

ABSTRACT

Title of Dissertation: EVALUATING AN ONLINE
INTERVENTION TO EDUCATE
PSYCHOLOGY GRADUATE STUDENTS
ABOUT GRIEF AND GRIEF COUNSELING
AND TO INCREASE THEIR SELF-
EFFICACY IN WORKING WITH BEREAVED
CLIENTS

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Psychology

Grief is a ubiquitous human experience with most if not all individuals experiencing a death loss at some point in their lives. Prior research found that all surveyed therapists reported having worked with bereaved clients at some point in their careers, with many (44.4%) noting that they provided grief counseling fairly often (Jankauskaite et al., 2021). However, research suggested that majority of therapists never received formal graduate training on grief counseling and may rely on outdated knowledge and questionable skills in working with grieving clients (e.g., Dodd et al., 2020; Jankauskaite et al., 2021; Ober et al., 2012), yet expressed desire to learn more about this clinical skill (Jankauskaite et al., 2021). Thus, the purposes of the present study were to develop an online intervention to educate psychology graduate students about grief and grief counseling and to evaluate whether the intervention can increase knowledge on grief and grief counseling and self-efficacy in working with grieving individuals. The study compared three

study conditions – full video intervention, partial video intervention, and a control consisting of a reading. The results indicated that while controlling for prior grief counseling training and experience, participants randomized to the full video intervention had higher grief and grief counseling knowledge and self-efficacy in working with bereaved individuals than those randomized to the partial intervention and control groups. Overall, the results indicated that the full intervention is a feasible and efficacious way to teach psychology doctoral students about grief and grief counseling and to increase their confidence in working with bereaved client population. We end by discussing clinical implications and future research considerations.

EVALUATING AN ONLINE INTERVENTION TO EDUCATE PSYCHOLOGY
GRADUATE STUDENTS ABOUT GRIEF AND GRIEF COUNSELING AND TO
INCREASE THEIR SELF-EFFICACY IN WORKING WITH BEREAVED CLIENTS

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Dedication

Airidija, this is in honor of you and the joyous light you've ignited within me; I miss you. I also dedicate my dissertation to all the loved ones, known and unknown, those still present with me and those who transitioned. You inspired me, sustained me, and continue to guide me in my life – I love you with all my heart.

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Chapter 1: Introduction

Evaluating an Online Intervention to Educate Psychology Graduate Students about Grief and Grief Counseling and to Increase Their Self-Efficacy in Working with Bereaved Clients

Many if not all individuals experience the death of someone close to them at some point in their lives. Although most bereaved individuals are expected to cope with loss in resilient ways and may not require professional assistance (Bonanno et al., 2004; Jordan & Neimeyer, 2003), many grieving individuals choose to seek professional support such as individual psychotherapy or grief group counseling (Ober et al., 2012). A recent study of therapists (staff mental health professionals and pre-doctoral psychology interns at U.S.-based university counseling centers) found that all had worked with bereaved clients at some point in their careers, and many (44.4%) had counseled bereaved clients fairly often (Jankauskaite et al., 2021). However, many therapists have limited or outdated knowledge, insufficient training, and questionable skills in providing grief counseling (e.g., Dodd et al., 2020; Jankauskaite et al., 2021; Ober et al., 2012), and many practicing therapists reported being interested in learning more about this topic (Jankauskaite et al., 2021). Ideally, grief counseling education should start early for therapists-in-training, such as in their graduate psychology programs or even earlier, during their undergraduate studies (Dodd et al., 2020; Jankauskaite et al., 2021). Thus, the purposes of the present study were to develop an online intervention to educate psychology graduate students about grief and grief counseling and to evaluate the efficacy of this intervention with regard to their enhanced knowledge and increased self-efficacy in providing grief counseling.

Grief

Loss is an inevitable human experience that often disrupts one's psychological and physiological state. Although losses come in many different forms (e.g., loss of a relationship, pet loss, immigration) and may be disenfranchised (Doka, 1999, 2008) or socially marginalized, this study focused on human death losses. Following death, the bereaved experience various emotional, cognitive, physiological, social, spiritual, and existential challenges. Although everyone's grief looks different, there are some common affective grief reactions that include sadness, longing for the deceased, anger, anxiety, or even positive emotional expressions such as relief (i.e., Bonanno et al., 2008; Dominick et al., 2010). Further, grieving individuals may experience physical or somatic effects (e.g., headaches, sleep disturbances, appetite changes), cognitive disturbances (e.g., difficulty concentrating, memory issues, rumination), behavioral reactions (i.e., crying, social withdrawal, restlessness), and increased susceptibility to illness and risk of death (Stroebe et al., 2007). Last, the bereaved also face spiritual or existential challenges, such as the shattering of their world assumptions, loss of faith or changes in spiritual practices, and search for meaning (i.e., Burke et al., 2014; Dominick et al., 2010; Matthews & Marwit, 2006).

Prolonged Grief Disorder

A considerable number of grieverers (around 7-10%; Lundorff et al., 2017) can develop complex, intensified grief, known as prolonged grief disorder (PGD; Maciejewski & Prigerson, 2017). Prolonged grief disorder can be distinguished from normative or uncomplicated grief in that it manifests in persistent (usually lasting for a year or more post loss) 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, and daily functional impairments (Prigerson et al., 2009;

Prigerson et al., 2021). Prolonged grief disorder is a distinct and separate condition from depression, anxiety, and post-traumatic stress disorder (Boelen et al., 2018; Prigerson et al., 2009), and is associated with reduced quality of life and mental health. Prolonged grief disorder also has been linked with physical problems, such as cardiovascular and immune system-related illnesses, higher suicide risk, greater physical distress, and insomnia (Morina et al., 2011; Ott, 2003; Pohlkamp et al., 2019). As previously mentioned, normative grief often resolves on its own, yet prolonged grief disorder may require professional intervention (Killikelly & Maercker, 2017). Additionally, after many years of research efforts and data evaluation, prolonged grief disorder has been added to the International Classification of Diseases 11th Revision (ICD-11) and has been scheduled to appear in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision (DSM-5-TR; Prigerson et al., 2021). Thus, it is imperative that therapists, and especially trainees who may be less familiar with this diagnosis, are knowledgeable about the symptoms and risk factors associated with prolonged grief disorder, how to assess it, and how to address the needs of all bereaved clients (Lichtenthal et al., 2018).

Grief Counseling

In the past few decades, the field of thanatology has produced a number of grief models (e.g., Kübler-Ross' Five Stages of Grief model [Kübler-Ross, 1969]; The Dual Process Model of Coping with Bereavement [Stroebe & Schut, 1999, 2010]; Meaning Reconstruction model [Gillies & Neimeyer, 2006; Neimeyer, 2001]; Four Tasks of Mourning [Worden, 2011]; Continuing Bonds theory [Klass et al., 2014]), yet there are a lack of uniform guidelines on how to conduct grief counseling. Several professionals have created educational handbooks (e.g., Meagher & Balk, 2013; Servaty-Seib & Chapple, 2021), trainings that lead to certification (e.g., Association for Death Education and Counseling, n.d.; Portland Institute for Loss and Transition,

n.d.; University of Maryland Graduate School, n.d.), and webinars (e.g., What's your grief?, n.d.) on grief and grief counseling, with some focused on specific grief models, while others incorporating a number of theoretical perspectives.

It is possible that these continuing education opportunities and trainings were created as a response to lacking formal education in undergraduate and graduate programs in psychology. Today, therapists are forced to seek training outside of their graduate education to learn about grief counseling. Interestingly, grief counseling has become a specialized profession of helping, where some counselors receive in-depth grief training and focus on bereaved clients (Harris & Winokuer, 2019). Although there are a small number of specialized grief counselors, given the prevalence of loss as client's presenting issue, all therapists need to be knowledgeable about grief and basic grief counseling principles.

It is interesting to note that in the field of applied thanatology, there is a distinction between grief counseling and grief therapy, where grief counseling refers to working in a supportive manner with clients who may present with more normative grief, whereas grief therapy is more intense treatment for individuals who may suffer from complicated or prolonged grief disorder (Worden, 2018). Many grief counseling treatments seem to be tailored around specific grief models. There are a few empirically supported grief interventions, yet they specifically address prolonged grief (e.g., Integrative Cognitive Behavioral Therapy for PGD [PG-CBT; Rosner et al., 2015]; Complicated Grief Treatment [Shear & Bloom, 2017]). Other therapies have shown preliminary efficacy (e.g., Meaning-Centered Grief Therapy [MCGT; Lichtenthal et al., 2019]), while many have not been tested with clinical trials (e.g., Meaning Reconstruction [Neimeyer, 2019]).

Within the varied forms of grief interventions, there are several common principles. First, grief work must be adapted to the client because grieving is unique to each individual (e.g., Rosenblatt, 2020). Thus, a therapist who works with a grieving client has to be attuned to individual differences, life experiences and cultural background. Further, the Association for Death Education and Counseling (ADEC), which is the largest U.S. professional organization in thanatology or study of death and dying, has proposed a Body of Knowledge Matrix (Meagher & Balk, 2013; Servaty-Seib & Chapple, 2021). This matrix summarizes important grief knowledge domains and underlines the salience of assessment and intervention in grief counseling, which both have to be supported by evidence and matched with the client's characteristics. Assessment of the client may need to incorporate not only the usual assessment questions, such as client's daily functioning and suicidal risk, but also indicators that grief might be protracted or complicated.

Another universal guideline in grief counseling is that the therapist needs to hold an empathic and open space for the client to share their reactions and emotions about the loss, and to provide an opportunity to retell the story of the death as narrating the details of the death might assist in healing (e.g., Neimeyer et al., 2010; Peri et al., 2016). Moreover, although specific grief interventions vary based on the client's needs and therapist's style, the goal of grief counseling is to process the loss, facilitate emotional expression, and ultimately help the client to integrate the loss, while supporting them in the reengagement with their life (Harris & Winokuer, 2019; Worden, 2018). Other useful grief counseling principles include helping the client to find meaning in their loss or facilitate a way to reconnect with their deceased loved one (Harris & Winokuer, 2019; Worden, 2018). Supporting grieving clients sometimes involves providing

psychoeducation about the nature of grief and grieving, as a way to normalize their experience (Harris & Winokuer, 2019).

Although loss may have profound effects on the bereaved, most grieving individuals cope with loss in resilient ways (Bonanno et al., 2004) and may not require professional intervention. In fact, there has been considerable debate about the effectiveness of grief counseling with some researchers reporting low effect sizes for grief interventions (Jordan & Neimeyer, 2003), and others arguing that grief interventions may produce negative outcomes (Neimeyer, 2000). Overall, the general consensus is that although not all bereaved need counseling, those who actively seek counseling (Schut, 2010), have difficulty adapting to loss, or experience prolonged grief (Iglewicz et al., 2020; Wittouck et al., 2011; Zisook & Reynolds, 2017), may benefit from professional grief interventions.

Grief Counseling Education

As mentioned earlier, many therapists reported working with grieving clients, yet received little training in this area perhaps because major counseling accreditation institutions do not require grief counseling in graduate training curricula (Council for Accreditation of Counseling and Related Educational Programs, 2016; Masters in Psychology and Counseling Accreditation Council, 2017). Furthermore, the American Psychological Association (APA), the largest professional organization representing all fields of psychology, does not include competencies related to dying, death, end-of-life issues, or grief counseling in their accreditation guidelines for psychology programs (American Psychological Association, 2015). However, APA has commented on the organization's responsibility and investment in these topic areas (American Psychological Association, 2017).

Moreover, the majority of training programs in counseling or clinical psychology do not provide education in the scientific study of death and dying (Jankauskaite et al., 2021; Servaty-Seib & Taub, 2010). Death and dying topics are often perceived as taboo in our society, which may contribute to the lack of investment in grief counseling training. Alternatively, generalist psychology training may be considered sufficient for addressing the needs of grieving clients. Some may argue that grief counseling is a specialized area of clinical practice, similar to other specializations such as addictions treatment or disordered eating treatment, and that not everyone needs to receive training in grief counseling. In other words, some may assume that a well-trained generalist therapist in training might be well-prepared to address bereaved client needs.

However, previous research highlighted that when therapists were presented with a hypothetical bereaved client case, they overwhelmingly disregarded salient grief counseling treatment and assessment considerations and often used outdated grief models that had little empirical support (Jankauskaite et al., 2021). Notably, in this same study, therapist's training/experience was the most robust predictor of self-reported grief counseling skills (Jankauskaite et al., 2021). Similarly, another study that assessed mental health professionals' knowledge, attitudes, skills, and training around the topic of complicated grief reported that participants exhibited deficits in professional training, which was evidenced in an overreliance on outdated grief literature (e.g., stage grief theory) and limited knowledge about empirically supported assessments of prolonged grief (Dodd et al., 2020). Thus, although grief counseling may be perceived as a specialized clinical practice, all therapists in training (i.e., psychology graduate student trainees) should have basic knowledge about grief and use up-to-date grief counseling models and strategies. Grief is a common presenting issue among clients, and therapists should be well prepared to address their needs.

Moreover, given that most graduate programs in psychology do not require or even offer coursework in death education or grief counseling (Jankauskaite et al., 2021; Servaty-Seib & Taub, 2010), it is likely that many therapists turn to self-educational means, such as reading books on grief counseling or attending webinars. In fact, within a sample of 171 therapists who work at university counseling centers, only 16.4% reported that they took a grief counseling or death education course in their graduate program, but 66.1% had read books or other educational materials on grief counseling, and 31.0% took continuing education courses in this topic area (Jankauskaite et al., 2021). This data reinforces the idea that grief counseling education is not consistent and not uniformly established within graduate psychology programs, which often leads to clinicians resorting to self-study or having no exposure to up-to-date grief counseling principles.

Online Training

One way to increase access to grief counseling training is to offer easily attainable and fiscally sound interventions that are conducted online. In the current study, an online training intervention was developed and implemented to teach graduate psychology students about grief and grief counseling. An online format is more feasible than an in-person intervention in that it is convenient, accessible, and less time-consuming for busy psychology graduate trainees. Further, given that only a small number of therapists receive education in grief counseling (Jankauskaite et al., 2021), an online intervention could disseminate knowledge to those professionals who may not be exposed to grief counseling. Additionally, if the online intervention is efficacious, the dissemination of such training will be easier and more cost-effective than in-person trainings. To our knowledge, there are no online trainings that were specifically designed to educate psychology trainees about grief and grief counseling and evaluate the efficacy of such

intervention. A recent online intervention successfully educated college students about grief and informed them how to support their bereaved peers (Hill & O'Brien, 2021). The findings from the evaluation of this intervention encourage further exploration of online trainings related to grief.

Overall, online trainings related to mental health were an efficacious means of education (e.g., Bennett-Levy et al., 2012; Fairburn et al., 2017). In fact, a comparison of three modes of teaching Dialectical Behavioral Therapy skills to clinicians found the multimedia interactive online training to be superior when compared to written manuals or in-person instruction (Dimeff et al., 2005). Online trainings offer a balance of being more engaging than written materials and more flexible than in-person trainings. However, free-standing online trainings, even if they are interactive in nature may lack deeper introspective work that is offered by in-person trainings. For example, online trainings likely will not have communal learning features, such as connecting with peers and participating in group discussions. Also, online trainings rarely include features that allow for questions and answers. Nonetheless, we believe that an online training that is both engaging and interactive yet targeted in scope and time-limited would be the most pragmatic tool to educate psychology graduate students about grief and grief counseling. This training could be a first step to disseminate basic knowledge about grief and grief counseling.

Theoretical Foundation

Social Cognitive Theory

Bandura's Social Cognitive Theory (SCT; Bandura, 1969; 1997) informed the development of the online intervention to educate psychology graduate students about grief and grief counseling. This theory posits that in addition to learning through experiences, individuals

also learn by observation of others' behaviors and its consequences. SCT proposes a model of learning, which consists of three interacting components: personal factors, environmental influences, and behavior (Bandura, 1969; 1997). Further, there are four major SCT components that play a role in learning: (1) modeling, which states that knowledge acquisition occurs by observation of others perform an activity and then imitation of that activity; (2) outcome expectancies, which implies that the learner needs to understand the potential outcomes (reward or punishment) if they perform certain behaviors; (3) self-efficacy, which is one's beliefs in their ability to master a specific skill; and (4) identification, which posits that learner is more likely to successfully follow through with modeled behavior if they perceive themselves as similar to the model (Bandura, 1969; 1997).

Self-efficacy, which is part of SCT (Bandura, 1969; 1997), was one of the key constructs of interest in the current study. Self-efficacy is the extent to which a person has confidence in their ability to perform a skill, which contributes to how goals and challenges are approached by that individual. Specifically, people with high self-efficacy are likely to report the ability to master challenges or skills and may be more adaptive in recovering from setbacks. In a way, someone who feels self-efficacious may be more willing to try and persist in learning, even if there are potential roadblocks or the possibility of failure. For this reason, self-efficacy is viewed as a crucial component in learning and performance and has received much attention in psychological research. Importantly, engagement in learning and training can improve therapists-in-training self-reported self-efficacy (e.g., Hatch-Maillette et al., 2019; Hill et al., 2020). Therefore, we posited that exposure to an online training in grief and grief counseling would likely enhance graduate students' self-efficacy in working with bereaved clients.

Further, the development of an online intervention was informed by SCT (Bandura, 1969; 1997) in that it included a cognitive learning component (i.e., knowledge acquisition by didactic portion of the training), modeling (i.e., demonstrations of how one might perform grief counseling with a client described in the intervention), and an opportunity to practice newly learned material within the intervention (i.e., opportunities to reflect on how one might respond to a grieving client). Thus, instruction, modeling, and practice were the primary components of the online intervention, as informed by SCT (Bandura, 1969; 1997). Further, Bandura's proposed four determinants of self-efficacy also were relevant to this study: mastery (participant's previous experiences and training in grief and grief counseling), vicarious experiences (seeing someone else similar to them successfully perform a task and model this behavior), persuasion (receiving messages of encouragement and support that one can succeed with a task), and physiological states (emotional and physical aspects that affect participant's ability to perform a particular task). For the script of the proposed full intervention, please refer to Appendix B.

Constructs

As mentioned earlier, there is a dearth of graduate training in death education (Jankauskaite et al., 2021; Servaty-Seib & Taub, 2010), which raises questions about trainee knowledge and self-efficacy in working with grieving clients. With the present study we hoped to explore whether a novel online training on grief and grief counseling could increase psychology graduate students' knowledge and confidence in this clinical area. Below we discuss the main outcome variables – grief and grief counseling knowledge and self-efficacy in grief counseling. We also discuss the role of prior training and experience in grief counseling, which served as a control variable in the present study.

Grief and Grief Counseling Knowledge

Although there are no official definitions of guidelines as to what constitutes knowledge in grief counseling, the ADEC Body of Knowledge Matrix (Meagher & Balk, 2013; Servaty-Seib & Chapple, 2021) is the only known resource that proposed specific guidelines as to what constitutes foundational knowledge in grief counseling.

