individuals and families.
31. I can provide a supportive presence for grieving client(s) in difficult times.

Appendix J

GRIEF COUNSELING SKILLS

Vignette – Bereaved College Student

Please read the following client vignette:

Mary is a second-year college student and has been seeing you for individual therapy for three weeks at your university counseling center. Your work has focused on her feelings of being overwhelmed and stressed due to her academic workload and her uncertainty regarding what to do after graduation from college. You feel that Mary has been invested in your work together and is making progress.

Mary comes to today's session distraught and crying, sits down in front of you, and tells you that her friend has been killed in a car accident. Please take a moment to vividly imagine this scenario as though Mary was your client.

Now, please answer the following questions in the boxes below:

1. Imagine how you might respond to your client. Write exactly what you would say to Mary about what she has told you as if you were speaking directly to her (similar to a movie script; e.g., write exactly what you would say). Please do not enter what you might think about the client here; focus specifically on what you would say.
2. What are four (4) most salient grief-related assessment and/or treatment principles or themes that you would want to focus on with this client over the next few sessions?
3. How comfortable do you feel about working with Mary regarding the sudden death of her friend?
4. What issues might come up for you with this bereaved client?

Vignette Rating Scale

Vignette Question	Rating Scale
1. Overall helpfulness of the therapist's initial response	(0) *not at all helpful* (1) *slightly helpful* (2) *moderately helpful* (3) *very helpful*
2. Grief-related assessment and treatment principles/themes	Code grief-related assessment and treatment principles/themes
3. Comfort of the therapist	(0) *not at all comfortable* (1) *slightly comfortable* (2) *moderately comfortable* (3) *very comfortable*
4. Issues mentioned	Code issues mentioned

Rubric for Vignette Rating Scale

Vignette Question	Response	Rating of Response
1. Overall helpfulness of the therapist's initial response	• Response **lacks emotional sensitivity/empathy** (e.g., "Oh no!," "This sucks") • Response in a question form, **without empathic response** (e.g., "How close of the friends were you?") • **A lot of information-seeking questions**	(0) *not at all helpful*
	• Response expressing **some empathy**, yet followed by a close-ended question (e.g., "This is terrible, Mary. Was she a close friend of yours?") • **No open-ended question (**e.g., "I'm so sorry for your loss") • OR followed by response that is **too long** • OR providing **untimely psycho-education** • OR **adding something** to the intervention that is not empathic • OR **focused on asking client what she needs** at this time from the therapist	(1) *slightly helpful*
	• Response that is **empathic** (or asking about current feelings), possibly containing an open-question, yet too wordy or not wordy enough (e.g., "This is terrible; Unfortunately, experiencing loss is so common among college students. How are you feeling?" or something too short, "This is so sad.") • OR Focused on the **therapist's own reactions (e.g. "Can't imagine how you feel…")**	(2) *moderately helpful*
	• Response that is empathic, short, and allows for silence ("This is awful/terrible, Mary. This must be so difficult for you.") • **Simple, empathic response:** "How are you feeling?" • **Does not ask for details** about the car accident, what happened, etc.	(3) *very helpful*
	• Missing data (no response provided or "NA")	(9) *missing data*
2. Grief-	• Code the assessment and treatment principles/themes:	