In the current study, we operationalized grief counseling knowledge as a composite of two elements: (1) therapist's conceptual knowledge of grief and grief counseling, and (2) applied knowledge, which is therapist's ability to identify salient themes in assessment and treatment planning of a bereaved client, including knowledge of the 3-Factor Grief Counseling Model (O'Brien et al., 2022), which was developed by a team of researchers including the first author of the present study (see Appendix C and Method section). Our definition of grief counseling knowledge was informed by the general bereavement literature review, foundational guidelines provided by the ADEC Handbook of Thanatology (Meagher & Balk, 2013; Servaty-Seib & Chapple, 2021), literature on bereavement risk factors (e.g., Morris et al., 2019; Stroebe et al., 2006; Stroebe & Schut, 2001), prolonged grief disorder assessment (e.g., Boelen et al., 2018; Jordan & Litz, 2014), and clinical and research expertise of a team of researchers (including the first author) in the grief counseling domain.

Very few research studies focus on grief counseling knowledge as a specific construct. In fact, only one known study (Jankauskaite et al., 2021) assessed therapists' grief knowledge by using an author-developed nine-item, multiple-choice question assessment that was informed by the ADEC Body of Knowledge Matrix (Meagher & Balk, 2013) and expert feedback. Their measure included items that focused on knowledge about grief models and theories, grief styles, normative grief, complicated grief, current evidence-based therapeutic strategies, risk factors associated with poor bereavement outcomes, and multicultural considerations in bereavement

(Jankauskaite et al., 2021). In this study, grief knowledge was found to be above average. The lack of variability in the results might have been due to participants potentially looking up some answers online, which would have produced somewhat inflated grief knowledge results. Alternatively, it is possible that the sample was actually very knowledgeable about grief, especially since the majority of participants were established psychologists with extensive clinical practice. Other than this study, research on broad grief counseling knowledge is scarce. Only a few other studies examined grief knowledge, but it mostly focused on complicated grief (Dodd et al., 2017; Dodd et al., 2020) or prolonged grief disorder (Bryant, 2018). It is important to note that these studies did not utilize a measure of knowledge but rather conducted qualitative interviews or performed systemic reviews of existing literature on the topic.

Grief Counseling Self-Efficacy

Informed by SCT (Bandura, 1969; 1997) and the general definition of self-efficacy, self-efficacy in grief counseling was defined as confidence in the ability to provide effective grief counseling. As one might expect, psychology trainees may report differing self-efficacy levels in working with bereaved clients for various reasons (e.g., prior training, experience, personal exposure or interest in this area). Self-efficacy might be particularly important for therapists-in-training because those who express high self-efficacy might be likely to persevere and recover from challenges or setbacks in their work. Importantly, learning through training can improve therapists-in-training self-reported self-efficacy (e.g., Goreczny et al., 2015; Hatch-Maillette et al., 2019; Hill et al., 2020). For example, a randomized training trial was conducted with a sample of substance use disorder counselors to examine the effects of training on counselors' self-efficacy and skills in talking to clients about sex and HIV risk (Hatch-Maillette et al., 2019).

Increases in counselors' confidence and skills were found in how they discussed these topics with their clients, and these effects remained significant after three months.

Another study followed a sample of undergraduate students five years after they completed a course designed to teach students the basics of counseling and found that those students who received additional mental health education and continued to practice the skills had higher self-efficacy than those participants who did not receive additional mental health training (Hill et al., 2020). Training in counseling can contribute to therapist's confidence to conduct therapy, and perhaps have lasting effects. Also, completion of specialized trainings (e.g., suicide assessment training) relates to trainees' confidence in working with clients who present with those concerns (e.g., Mitchell et al., 2020). Thus, we posited that a specialized training on grief and grief counseling may also improve therapists-in-training confidence to work with bereaved clients. Moreover, in line with self-efficacy theory, therapists who feel confident in their ability to address the needs of grieving clients might be willing to work with this population or feel more persistent in their efforts.

Grief Counseling Experience and Training

Grief counseling experience and training served as a control variable in the current study. In line with previous work (Jankauskaite et al., 2021; Ober et al., 2012), grief counseling experience and training was defined as trainee's previous clinical training, supervision received, experience working with bereaved clients, and other sources of training in grief work. Previous research has found that training and experience in grief counseling was the most robust predictor of therapist self-perceived grief counseling skills (Jankauskaite et al., 2021; Ober et al., 2012). It seems likely that therapists-in-training who have exposure to grief topics and experience in working with grieving clients will report high confidence in their ability to do grief counseling.

In addition, therapists' overall training might contribute to their overall self-efficacy in providing counseling. For example, a curvilinear relationship was found between the level of training and self-reported self-efficacy in counseling in a sample of trainees (undergraduates to advanced graduate students in a Master's program in counseling psychology; Goreczny et al., 2015). In addition, the highest level of self-efficacy was reported by the most advanced graduate students who had received the most training in counseling (Goreczny et al., 2015). Although research on therapists' self-efficacy in grief counseling is scarce, a study that assessed the efficacy of an online intervention to educate undergraduates about grief and how to support their grieving friends found that the training increased students' self-efficacy (Hill & O'Brien, 2021). These findings are encouraging in that they show that training in grief topics can meaningfully affect confidence in how to talk about grief. Similarly, in the current study, participant's prior training in grief-related topics and experience working with bereaved clients was used as a control variable.

Current Study

As research suggested, graduate psychology students may not be receiving much education and training in grief counseling (e.g., Jankauskaite et al., 2021). Thus, the purpose of this study was to develop and assess the efficacy of an online training intervention to educate clinical and counseling psychology doctoral students in graduate programs in the United States about grief and grief counseling. The study consisted of three conditions – full intervention (see Appendix B), partial intervention (see Appendix D), and control (see Appendix E). Both partial and full interventions were online video interventions developed by the research team (including the first author) with the aim to teach participants about grief and grief counseling. The partial intervention included basic information about grief and covered several existing grief models,

while the full intervention included the same information covered in the partial intervention video plus an interactive overview of a specific case vignette with proposed grief counseling application, including an overview of the 3-Factor Grief Counseling model (O'Brien et al., 2022) developed by the research team. Specifically, we evaluated whether these online trainings would improve graduate student grief and grief counseling knowledge and self-efficacy in grief counseling. We hypothesized the following:

1. Controlling for prior grief counseling experience and training and pre-test grief and grief counseling knowledge, participants in the *full online intervention* group will report higher post-test grief and grief counseling knowledge than participants in the partial intervention and control groups.
2. Controlling for prior grief counseling experience and training and pre-test grief counseling self-efficacy, participants in the *full online intervention* group will report higher post-test grief counseling self-efficacy than participants in the partial intervention and control groups.

Chapter 2: Method

Procedures

An *a priori* statistical power analysis, using the G*POWER v3 software (Faul et al., 2007) indicated that a total sample size of 143 participants was needed to achieve statistical power of 0.9, a medium effect size (Cohen's $f = 0.25$), with an overall $\alpha = 0.05$ for a repeated measures MANOVA. In the current study, one analysis of covariance (ANCOVA) and one multivariate analyses of covariance (MANCOVA) were calculated to test the main hypotheses. In addition, a separate multivariate analysis of variance (MANOVA) was calculated to examine the evaluation of intervention scores.

The present study was part of a larger project led by a team of international researchers (see more information about the research team in the Intervention section below) who collected data in two countries – the United States and Korea. This team collaboratively developed the online training interventions used in the present study and assessed their efficacy with two samples of practicing therapists and trainees in Korea and the United States. The present study used only the United States-based clinical and counseling psychology doctoral student sample.

Several recruitment methods were used. First, the clinical training directors of APA-accredited counseling and clinical psychology doctoral programs in the U.S. were contacted by email and asked to forward a study recruitment email to their students. We contacted 71 APA-accredited counseling psychology doctoral (Ph.D. and Psy.D.) programs and 220 clinical psychology doctoral (Ph.D. and Psy.D.) programs. Second, we also contacted training directors of 163 university counseling centers in the U.S. that house APA-accredited internships and asked them to forward the recruitment email to their trainees. The recruitment email contained information about the study, the IRB approval number, and a link to an online survey. Third,

participants were recruited by email through personal contacts and professional networks, such as APA Division 17 listserv and graduate student groups. Potential participants who accessed the link to the survey provided in the recruitment materials were asked to answer inclusion criteria questions (see Appendix F). Those who confirmed that they were currently enrolled in a counseling or clinical psychology doctoral (Ph.D. or Psy.D.) program 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, the participants were presented with pre-test study measures (see Figure 1 for the study flow diagram) and after completion, were then randomized into the full intervention, partial intervention, or the control group. In the partial and full intervention conditions, participants were shown a researcher-developed online training in the form of a video that educated graduate student trainees about grief and grief counseling (see Appendix B for the full intervention script). Of note, the main difference between the partial and full interventions was that the full intervention was more comprehensive and included a case vignette example and an overview of the researcher-proposed grief model titled, the 3-Factor Grief Counseling Model (O'Brien et al., 2022; Appendix C). Participants in the control group were directed to a document (see Appendix E) containing basic information on grief and grief counseling taken from an existing webpage available to the general public and asked to read the information. Then, after completing their assigned tasks, participants in all three groups were presented with post-test study measures. Participants in the control and partial interventions groups were invited to view the full intervention video after they completed the post-test measures, if desired. All questionnaires were administered through online Qualtrics software.

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 a monetary gift card of \$20.00 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. The total participation in the study took no more than 75 minutes.

Participants

One thousand two hundred and fifty-nine students accessed the survey, while 795 individuals met inclusion criteria and provided consent to participate. One hundred and twenty-four participants did not start the survey after consenting to participate in the study. Then, data from participants who failed to complete at least 85% of the items on the survey were deleted ($n = 498$). In addition, four participants failed to provide a correct answer to at least one of the two validity checks and were removed. Thus, the final sample consisted of 169 participants who completed the measures (see Figure 2). All 169 participants met the inclusion criteria and were doctoral students in counseling or clinical psychology programs in the United States.

Regarding the characteristics of the sample, see Table 1 for demographic information and Table 2 for professional background and education information. The participants ranged in age from 22 to 52 years old ($M = 27.62$, $SD = 3.98$). The gender identities of the participants were women (79.9%), men (16.0%), and non-binary/gender queer/gender flexible (4.14%), with two participants (1.2%) identifying as transgender, while the rest were cisgender (98.8%).

In terms of racial identity/ethnicity, the majority of the sample (59.8%) identified as White or European, Asian or Asian American (17.7%), Biracial or Multiracial (9.5%), Black or

African (6.5%), Hispanic/Latinx (2.9%), Middle Eastern (2.4%), and Other (1.2%). Furthermore, the most commonly endorsed sexual orientation was straight/heterosexual (69.8%).

With regard to educational background, all were current graduate students, with most having a Master's degree (M.S. or M.A.; 67.5%), while 26.0% reported earned a Bachelor's degree (B.S. or B.A.), and 6.5% already had a doctorate degree (Ph.D. or Psy.D.). The majority (50.3%) of the participants were counseling psychology Ph.D. students, while others were enrolled in clinical psychology Ph.D. (23.7%), clinical psychology Psy.D. (19.5%), and counseling psychology Psy.D. (6.5%) programs. There also was representation of participants coming in different doctoral program years: 1st year (15.4%), 2nd year (24.9%), 3rd year (20.1%), 4th year (18.3%), 5th year (16.0%), 6th year (3.0%), and 7th year and beyond (2.4%). Of those enrolled in the study, 4.7% had a license to practice counseling/psychotherapy. The participants ranged in the average number of direct clinical hours from 0 to 7000 ($M = 551.22$, $SD = 804.97$). We also asked about various counseling/clinical training sites that participants either worked previously or were currently working: 53.2% university training clinic, 49.1% community clinic/center, 47.9% university counseling centers, 31.4% hospital or academic medical center, 13.0% VA or other military medical center, and 13.0% reporting as "other" placements.

When asked about the degree to which their typical caseload consisted of clients who presented with grief issues/bereavement, 78.1% endorsed seeing bereaved clients (1.2% did not answer this question). Close to a third (30.8%) reported their caseload contained 1 to 5% bereaved clients. Furthermore, when considering the years that they had done therapy, 17.8% reported that they have never worked with a grieving client. Information also was collected regarding the training, education, or other experiences that graduate students received related to death, dying, and grief counseling. A small percentage of participants (5.9%) completed grief

counseling or death education coursework in their graduate training. Of note, all of those who completed the coursework reported that it was elective and not a required training by their program. Less than a quarter of the sample (23.7%) obtained grief counseling experience/training in their practica, externships, or internships. A sizeable number of graduate students (42.6%) read books or other educational material on grief counseling. A small number of participants (4.1%) completed continuing education courses in grief counseling or death education, 4.7% attended professional conferences that focused on grief counseling or death education, and one participant (0.6%) received a certification in grief counseling. Some participants (9.5%) worked with terminally ill clients, 8.9% volunteered/worked in hospice, 5.9% facilitated a grief counseling group, 5.3% were or currently are primary caregivers to someone who is critically ill.

We also asked participants about the importance of and their interest in receiving more grief counseling education. Most participants expressed being very interested (58.6%) or interested (33.1%). Also, when asked about the importance of grief counseling education for therapists-in-training (i.e., graduate students), the majority thought that it was very important (62.1%) or important (36.1%), with no participants reporting it as not important at all. Similarly, when asked about the importance of ongoing/continued education in grief counseling education for psychologists, the vast majority thought it very important (57.4%) or important (33.7%), with no participants reporting it as not important. Finally, the majority of participants (71.0%) had experienced significant deaths in their life; 43.3% endorsed the losses as mostly resolved, 30.0% completely resolved, 19.2% slightly unresolved/unfinished, 6.7% very unresolved/unfinished, and 0.8% extremely unresolved/unfinished.

Study Conditions

As noted previously, participants were randomized into one of the three study conditions: full intervention (n = 43), partial intervention (n = 58), and a control group (n = 68). The full (Appendix B) and partial intervention (Appendix D) groups were shown an online video training intervention designed to educate psychology trainees about grief and grief counseling. The interventions were developed collaboratively by a group of international researchers with extensive expertise in counseling psychology and bereavement research. This research team was formed to create and evaluate the intervention with therapists who work in the U.S. and Korea. The research team consisted of two licensed counseling psychologists – one American doctoral-level licensed psychologist with over 25 years of clinical experience who completed a graduate certificate program in applied thanatology and one Korean doctoral-level psychologist with over 24 years of professional experience in the field of counseling psychology. The team also included four advanced doctoral-level graduate students – two were studying in the U.S. (one of them is the first author of the present study) and two studying in Korea. All four graduate students conducted therapy and previously worked with grieving clients. Additionally, both of the U.S.-based graduate students had extensive experience conducting research on bereavement, end-of-life issues, and grief counseling.

Full Intervention

The online intervention on grief and grief counseling was informed by a literature review and the research team's expertise (see Appendix B for script; full intervention can be found at <https://go.umd.edu/GriefCounseling>). The team identified three components of the intervention: (1) grief, (2) grief-related models, and (3) the team-developed 3-Factor Grief Counseling Model (O'Brien et al., 2022). The first part of the intervention was informed by a previous study (Hill & O'Brien, 2021) and focused on the definition of grief (e.g., occurs after loss, comes in waves,

changes over time), common reactions to loss (e.g., longing for the person who died, experiencing changes in sleeping or eating patterns, thinking about past losses), influences on grieving (e.g., identities, how the person died, past losses), styles of grieving (e.g., instrumental, intuitive), role of culture and generation status in grieving (e.g., what death means, rituals that occur after death, ways in which we remember the deceased), the grieving journey (e.g., most people grieve and eventually adapt to a new way of living, prolonged grief disorder), and risk factors for experiencing challenges with grieving (e.g., circumstances of the death, relationship with the deceased, attachment).

The second component of the intervention focused on grief-related models, post-traumatic growth, and disenfranchised grief. Specifically, this part of the training provided a brief overview of popular grief-related models, such as the Four Tasks of Mourning (Worden, 2011), The Dual Process Model of Coping with Bereavement (Stroebe & Schut, 1999, 2010), the Meaning Reconstruction model (Gillies & Neimeyer, 2006; Neimeyer, 2001), Continuing Bonds theory (Klass et al., 2014), and a critique of Kübler-Ross' Five Stages of Grief model (Kübler-Ross, 1969). Additionally, this section also mentioned that grieving can be disenfranchised, or socially unrecognized or minimized for various reasons (Doka, 2008), and that there is a possibility of experiencing growth after loss (Tedeschi & Calhoun, 2004).

The third component of the intervention provided information about the 3-Factor Grief Counseling model (O'Brien et al., 2022; see Appendix C). The 3-Factor Grief Counseling Model consists of three domains: Assess (assess for therapist readiness, assess client functioning, and assess for prolonged grief disorder), Assist (assist in identifying social support, assist in completing life tasks, assist in engagement in life, and assist in facilitating reflection), and

Accompany (walk with the client on their journey, educate the client, and embrace the client's traditions).

Specifically, the third intervention section addressed therapist readiness to provide grief counseling (e.g., therapist's personal losses and how they might affect the work), how to accompany the client on their grief journey (e.g., being present and focused on the client, provide a safe space for client to tell their grief story when they are ready), the need to embrace grieving traditions and practices (e.g., cultural/ethnic, generational, religious/spiritual), the need to assess current functioning (e.g., client's current functioning in their everyday life and how this functioning has changed since their loss), the need to assess for prolonged grief disorder (e.g., using a checklist to determine if client might be experiencing prolonged grief disorder), the need to educate the client about grieving (e.g., typical reactions, no right way of grieving), how to assist client in completing necessary life tasks (e.g., check in regarding ability to work, interact socially, get things done, help client identify new roles/identities/responsibilities), how to help identify need for and sources of social support (e.g., encourage client to think about how their social support has changed after the death, help client articulate their current needs for support), how to encourage client to engage in life and construct a life without the deceased (e.g., help the client integrate the death into their life story, address any unfinished business that may exist), how to facilitate identification of areas of change/progress/growth (e.g., in time and if appropriate, ask the client to reflect on how they, their relationships, attitudes, beliefs, confidence, and behaviors may have changed as a result of the death), and helpful tools/techniques for grief counseling that the therapist can utilize (e.g., journaling, empty chair or to two chair techniques).

In addition to providing educational information on grief, grief-related models, and suggested grief counseling guidelines, the full intervention included brief, imbedded reflection opportunities and an overview of a practice clinical case describing a bereaved therapy client. In line with the SCT concept of modeling (Bandura, 1969; 1997), these reflections allowed the participant to think about the material presented, apply the information to a practice clinical case, and further learn from the 3-Factor Grief Counseling model.

Partial Intervention

To provide a comparison with the full intervention, the partial intervention was a shorter version of the full intervention and only contained two components that provided information on (1) grief and (2) grief-related models (see Appendix D for script and https://go.umd.edu/Grief_B). Unlike the full intervention video, the partial intervention did not provide information on the team-developed 3-Factor Grief Counseling Model (O'Brien et al., 2022) nor included a practice clinical case that explained how to apply the grief counseling principles with a grieving client. The rationale for making the partial intervention consist only of the didactic information on grief and grief-related models was to educate about grief and grief counseling knowledge in all three conditions, and to determine whether differences in knowledge and confidence occurred across conditions at posttest in the absence of learning about and applying knowledge of the 3-Factor Grief Counseling Model to the clinical case vignette. Besides these crucial differences, the partial intervention used the same video training material as the full intervention.

Control

Participants randomized to the control group were asked to read written material (see Appendix E) on basic grief and grief counseling that was taken directly from an existing

webpage (<https://www.goodtherapy.org/learn-about-therapy/issues/grief>). The written material included information on common reactions to grief, well known grief models (e.g., Five Stages of Grief, Four Tasks of Mourning, Dual Process Model), an overview of complicated grief, information on bereavement and culture, disenfranchised grief, and a description of a case vignette (without notes on how one might approach this case), among other introductory topics related to grief and grief counseling.