related assessment and treatment principles/themes	1. Explore client's feelings and/or reactions 2. Process loss/grief 3. Assessment of client's functioning 4. Assess suicidal ideation/intent 5. Explore client's relationship (e.g., closeness, memories/reflections) with the deceased 6. Previous loss history 7. Existing support system 8. Assessing client's grief style 9. Multicultural considerations (e.g., family cultural background, spiritual and religious beliefs, beliefs in the afterlife, race/ethnicity, gender norms considerations) 10. Explore ways to maintain a continuing bond with the deceased 11. Explore ways to reconstruct meaning of the loss (meaning-making) 12. Provide grief psycho-education 13. Help client memorialize her deceased friend (e.g., meaningful ritual) 14. Provide bereavement-related resources 15. Stages/tasks models of grief (e.g. Kubler Ross, Worden) 16. Explore client's existential concerns (e.g., own mortality) 17. Self-care 18. Help with academic accommodations 19. Coping skills 20. How grief is affecting her initial goals of therapy 21. Assess for PGD/complicated grief 22. Other	
3. How comfort-able do you feel about working with Mary regarding the sudden death of her friend?	• Participant states that they would feel uncomfortable working with Mary; cites lack of training. Possibly mentions a referral to a different provider (e.g., off-campus or a colleague at the CC) instead of working with Mary.	(0) *un-comfort-able*
	• Participant expresses slight hesitation about their comfort in working with the client ("Topic of death makes me feel a bit anxious, but I would still do it"; "This is a hard topic to discuss with young adults and I am not a trained grief counselor, but I would still work with this client.")	(1) *slightly comfort-able*
	• Participant acknowledges the difficulty discussing death, but also expresses confidence in working with the bereaved client (e.g., "This is a difficult topic, but I feel comfortable in working with Mary.")	(2) *moderately/fairly/pretty/mostly*

		comfort-able
	• Participant self-identifies as comfortable/very comfortable in working with the bereaved client; possibly states that this is a common presenting concern for UCC clients.	(3) *quite/very comfort-able*
	• Missing data (no response provided or "NA")	(9) *missing data*
4. What issues might come up for you with this bereaved client?	• Code issues: 1. Intense sadness/emotional difficulty 2. Helplessness related to working with client 3. Increased death awareness/existential questions 4. Death anxiety (own or someone else's) 5. Countertransference due to similar loss circumstances (e.g., unexpected loss of a friend) 6. Issues related to personal loss history (recent and older losses) 7. Lack of personal loss history 8. Lack of training in grief counseling 9. Issues NOT related to the therapist themselves (e.g., impeded therapeutic work) 10. Religious/spiritual/existential concerns 11. Need to consult with peers/supervisors 12. Concerns regarding self-efficacy or limitations in helping this client 13. Talked about client and not their own personal issues 14. Did not report any issues 15. Other	

Appendix K

Demographics

1. Your Age: _____

2. Gender:

☐Female ☐Male ☐Trans female/trans woman ☐Trans male/trans man

☐ Genderqueer/Gender non-conforming ☐Prefer to self-describe_____

☐Prefer not to say

3. Race/Ethnicity:

☐Asian ☐Biracial/ Multicultural ☐Black/African American ☐Hispanic/Latinx

☐Native American ☐Pacific Islander ☐White ☐Prefer to self-describe:_____

4. Sexual orientation:

☐ Straight ☐ Bisexual ☐ Lesbian, Gay, Homosexual

☐ Prefer to self-describe_____

5. Relationship/Marital Status:

☐Divorced ☐In a domestic partnership/relationship ☐Married

☐Separated ☐Single (Never married) ☐ Widowed

6. Please indicate your religious/spiritual identity:

☐Agnostic ☐Atheist ☐Buddhist ☐Christian ☐Hindu ☐Jewish ☐Muslim

☐Spiritual, but not religious ☐Other, please specify: _____

7. How important is your religious and/or spiritual identity to you?

☐Not at all important ☐ Slightly important ☐ Moderately important ☐ Important

☐ Very important ☐ Prefer not to answer

8. How important is your religious and/or spiritual identity or views in the way you approach clinical work with grieving clients?

□Not at all important □ Slightly important □ Moderately important □ Important

□ Very important □ Prefer not to answer

9. What is your highest educational degree?

☐ Associate of Arts (AA) or Associate of Science (AS)
☐ Bachelor of Arts (BA)
☐ Master of Arts (MA) or Master of Science (MS)
☐ Doctor of Psychology (PsyD)
☐ Doctor of Philosophy (PhD)
☐ Medical Doctor (MD)

10. In what area is your highest degree in?

☐ Addiction Counseling
☐ Art Therapy
☐ Counseling Psychology
☐ Clinical Psychology
☐ Family and Marriage Counseling
☐ Mental health counseling
☐ Pastoral counseling
☐ Psychiatry
☐ Social Work

11. Years in counseling/clinical practice: _____

12. Are you currently licensed to provide mental health care?

☐ Yes
☐ No

13. What is your theoretical orientation?

☐ Psychoanalytic
☐ Psychodynamic
☐ Humanistic
☐ Cognitive Behavioral Theory
☐ Existential
☐ Integrative
☐ Other, please specify:_____

14. What kind of institution is the counseling center you are currently employed at located?

☐ Community college
☐ 2-year college
☐ 4-year public college/university
☐ 4-year private college/university
☐ Other, please specify:_____

15. Typically what percentage of your caseload are clients dealing with grief issues/bereavement?

☐0% ☐1-5% ☐6-10% ☐11-20% ☐21-40% ☐41-70% ☐71-100%

16. In all of your years of doing therapy, how often have you worked with bereaved

clients?

☐Never ☐Rarely ☐Fairly often ☐Often ☐Very often

17. Have you done any of the following? Please check all that apply to you:

☐ Took grief counseling or death education courses in graduate program
☐ Received grief counseling experience/training in practica/externship/internship
☐ Took continuing education courses in grief counseling or death education
☐ Attended professional conferences that focused on grief counseling or death education
☐ Read books or other educational material on grief counseling
☐ ADEC Certified Grief Therapist (CGT)
☐ ADEC Certified Grief Counselor (CGC)
☐ Received other certification in grief counseling
☐ Were/are a primary caregiver to someone critically ill
☐ Volunteered/worked in hospice
☐ Worked with terminally-ill clients

18. Have you experienced any significant deaths in your life?

☐ Yes ☐ No

19. To what degree do any of these losses feel unresolved or unfinished?

1- Extremely unresolved/unfinished

2 –Very unresolved/unfinished
3 –Slightly unresolved/unfinished
4 – Mostly resolved
5 – Completely resolved

20. For *university counseling center therapists*, ongoing/continuing education in grief counseling is:

1- Not important at all
2 - Slightly important
3 - Moderately important
4 - Important
5 - Very important

21. Please rate your *grief counseling knowledge* by checking the appropriate answer below.

☐ I feel I need to learn a great deal more before I would call myself knowledgeable.
☐ I still have much to learn to call myself knowledgeable.
☐ I feel comfortable with my knowledge level.
☐ I am highly knowledgeable, I could teach others.

22. How interested would you be in learning more about grief counseling?

1- Not interested at all interested
2 - Slightly interested
3 - Moderately interested
4 - Interested
5 - Very interested

Validity Check Questions

1. Please select "4= This Describes Me" to this question:

1 = This Does Not Describe Me
2 = This Barely Describes Me
3 = This Somewhat Describes Me
4 = This Describes Me
5 = This Describes Me Very Well

2. Please select “Strongly agree” to this question:

☐Strongly Disagree ☐Disagree ☐Moderately disagree ☐Undecided

☐Moderately agree

☐Agree ☐Strongly agree

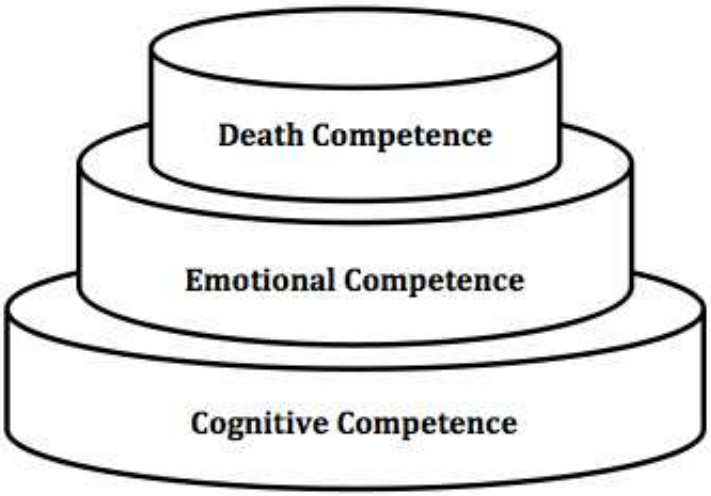

Figure 1. Hierarchical model of death competence (Gamino & Ritter, 2009)