Measures

Grief and Grief Counseling Knowledge

In the current study, grief and grief counseling knowledge was measured in two ways – quantitatively and qualitatively, using open-ended responses. The quantitative Grief and Grief Counseling Knowledge Assessment (see Appendix G) assessed therapist’s conceptual knowledge of grief and grief counseling and was developed by the international research team described earlier. The items of this measure were informed by a grief knowledge measure used in a previous study (Jankauskaite et al., 2021). The initial list of items was developed by the first author and was then refined and edited based on the research team’s expertise and bereavement literature review. Grief and Grief Counseling Knowledge Assessment focused on the following elements: definition of grief, common reactions to grief, symptoms and assessment of prolonged grief disorder, protective factors and risk factors in grief, knowledge of a number of well-known grief-related models (i.e., disenfranchised grief [Doka, 1999, 2008], Meaning Reconstruction model [Gillies & Neimeyer, 2006; Neimeyer, 2001]; Continuing Bonds theory [Klass et al., 2014]; Kübler-Ross’ Five Stages of Grief model [Kübler-Ross, 1969]; grieving styles [Martin & Doka, 2008], The Dual Process Model of Coping with Bereavement [Stroebe & Schut, 1999, 2010]; posttraumatic growth following loss (Tedeschi & Calhoun, 2004); Four Tasks of

Mourning [Worden, 2011]), salient cultural and generational considerations in grief, important components in grief counseling, specific components of the 3-Factor Grief Counseling Model (O'Brien et al., 2022), and helpful grief counseling techniques.

The final Grief and Grief Counseling Knowledge Assessment consisted of eighteen items that assessed therapist's knowledge regarding various grief-related concepts and theories using a 5-point Likert scale ranging from 0 (*not at all knowledgeable*) to 5 (*extremely knowledgeable*). Examples items included: "Assessment of prolonged grief disorder," "Four Tasks of Grief model (i.e., Worden)," and "Important components of grief counseling." In addition to the eighteen knowledge items, this measure also included two validity check items that described non-existent grief theories ("Grief Integration theory [i.e., Jung et al.]" and "Waves of Mourning Theory [i.e., Lee]"). These validity checks were included to identify potential overreporting of knowledge about theories that do not exist in the grief literature, and/or identify distracted participants who may not be paying attention to the measure. Of the 169 total participants, 86.4% passed the validity and reported no knowledge of the Grief Integration theory (i.e., Jung et al.), while 92.3% passed the validity and reported no knowledge of the Waves of Mourning Theory (i.e., Lee). In the current study, the reliability estimate for the pre-test Grief and Grief Counseling Knowledge Assessment was .90 and the post-test reliability estimate was .93.

In addition, for the larger study, grief and grief counseling knowledge also was measured qualitatively and focused on the applied aspects of knowledge, such as the therapist's ability to identify salient themes in assessment and treatment planning of a bereaved client as well as their knowledge of how to apply the 3-Factor Grief Counseling model (O'Brien et al., 2022), which was introduced in the present study. Modeled after previous studies (Jankauskaite et al., 2021, Parent et al., 2018), an author-developed case vignette depicting a bereaved client (Kim) was

presented to the participants (see Appendix H for the vignette). Specifically, after participants read the vignette depicting a bereaved client, they were asked to provide short, written answers to three questions. The first question addressed assessment questions/domains and read as follows:

Now, we would like you to imagine yourself as Kim's therapist. What would you want to assess as you conceptualize her case and plan her treatment? What specific assessment questions would you ask her directly or consider indirectly? List the four most important assessment questions/domains that you would focus on – please list only the top four most important questions/domains.

The second question will focus on treatment planning:

Next, think about a possible treatment plan for your work with Kim. How will you structure your treatment and what will you focus on when trying to address her grief? What are the four most important treatment plan steps or treatment domains that you would focus on throughout your work? Please list only the top four most important steps/domains.

Last, the third question assessed therapist's knowledge of how to apply the 3-Factor Grief Counseling model, which was included in the full video intervention ("Describe four ways that you could use the 3-Factor Grief Counseling Model with this client").

Informed by a bereavement literature review, guidelines provided by the ADEC Handbook of Thanatology (Meagher & Balk, 2013), and researcher expertise, a list of important grief counseling assessment and treatment domains and the components of the 3-Factor Grief Counseling Model was generated, and a standardized rubric was developed by the research team. For example, some of the following most salient assessment themes were considered in the

development of the knowledge assessment rubric: client's current functioning, signs of prolonged grief disorder, existing support system, closeness to the deceased, circumstances of the death, previous loss history, client's grief style, cultural considerations (e.g., spiritual and religious beliefs). In addition to assessment knowledge, some of the following treatment plan themes were considered in the development of the rubric: focusing on the client and validating the client's grief reactions, holding a safe and empathic space for the client, providing opportunity to narrate the death story when client is ready, psycho-education about grief, possible ways to maintain a continuing bond with the deceased or explore ways to reconstruct meaning of the loss, and the integration of loss into one's life.

The rubric with a list of grief counseling assessment and treatment domains and components of the 3-Factor Grief Counseling Model was used to code the three open-ended case vignette question responses. As the coding progressed, the coding rubric was continuously updated to reflect the themes that were identified by the coders – either by adding a new theme for responses that were repeating or by removing those themes that ended up not being used in the coding process.

Using the coding rubric, three coders independently coded responses provided by the participants with regard to how they would assess the client, their treatment plan, and how they might use the components of the 3-Factor Grief Counseling Model with a grieving client. The coding team consisted of two advanced Psychology major undergraduate students, one postbaccalaureate student with a B.S. in Psychology, and the first author, a counseling psychology Ph.D. student, who acted as the team leader. The time point (pre-test or post-test) and study condition (full intervention, partial intervention, or control) were masked from the whole coding team and was only known by the first author's research advisor who randomized

and blinded the data from the rest of the coding team. Thus, the coding team was not aware which time point or condition each response belonged to, minimizing the potential bias in the coding process.

Initially, the first author led an introductory meeting where three coders were given basic information on the purpose of the study and the process of coding. During this initial meeting, the coding team discussed the preliminary coding rubric, which was expected to change, as the process went on and codes were added to the list based on the team's feedback. Then, three independent coders completed a subset of practice codes to familiarize themselves with the rubric and coded the first 30 to 50 responses for each question. The team met after each practice coding activity, discussed questions that arose, and consensually discussed the addition/subtraction of different codes that emerged from the data. The coding team worked in batches, independently coding subsets of responses for each question. The coding team met multiple times throughout the process to discuss the logistics of coding each vignette question and adjust the coding rubric based on the feedback provided by the independent coders. In cases of incongruence among the raters for any vignette question, the fourth coder (first author) looked at the discrepant codes and made the decision on the final code. Overall, the qualitative assessment using the case vignette was a supplementary way to assess participant knowledge of grief and grief counseling, including their understanding and application of the 3-Factor Grief Counseling Model. For the purposes of the current study, the pre-test and post-test themes for the combined sample are presented in table format. Originally, the responses were going to be quantified based on expert ratings of the most important themes. This was unable to be completed for three reasons: (1) the complexity of grief counseling and the case made identifying the most important themes impossible; (2) the experts asked to complete this task confirmed that

it was not possible to rank order the multitude of responses that were salient in grief counseling; and (3) many participants provided more than the requested four responses which would, if coded, have negatively affected the coding of the responses of those who adhered to the directions. In the larger international study, additional analyses will be conducted with the response themes.

Grief Counseling Self-Efficacy

Grief counseling self-efficacy was assessed using an edited quantitative measure. The Death Counseling Survey (DCS; Charkow, 2001) was originally developed to assess grief counseling competencies among family counselors and consists of two parts (Part I and Part II) that include 58 items. Part I consists of 11 items that assess therapists' personal grief counseling competencies, while the remaining four subscales (i.e., Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills) comprise DCS Part II. For the purpose of the current study, only DCS Part II (47 items) was reviewed and items were edited, removed, and new items were generated. This altered measure based on the DCS Part II was used to assess trainees' self-efficacy in grief counseling.

In the current study and in line with previous work (Jankauskaite et al., 2021), the DCS Part II items were edited or removed, and new items were generated by the research team, resulting in a new 47-item grief counseling self-efficacy measure (see Appendix I). These changes were necessary as the original DCS Part II measure included some double-barreled items or did not adequately address some important grief counseling competencies as judged by the research team. Instead of creating a completely new grief counseling self-efficacy measure, the research team edited the existing DCS measure. Each DCS Part II item was reviewed by the team, assessed for its quality, clarity, and scope, and presence in the intervention. For example,

DCS Part II items that were not related to any topic addressed in the intervention were removed. Also, some items were generated by the six-member research team to capture grief counseling domains that were specific to the intervention yet not addressed in the DCS Part II.

Specifically, in the Conceptual Skills and Knowledge subscale (9 original items), five items were retained (“Define and articulate the nature of “normal” bereavement and grief as detailed by theoretical models,” “Describe general differences in the grief experience as determined by different status and process variables (i.e. personality, relationship to the deceased),” “Describe common functional coping styles of bereaved persons,” “Describe common dysfunctional coping styles of bereaved persons,” and “Describe how various individual counseling theories can be applied to grief counseling with individuals and families”). Additionally, one item was slightly edited by removing the word “situations” after grief and by adding “prolonged” instead of “complicated” (“Define and articulate the nature and symptoms of complicated/unresolved grief”), while eight new items were generated by the research team (“Consider the limitations of grief-related theories when conducting grief counseling,” “Articulate the problems associated with Kübler Ross Five Stage model,” “Respect the client’s unique process of grieving,” “Identify which of the grief-related tasks the client is working on,” “Describe the oscillating aspect of grieving,” “Recognize the specific areas of posttraumatic growth in the client,” “Describe the differences between externalized and internalized continuing bonds,” and “Articulate the diagnostic criteria for Prolonged Grief Disorder”).

In the Assessment Skills subscale (9 original items), three items were retained (“Assess for unresolved losses that may not be stated as a presenting problem,” “Assess individuals’ progress on theoretically defined grief tasks,” and “Identify symptoms that warrant medical evaluation and refer to a physician), while one item was edited (“Identify cultural differences

that affect assessment” was changed to “Identify cultural or generational differences that affect assessment of the client’s grief”). Additionally, five new items were added by the research team (“Assess the client’s beliefs related to death and grieving,” “Assess the client’s current functioning (e.g., sleep, nutrition, concentration, motivation),” “Assess the client’s relationship with the deceased,” “Conduct an assessment for Prolonged Grief Disorder,” and “Assess the client’s existing social support”).

In the Treatment Skills subscale (22 original items), one item was retained (“Facilitate individual grief counseling sessions”), while seven items were edited (“Provide psycho-education to clients related to the grief experience for themselves and others” changed to “Provide grief-related psycho-education to the client;” “Use concrete terms regarding death to address the reality of death and convey the ability to discuss death-related issues” changed to “Use concrete terms regarding death;” “Teach clients how to obtain support and resources in the community” changed to “Teach a grieving client how to obtain support and resources in the community;” “Identify cultural differences that affect treatment” changed to “Identify cultural or generational differences that affect treatment for a grieving client;” “Exhibit effective active listening skills” changed to “Exhibit effective active listening skills with a grieving client;” “Provide hope without giving false reassurance” changed to “Provide hope without giving false reassurance to a grieving client;” “Provide a supportive presence for client(s) in difficult times” changed to “Provide a supportive presence for a grieving client in difficult times”). The following twelve new items were added to this Treatment Skills subscale: “Provide a safe therapeutic environment for a grieving client,” “Explain the 3-Factor Grief Counseling Model to a grieving client,” “Support the client as they create ways to remember the deceased (if desired),” “Assist a grieving client in completing necessary life tasks (e.g., working,

socializing),” “Support a client to identify and deal with new responsibilities that they may have after loss,” “Validate the client’s feelings related to grieving,” “Support the client to engage in life without the deceased,” “Facilitate areas of growth that the client may experience after loss,” “Facilitate meaning making that the client may experience after loss,” “Notice any unfinished business that may be associated with the loss,” “Use counseling techniques (e.g., empty chair, journaling) with a grieving client based on their needs,” “Help the client find their own way to maintain continuing bonds with the deceased (if desired).”

In the last DCS subscale, Professional Skills (7 original items), no items were retained in their original form, but one item was edited (“Read and apply current research and literature related to grief and effective treatment interventions” changed to “Apply current research and literature related to grief and effective treatment interventions”). Three new items were added to this subscale: “Use the 3-Factor Grief Counseling Model when working with a grieving client,” “Accurately assess your readiness to provide grief counseling,” “Seek support when providing grief therapy becomes challenging.”

The original DCS items were preceded by the statement “I can.” In the current study, to focus on self-efficacy instead of competencies, these phrases were removed. Also, one response scale point was changed from *confidence* to *moderate confidence* to specify that response of 4 corresponds to the “average” level of confidence. Thus, participants responded to 47 items using a 5-point Likert scale ranging from 1 (*very low confidence*) to 5 (*very high confidence*). The items of each separate subscale were summed, and the item means were calculated. High scores on the DCS indicated self-efficacy in performing tasks associated with grief counseling.

Given that the original DCS was greatly edited by the research team for the purposes of the current study, this measure was piloted to determine its psychometric properties. With regard

to the original DCS scale, support for the reliability of the measure was demonstrated with a sample of 369 licensed professional counselors: Conceptual Skills and Knowledge ($\alpha = .91$), Assessment Skills ($\alpha = .86$), Treatment Skills ($\alpha = .94$), and Professional Skills ($\alpha = .84$; Ober et al., 2012). In another study with a sample of 171 therapists employed at university counseling centers, the reliability estimates were .93 for the Treatment Skills subscale and .81 for the Assessment Skills subscale (Jankauskaite et al., 2021). Validity support was found in the presence of 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 for the pre-test Grief Counseling Self-Efficacy scale were: Conceptual Skills and Knowledge ($\alpha = .92$), Assessment Skills ($\alpha = .90$), Treatment Skills ($\alpha = .95$), and Professional Skills ($\alpha = .58$). The post-test Grief Counseling Self-Efficacy measure reliability estimates were: Conceptual Skills and Knowledge ($\alpha = .94$), Assessment Skills ($\alpha = .91$), Treatment Skills ($\alpha = .94$), and Professional Skills ($\alpha = .67$).

Grief Counseling Experience and Training

The Grief Counseling Experience and Training Survey (GCETS; Ober et al., 2012) was used to assess participants' prior grief counseling experience and training. The GCETS consists of 12 items that assess counselor's clinical training, supervision, experience, and formal education in grief counseling (see Appendix J). 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 the GCETS corresponded with considerable levels of experience and training in grief counseling.

The GCETS was piloted with 21 practicing mental health providers and found to have an acceptable reliability estimate ($\alpha = .86$; 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). Another study with a sample of 171 university counseling center therapists found the reliability estimate to be .87 for the edited measure (Jankauskaite et al., 2021). In the current study, the reliability estimate for the GCETS was .83.

Evaluation of Intervention

Additionally, participants in all three study conditions were asked to evaluate the intervention to which they were randomized (full video intervention, partial video intervention, or the control). The post-test Evaluation of Intervention (see Appendix K) consisted of two subscales and assessed how much participants learned from the intervention they were randomized to. The two subscales were: 1) Learning about Grief and Grief Models (“I learned new information about grief from the intervention” and “I learned new information about grief-related models from the intervention”), and 2) Learning about 3-Factor Grief Counseling Model (“I learned new information about the 3-Factor Grief Counseling Model from the intervention” and “I plan to apply the 3-Factor Grief Counseling Model to my work with grieving clients”). Participants responded to these items using a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Item mean was calculated for each subscale. High scores on the Learning about Grief and Grief Models subscale corresponded with high levels of learned material about grief and grief models, while Learning about 3-Factor Grief Counseling Model subscale corresponded with learning about and planned application of the 3-Factor Grief Counseling model. The reliability estimate for the total 4-item Evaluation of Intervention was .77. The reliability estimate for the Learning about Grief and Grief Models subscale was .82,

while the reliability estimate for the Learning about 3-Factor Grief Counseling Model subscale was .90.

Demographics

As part of the post-test measures, participants were asked to provide information regarding their age, gender, race/ethnicity, program of study, degree sought, year in the program, highest educational degree, approximate number of clinical hours accrued to date, types of sites in which participant completed or is currently completing their clinical training, death education and training received, overall and current bereaved client caseload, personal loss history (and the degree to which any of the losses felt unresolved), importance of receiving grief counseling training for therapists-in-training and psychologists, and their interest in learning more about grief counseling (see Appendix L).

Chapter 3: Results

Descriptive Statistics and Correlations

The means, standard deviations, ranges, reliabilities, and correlations for all scales and subscales were calculated and are provided in Table 3. Overall, the doctoral students in this sample reported having less than average amount of grief education and training experience, very low pre-test knowledge of grief and grief counseling, and low pre-test self-efficacy in Conceptual Skills. They reported average pre-test self-efficacy in Assessment Skills, Treatment Skills, and Professional Skills. In terms of the post-test scores, participants overall reported average knowledge of grief and grief counseling, and slightly above average self-efficacy in Conceptual Skills, Assessment Skills, Treatment Skills, and Professional Skills. Last, participants reported above average evaluation of intervention scores, both for how much they learned about grief and grief counseling, and how much they learned about and whether they plan to apply the 3-Factor Grief Counseling Model.

Analyses of Variance and Covariance (ANOVA, ANCOVA, MANCOVA)

Before running the analyses of variance, the assumptions for conducting a repeated measures MANCOVA were assessed. Results indicated that most of the assumptions for a repeated measures MANCOVA (i.e., independent variable is categorical, independence of observations, no missing data, no extreme outliers, homogeneity of covariances) were met. However, some data did not meet the assumptions of a normal distribution. Given that the sample consisted of graduate students with potentially limited prior training on grief and grief counseling, the data for the control variable (prior grief counseling experience and training, GCETS), the pre-test knowledge of grief and grief counseling, self-efficacy in conceptual skills and knowledge, self-efficacy in assessment skills, self-efficacy in treatment skills, and self-

efficacy in professional skills did not meet the assumptions of a normal distribution because they were clustered at the low end of potential responses. Additionally, all post-test scores except for the self-efficacy in professional skills were normally distributed and met the assumption. The post-test self-efficacy in professional skills may not have met the normality assumption was due to one question assessing participant confidence in using the 3-Factor Grief Counseling model with a grieving client, which was not described to those randomized to the partial intervention and control conditions, thus skewing the data. Based on this reasoning, no transformations were made to the data.

An ANOVA was calculated to assess for potential differences in prior grief counseling experience training and experience (GCETS score) among the participants randomized to the three study conditions; no differences were found: $F(2, 166) = .33, p = .72, \eta^2 = .004$. Next, one univariate analysis of covariance (ANCOVA) and one multivariate analysis of covariance (MANCOVA) were used to test the hypotheses. For each analysis, experimental condition was the independent variable, prior scores on the Grief Counseling Experience and Training Survey (GCETS) and pre-test scores on the measures of interest were the covariates, and post-test scores on the measures of interest were the dependent measures. Finally, we calculated one MANOVA to assess for potential differences in the evaluation of the interventions to which the participants were randomized. An alpha level of .05 was used to assess significance for all analyses.