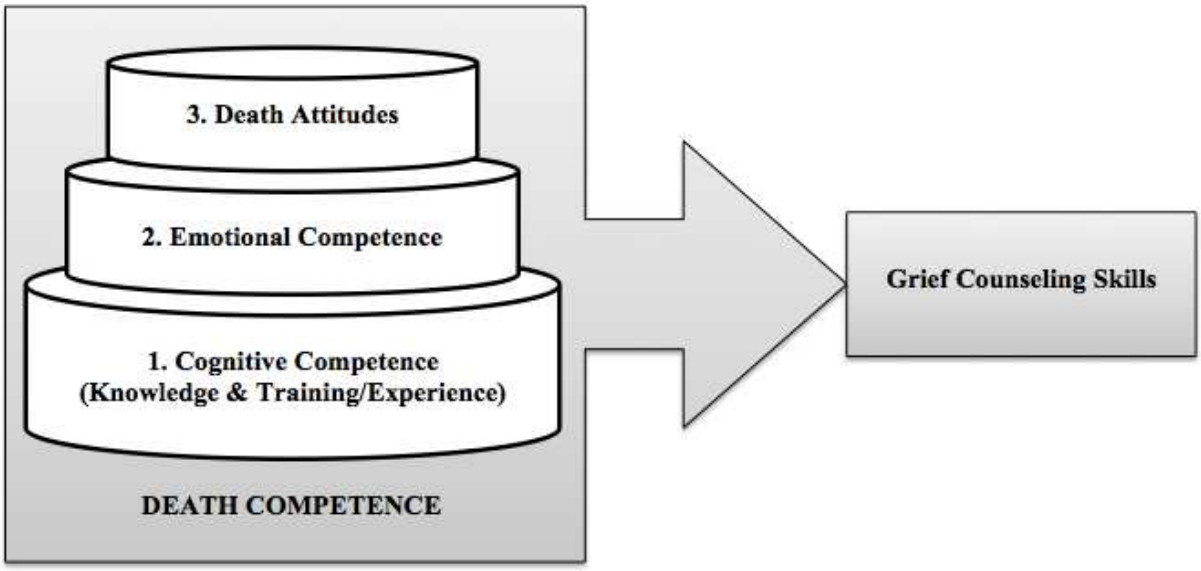

Figure 2. Proposed model of death competence predicting grief counseling skills (Jankauskaite & O'Brien, 2018)

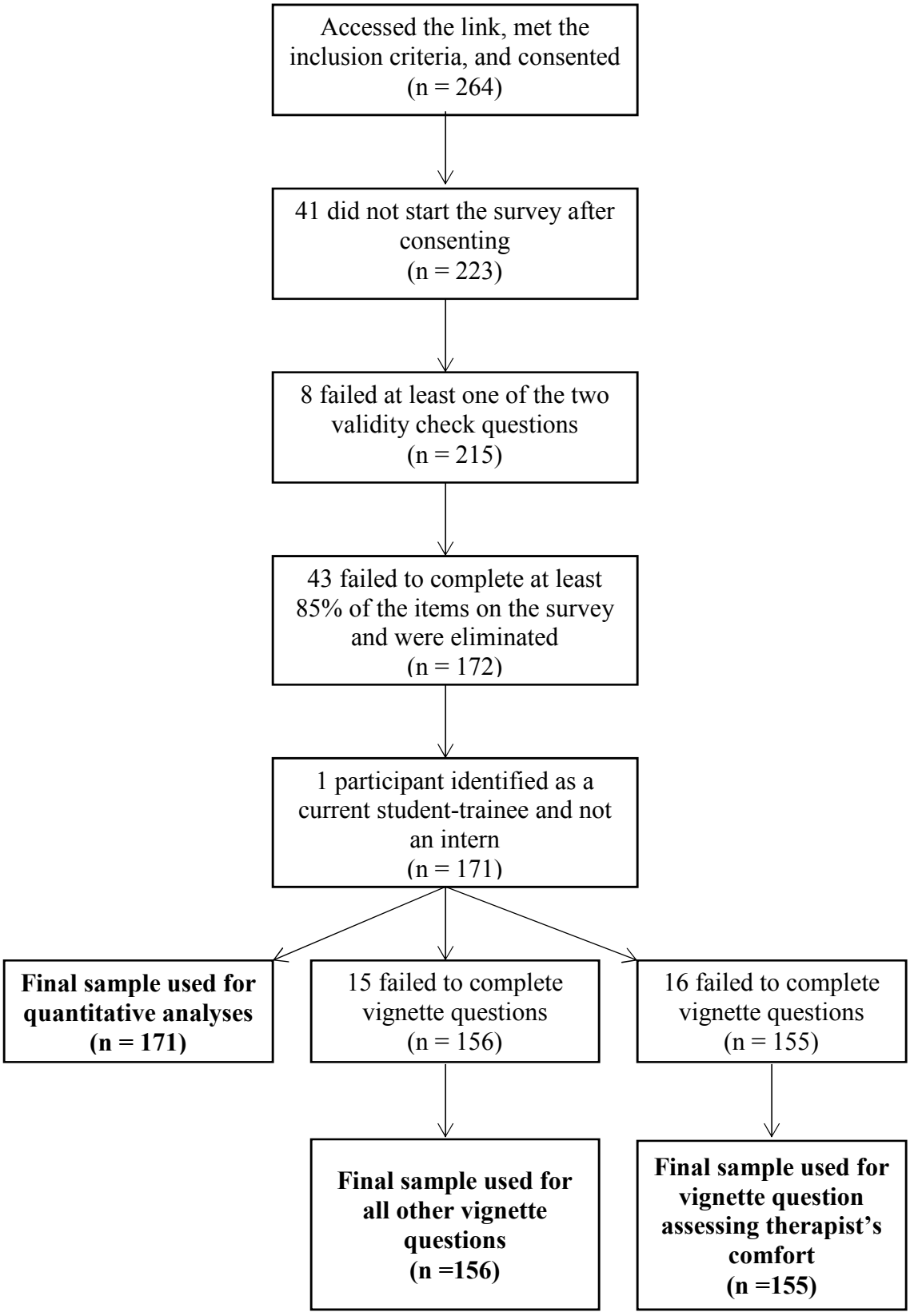

Figure 3. Final sample.

Table 1

Demographics (n =171)

Variable	Total %	(n)
Race/Ethnicity		
White	62.0	(106)
Hispanic/Latinx	7.6	(13)
Asian	6.4	(11)
Biracial/Multiracial	6.4	(11)
Black/African American	4.7	(8)
Native American	1.2	(2)
Other (Prefer to self-describe)	1.2	(2)
Gender		
Female	68.4	(117)
Male	19.3	(33)
Trans male/trans man	0.6	(1)
Gender queer/Gender non-conforming	0.6	(1)
Other (Prefer to self-describe)	0.6	(1)
Sexual orientation		
Straight (heterosexual)	66.7	(114)
Bisexual	11.7	(20)
Lesbian, Gay, Homosexual	8.2	(14)
Queer	1.8	(3)
Other (Prefer to self-describe)	1.2	(2)
Relationship/ Marital Status		
Married	52.0	(89)
Single (Never married)	21.1	(36)
In a domestic partnership/relationship	11.7	(20)
Divorced	4.1	(7)
Widowed	0.6	(1)
Religious/spiritual identity		
Christian	34.5	(59)
Agnostic	15.8	(27)
Spiritual, but not religious	14.6	(25)
Other	12.9	(22)
Jewish	4.1	(7)
Atheist	3.5	(6)
Buddhist	2.9	(5)
Muslim	0.6	(1)
Hindu	0.6	(1)
How important is your religious and/or spiritual identity to you?		
Very important	24.6	(42)
Important	21.6	(37)
Moderately important	20.5	(35)