The ANCOVA assessed post-test differences in the quantitative measure of grief and grief counseling knowledge among the full intervention, partial intervention and control conditions while controlling for prior grief counseling experience and training. There were differences in grief and grief counseling knowledge among the three study conditions (full intervention, partial intervention, and control): $F(2, 164) = 19.35, p < .001, \eta_p^2 = .19$ (large

effect size; Norouzian & Plonsky, 2018). The results of the least significant difference (LSD) post hoc tests are presented in Table 4. Individuals who participated in the full intervention condition reported the most grief and grief counseling knowledge relative to the partial intervention and control groups.

The MANCOVA assessed post-test differences on four dimensions of grief counseling self-efficacy (i.e., Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills subscales) for participants in the full intervention, partial intervention and control conditions while controlling for prior grief counseling experience and training. There were differences in scores on the dependent variables for the study conditions after controlling for prior grief counseling experience and training: $F(8, 316) = 11.12, p < .001$, Wilks' $\lambda = .61, \eta_p^2 = .22$ (large effect size; Norouzian & Plonsky, 2018). Differences were found: Conceptual Skills and Knowledge subscale, $F(4, 158) = 11.28, p < .001$, Wilks' $\lambda = .78, \eta_p^2 = .22$ (large effect size; Norouzian & Plonsky, 2018); Assessment Skills subscale, $F(4, 158) = 19.47, p < .001$, Wilks' $\lambda = .67, \eta_p^2 = .33$ (large effect size; Norouzian & Plonsky, 2018); Treatment Skills subscale, $F(4, 158) = 20.87, p < .001$, Wilks' $\lambda = .65, \eta_p^2 = .35$ (large effect size; Norouzian & Plonsky, 2018); and Professional Skills subscale, $F(4, 158) = 11.28, p < .001$, Wilks' $\lambda = .78, \eta_p^2 = .22$ (large effect size; Norouzian & Plonsky, 2018). The results of the least significant difference (LSD) post hoc tests are presented in Table 5.

Specifically, graduate psychology students who participated in the full video intervention reported the most confidence in applying conceptual skills and knowledge of grief, assessing grieving clients, treating them, and had the highest self-efficacy in professional skills when compared with those in the partial intervention and control condition. Interestingly, there were differences among all three study conditions on the self-efficacy subscale of Conceptual Skills

and Knowledge. Although the full intervention group also differed from the partial intervention and control groups on the Assessment Skills, Treatment Skills, and Professional Skills subscales, the partial and control conditions did not differ from one another on these subscales. To summarize, as hypothesized, participants exposed to the full video intervention demonstrated the highest grief and grief counseling knowledge and confidence in their ability to work with grieving clients.

Last, we analyzed whether participants randomized to each study condition reported different evaluation of intervention scores. One MANOVA was calculated to assess for potential differences in the evaluation of the intervention subscales (i.e., Learning about Grief and Grief Models and Learning about the 3-Factor Grief Counseling Model), among the full intervention, partial intervention and control conditions. There was a difference between the study conditions on the combined dependent variables, $F(4, 330) = 33.29, p < .001, \text{Wilks' } \lambda = .51, \eta_p^2 = .29$ (large effect size; Norouzian & Plonsky, 2018). The results of least significant difference (LSD) post hoc tests are presented in Table 6. Those who were randomized to the full and partial interventions learned more about grief and grief models (i.e., Learning about Grief and Grief Models subscale) when compared to those randomized to the control group. However, there was no difference between full and partial intervention conditions on the Learning about Grief and Grief Models subscale. Furthermore, differences were found among all three conditions regarding how much participants learned about and planned to apply the 3-Factor Grief Counseling Model (i.e., Learning about 3-Factor Grief Counseling Model subscale). Those who were randomized to the full intervention scored higher on the Learning about 3-Factor Grief Counseling Model subscale than those in the partial intervention and control groups.

Case Vignette Results

The case vignette responses were coded into themes to reflect the applied knowledge of grief and grief counseling. Specifically, the coded responses were assessed at two timepoints (i.e., pre-test and post-test) for content of the assessment (see Table 7 and Table 8), treatment (see Table 9 and Table 10), and application of the 3-Factor Grief Counseling model (see Table 11 and Table 12) with a fictitious case vignette client. Each participant was asked to provide four distinct answers for each vignette question, and these answers were then coded into themes. Of note, many participants provided complex answers that resulted in more than four distinct codes for each question, inflating the total themes in each vignette question.

Pre-test Assessment Vignette Question

The full list of pre-test assessment themes can be found in Table 7. A total of 757 responses were coded and the percentages below reflect the percentage of total responses provided by the participants at pre-test. The most common assessment themes included: social support/relationships (15.2%), emotional state/mood assessment (11.8%), risk assessment (i.e., suicidal ideation, self-harm; 10.4%), symptoms of mental health disorder (e.g., depression, anxiety, PTSD, adjustment; 8.7%), coping strategies/selfcare/pleasurable activities (5.8%), and daily physical functioning (i.e., sleep, eating; 3.6%). Also, 4.9% of the responses were coded as “Other.” Notably, only 1.5% responses indicated that the therapist should assess for client’s culture and important identities, only 2.6% suggested that they assess the nature of the client’s relationship with her husband before he died, and 0.5% said they would assess the client’s relationship with husband after his death (e.g., continuing bonds, legacy). Interestingly, not many participants focused on assessing vignette client’s previous loss history 1.8%, previous mental health history and/or use of therapy 1.5% or prolonged grief disorder 0.5%.

Post-test Assessment Vignette Question

The full list of post-test assessment themes can be found in Table 8. A total of 812 responses were coded and the percentages below indicate the percentage of total responses provided by the participants at post-test. The most commonly provided assessment themes included: social support/relationships (12.4%), culture and important identities (7.5%), emotional state/mood assessment (7.1%), daily physical functioning (i.e., sleep, eating; 6.5%), risk assessment (i.e., suicidal ideation, self-harm; 6.5%), and relationship with husband before his death (5.8%). Also, 5.3% of the participants provided assessment themes that did not overlap with the coding rubric and were coded as “Other.” Interestingly, at post-test, participant responses reflected higher interest in assessing for prolonged grief disorder (or complicated grief; 3.3%), relationship with husband after his death (e.g., continuing bonds, legacy, 3.1%), and client’s spiritual/religious beliefs and coping (2.5%). Also, at post-test, unique themes emerged that were not identified at pre-test, such as assessing for grief style (2.6%), posttraumatic growth (0.6%), new responsibilities and roles due to the husband’s death (0.6%), loss-oriented and restoration-oriented activities (i.e., Dual Process Model of Grief application; 0.5%), and therapist’s readiness to work with client or countertransference (0.5%).

Pre-test Treatment Vignette Question

The full list of pre-test treatment themes can be found in Table 9. A total of 763 responses were coded and the percentages below reflect the percentage of total responses provided by the participants at pre-test. The most common treatment themes were: exploring/helping process client’s emotions (i.e., guilt, sadness, loneliness; 13.8%), exploring social supports and/or relationships (12.2%), exploring coping skills/selfcare/hobbies and/or behavioral activation (10.1%), Cognitive Behavioral Therapy (CBT) principles (5.5%), process grief or let client narrate her loss story (5.0%), and helping client find meaning in her life (3.7%).

Also, many (4.8%) responders provided treatment themes that did not overlap with the coding rubric and were coded as “Other.” Interestingly, only few participants reported that they would provide general grief psychoeducation to the client (2.9%), discuss her relationship (e.g., closeness) with husband before his death (1.7%), or explore ways to maintain a continuing bond with her husband (2.4%), or help the client adjust to the new normal without her husband (1.4%). Notably, some participants (1.7%) talked about using the Kübler-Ross 5 Stages of Grief model to treat the client. Lastly, only a minority of participants highlighted that they would address daily physical functioning (e.g., sleep, appetite; 0.9%), symptoms of mental health disorder (e.g., prolonged grief disorder, depression, anxiety, PTSD, adjustment, 0.9%), or multicultural considerations (e.g., culture, identities, spiritual/religious beliefs, beliefs in afterlife; 0.4%).

Post-test Treatment Vignette Question

The full list of post-test treatment themes can be found in Table 10. A total of 823 responses were coded and the percentages below reflect the fraction of all total responses provided by the participants at post-test. The most common treatment themes included: exploring social supports and/or relationships (10.1%), exploring/helping process her emotions (i.e., guilt, sadness, loneliness; 8.7%), exploring ways to maintain a continuing bond with her husband (8.7%), exploring coping skills/selfcare/hobbies and/or behavioral activation (7.3%), helping her adjust to the new normal without her husband (6.2%), and providing general grief psychoeducation (6.1%). Compared to the pre-test, more responders (2.6%) highlighted the need to explore multicultural considerations (e.g., culture, identities, spiritual/religious beliefs, beliefs in afterlife) with the client and her relationship with husband before his death (2.4%). Interestingly, less individuals (0.6%) than at pre-test (1.7%) cited that they would use the Kübler-Ross 5 Stages of Grief model in their treatment. Lastly, likely explained by the

interventions participants were exposed to, some participants suggested treatment domains that were not identified at pre-test: applying the Dual Process Model of Grief (1.7%), providing psychoeducation about specific grief models (1.2%), and addressing any “unfinished business” (0.7%) with the client.

Pre-test 3-Factor Grief Counseling Model Vignette Question

The list of pre-test themes that emerged from the 3-Factor Grief Counseling Model application vignette question can be found in Table 11. A total of 681 responses were coded at pre-test. The majority of participants (66.2%) responded that they were not familiar with the 3-Factor Grief Counseling Model (“I don’t know”/NA/blank); this was expected because they were not yet exposed to the interventions. Nonetheless, some participants provided responses that generally mapped on the coding rubric and are provided below. Here are the most common responses the participants provided on how they might apply the 3-Factor Grief Counseling Model with the vignette client: accompany the client on their grief journey (9.0%), assist the client in engaging in life and constructing a life without the deceased (6.0%), assist the client in identifying the need for and sources of social support (5.6%), using specific helpful tools/techniques for grief counseling (2.1%), educating the client (1.8%). Lastly, a sizeable number of participants (4.6%) provided responses that did not align with the 3-Factor Grief Counseling Model coding rubric and were coded as “Other.”

Post-test 3-Factor Grief Counseling Model Vignette Question

The list of post-test themes that emerged from the 3-Factor Grief Counseling Model application vignette question can be found in Table 12. A total of 696 responses were coded. A good number of participants (25.1%) provided an “I don’t know”/NA/blank response. Further, the most commonly provided 3-Factor Grief Counseling Model application responses included:

accompany the client on their grief journey (19.0%), assist the client in engaging in life and constructing a life without the deceased (17.1%), assist the client in identifying the need for and sources of social support (8.0%), educate the client (5.3%), and assist the client in facilitating reflection regarding areas of change/ progress/growth (4.3%). Lastly, many individuals (5.9%) provided responses that did not fit into the standardized coding rubric and were coded as “Other.”

Chapter 4: Discussion

This study was the first to develop and experimentally test the efficacy of an online video training on grief and grief counseling with a sample of counseling and clinical psychology doctoral students in the U.S. We were interested in whether a video training intervention could increase therapists-in-training knowledge of grief and grief counseling and their self-efficacy in working with bereaved clients while controlling for their prior grief counseling experience and training. Three conditions were compared – full video intervention, partial video intervention, and control group. Confirming our hypotheses, psychology graduate students who viewed the full intervention had greater knowledge of grief and grief counseling and confidence in working with grieving clients than those exposed to the other conditions. Our findings are encouraging as this time-limited video training on grief and grief counseling may be a feasible and efficacious tool to increase psychology graduate student knowledge and self-efficacy in supporting their bereaved clients.

Sample Characteristics

When interpreting the results, it is important to situate the findings in relation to the current sample. The sample consisted of 169 doctoral students in counseling and clinical psychology programs located in the United States. The majority of the sample were White, heterosexual, cisgender women who were completing their doctoral degrees in counseling psychology programs. The sample was fairly homogenous in terms of race and gender (although comparable to the published data on students in the health service psychology doctoral training programs in the U.S.; Page et al., 2017). Moreover, given that the sample consisted of students still in training with reportedly low prior training in grief counseling, the results need to be interpreted in this context. Interestingly, though not surprisingly given prior research findings on

the lack of formal training in grief counseling (see Jankauskaite et al., 2021), only ten participants reported that they took grief counseling or death education graduate courses, though no one reported that these courses were required by their program. It is likely that for many individuals the provided training in all study conditions (including the control) was one of the first times that they were exposed to the grief education material. Thus, the level of how much they learned and how much their self-reported confidence increased after learning the material needs to be interpreted with this in mind.

Grief and Grief Counseling Knowledge and Self-Efficacy

Consistent with our hypotheses, when controlling for prior grief counseling training and experience, participants who viewed the full intervention training video reported higher knowledge of grief and grief counseling and higher self-efficacy in grief counseling (on all four subscales of the grief counseling self-efficacy measure: Conceptual Skills and Knowledge, Assessment Skills, Treatment Skills, and Professional Skills) than those who viewed the partial video intervention and those who read the written material in the control group. Considering that the full video intervention was the most comprehensive training on grief and grief counseling as compared to the partial intervention and control group, these findings fit well with our expectations. Although both the full and partial interventions consisted of videos that provided exactly the same information on basic concepts of grief and an overview of existing grief models, only the full intervention included introduction of the 3-Factor Grief Counseling Model (O'Brien et al., 2022) and an application of grief counseling techniques with a fictitious bereaved client. Thus, the full intervention contained more information on how one might apply the principles of grief counseling with an actual client and more opportunities to reflect on their skills, which likely translated to learning more about grief, grief counseling principles, and the

process of working with a grieving client. Moreover, the study results produced large effect sizes that are comparable to or even larger than the effect sizes of many other educational intervention studies (Kraft, 2020).

Notably, the results also highlighted differences between the partial and control conditions. Results indicated that all three study conditions differed on the Grief and Grief Counseling Knowledge measure and the Conceptual Skills and Knowledge subscale, which assessed self-efficacy in being able to describe different theoretical grief models or identify some of the more conceptual information on grief and grief counseling (e.g., symptoms of prolonged grief disorder). These findings align with what we would expect, as those randomized to the partial intervention received quite a bit of information on the various grief theories and models and other conceptual information on grief. Although the reading completed by the control group also covered some of the conceptual grief topics, the participants who viewed the partial video intervention had higher confidence in this domain.

Overall, the study findings align well with Social Learning Theory (Bandura, 1969; 1997), which highlights observational learning as an important component of how one learns new material. According to this theory, watching someone perform a task or a skill can be a powerful way to learn the task or skill. Participants who were shown the video interventions learned more than those who simply read the written material in the control group. Moreover, it was interesting to note that the partial intervention and control group did not differ on post-test confidence in assessment, treatment, and professional skills of grief counseling. These findings further support Social Learning Theory (SCT; Bandura, 1969; 1997). Specifically, the results highlight the potential advantages of modeling on one's confidence to perform a task. In addition to being introduced to the case vignette, participants in the full intervention group had a chance

to reflect on questions related to how they might approach therapy with this particular client. These reflective pauses provided a chance to practice and hypothetically apply the information that was being taught in the training. Thus, we can speculate that the 3-Factor Grief Counseling Model, modeling, and practice components were important parts of the training that contributed to the increase in confidence in working with grieving clients. These findings fit well within the context of prior research indicating that modeling of a behavior and observational learning can be powerful tools to increase therapist's self-efficacy in completing a task (e.g., Anderson et al., 2020). Overall, an overwhelming amount of research suggests that therapists with greater experience and training are more likely to report higher self-efficacy in counseling than those without training or experience (e.g., Mesrie et al., 2018; Urbani et al., 2002). Thus, the study results provide further support for the finding that when therapists-in-training receive information and instruction on how to perform grief counseling, they feel confident in their abilities.

Moreover, it is important to note the mode of content presentation between the three study conditions. Both the full and partial interventions were in a video format and only differed on the additional modeling component present in the full intervention. Thus, the full and partial interventions were able to be compared on the content rather than the mode of the presentation of material. However, when comparing the intervention conditions to the control group, we cannot parse out the effects of the video animation from the content of the control group material because the full and partial interventions were in the form of a video with animated features, while the control group consisted of written material. Further, the written material used in the control group was not identical to the information provided in the partial or full interventions. In other words, we cannot conclusively state that the higher post-test knowledge in grief and grief

counseling and confidence resulted solely from the more comprehensive training that was provided in the full and partial interventions as compared to the control, or if the method of presenting material (video or a reading) was also a significant factor.

In addition to the primary variables of interest, we evaluated the degree to which participants reported learning from each study condition. Participants randomized to the full and partial intervention training videos self-reported higher learning about grief and grief models than those who completed the reading in the control group. These findings were not surprising as the full and partial interventions offered more comprehensive information, which likely related to higher ratings of learned material. In addition, differences were found among all three groups in terms of how much participants learned about 3-Factor Grief Counseling Model (O'Brien et al., 2022) and the likelihood of applying this model in future clinical work. This finding was surprising, as only the full intervention group was shown the 3-Factor Grief Counseling Model, so we would expect this group to be different from both partial intervention and control group. The partial intervention evaluation results may be inflated, as these participants should not have known about the 3-Factor Grief Counseling model to report it as something they learned about and planned to use in the future. Thus, these findings need to be interpreted with caution, as they may indicate overreporting of their knowledge by the participants.

Case Vignette

The current study included a case vignette about a bereaved woman (Kim) whose husband died seven months ago. Therapists-in-training answered three open-ended questions related to this case, including how they may assess the client, components of their treatment plan, and how they might apply the 3-Factor Grief Counseling Model (O'Brien et al., 2022) with this bereaved client. The responses were rich in content and many assessment and treatment themes

emerged in the pre-test (see Tables 7, 9, and 11) and post-test responses (see Tables 8, 10, and 12). These data will be analyzed based on study conditions for the larger international study.

Strengths of the Study

This study was the first study to develop a training on grief and grief counseling education and experimentally test the intervention with a sample of psychology graduate students in the U.S. The project advanced the knowledge of grief counseling education for therapists-in-training and found an efficacious and feasible teaching method of increasing grief and grief counseling knowledge and self-efficacy, which ultimately would better prepare them to address the needs of their grieving clients.

One of the main strengths of the study was the experimental design that compared three study conditions – full video intervention, partial video intervention, and a control group consisting of a reading. The control group condition was a strong comparison option, as it was an existing website that the general public, including therapists-in-training, can access. Having this real-life quality control added to the importance of our results. Further, the two experimental conditions were a strength of our study design, as the only difference between the partial and full interventions were the addition of the 3-Factor Grief Counseling Model (O’Brien et al., 2022) and a case vignette with modeling, which were part of the full intervention. Having these conditions identical with the exception of these two components allowed us to meaningfully compare the effects of both interventions on knowledge of grief and grief counseling and their self-efficacy of working with grieving individuals.

The study sample also was a strength of the project as participants were recruited from all APA-accredited counseling (77) and clinical (220) psychology doctoral programs in the U.S. and all U.S.-based university counseling centers that housed an APA-accredited internships. This

recruitment method was important in ensuring some geographic diversity and maximizing the generalizability of our results.

Limitations

It is important to note several limitations of this study. First, the bereavement literature has a lack of psychometrically strong and validated measures assessing concepts of grief knowledge and grief counseling. For this reason, an author-developed grief and grief counseling knowledge assessment was piloted and used in the current study. The psychometric properties of this assessment have not been established.