Slightly important	15.2	(26)
Not at all important	7.0	(12)
Prefer not to answer	0.6	(1)
How important is your religious and/or spiritual identity or views in the way you approach clinical work with grieving clients?		
Slightly important	24.0	(41)
Moderately important	22.2	(38)
Not at all important	21.6	(37)
Important	15.8	(27)
Very important	5.3	(9)
Prefer not to answer	0.6	(1)
Have you experienced any significant deaths in your life?		
Yes	74.9	(128)
No	14.6	(25)
To what degree do any of these losses feel unresolved or unfinished?		
Mostly resolved	45.0	(77)
Completely resolved	18.7	(32)
Slightly unresolved/unfinished	8.2	(14)
Very unresolved/unfinished	2.3	(4)
Extremely unresolved/unfinished	0.6	(1)

Table 2

Professional Background and Education (n =171)

Variable	Total %	(n)
Highest educational degree		
Doctor of Philosophy (PhD)	38.6	(66)
Master of Arts (MA) or Master of Science (MS)	34.5	(59)
Doctor of Psychology (PsyD)	16.4	(28)
In what area is your highest degree in?		
Counseling Psychology	37.4	(64)
Clinical Psychology	31.0	(53)
Mental Health Counseling	11.1	(19)
Social Work	7.6	(13)
Family and Marriage Counseling	1.8	(3)
Art Therapy	0.6	(1)
Are you currently licensed to provide mental health care?		
Yes	67.8	(116)
No	21.6	(37)
Theoretical orientation		
Integrative	50.9	(87)
Cognitive Behavioral Theory	25.1	(43)
Humanistic	24.0	(41)
Other	23.4	(40)
Psychodynamic	19.3	(33)
Existential	5.3	(9)
Psychoanalytic	1.2	(2)
Current employment institution		
4-year public college/university	74.3	(127)
4-year private college/university	12.3	(21)
Other	2.9	(5)
Typically what percentage of your caseload are clients dealing with grief issues/bereavement?		
1-5%	33.3	(57)
6-10%	33.3	(57)
11-20%	17.0	(29)
21-40%	3.5	(6)
41-70%	1.2	(2)
71-100%	0.6	(1)
0%	0.6	(1)
In all of your years of doing therapy, how often have you worked with bereaved clients?		
Fairly often	44.4	(76)
Rarely	28.1	(48)
Often	12.9	(22)

Very often	3.5	(6)
Have you done any of the following?		
Read books or other educational material on grief counseling	66.1	(113)
Received grief counseling experience/training in practica/externship/internship	47.4	(81)
Took continuing education courses in grief counseling or death education	31.0	(53)
Were/are a primary caregiver to someone critically ill	17.5	(30)
Took grief counseling or death education courses in graduate program	16.4	(28)
Attended professional conferences that focused on grief counseling or death education	11.1	(19)
Worked with terminally-ill clients	7.0	(12)
Volunteered/worked in hospice	6.4	(11)
Received other certification in grief counseling	0.6	(1)
For *university counseling center therapists*, ongoing/continuing education in grief counseling is:		
Important	40.9	(70)
Very important	30.4	(52)
Moderately important	15.8	(27)
Slightly important	2.3	(4)
Grief counseling knowledge		
I still have much to learn to call myself knowledgeable	55.6	(95)
I feel comfortable with my knowledge level	22.8	(39)
I feel I need to learn a great deal more before I would call myself knowledgeable	9.4	(16)
I am highly knowledgeable, I could teach others	1.8	(3)
How interested would you be in learning more about grief counseling?		
Very interested	42.1	(72)
Interested	28.1	(48)
Moderately interested	15.2	(26)
Slightly interested	4.1	(7)

Table 3

Means, Standard Deviations, Reliability Estimates, and Intercorrelations (n = 171)

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Grief Knowledge	1											
2. Training/ Experience	.11	1										
3. Personal Grief Counseling Competencies	.09	.52**	1									
4. Emotional Coping	.06	.35**	.58**	1								
5. Fear of Death	.04	-.10	-.30*	-.28**	1							
6. Death Avoidance	.02	-.23**	-.21**	-.17*	.55**	1						
7. Neutral Acceptance	-.04	.12	.35*	.18*	-.32**	-.39**	1					
8. Treatment Skills	.16*	.73**	.57**	.50**	-.14	-.14	.14	1				
9. Assessment Skills	.09	.66**	.51**	.38**	-.14	-.10	.14	.82**	1			
10. Grief Counseling Skills Total	.15	.74**	.57**	.48**	-.15	-.13	.15	.99**	.90**	1		
11. Vignette: Response Quality[a]	-.06	-.14	-.11	-.12	.15	.12	-.04	-.16*	-.23**	-.19*	1	
12. Vignette: Therapists' Comfort[b]	-.04	.37**	.34**	.31**	-.04	-.11	.14	.39**	.34**	.39**	-.13	1
Mean	8.82	2.89	4.31	12.53	3.65	2.30	6.14	3.69	3.82	3.73	1.06	2.41
(SD)	(1.39)	(.66)	(.41)	(1.71)	(1.15)	(1.00)	(.76)	(.57)	(.53)	(.54)	(.06)	(.05)
Actual Range	5-12.93[c]	1.09-4.91	3.18-5	6-15	1-7	1-6.40	2-7	2.14-5	2.22-5	2.19-4.97	0-3	0-3
Possible Range	0-12	1-5	1-5	3-15	1-7	1-7	1-7	1-5	1-5	1-5	0-3	0-3
Cronbach Alpha	NA	.87	.74	.80	.82	.89	.82	.93	.81	.94	NA	NA

Note: *$p < .05$, **$p < .01$, [a]n = 156, [b]n = 155, [c]EM was used to impute the missing data. Thus, the possible range became 0-13.

Table 4

Hierarchical Regression Analysis Predicting Grief Counseling Skills as Measured by Death Counseling Survey (n = 171)

Variable	*B*	*SE B*	β	*T*	*df*	*R*	R^2	ΔR^2	*F*	ΔF
Step 1					2, 168	.74	.55	.55	101.0**	101.0**
Grief Knowledge	.02	.02	.06	1.2						
Training/Experience	.59	.04	.73	13.93**						
Step 2					4, 166	.78	.62	.07	66.60**	15.16**
Grief Knowledge	.02	.02	.05	1.1						
Training/Experience	.47	.05	.58	10.26**						
Personal Grief Counseling Competencies	.22	.08	.16	2.55*						
Emotional Coping	.06	.02	.18	2.98**						
Step 3					7, 163	.79	.62	.01	38.27	.81
Grief Knowledge	.02	.02	.05	1.10						
Training/Experience	.49	.05	.60	10.24**						
Personal Grief Counseling Competencies	.21	.09	.16	2.32*						
Emotional Coping	.06	.02	.18	2.94**						
Fear of Death	-.02	.03	-.04	-.60						
Death Avoidance	.05	.03	.09	1.52						
Neutral Acceptance	.01	.04	.01	.18						

Note: *$p < .03$, **$p < .01$

Table 5

Hierarchical Regression Analysis Predicting Grief Counseling Skill as Measured by Vignette Rating (n = 156)

Variable	*B*	*SE B*	β	*T*	*df*	*R*	R^2	ΔR^2	*F*	ΔF
Step 1					2, 153	.15	.02	.02	1.8	1.8
Grief Knowledge	-.03	.05	-.05	-.59						
Training/Experience	-.17	.09	.14	-1.75						
Step 2					4, 151	.17	.03	.01	1.1	.38
Grief Knowledge	-.03	.05	-.05	-.58						
Training/Experience	-.13	.11	-.11	-1.21						
Personal Grief Counseling Competencies	.00	.22	.00	.02						
Emotional Coping	-.04	.05	-.08	-.74						
Step 3					7, 148	.21	.05	.02	.99	.88
Grief Knowledge	-.03	.05	-.05	-.62						
Training/Experience	-.13	.11	-.11	-1.17						
Personal Grief Counseling Competencies	.06	.24	.03	.26						
Emotional Coping	-.03	.05	-.06	-.57						
Fear of Death	.08	.07	.12	1.20						
Death Avoidance	.03	.08	.04	.36						
Neutral Acceptance	.02	.10	.02	.25						