Further, we used an existing measure of grief counseling skills, but edited it for the purposes of our study due to our focus on self-efficacy for grief counseling. We retained some items of the original Death Counseling Survey (DCS; Charkow, 2011), though the majority of items were edited or new. Thus, the resulting grief counseling self-efficacy measure was used for the first time in this study and its psychometric properties need to be established in future research. Relatedly, the reliability estimate for the pre-test self-efficacy on the Professionals Skills subscale was low (Cronbach's $\alpha = .58$).

Another limitation that is important to note was our sample. The participants were fairly homogenous, consisting mostly of White, cisgender, straight or heterosexual women. Though our sample was similar to the racial and gender representation within health service psychology doctoral programs in the U.S. (Page et al., 2017), it is important to remain critical of the overall diversity issues and lack of representativeness within higher educational systems and the field of psychology itself, and how this impacted our study. For example, just like majority of the research conducted in the U.S., our study is viewed through overwhelmingly Westernized lens, such as it only included grief models that were developed by the Western grief experts (Harris &

Bordere, 2016). Thus, lack of diverse viewpoints within the bereavement field is undoubtedly influencing not only the development of our intervention but also how the study sample interacted with the material given their own intersecting identities.

It is interesting to note that although many more clinical psychology doctoral programs exist in the U.S. (APA, 2021) and were contacted by the first author, the majority of the participants came from counseling psychology doctoral programs. Given that the first author and the research team were all from the counseling psychology discipline, this could be due to the recruitment efforts that included personally accessible professional networks (e.g., membership in APA Division 17 listserv and Division 17 Student group) and personal contacts. Though clinical and counseling psychology graduate trainings have historically been noted to have somewhat distinct training models (Lichtenberg et al., 2018), we believe that the general focus on providing health service psychology services to clients is a shared value focused on by both disciplines. We also do not anticipate that students enrolled in any health psychology graduate programs would exhibit significant differences in their exposure to grief counseling training nor the number of grieving clients they see. Nonetheless, this is an unaddressed question in the literature, and our sample must be taken into consideration as possibly not the most representative of all the graduate psychology students who provide clinical services in the U.S.

Further, it is possible that the participants may exhibit self-selection bias, whereas only those students who had prior interest in grief counseling participated in the study. On the other hand, given that we advertised our study as both a research study and an opportunity to complete free grief counseling training, those who lacked prior grief counseling training may have been interested in learning more about this topic.

The current study may not be immune to participant overreporting bias. Given that the measures were based on self-report and the fact that participants rated their baseline grief and grief counseling knowledge as low, it is possible that they felt that they learned a great deal, thus, inflating how much they learned or their confidence in providing grief counseling. In fact, previous research found that therapists tend to overestimate their clinical competence. Walfish et al. (2012) found that close to 25% of clinicians rated themselves as being in the top 10% with regard to clinical skills, while no clinicians saw themselves in the below average category, suggesting that therapists may overestimate their clinical abilities. Thus, our results regarding grief counseling knowledge and self-efficacy need to be interpreted with this in mind.

Lastly, we had unequal samples among study conditions, with the full intervention containing the least number of participants. Given that the full intervention condition contained the longest intervention, it is likely that a sizeable number of individuals did not continue with the study after being randomized to this study condition. Nonetheless, given the overall adequate sample size and the robustness of the multivariate analysis of covariance, unequal groups were analyzed.

Future Research Directions

Future research should replicate the study with diverse samples based on identity factors (e.g., gender, race, ethnic representation) and diverse disciplines in the mental health field, such as Masters-level clinicians or already-practicing clinicians. Further, the existing training could be modified and tested with providers specializing in working with specific populations, such as grieving children, individuals with developmental disabilities, older adults, immigrant populations, or individuals from specific ethnic backgrounds and religions. There are an ample

of ways to assess the efficacy of the training by adding or modifying components, ideally with stakeholder feedback (i.e., using community-based focus groups).

Further, to improve the intervention, future work may use participant feedback and update the content based on the most current developments in the bereavement field. For example, as evidenced by the changes made to diagnostic criteria of the prolonged grief disorder (Prigerson et al., 2021) during the process of the current study, similar changes may occur within the bereavement field, necessitating continued updates to the training video.

The current video intervention also could be adapted to align with more active learning principles (Bernstein, 2018), such as shorter didactic modules and more activities that would allow participants to practice learned skills. For example, the intervention could include more active practice activities in-between the three components (i.e., grief, grief-related models, and the 3-Factor Grief Counseling Model with a case vignette). To achieve this, future interventions could be expanded in scope and delivered in smaller segments with opportunities to apply the learned material with actual grieving clients, and then assess trainee knowledge and confidence over time.

Another possible future direction could be to expand the current intervention to include more real-time feedback during the intervention. For example, a larger scale project could include a computer-simulated grieving client where the trainee is asked to provide verbal, in-vivo, grief counseling with feedback that follows their responses. A similar approach of using an in-person simulated patients or standardized patients has been employed in medical education, such as in undergraduate psychiatry teaching (Eagles et al., 2007). Video-feedback simulated trainings, such as communication skills training for physicians (e.g., Roter et al., 2004), have shown much promise. Similarly, instead of using a written case vignette, future projects may

employ a video-simulated and live-feedback module where trainees could practice learned material. This approach could be a powerful way to enhance the training on grief counseling by providing a more realistic practice opportunity. To enhance the modeling component of the intervention, future research may include videotaped examples of therapists demonstrating various grief counseling skills that participants are later asked to practice.

Last, future work should include follow-up surveys that may include questions on grief and grief counseling knowledge, self-efficacy, and feedback on whether they applied the learned materials, including the 3-Factor Grief Counseling Model (O'Brien et al., 2022) with their grieving clients.

Clinical Implications

The results of the study have clear clinical implications, such as improving the existing training for counseling and clinical doctoral psychology students by implementing this time-limited and fiscally responsible full video intervention into graduate training programs, perhaps in counseling and clinical practicum courses. Additionally, the video training could be shared with externship sites outside of students' graduate programs. For example, partnerships could be developed with external training sites that may deal with grief concerns, such as community mental health clinics, hospitals, hospice organizations, and school counseling centers. Further, clinical sites that house pre-doctoral internships (e.g., university counseling centers, community clinics, hospitals) could incorporate the video training into their intern training seminars. The training also may be further expanded by including additional clinical cases that trainees would discuss as a group with their supervisors. Instructors who lead the training seminars could be provided with a standardized instructor's manual that outlines the training objectives and provides clinical cases for the group discussion.

Ideally, part of the implementation process would include a research component that would periodically assess how much students learned, retained the information, whether they apply the learned material with their real-life clients, and any feedback about the training. Furthermore, given the lack of grief counseling training among psychologists (Jankauskaite et al., 2021), this training could be made available to practicing psychologists for continuing education credit.

Yet another application of the training could be implemented with younger students, such as undergraduates studying healthcare professions (i.e., psychology, pre-med, public health, family science) or who plan attend graduate training in health-related fields. Prior research indicated that a video training on peer grief communication amongst undergraduate students had promising results (Hill & O'Brien, 2021), thus a modified version of the current training could be added to existing undergraduate curricula. Starting training early might be a beneficial way to increase the knowledge of grief and normalize conversations around this taboo topic.

Given the lack of grief education within the field of psychology, it is likely that many other disciplines also lack formal acknowledgement of how to best address the needs of grieving individuals. Another possible avenue would be to disseminate the training among healthcare providers, such as medical students, residents, physicians, nurses, and other medical staff who work with individuals with advanced illness or at the end of their lives as well as their caregivers. There is an evident lack of training on end-of-life communication and grief for medical trainees and providers (e.g., Silkstrom et al., 2019); a modified intervention such as the one used in the current study would be a meaningful first step to increase available training. Similarly to the psychology training programs, this training could be piloted with medical students longitudinally, at different timepoints, as they start out their training, and then again, as they

begin clinical rotations on their residency, and further as they progress with medical specializations.

Last, the current training focused on death losses; future trainings could incorporate information on how to address non-death losses and disenfranchised grief (Doka, 1999; 2008), which could be applied to wider audiences (e.g., immigrants, individuals with physical illness resulting in loss of function, individuals coping with relationship loss, people experiencing changes in their identity), ultimately expanding the clinical implications of the current training.

Conclusion

In conclusion, participants who were randomized to the full video intervention demonstrated higher grief and grief counseling knowledge and self-efficacy than those in the partial intervention and control conditions. The current intervention represents a feasible mechanism to increase graduate student knowledge and confidence in grief counseling in applied mental health fields. Further, this training could be used to increase awareness and knowledge of loss-related concerns for other mental health, education, and healthcare providers. It is our hope that this intervention will serve as an inspiration to advance death education, advocate for the needs of grieving individuals and most importantly, enhance the quality of counseling and support received by those grieving the loss of a loved one.

Appendices

Appendix A

Review of Literature

The literature review is divided into six subsections. The first section discusses common reactions to grief, including a review on the prolonged grief disorder. The second section reviews the basics of grief counseling. The third section covers what is known about grief counseling education and training. The fourth section describes the Social Cognitive Theory (Bandura, 1969; 1997), which is the theoretical foundation for the current study. The fifth and sixth sections provide the background for the variables of interest: grief and grief counseling knowledge and grief counseling self-efficacy.

Grief

Experiencing death loss is something that most humans encounter in their lifetime. Grief is a common reaction to significant loss that often manifests in one's physiological, psychological, social, and spiritual domains of functioning. It is important to note that although losses can vary greatly and may include non-death losses (e.g., divorce, relocation, graduation), given the scope of the current study, the present literature review will focus primarily on human death losses. Grief reactions vary person by person and loss to loss, yet research has identified a number of symptoms that can manifest in one's life. Some common and normative emotional reactions to loss include sadness, disbelief, longing for the deceased, anger, guilt, and even potential relief, especially if the person suffered at the end of their life (i.e., Bonanno et al., 2008; Dominick et al., 2010).

The severity and the expression of grief reactions also depend on a number of factors, such as the relationship with the deceased, circumstances of the death, the bereaved person's

prior mental health, among other influences (Carmassi et al., 2018). For example, a recent study conducted in Australia recruited 142 adults bereaved by suicide and 63 bereaved by a sudden death of a family member and assessed their short-term grief reactions, mental health, and suicidality six months after the loss (Kölves et al., 2018). After adjusting for confounding factors, those bereaved by suicide had experienced more rejection and stigmatization, had higher somatic reactions, and reported more responsibility and shame than those who experienced a sudden non-suicide death of a family member. Bereavement type did not predict mental health outcomes or suicidality. Thus, though research indicates some common emotional reactions to grief, each individual's reaction to loss and grieving trajectory will be unique, nuanced, and imbedded in the contextual factors associated with that loss.

Although emotional reactions to grief may be the most obvious, some griever experience physical and somatic symptoms as well. For example, bereaved individuals reported more physical health complaints, such as headaches, chest pain, dizziness, and digestive issues. They also had an increased prevalence of illness and disability, and some also were more likely to use medical services and drugs (Parkes & Prigerson, 2013; Stroebe et al., 2008). Sleep difficulties are a fairly common complaint among grieving individuals. 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 in the U.S. 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, a higher risk for complicated grief symptoms existed 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 emotionally close person might be as difficult and as distressing as losing a family member (Hardison et al., 2005).

Bereaved individuals also are at risk for increased mortality, or dying from a “broken heart,” especially among older spouses (see Stroebe et al., 2007). For example, one longitudinal study followed 12,316 individuals for ten years and then assessed whether the bereaved individuals whose spouse has died experienced higher mortality than those who did not lose their spouse (Moon et al., 2014). The odds of the bereaved spouse dying in the first three months following their partner’s death were higher than individuals who did not experience a prior spousal loss (odds ratio for men = 1.87, 95% CI: 1.27, 2.75; odds ratio for women = 1.47, 95% CI: 0.96, 2.24). Importantly, these results were produced in models that adjusted for participant age, gender, race, socioeconomic status, and various behavioral risk factors and co-morbidities (Moon et al., 2014).

Another interesting study with a sample of recently bereaved individuals who lost their spouse ($n = 99$) examined inflammation, which is an important predictor for cardiovascular disease, morbidity, and mortality (Fagundes et al., 2019). Bereaved participants who reported higher grief severity had higher proinflammatory cytokines than those with lower grief severity. This study was the first to demonstrate that inflammatory markers can identify widowed individuals based on grief severity (Fagundes et al., 2019).

It is important to note that most studies in bereavement field have been conducted with adults grieving their partners, although more recently, studies on other types of losses, such as sibling loss (Funk et al., 2018) and child loss (Brooten et al., 2018), have been growing as well.

For example, one study examined parents' (176 mothers, 73 fathers; 44% Hispanic, 35% Black non-Hispanic, and 21% White non-Hispanic) physical health one year after they experienced an infant or child death and found that mothers had significantly higher morbidity than fathers, while no differences between race/ethnicity were found (Brooten et al., 2018). Although research on non-spousal bereavement is beginning to accumulate, our knowledge on grief effects and reactions is still rooted in data on bereaved partners/spouses.

Moreover, bereaved individuals report other grief reactions that manifest in cognitive disturbances (e.g., difficulty concentrating, memory issues; Stroebe et al., 2007), changed social life and relationships (e.g., withdrawal), and altered sense of spirituality and existential beliefs (e.g., crisis in one's faith or spirituality; Burke et al., 2014). For example, one study (Neimeyer & Burke, 2017) examined a diverse sample of 59 bereaved individuals who identified as Christians and who experienced either a violent loss (e.g., homicide, suicide) or a loss to natural causes (e.g., prolonged illness). Those who experienced a violent loss reported more negative religious coping, and those who had higher level of reported depression endorsed greater spiritual struggle, such as a disrupted relationship with God (Neimeyer & Burke, 2017). This study is one example of how grief can not only affect one's affective state or physical health, but also alter other domains of life, including one's religiosity and spiritual views.

Prolonged Grief Disorder

Although most bereaved individuals are expected to cope with loss in resilient ways (Bonanno et al., 2004), a considerable minority of griever (around 7-10%; Lundorff et al., 2017) can develop complex, more intensified grief, which is known as prolonged grief disorder (Maciejewski & Prigerson, 2017). It is important to note that complicated grief (Shear & Bloom, 2017) is another name often used by professionals to refer to grief that is more complex in

nature, yet in the present study we will focus on prolonged grief disorder. Although two camps of researchers are known for studying prolonged grief disorder (Maciejewski & Prigerson, 2017) and complicated grief (Shear & Bloom, 2017), there are distinctions between the two conditions and how they are conceptualized. Recently, the most prominent researchers studying complex forms of grief agreed to integrate their findings, which resulted in a proposal to include prolonged grief disorder in the DSM-5 (Boelen et al., 2020).

Prolonged grief disorder 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 & Reynolds, 2017). 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 (Killikelly & Maercker, 2017).

For some bereaved individuals, especially those who had other risk factors (e.g., those who had experienced other recent losses; Neimeyer & Burke, 2013), prolonged grief disorder could cause severe long-term psychological and physical problems, such as generalized anxiety, depression, cardiovascular and immune system-related illnesses, higher suicide risk, and insomnia (Morina et al., 2011; Ott, 2003; Pohlkamp et al., 2019). Further, early efforts have examined impairment that associated with individual prolonged grief symptoms. A recent study used an advanced statistical method of network analysis to study a sample of 215 bereaved individuals (Maccallum & Bryant, 2020). Researchers analyzed associations between prolonged grief symptoms and quality of life impairments. Prolonged grief symptoms of meaninglessness and role confusion were related to reduced psychological quality of life, trust difficulties were

linked to reduced social quality of life, while bitterness was associated with environmental quality of life. The results supported earlier models that proposed that self-identity and loss of meaning may be particularly salient among individuals who struggle with prolonged grief (Maccallum & Bryant, 2020).

It is also worth noting that prolonged grief disorder is considered to be distinct and separate condition from depression, anxiety, and post-traumatic stress disorder (Boelen et al., 2018; Prigerson et al., 2009). Given extensive evidence on the distinctiveness of this grief condition, prolonged grief disorder was recently added as a new diagnosis to the 11th revision of the International Classification of Diseases (ICD-11; World Health Organization, 2018). Although a similar condition, persistent complex bereavement disorder (PCBD), was described in the Diagnostic and Statistical Manual for Mental Disorders (DSM-5; American Psychiatric Association, 2013), more evidence is being accumulated before a formal new diagnosis is considered for the future DSM. A recent study (Bonanno & Malgaroli, 2020) examined how both prolonged grief disorder and persistent complex bereavement disorder capture symptoms of grief over time and how these symptoms would relate to the long-term outcomes. In this study, researchers recruited a community sample of 282 adults who recently lost their spouse and then conducted semi-structured interviews at 3, 14, and 25 months post loss to assess their symptoms. At 25 months post-loss, outcomes assessed included depression, global functioning, interviewer ratings of perceived participant suffering, and case congruence analysis of both prolonged grief disorder and persistent complex bereavement disorder. Prolonged grief disorder was better at differentiating symptoms, capturing psychopathology and other outcomes, and also more sensitive to change over time. Prolonged grief disorder also had five distinct outcome trajectories: resilience, moderate-improving, acute-recovering, prolonged-stable symptoms, and

prolonged-worsening symptoms (Bonanno & Malgaroli, 2020). Overall, the results supported the clinical utility of prolonged grief disorder.

Grief Counseling

Grief counseling is not needed for all individuals who experience loss, and that only those who actively desire and seek professional help (Schut, 2010) and those who present with more prolonged or complicated grief benefit from grief counseling (Iglewicz et al., 2020; Wittouck et al., 2011; Zisook & Reynolds, 2017). Interestingly, attitudes about grief counseling also play a role in why many individuals do not seek this mental health service. One study assessed community attitudes toward grief counseling with a sample of 156 adults (Breen et al., 2018). Women held more positive views than men, yet when controlling for gender, beliefs and affects explained attitudes towards grief counseling, while behavioral responses did not. Also, there were no associations between attitudes and country of birth, age, previous counseling, or bereavement experience. Overall, attending to people's attitudes about grief counseling might be paramount to ensure that bereaved individuals, and especially those who may be the most distressed, seek grief counseling when needed (Breen et al., 2018).

Over the years, many different grief models and theories have been proposed, yet there is a lack of uniform guidelines on how to conduct grief counseling. In fact, some have suggested that there might be a distinction between grief counseling and grief therapy (Worden, 2018). According to this view, grief counseling refers to counseling the bereaved who present with normative grief in a supportive and empathic manner, whereas grief therapy is more specialized and intense treatment for grieving individuals who present with complicated or prolonged grief (Worden, 2018). Although efforts are underway to develop and to empirically validate specialized grief therapies that might be particularly helpful for individuals with intense and

protracted grief (e.g., Meaning-Centered Grief Therapy [MCGT; Lichtenthal et al., 2019; Integrative Cognitive Behavioral Therapy for PGD [PG-CBT; Rosner et al., 2015]; Complicated Grief Treatment [Shear & Bloom, 2017]), most other grief counseling models have been developed with more normative samples in mind (e.g., Meaning Reconstruction model [Gillies & Neimeyer, 2006; Neimeyer, 2001]; Continuing Bonds theory [Klass et al., 2014]; Kübler-Ross' Five Stages of Grief model [Kübler-Ross, 1969]; The Dual Process Model of Coping with Bereavement [Stroebe & Schut, 1999, 2010]; Four Tasks of Mourning [Worden, 2011]).