Note: **p* < .03, ***p* < .01

Table 6

Hierarchical Regression Analysis Predicting Therapist Comfort (n = 155)

Variable	*B*	*SE B*	β	*T*	*df*	*R*	R^2	ΔR^2	*F*	ΔF
Step 1					2, 152	.38	.14	.14	12.58**	12.58**
Grief Knowledge	-.03	.03	-.07	-.96						
Training/Experience	.32	.06	.38	4.99**						
Step 2					4, 150	.43	.18	.04	8.42**	3.79*
Grief Knowledge	-.03	.03	-.07	-1.00						
Training/Experience	.22	.07	.26	2.96**						
Personal Grief Counseling Competencies	.18	.15	.12	1.18						
Emotional Coping	.05	.03	.14	1.46						
Step 3					7, 147	.44	.19	.01	4.99**	.53
Grief Knowledge	-.03	.03	-.07	-.95						
Training/Experience	.22	.08	.25	2.77**						
Personal Grief Counseling Competencies	.18	.16	.12	1.12						
Emotional Coping	.05	.03	.15	1.59						
Fear of Death	.05	.05	.10	1.04						
Death Avoidance	-.01	.05	-.02	-.17						
Neutral Acceptance	.05	.06	.07	.79						

Note: *$p < .03$, **$p < .01$

Table 7

Grief-Related Assessment and Treatment Principles/Themes as Measured by Vignette Responses (n = 156)

Theme	Total %	(n)
1. Process loss/grief	60.2	(94)
2. Explore client's feelings and/or reactions	57. 7	(90)
3. Existing support system	35.2	(55)
4. Assess suicidal ideation/intent	31.4	(49)
5. Provide grief psycho-education	30.8	(48)
6. Assessment of client's functioning	26.9	(42)
7. Self-care	25.0	(39)
8. Stages/tasks models of grief (e.g. Kubler Ross, Worden)	23.7	(37)
9. Multicultural considerations	18.6	(29)
10. Coping skills	15.4	(24)
11. Previous loss history	14.1	(22)
12. Explore client's relationship with the deceased	13.5	(21)
13. Explore ways to reconstruct meaning of the loss (meaning-making)	13.5	(21)
14. Help client memorialize her deceased friend	11.5	(18)
15. Explore existential concerns	10.2	(16)
16. Provide bereavement-related resources	6.4	(10)
17. How grief is affecting her initial goals of therapy	5.1	(8)
18. Assess for PGD/complicated grief	3.8	(6)
19. Explore ways to maintain a continuing bond with the deceased	3.2	(5)
20. Help with academic accommodations	1.3	(2)
21. Assess client's grief style	0.6	(1)
22. Other	21.8	(34)

Table 8

Therapist Self-Reported Issues as Measured by Vignette Responses (n = 156)

Theme	Total %	(n)
1. Issues related to personal loss history (recent and older losses)	29.5	(46)
2. Intense sadness/emotional difficulty	11.5	(18)
3. Death anxiety (own or someone else's)	9.6	(15)
4. Countertransference due to similar loss circumstances (e.g., unexpected loss of a friend)	8.3	(13)
5. Did not report any issues	7.7	(12)
6. Concerns regarding self-efficacy or limitations in helping this client	7.0	(11)
7. Religious/spiritual/existential concerns	6.4	(10)
8. Issues not related to the therapist themselves	6.4	(10)
9. Need to consult with peers/supervisors	6.4	(10)
10. Helplessness related to working with client	4.5	(7)
11. Increased death awareness/existential questions	3.8	(6)
12. Lack of personal loss history	2.6	(4)
13. Lack of training in grief counseling	1.9	(3)
14. Talked about client and not their own issues	12.8	(20)
15. Other	28.8	(45)

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