The Association for Death Education and Counseling (ADEC) 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. Similar to typical 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.

Although grief counseling may look different based on the grief model that the therapist is using, overall, grief counseling draws many of its guidelines from the generally recognized tenants of effective therapy: emphasizing an open and supportive space for the client to share their feelings, to process their experience, to maintaining a strong relationship or alliance between the client and the therapist, and to provide psychoeducation to the client when necessary. In addition, grief counselors also strive to help the client integrate their loss, while

supporting them in reentering and continuing with their life, while also possibly maintaining an ongoing relationship with their deceased loved one (Harris & Winokuer, 2019; Worden, 2018).

Furthermore, the consideration of multicultural factors is 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 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.

Grief Counseling Education and Training

In terms of current training and preparation of therapists to perform grief counseling, the field of psychology 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 et al., 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 covered 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 infused grief counseling into other foundation courses and practica (Humphrey, 1993).

A more recent study assessed death and dying course offerings in U.S. psychology departments, yet their recruitment was limited only to nine 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 a course were asked for the reasons why, but only 54 schools (42.5%) responded to this question. The most common reasons 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 and training are conflicting – many schools seemed to recognize that topics of death and dying and grief counseling were important, yet a small minority offered courses on this topic.

In terms of empirical research that assessed counselors' 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 et al., 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 were assessed.

The results of this study (Charkow, 2001) revealed that the 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, 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 (Charkow, 2001).

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 the Texas Revised Inventory of Grief (TRIG; Faschingbauer et al., 1977) 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.

Lastly, informed by the previous studies, a more recent project assessed predictors of grief counseling skills among 171 therapists recruited from an APA-accredited university counseling centers in the U.S (Jankauskaite et al., 2021). In this mixed methods study grounded in the Death Competence model (Gamino & Ritter, 2012), researchers examined therapists' cognitive competence, emotional competence, and death attitudes. Cognitive competence and emotional competence predicted grief counseling skills, with training/experience being the most robust predictor. In this study, only a small minority (16.4%) of participating therapists 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 at their clinical training sites (i.e., practica, externship, or internship; Jankauskaite et al., 2021).

Theoretical Foundation: Social Cognitive Theory

Social Cognitive Theory is a widely popular theory developed by Albert Bandura and evolved from Social Learning Theory (SCT; Bandura, 1969; 1997). This theory suggests that learning occurs when a person, environment, and behaviors interact with each other in a reciprocal manner. In other words, learning happens in the context of the dynamic interplay between the person and their social environment and their past experiences. Social Learning Theory proposed a number of salient constructs: 1) reciprocal determinism, which is the idea that there is a three-way interaction between an individual with their unique learned experiences, their social environment, and individual's behavior or responses; 2) behavioral capability, which refers to person's actual skills and knowledge to perform a particular skill, which might be based on their prior experiences; 3) observational learning, which is described as learning vicariously by observing others' behaviors and actions and then potentially modeling others' behaviors; 4) reinforcements, which are either internal or external signals that either promote a specific

behavior or inhibit it, which result in a person either continuing a specific behavior or possibly stopping it; and 5) expectations, which refer to anticipated outcomes of a specific behavior and are usually based on person's previous experiences with a particular behavior. Further, when Social Learning Theory later evolved into Social Cognitive Theory, another salient construct was added to this model. Self-efficacy is conceptualized as a one's beliefs in the ability to perform a particular skill, and these beliefs or confidence are thought to influence how one approaches challenges and behaviors (Bandura, 1969; 1997).

Social Cognitive Theory (Bandura, 1969; 1997) has been applied to the examination of various constructs. For example, Social Cognitive Theory was examined in light of mass communication (e.g., Bandura, 2001), self-regulation (e.g., Bandura, 1991), organizational management (e.g., Wood & Bandura, 1989), group behavior (e.g., Turner, 2010), health promotion (e.g., Bandura, 1998), personality (e.g., Bandura, 1999), moral thought and action (e.g., Bandura, 2014), and vocational and academic concerns (e.g., Lent et al., 1994). Further, of particular interest within the larger psychological counseling literature is the construct of counseling self-efficacy (Larson & Daniels, 1998), which has been studied among trainees (e.g., Flasch et al., 2016; Johnson et al., 1989; Ikonopoulou et al., 2016; Larson et al., 1999), in light of the performance feedback (Daniels & Larson, 2001), and supervision (e.g., Barnes, 2004; Cashwell & Dooley, 2001; Morrison & Lent, 2018), including multiculturally-focused supervision (Constantine, 2002), among other areas. Even though a thorough analysis of the self-efficacy in counseling literature is beyond the scope of this current review, overall, an overwhelming amount of research suggests that therapists with greater experience and training are more likely to report higher self-efficacy in counseling than those without training or experience (e.g., Mesrie et al., 2018; Urbani et al., 2002).

Even though Social Cognitive Theory (Bandura, 1969; 1997) has been applied to general counseling and helping domains, it has not been widely studied within the grief counseling literature. In fact, there are only a few studies that related self-efficacy to working with a grieving client. For example, two studies examined counselors' self-efficacy to address a crisis situation with a client, which included a death loss specifically (Morris & Minton, 2012; Sawyer et al., 2013). These studies are discussed in more detail below; the results indicated that specialized training in crisis intervention resulted in increased self-efficacy in working with clients presenting with crises, including a sudden or traumatic death of a significant person (Sawyer et al., 2013).

Interestingly, although Social Cognitive Theory (Bandura, 1969; 1997) has not been applied within the grief counseling literature, the self-efficacy construct has been explored with the bereaved population. For example, one study (Bauer & Bonanno, 2001) interviewed 69 recently bereaved spouses (lost partner in the last 3 to 6 months) with the goal to assess their self-evaluation and coping with loss. In addition, participants completed other measures of grief at 6, 14, and 25 months post-loss. As hypothesized by the researchers, self-described self-efficacy predicted less grief over time, and interestingly, this held true even when controlling for how one perceived they were doing and feeling. Moreover, self-efficacy was protective when one was evaluating their behaviors negatively. Overall, the positive role of self-efficacy in bereavement adaptation was highlighted (Bauer & Bonanno, 2001).

Further, another study examined the effects of a nine-session educational Mindfulness Based Stress Reduction (MBSR) program on therapists' self-efficacy (Supiano & Overfelt, 2018). Specifically, this study recruited 15 therapists who run grief support groups and used a mixed methods approach to assess their self-efficacy on 13 different dimensions using an author-

developed measure. Before and after participants completed the Mindfulness Based Stress Reduction (MBSR) program, they provided short narratives and completed self-efficacy survey. Results indicated that clinicians, even those with prior experience with mindfulness, reported increased self-efficacy in professional and personal practice. Overall, personal mindfulness practice was beneficial in increasing self-efficacy for therapists who work with grieving individuals (Supiano & Overfelt, 2018).

Grief Counseling Knowledge

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, the Association for Death Education and Counseling 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: 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.

A study that was described earlier (Ober et al., 2012) also assessed grief counseling knowledge among 369 licensed professional counselors. In this study, researchers utilized the Death Counseling Survey (Charkow, 2001) in addition to Texas Revised Inventory of Grief (TRIG; Faschingbauer et al., 1977) and Grief Counseling Experience and Training Survey (GCETS; Ober, 2007). Participants were asked about their familiarity with various grief models

and theories, and the results revealed that most respondents had limited knowledge about most widely recognized theories. Moreover, the most familiar theories were stage and task theories of grief (e.g., Kübler-Ross, 1969), though these theories have questionable validity in the field. On the other hand, more validated theories (Richardson, 2007; Schut et al., 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 ($M = 3.07$, $SD = 0.91$; Ober et al., 2012).

Furthermore, another study (Jankauskaite et al., 2021) also examined knowledge among therapists, with a sample of 171 practicing university counseling center therapists. Therapists had limited self-reported and vignette-evaluated knowledge in grief counseling. Specifically, when asked to respond to a clinical vignette describing a bereaved college student, a sizeable number of participants (21.2%) recommended using an empirically lacking stage grief model (i.e., Kübler-Ross model), and also did not suggest the exploration of multicultural considerations (18.6%) or assessment of the client's relationship closeness to their deceased friend (13.5%, Jankauskaite et al., 2021). Overall, mental health providers working with grieving individuals have questionable levels of knowledge regarding salient aspects of effective grief counseling.

Grief Counseling Self-Efficacy

Self-efficacy, which is a key aspect of Social Cognitive Theory, is broadly defined as a belief in the ability to master a specific skill (Bandura, 1969; 1997). Self-efficacy is a widely studied phenomenon as the degree to which an individual has confidence in their ability influences how they approach and deal with encountered challenges. Self-efficacy has been examined in various domains, such as classroom learning of cognitive skills (Schunk, 1985),

self-regulated learning (Pajares, 2002), health related outcomes (Holden, 1992), college outcomes (Gore, 2006), among many other psychological constructs. Overall, self-efficacy has been recognized as an important construct that often predicts one's ability to perform. Given its importance to skill-building and ability, it is quite surprising that self-efficacy has not been more widely studied within the grief counseling literature. In fact, there are no studies that looked at the self-efficacy as the primary outcome in grief counseling competencies. Thus, future research should further explore this construct as it applies to grief counseling.

Nonetheless, a few studies (Morris & Minton, 2012; Sawyer et al., 2013) assessed counselors' self-efficacy with regard to a crisis situation. One study examined school counselors' self-efficacy to support clients in crisis (Sawyer et al., 2013), which they argued, might include client experiencing a significant death loss. The sample consisted of 34 master's-level school counselors enrolled in a required Crises Intervention Preparation course for Mental Health Responders. Their self-efficacy was measured using an author-modified measure, The Counselor's Self-Efficacy Scale, pre- and post- taking the course (Sawyer et al., 2013). Among the client crises assessed, one was focused on the death loss. The course that trainees took was helpful in increasing beginning therapists' self-efficacy to work with bereaved clients. Specifically, the post-test results suggested overall increased confidence. For example, the pre-test indicated that the largest number of students (32.4%) reported having "little confidence" to address a death crisis, while the post-test results revealed that the largest number of students (48.5%) rated themselves as "very much confident" (Sawyer et al., 2013). Even though this study did not explicitly address grief counseling, the results seem to underlie the importance of education and training to increase trainees' self-efficacy to work with bereaved clients.

Another innovative study that included a self-efficacy outcome was an unpublished dissertation (Brown, 2005) that examined whether viewing short clips from motion pictures could enhance counselors' effectiveness in grief counseling. The study's sample consisted of 79 individuals who were Licensed Professional Counselors, counseling students, social workers, paraprofessionals, and marriage and family therapists. The six-week grief counseling program that was assessed utilized popular movie clips and examined its effects on grief counseling comfort, death anxiety, and grief counseling self-efficacy. The results were not significant, and the author suggested that future research on grief counseling intervention might consider utilizing a longer intervention or might include movie clips that depict more complex grief situations. Further, authors also advocated that grief counseling education should be incorporated throughout the graduate curriculum (e.g., ethics course, multicultural issues, client conceptualization, skills, human development; Brown, 2005).

Research Hypothesis

The research hypotheses were as follows:

1. Controlling for prior grief counseling experience and training and pre-test grief and grief counseling knowledge, participants in the *full online intervention* group would report higher post-test grief and grief counseling knowledge than participants in the partial intervention and control groups.
2. Controlling for prior grief counseling experience and training and pre-test grief counseling self-efficacy, participants in the *full online intervention* group would report higher post-test grief counseling self-efficacy than participants in the partial intervention and control groups.

Appendix B

Full Intervention Script

Hello! We are researchers at the University of Maryland and Ewha Womans University. We want to advance understanding regarding grief and grief counseling for therapists and counselors.

This training will provide an overview of grief and grief-related models. We then will describe the 3-Factor Grief Counseling Model that may enhance your work with grieving clients.

COMPONENT 1: GRIEF

First, what is grief?

Grief is something that occurs after loss. Grief occurs after many kinds of losses – for example, the death of a family member, friend, or pet, the ending of a relationship, the loss of a job, home or treasured object, the loss of good health or financial stability, the many losses associated with a global pandemic, or even the end of a dream or goal. This training will focus on losses due to death.

Grief can involve lots of different feelings, thoughts, and even physical reactions. Some people say grief comes in waves. Grief changes over time, and there is no time limit for grieving - people often grieve the loss of those closest to them for their entire lives.

Grief is different for everyone. Some common reactions to loss include:

- feeling sad, numb, exhausted, guilty, relieved, scared, or angry,
- being easily annoyed by little things,
- longing for the person who died,

- experiencing changes in sleeping or eating patterns,
- having difficulty getting out of bed in the morning to go to school or work,
- struggling to concentrate and complete tasks,
- losing interest in activities,

- worrying about one's safety or that of others,
- being afraid that others might die or being more aware of one's mortality,
- remembering the person who died or avoiding reminders of this person, and
- thinking about past losses.

It is really important to note that most people grieve and eventually adapt to a new way of living after experiencing a loss. For these individuals, counseling is not required but if desired, can provide support throughout the grieving process.

Now, please take a moment to think about what happens when someone really struggles as they grieve. What might they be feeling and experiencing?

For a small number of people, grief remains very intense for an extended period of time and they experience considerable difficulty completing the normal tasks of life. If the intensity of grief continues past 12 months, the client may be experiencing Prolonged Grief Disorder. Prigerson, Shear and their colleagues noted that some of the signs of this disorder include:

- acute feelings of longing and yearning for the deceased,
- continued preoccupation with the deceased,
- intense emotional pain and feeling that life has no meaning,
- difficulty functioning and an inability to adjust to the loss, and
- reactions that exceed typical grieving for the person's culture.

For those who are experiencing prolonged grief disorder or struggling to cope with the loss, counseling can make a powerful difference in their grieving journey.

What do you think are some factors that contribute to how people grieve?

There are many factors that play a role in how individuals grieve. Some risk factors are the circumstances of the death including the cause of death and how the person died - like whether the death was unexpected or violent like deaths due to suicide, homicide or accidents. Other risk factors include what led up to the death - was the deceased very ill or in pain before they died? - and how the griever was notified of the death.

Also important with regard to grieving is the relationship the griever had with the deceased – was the relationship close, complicated or conflictual? In addition, the client's prior mental health, attachment style, and existing support systems may play a role in their grieving. Prior losses and family conflict related to the death also contribute to how individuals grieve.

Additional influences on how people grieve include culture, traditions, generations within families, identities, and spiritual beliefs. These influences play a powerful role in grieving through beliefs about death and what happens when someone dies, cherished rituals at the time of and after death, acceptable forms of grieving, and how we remember the deceased.

For example, the clothing that is worn, the intensity and affective expressions of loss and sadness, and the traditions and practices to honor the deceased vary greatly across cultures and even within generations in families. For example, grandparents' beliefs and rituals related to grieving may differ from those of younger members in a family.

In addition, the degree to which others recognize the loss is an important factor in grieving. Some losses, like deaths by suicide, overdose, miscarriage, or the death of a close friend, may not be acknowledged and may even be stigmatized. The grief that accompanies losses that are not honored is referred to as "disenfranchised grief."

Finally, we know that people grieve in many different ways – even people grieving the same loss may have very different reactions. Several styles of grieving have been identified by Martin and Doka.

- Intuitive grievers focus on feelings and affect - they may cry, talk about their loved one, and seek therapy to process their feelings.
- Instrumental grievers get to work. They take action like figuring out finances or clearing belongings from the home.
- Blended grievers engage in a combination of both feeling-oriented and action-oriented tasks.
- Finally, dissonant grievers are people whose internal experiences do not match their external expressions. They hold their feelings in and will not allow expression of their emotions.

It would be helpful for therapists to think about their grieving style. How might you grieve the death of someone you love?

Sometimes, problems may emerge in relationships or families or among friends when the grieving styles of those in mourning do not match. For example, parents who are grieving the death of their child might experience difficulties in their relationship if their grieving styles do not match or if they have expectations for how their partner should grieve.

To summarize, we provided an overview of grief and highlighted that most people grieve and eventually adapt to a new way of living after experiencing a loss – without needing professional intervention. We also described challenges with grieving, characteristics of prolonged grief disorder and factors contributing to how people grieve. For those experiencing prolonged grief or wanting professional support, counseling can make a powerful difference in their lives. Finally, several styles of grieving were explained – remember that although all humans will experience loss, grief is unique, may come in waves, and has no time limit.

COMPONENT 2: GRIEF-RELATED MODELS

We now will provide an overview of several models that may inform your work when counseling grieving clients.

What models do you use when you work with grieving clients?

You may have heard of the **Five Stages of Grief** theory created by Kübler-Ross based on her earlier work with dying individuals. Although not intended, this theory often is interpreted as consisting of five sequential stages that include Denial, Anger, Bargaining, Depression, and Acceptance.

It is important to note that research does not support the stages that were proposed in the Kübler-Ross theory for grieving individuals. Grief is unique and many grieving individuals do not experience all or even most of these stages – and they definitely do not move through them in a sequential manner.

Therapists – and people who are grieving – should be very cautious if using this theory as grief should not be expected to correspond with the five stages. Griefers may feel that they are not grieving correctly if they do not experience each of the five stages.

One theory that shows much promise is the **Four Tasks of Mourning** theory developed by Worden. This theory emphasizes necessary “tasks” (not stages) of grieving that do **not** need to be addressed in a specific order. Griefers engage in “grief work” that consists of the following tasks:

- To accept the reality of the loss,
- To process the pain of grief,
- To adjust to the world without the deceased, and
- To find a way to remember the deceased while embarking on the rest of one’s journey through life.

Therapists should not misinterpret this theory as a sequential or a stage model. It is important to note that this theory does not address the growth that may occur as a result of the loss that the client experienced, something that will be discussed in some of the following theories.

Next, we would like to describe the **Dual Process Model of Coping with Bereavement**, advanced by Stroebe and Schut. This model is focused on the process of *coping* with loss with the assumption that if coping is effective, then the suffering associated with loss should eventually be reduced.

This model suggests that grieving may occur in doses and that griefers may oscillate between actively focusing on and processing the loss (or “loss-orientation”) and addressing secondary life stressors related to the death (or “restoration-orientation”). An example of loss-orientation is remembering and yearning for the deceased. Restoration-orientation could involve learning new tasks that the deceased used to do like paying bills or making family dinners.

An important and typically very helpful part of this model is the idea that griefers may take “time outs” from actively grieving. For example, a client mentioned that his work provided some respite from actively grieving the death of his mother. The client was relieved to learn that this was ok – and even recommended by this model.

One area not addressed by this model is the content of what the client might be working through as they grieve.

A model that resonates with many therapists is the **Meaning Reconstruction Model** created by Neimeyer and updated by Gillies and Neimeyer. This model emphasizes the importance of providing grieving clients with the opportunity to tell their grieving story and find meaning associated with their loss. According to this model, if a grieving client goes through the meaning-making process and finds this process helpful, the psychological distress associated with the death will lessen.

To construct meaning in response to the loss, griefers engage in three main activities:

- Sense-Making occurs when grievors strive to find reasons for what happened or “make sense” out of the loss; for example, they may try to understand why the death happened, why the death happened to the deceased and to them, and what this experience of loss means to them.
- Benefit Finding refers to trying to identify positive outcomes that occurred as a result of the loss – for example, some grievors may reflect on how the deceased is no longer suffering or how some relationships have deepened after the death. It’s important to note that benefits do not happen immediately after the loss but sometimes months or years later. Not everyone finds positive aspects from their loss.
- Identity Change refers to reconstructing oneself after the loss. For example, grievors may report a changed sense of self, spiritual or personal growth, increased resilience, new relationships with others, continuing bonds with the deceased, or a new outlook on life.

It’s important to emphasize that some clients may feel upset or misunderstood if therapists expect that the client will find meaning or benefits as a result of the loss; they may not want to engage in a meaning making process or experience positive outcomes after the loss. In therapy, it may be most helpful to recognize and reflect the moments where clients mention areas of growth or a desire to find meaning from their loss.

Related to this model is the idea of **Post-Traumatic Growth**, advanced by Tedeschi and Calhoun. Post-traumatic growth is positive change that occurs as a result of experiencing a challenging life event. Post-traumatic growth has occurred among individuals who experienced combat, life-threatening illness, and violence. Some grieving individuals also report post-traumatic growth after loss. Research on this construct has identified five manifestations of posttraumatic growth:

- Greater appreciation of life,
- More meaning and closeness in relationships,
- Increased sense of strength,
- New opportunities and possibilities, and a
- Deepening of spiritual life.

So far, we have talked about theories and models that address the tasks or process of grieving, how some clients engage in a search for meaning as they grieve, and how growth may occur after experiencing a loss. We now turn to a theory that focuses on the relationship that the griever had with the deceased.

An important aspect of counseling clients who are grieving is processing their relationship with person who died. **Continuing Bonds Theory** was proposed by Klass, Silverman and Nickman and focuses on how some grievors might continue their relationship - or maintain continuing bonds - with the deceased after their death.

In the past, maintaining a connection with someone who died was seen as problematic – even pathological. In contrast, this theory states that continuing bonds may be healthy and normal for grievors who want to maintain a connection with the deceased.

Researchers have identified two types of continuing bonds, internalized and externalized. Internalized continuing bonds reflect an internal process in which a connection to the deceased is maintained. Some examples include imagining talking to the deceased, thinking about special memories of the deceased, or being aware of the positive influence that the deceased had on their lives.

Externalized continuing bonds include actions that maintain a connection with the deceased - for example, visiting a cemetery or memorial site, wearing jewelry that belonged to the deceased, and engaging in rituals to remember the deceased.

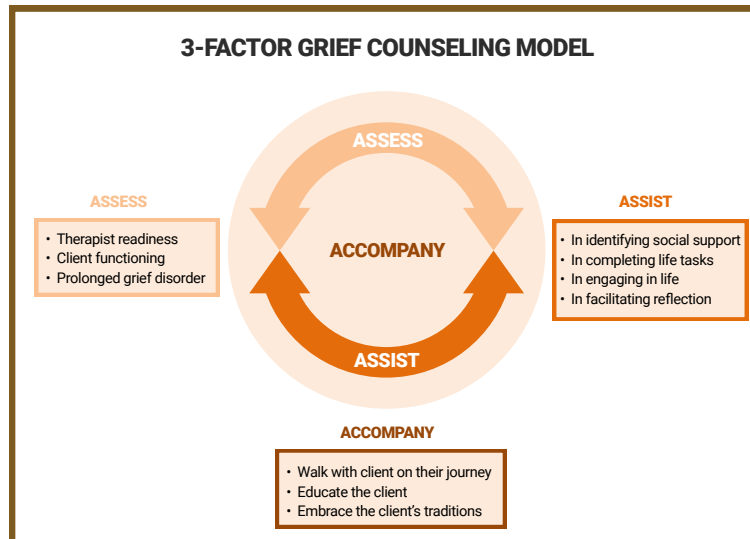
It's important to note that connections with the deceased do not remain fixed and static. They change and evolve over time - similar to relationships with the living.

Finally, some people do not want to maintain continuing bonds with the deceased – and that's ok, too. This sometimes occurs when the relationship was harmful or conflictual or if maintaining bonds is not consistent with their cultural norms or personal preference.

At this time, please reflect on which components of these models you would use in your work with grieving clients.

COMPONENT 3: 3-FACTOR GRIEF COUNSELING MODEL

Now, we will describe the **3-Factor Grief Counseling Model** that provides general guidelines for grief counseling informed by theories described previously. This model consists of three main factors: Accompany, Assess, and Assist. Therapists should attend carefully to **assessing** salient constructs, **accompanying** the client on their grief journey, and **assisting** clients to adjust to and embrace a new way of life without the deceased. Our guidelines provide recommendations for important components of grief counseling– **not** ordered steps on a checklist. It is likely that several of these components will need to be addressed multiple times throughout the process of grief counseling. Also, therapists will need to consider the client's unique experiences of grief as they engage in the grief therapy process.



We will provide opportunities for you to apply what you are learning about the 3-Factor Grief Counseling Model to the following clinical case.

Hannah is an undergraduate student majoring in art history. One year ago, Hannah and her brother were studying abroad in Europe. Their parents, who resided in [Korea/U.S.], did not tell their children that their mom was diagnosed with cancer so they would not worry about her while they were far from home. As their mother's health declined, their father asked them to return to [Korea/U.S.] to be with their mom during her last days. Hannah and her brother returned to their family's home sad and devastated - they were not ready to accept their mother's condition. They also were unable to express their feelings of despair, sadness and anger at their parents during this profoundly difficult time. Their mom died soon after their return home.

Hannah, her brother and her father were all very close to the mother, but not close to one another. After Hannah's mom died, the family found it challenging to deal with their grief together. With much unfinished business and many unprocessed feelings, Hannah and her brother returned to Europe to continue their studies. Soon after, Hannah's father flew to Europe and stayed with them, but they never spoke about the mother's death.

A friend recommended that Hannah seek counseling from you. In your first therapy session, Hannah was calm and presented her main issue as being uncertain about her future career choice. Hannah mentioned the death of her mom but wanted to focus on career issues. As she talked about her mother's death, she began to cry.

First, we will discuss the importance of assessment with grieving clients and provide opportunities for you to apply what you are learning about grief counseling to this case.

Assess therapist readiness to provide grief counseling (ASSESS)

Before providing grief counseling, it is important for the therapist to critically evaluate their readiness to work with a grieving client.

The therapist should think about the losses that they experienced and assess whether they are actively grieving a loss. If a therapist has unresolved losses or currently is mourning a loss, they should refer the grieving client to another therapist.

As you reflect on Hannah's case, what are your reactions? What emotions or countertransference are you experiencing? Perhaps this case reminds you of your losses or someone you know who has cancer? Maybe there are specific parts of Hannah's case that resonate with you?

It is important for therapists to be aware of countertransference and their ability to work effectively with a grieving client.

Assess the client's current functioning (ASSESS)

When working with a grieving client, it is important for therapists to assess the client's current functioning. Therapists can ask the client how they are doing with their grieving and the degree to which they are able to take care of themselves and complete everyday life tasks. Assessment of functioning includes questions that inquire about sleep, nutrition, energy level, concentration, motivation, social engagement, risk assessment, and substance use. It also is helpful to talk about how the client perceives their functioning to have changed since the loss.

This assessment of current functioning is ongoing and occurs throughout the counseling relationship.

How would you assess Hannah's functioning? What questions would you ask and which assessment tools might you use?

It is important to obtain Hannah's perceptions of any changes in her functioning since her mom's death.

Assess for prolonged grief disorder (ASSESS)

When clients exhibit intense difficulty related to their grief for an extended period of time, it is important to assess whether the client may be experiencing Prolonged Grief Disorder. The American Psychiatric Association has proposed the following diagnostic criteria for this disorder:

- Experiencing the death of a person close to the client at least 12 months ago,
- Intense yearning/longing for the deceased or a preoccupation with thoughts or memories of the deceased to a significant degree nearly every day for at least the last month, and
- Experiencing at least three of the following symptoms to a significant degree as a result of the death, nearly every day, for at least the last month:
 - Identity disruption (for example, feeling as though part of oneself has died),
 - Strong sense of disbelief about the death,
 - Avoidance of reminders that the person is dead,
 - Intense emotional pain related to the death,
 - Difficulty moving on with life,

- Emotional numbness,
- Feeling that life is meaningless, and
- Intense loneliness.
- These reactions must cause significant distress or impairment in social, occupational, or other important areas of functioning.
- Also, the duration of the reaction exceeds expected social, cultural or religious norms, and
- The symptoms are not better explained by another psychological disorder.

Treating a client with Prolonged Grief Disorder extends beyond the scope of this training. Therapists who work with clients who meet the criteria for Prolonged Grief Disorder may want to learn more about treatments that have received some empirical support for their efficacy including grief-specific Cognitive Behavioral Therapy with exposure and Complicated Grief Therapy. In addition, a referral to a psychiatrist for medication evaluation may be helpful for clients who may need additional assistance.

Given what you know about Hannah's case, how might you assess for Prolonged Grief Disorder?

At present, we do not know enough about Hannah's functioning and her grieving process, so further assessment is needed. Considering that Hannah's mother died over a year ago and that the death was unexpected, it would be helpful to assess her grief reactions using the Prolonged Grief Disorder symptom checklist. We do not want to pathologize her grief, however it is important to know the extent of her grief and how she is coping.

Now, we will address how to accompany clients on their grief journey.

Accompany the client on their grief journey (ACCOMPANY)

Once grief counseling begins, the most powerful aspect of this work is being with or accompanying the client on their grief journey. To do this, therapists listen carefully and are fully present with the client in the counseling sessions.

Therapy provides a safe space for the client to tell their grief story - when they are ready. This may involve telling the therapist about the death or how they learned about the death.

The grief story also may include the griever's relationship with the deceased – the closeness of their connection or the conflict that existed between them. Clients process what they miss about the deceased or how their lives will be forever changed as a result of their loss.

Normalizing whatever feelings emerge for the client is important - provided, of course, that they are not going to harm themselves or others. As grief researcher Doka noted, "The heart of grief counseling is validation."

To facilitate the telling and processing of the grief story, therapists use existing counseling skills and techniques. Active listening, reflections, open questions, silence, and journaling can assist the griever in sharing feelings, fears, thoughts, regrets, and needs. As in non-grief counseling,

therapists are not there to provide answers – many of the questions that grieving clients ask cannot be answered. Therapists need to be comfortable with not knowing and be able to sit with expressions of intense affect.

Some clients will seek counseling to process their grief while others may present with other issues (like depression or career concerns) and initially not be ready to discuss their grief. As with any client, therapists never exert pressure to share if the grieving client is hesitant to talk. Instead, therapists provide a safe space and understand that the client may need to move in and out of their grief work.

Imagine that Hannah sits before you in your first session, crying about the death of her mom. How might you begin your grief work with Hannah?

Remember that Hannah originally wanted to focus on career issues in counseling. As you explore her grief, be sure to follow Hannah's lead in how much and at what pace she wants to process her loss.

Embrace the client's grieving traditions/practices (ACCOMPANY)

Therapists working with grieving clients should seek to understand and acknowledge the client's cultural, ethnic, generational, or faith-based beliefs, traditions and practices and other identities that play a role in their grieving. For example, the typical expressions of grief (like whether the griever can cry loudly or intensely) will differ across cultures and even generations within a family. The degree to which keeping belongings or wearing the clothing or jewelry of the deceased is considered appropriate also varies. Therapists should explore client's beliefs about death and grieving, and how their cultural background and identities affect their grief process. It is important to ask these questions even if the client does not readily share them with the therapist, as grieving is imbedded in our cultural norms and practices. Ideally, therapists educate themselves about these influences without relying on the client to teach them.

Also, therapists should use caution in assuming that all clients from a particular culture, generation or religion adhere to the practices associated with these groups.

How might you explore Hannah's cultural background and values, while showing respect for a diversity of cultural practices? What specific questions might you pose to Hannah about her culture and her adherence to cultural norms?

At this time, we do not know much about Hannah's cultural background or identities. It will be important to assess and attend to the ways in which her grief is influenced by her age, gender, familial background, prior losses, spiritual/religious views, and cultural grieving traditions while recognizing that Hannah's grieving is an individualized process.

Educate the client (ACCOMPANY)

A salient component of grief counseling is educating the client about grief, grieving and the process of grief counseling. The initial grief response can feel very intense and overwhelming for clients – some clients even report feeling like they are “going crazy.” Psychoeducation about

typical grief reactions, that grief comes in waves, and that there is no right way of grieving can be very helpful to grieving clients.

Clients often are comforted by knowing that griever may need to take breaks from grieving and oscillate between loss-orientation and restoration-orientation tasks as proposed in the Dual Process Model of Coping.

Similarly, the therapist, when appropriate, may let the client know that grief changes over time and while the client may grieve this loss forever, they will not always feel the intensity of feelings that accompany the initial experience of grief. This may provide some hope for the client while honoring their current feelings and allowing room for the processing of all feelings related to the loss.

Clients also may appreciate learning that staying connected with the deceased or “maintaining continuing bonds” is considered a healthy and important part of grieving for those who want to remain connected to the deceased.

When appropriate, therapists may educate clients about the process of meaning making that some clients chose to engage in as they try to make sense of the death or search for meaning related to the loss.

Reflecting on Hannah’s case, what psychoeducation would you incorporate in your work with her?

Educating Hannah about grief may normalize and validate her feelings. Also, letting Hannah know that the relationship with her mother can continue may be comforting as Hannah works on her grief during the counseling sessions.

Finally, several ways in which the therapist can assist the client during grief counseling will be described.

Assist client in completing necessary life tasks (ASSIST)

When grieving, clients often need support to complete necessary life tasks, many of which may feel overwhelming. It is important to check in regarding the client’s ability to work or study, interact socially, and get things done. Normalizing the feelings associated with completing life tasks can be reassuring, and brainstorming what the client needs to do to complete necessary tasks can be helpful. At times, grieving clients may need encouragement to engage in healthy behaviors like eating nutritious food, getting enough sleep, and exercising regularly.

Sometimes, a client may feel especially overwhelmed if they have to take care of tasks that they have never done before – like managing finances or helping a child with homework. Grief counseling may help the client identify their new responsibilities, process feelings related to these changed roles, and learn the skills that are needed to complete the tasks.

What are some of the new life tasks that Hannah may be responsible for since her mom’s death? To what degree might Hannah feel overwhelmed by these new tasks?

Given that Hannah's mom died a year ago, Hannah might be dealing with new responsibilities. If Hannah struggles with engaging in healthy behaviors and necessary life tasks, normalizing her feelings and validating her struggles can be reassuring. Additionally, providing homework to encourage Hannah to engage in healthy behaviors could be helpful to Hannah and also allow the therapist to continue to evaluate her current functioning.

Assist the client in identifying the need for and sources of social support (ASSIST)

Receiving care and support serves as a protective factor against negative outcomes associated with grieving. Therapists providing grief counseling should educate their clients about the importance of social support and explain the different types of social support, including emotional, instrumental, appraisal, and informational support. In addition, therapists may help their client think about the social support available to them with regard to what needs are being met and not being met. For some griever, the deceased may have been their primary source of social support. It is important to help the client identify who will be there for them – and to help the client rely on more than one person to meet their varied needs.

Reflecting on how the client's social support has changed since the death also can be helpful. Often, there may be many expressions of support and assistance immediately after the death, but this support often diminishes over time. Many griever report that their close relationships and friendships may change – they typically learn who is really there for them as they grieve. It is not unusual to develop new connections or relationships. For example, the client may become close to others who are mourning the deceased or who experienced a similar loss. Therapists often provide referrals to grief groups as these groups may provide needed social support.

How might you work with Hannah to identify her need for and sources of social support?

You might brainstorm the different types of social support that could be helpful, and assist Hannah in reflecting on how she might go about obtaining support. Hannah's friend who recommended counseling could be a source of support.

Also, you may process Hannah's feelings about her father and brother as they do not seem to be connected to one another as they grieve the death of her mother.

Assist the client in engaging in life and constructing a life without the deceased (ASSIST)

Throughout therapy with a grieving client, the ultimate goal is to facilitate adjustment and engagement in life – albeit a different life without the presence of the deceased.

Therapists help the client integrate the death into their life story, address any unfinished business, and understand how attachment to others and their sense of security may be affected by the loss. This may be especially salient when the relationship with the person who died was very close or very conflictual. Therapists also can assist the client in articulating what they hope for in their life, given the reality of the loss.

If desired, the client may identify ways in which they will maintain continuing bonds with the deceased or honor their legacy. For example, some clients reflect on what advice they might

receive from the deceased when facing an important decision, light a candle to remember the deceased on special days, make their favorite recipes, or donate money or time to an organization in their memory.

As with all therapy, the client is never finished with grief work – and part of the therapy may be helping the client plan for grieving over time especially on special days like anniversaries, holidays, and birthdays.

What do you think may be unfinished for Hannah with regard to the death of her mother?

Hannah's parents withheld information about the extent of her mother's illness and Hannah had limited time to say goodbye to her mom. It is possible that Hannah might have unresolved feelings - perhaps anger at her parents for not telling her earlier or maybe sadness or regret about things that she wished she could have told her mom before she died. It is important to provide a space for Hannah to reflect and process unfinished business.

Also, Hannah might be open to thinking about how to remain connected to her mother. For example, Hannah might consider what her mom might say related to the career concerns that she presented in therapy. Maintaining continuing bonds can be comforting to clients as they grieve and reflect on how to keep the person who died present in their life.

Assist the client in facilitating reflection regarding areas of change/ progress / growth (ASSIST)

Some time after the death, clients may experience posttraumatic growth or positive changes that occur as a result of a challenging life event. As noted earlier, these changes may be found in:

- An increased appreciation of life,
- More meaningful and close relationships,
- Increased personal strength and the belief that one can survive difficult times,
- New opportunities and possibilities, and
- A richer spiritual or existential life.

Discussing the possibility of growth after loss should occur long after the death and only when appropriate. Ideally, a client will mention positive changes that they noticed as a result of their loss. Therapists then may help the client reflect on how they, their relationships, attitudes, beliefs, confidence, or behaviors may have changed for the better as they grieved their loss. Reflecting on their progress in therapy and in dealing with their loss may be important – especially when terminating the therapeutic relationship.

It is important to note that not all clients experience growth after loss. Some clients may feel angry if asked about positive outcomes associated with this painful time in their lives and others may feel that they failed in their grieving if they do not identify areas of personal growth.

To what degree do you think that Hannah might experience growth after the death of her mother? In what areas might this growth occur?

Although Hannah's mother's death was unexpected and potentially traumatic, in time, Hannah may begin to reflect on potential change, progress, and growth that occurred as a result of her mom's death. If Hannah alludes to growth in your sessions, reflecting on positive changes could help her develop new insights and build resilience. Providing a space to think about the meaning of her experiences and exploring her growth, personal strength, and changed perspectives could be powerful for Hannah on her grief journey.

Helpful tools/techniques for grief counseling

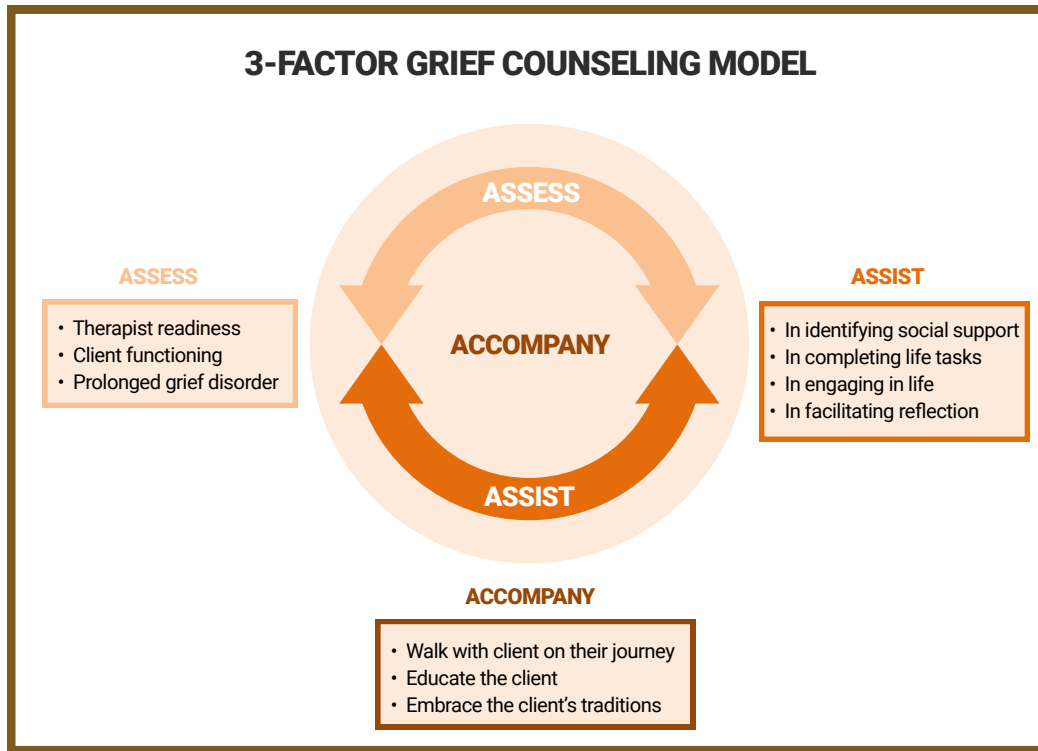
We have described the 3-Factor Model of Grief Counseling to provide guidelines for therapists working with grieving clients. Fortunately, many of the tools and techniques that therapists use in counseling can be applied to grief counseling. Providing a safe space to narrate and retell the loss experience and reflect on the relationship with the deceased are powerful components of grief work. Basic listening skills, open-ended questions, restatements, and reflection and validation of feelings also can be useful in grief counseling. Some of the classic cognitive behavioral therapy, dialectical behavioral therapy, acceptance and commitment therapy, and interpersonal therapy techniques may be beneficial to the client. For example, journaling about feelings, writing letters to the deceased and imagining their reply, and discussing family trees and life graphs can advance the work of grief counseling. Similarly, the empty chair and two chair techniques can be used to have an imaginary conversation or work through a conflict with the deceased.

Our final question for you... which particular techniques would you use to help Hannah process her grieving?

To conclude, the 3-Factor Model of Grief Counseling includes assessing salient constructs, accompanying the client on their grief journey, and assisting clients to adjust to and embrace a new way of life without the deceased. These recommendations should **not** be considered sequential steps or a must do checklist. Therapists may integrate and revisit these components throughout the process of grief counseling. Ultimately, most clients integrate grief into their lives and embark, changed, to continue their life journey.

Appendix C

3-Factor Grief Counseling Model (O'Brien et al., 2022)



Appendix D

Partial Intervention Script

Hello! We are researchers at the University of Maryland and Ewha Womans University. We want to advance understanding regarding grief and grief counseling for therapists and counselors.

This training will provide an overview of grief and grief-related models.

COMPONENT 1: GRIEF

First, what is grief?

Grief is something that occurs after loss. Grief occurs after many kinds of losses – for example, the death of a family member, friend, or pet, the ending of a relationship, the loss of a job, home or treasured object, the loss of good health or financial stability, the many losses associated with a global pandemic, or even the end of a dream or goal. This training will focus on losses due to death.

Grief can involve lots of different feelings, thoughts, and even physical reactions. Some people say grief comes in waves. Grief changes over time, and there is no time limit for grieving - people often grieve the loss of those closest to them for their entire lives.

Grief is different for everyone. Some common reactions to loss include:

- feeling sad, numb, exhausted, guilty, relieved, scared, or angry,
- being easily annoyed by little things,
- longing for the person who died,

- experiencing changes in sleeping or eating patterns,
- having difficulty getting out of bed in the morning to go to school or work,
- struggling to concentrate and complete tasks,
- losing interest in activities,

- worrying about one's safety or that of others,
- being afraid that others might die or being more aware of one's mortality,
- remembering the person who died or avoiding reminders of this person, and
- thinking about past losses.

It is really important to note that most people grieve and eventually adapt to a new way of living after experiencing a loss. For these individuals, counseling is not required but if desired, can provide support throughout the grieving process.

Now, please take a moment to think about what happens when someone really struggles as they grieve. What might they be feeling and experiencing?

For a small number of people, grief remains very intense for an extended period of time and they experience considerable difficulty completing the normal tasks of life. If the intensity of grief continues past 12 months, the client may be experiencing Prolonged Grief Disorder. Prigerson, Shear and their colleagues noted that some of the signs of this disorder include:

- acute feelings of longing and yearning for the deceased,
- continued preoccupation with the deceased,
- intense emotional pain and feeling that life has no meaning,
- difficulty functioning and an inability to adjust to the loss, and
- reactions that exceed typical grieving for the person's culture.

For those who are experiencing prolonged grief disorder or struggling to cope with the loss, counseling can make a powerful difference in their grieving journey.

What do you think are some factors that contribute to how people grieve?

There are many factors that play a role in how individuals grieve. Some risk factors are the circumstances of the death including the cause of death and how the person died - like whether the death was unexpected or violent like deaths due to suicide, homicide or accidents. Other risk factors include what led up to the death - was the deceased very ill or in pain before they died? - and how the griever was notified of the death.

Also important with regard to grieving is the relationship the griever had with the deceased – was the relationship close, complicated or conflictual? In addition, the client's prior mental health, attachment style, and existing support systems may play a role in their grieving. Prior losses and family conflict related to the death also contribute to how individuals grieve.

Additional influences on how people grieve include culture, traditions, generations within families, identities, and spiritual beliefs. These influences play a powerful role in grieving through beliefs about death and what happens when someone dies, cherished rituals at the time of and after death, acceptable forms of grieving, and how we remember the deceased.

For example, the clothing that is worn, the intensity and affective expressions of loss and sadness, and the traditions and practices to honor the deceased vary greatly across cultures and even within generations in families. For example, grandparents' beliefs and rituals related to grieving may differ from those of younger members in a family.

In addition, the degree to which others recognize the loss is an important factor in grieving. Some losses, like deaths by suicide, overdose, miscarriage, or the death of a close friend, may not be acknowledged and may even be stigmatized. The grief that accompanies losses that are not honored is referred to as "disenfranchised grief."

Finally, we know that people grieve in many different ways – even people grieving the same loss may have very different reactions. Several styles of grieving have been identified by Martin and Doka.

- Intuitive grievers focus on feelings and affect - they may cry, talk about their loved one, and seek therapy to process their feelings.
- Instrumental grievers get to work. They take action like figuring out finances or clearing belongings from the home.
- Blended grievers engage in a combination of both feeling-oriented and action-oriented tasks.
- Finally, dissonant grievers are people whose internal experiences do not match their external expressions. They hold their feelings in and will not allow expression of their emotions.

It would be helpful for therapists to think about their grieving style. How might you grieve the death of someone you love?

Sometimes, problems may emerge in relationships or families or among friends when the grieving styles of those in mourning do not match. For example, parents who are grieving the death of their child might experience difficulties in their relationship if their grieving styles do not match or if they have expectations for how their partner should grieve.

To summarize, we provided an overview of grief and highlighted that most people grieve and eventually adapt to a new way of living after experiencing a loss – without needing professional intervention. We also described challenges with grieving, characteristics of prolonged grief disorder and factors contributing to how people grieve. For those experiencing prolonged grief or wanting professional support, counseling can make a powerful difference in their lives. Finally, several styles of grieving were explained – remember that although all humans will experience loss, grief is unique, may come in waves, and has no time limit.

COMPONENT 2: GRIEF-RELATED MODELS

We now will provide an overview of several models that may inform your work when counseling grieving clients.

What models do you use when you work with grieving clients?

You may have heard of the **Five Stages of Grief** theory created by Kübler-Ross based on her earlier work with dying individuals. Although not intended, this theory often is interpreted as consisting of five sequential stages that include Denial, Anger, Bargaining, Depression, and Acceptance.

It is important to note that research does not support the stages that were proposed in the Kübler-Ross theory for grieving individuals. Grief is unique and many grieving individuals do not experience all or even most of these stages – and they definitely do not move through them in a sequential manner.

Therapists – and people who are grieving – should be very cautious if using this theory as grief should not be expected to correspond with the five stages. Grievers may feel that they are not grieving correctly if they do not experience each of the five stages.

One theory that shows much promise is the **Four Tasks of Mourning** theory developed by Worden. This theory emphasizes necessary “tasks” (not stages) of grieving that do **not** need to be addressed in a specific order. Grievers engage in “grief work” that consists of the following tasks:

- To accept the reality of the loss,
- To process the pain of grief,
- To adjust to the world without the deceased, and
- To find a way to remember the deceased while embarking on the rest of one’s journey through life.

Therapists should not misinterpret this theory as a sequential or a stage model. It is important to note that this theory does not address the growth that may occur as a result of the loss that the client experienced, something that will be discussed in some of the following theories.

Next, we would like to describe the **Dual Process Model of Coping with Bereavement**, advanced by Stroebe and Schut. This model is focused on the process of *coping* with loss with the assumption that if coping is effective, then the suffering associated with loss should eventually be reduced.

This model suggests that grieving may occur in doses and that grievers may oscillate between actively focusing on and processing the loss (or “loss-orientation”) and addressing secondary life stressors related to the death (or “restoration-orientation”). An example of loss-orientation is remembering and yearning for the deceased. Restoration-orientation could involve learning new tasks that the deceased used to do like paying bills or making family dinners.

An important and typically very helpful part of this model is the idea that grievers may take “time outs” from actively grieving. For example, a client mentioned that his work provided some respite from actively grieving the death of his mother. The client was relieved to learn that this was ok – and even recommended by this model.

One area not addressed by this model is the content of what the client might be working through as they grieve.

A model that resonates with many therapists is the **Meaning Reconstruction Model** created by Neimeyer and updated by Gillies and Neimeyer. This model emphasizes the importance of providing grieving clients with the opportunity to tell their grieving story and find meaning associated with their loss. According to this model, if a grieving client goes through the meaning-making process and finds this process helpful, the psychological distress associated with the death will lessen.

To construct meaning in response to the loss, grievers engage in three main activities:

- Sense-Making occurs when grievers strive to find reasons for what happened or “make sense” out of the loss; for example, they may try to understand why the death happened, why the death happened to the deceased and to them, and what this experience of loss means to them.

- Benefit Finding refers to trying to identify positive outcomes that occurred as a result of the loss – for example, some griever may reflect on how the deceased is no longer suffering or how some relationships have deepened after the death. It's important to note that benefits do not happen immediately after the loss but sometimes months or years later. Not everyone finds positive aspects from their loss.
- Identity Change refers to reconstructing oneself after the loss. For example, griever may report a changed sense of self, spiritual or personal growth, increased resilience, new relationships with others, continuing bonds with the deceased, or a new outlook on life.

It's important to emphasize that some clients may feel upset or misunderstood if therapists expect that the client will find meaning or benefits as a result of the loss; they may not want to engage in a meaning making process or experience positive outcomes after the loss. In therapy, it may be most helpful to recognize and reflect the moments where clients mention areas of growth or a desire to find meaning from their loss.

Related to this model is the idea of **Post-Traumatic Growth**, advanced by Tedeschi and Calhoun. Post-traumatic growth is positive change that occurs as a result of experiencing a challenging life event. Post-traumatic growth has occurred among individuals who experienced combat, life-threatening illness, and violence. Some grieving individuals also report post-traumatic growth after loss. Research on this construct has identified five manifestations of posttraumatic growth:

- Greater appreciation of life,
- More meaning and closeness in relationships,
- Increased sense of strength,
- New opportunities and possibilities, and a
- Deepening of spiritual life.

So far, we have talked about theories and models that address the tasks or process of grieving, how some clients engage in a search for meaning as they grieve, and how growth may occur after experiencing a loss. We now turn to a theory that focuses on the relationship that the griever had with the deceased.

An important aspect of counseling clients who are grieving is processing their relationship with person who died. **Continuing Bonds Theory** was proposed by Klass, Silverman and Nickman and focuses on how some griever might continue their relationship - or maintain continuing bonds - with the deceased after their death.

In the past, maintaining a connection with someone who died was seen as problematic – even pathological. In contrast, this theory states that continuing bonds may be healthy and normal for griever who want to maintain a connection with the deceased.

Researchers have identified two types of continuing bonds, internalized and externalized. Internalized continuing bonds reflect an internal process in which a connection to the deceased is maintained. Some examples include imagining talking to the deceased, thinking about special

memories of the deceased, or being aware of the positive influence that the deceased had on their lives.

Externalized continuing bonds include actions that maintain a connection with the deceased - for example, visiting a cemetery or memorial site, wearing jewelry that belonged to the deceased, and engaging in rituals to remember the deceased.

It's important to note that connections with the deceased do not remain fixed and static. They change and evolve over time - similar to relationships with the living.

Finally, some people do not want to maintain continuing bonds with the deceased – and that's ok, too. This sometimes occurs when the relationship was harmful or conflictual or if maintaining bonds is not consistent with their cultural norms or personal preference.

At this time, please reflect on which components of these models you would use in your work with grieving clients.

Appendix E

Control Condition Reading

GRIEF, LOSS, AND BEREAVEMENT

[Information is taken from the following website <https://www.goodtherapy.org/learn-about-therapy/issues/grief>]

Most people will experience **loss** at some point in their lives. **Grief** is a reaction to any form of loss. **Bereavement** is a type of grief involving the death of a loved one. Bereavement and grief encompass a range of feelings from deep sadness to anger. The process of adapting to a significant loss can vary dramatically from one person to another. It often depends on a person's background, beliefs, and relationship to what was lost.



GRIEVING THOUGHTS AND BEHAVIORS

Grief is not limited to feelings of sadness. It can also involve guilt, yearning, anger, and regret. Emotions are often surprising in their strength or mildness. They can also be confusing. One person may find themselves grieving a painful relationship. Another may mourn a loved one who died from cancer and yet feel relief that the person is no longer suffering.

People in grief can bounce between different thoughts as they make sense of their loss. Thoughts can range from soothing (“She had a good life.”) to troubling (“It wasn’t her time.”). People may assign themselves varying levels of responsibility, from “There was nothing I could have done,” to “It’s all my fault.”

Grieving behaviors also have a wide range. Some people find comfort in sharing their feelings among company. Other people may prefer to be alone with their feelings, engaging in silent activities like exercising or writing.

The different feelings, thoughts, and behaviors people express during grief can be categorized into two main styles: instrumental and intuitive. Most people display a blend of these two styles of grieving:

- **Instrumental grieving** has a focus primarily on problem-solving tasks. This style involves controlling or minimizing emotional expression.

- **Intuitive grieving** is based on a heightened emotional experience. This style involves sharing feelings, exploring the lost relationship, and considering mortality.

No one way of grieving is better than any other. Some people are more emotional and dive into their feelings. Others are stoic and may seek distraction from dwelling on an unchangeable fact of living. Every individual has unique needs when coping with loss.

MODELS OF GRIEF

Grief can vary between individuals. However, there are still global trends in how people cope with loss. Psychologists and researchers have outlined various models of grief. Some of the most familiar models include the five stages of grief, the four tasks of mourning, and the dual process model.

Five Stages of Grief

In 1969, Elisabeth Kübler-Ross identified five linear stages of grief:

- Denial
- Anger
- Bargaining
- Depression
- Acceptance

Kübler-Ross originally developed this model to illustrate the process of bereavement. Yet she eventually adapted the model to account for any type of grief. Kübler-Ross noted that everyone experiences at least two of the five stages of grief. She acknowledged that some people may revisit certain stages over many years or throughout life.

Four Tasks of Mourning

Psychologist J. W. Worden also created a stage-based model for coping with the death of a loved one. He divided the bereavement process into four tasks:

- To accept the reality of the loss
- To work through the pain of grief
- To adjust to life without the deceased
- To maintain a connection to the deceased while moving on with life

Dual Process Model

As an alternative to the linear stage-based model, Margaret Stroebe and Hank Schut developed a dual process model of bereavement. They identified two processes associated with bereavement:

Loss-oriented activities and stressors are those directly related to the death. These include:

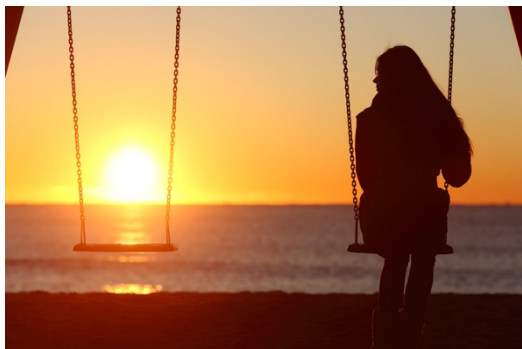
- Crying
- Yearning
- Experiencing sadness, denial, or anger
- Dwelling on the circumstances of the death
- Avoiding restoration activities

Restoration-oriented activities and stressors are associated with secondary losses. They may involve lifestyle, routine, and relationships. Restoration-oriented processes include:

- Adapting to a new role
- Managing changes in routine
- Developing new ways of connecting with family and friends
- Cultivating a new way of life.

Stroebe and Schut suggest most people will move back and forth between loss-oriented and restoration-oriented activities.

THE PROCESS OF RECOVERING FROM GRIEF



Everyone grieves in their own way and in their own time. Some people recover from grief and resume normal activities within six months, though they continue to feel moments of sadness. Others may feel better after about a year.

Sometimes people grieve for years without seeming to find even temporary relief. Grief can be complicated by other conditions, most notably depression. The person's level of dependency on the departed can also cause complications.

The grieving process often involves many difficult and complicated emotions. Yet joy, contentment, and humor do not have to be absent during this difficult time. Self-care,

recreation, and social support can be vital to the recovery. Feeling occasional happiness does not mean a person is done mourning.

Grieving the loss of a loved one be a difficult process, whether the loss is due to death, a breakup, or other circumstance. One of the hardest challenges is adjusting to the new reality of living in the absence of the loved one. Adjusting may require a person to develop a new daily routine or to rethink their plans for the future. While creating a new life, a person may adopt a new sense of identity.

COMPLICATED GRIEF

The experience of grief is not something a person ever recovers from completely. However, time typically tempers its intensity. Yet an estimated 15% of people who have lost a loved one will experience “complicated grief.” This term refers to a persistent form of bereavement, lasting for one year or more.

Again, the length of time it takes for a person to grieve is highly variable and dependent on context. But when symptoms persist without improvement for an extended period, they may qualify as complicated grief. In addition, the symptoms of complicated grief to be more severe. Complicated grief often dominates a person’s life, interfering with their daily functioning.

Prolonged symptoms may include:

- Intense sadness and emotional pain
- Feelings of emptiness and hopelessness
- Yearning to be reunited with the deceased
- Preoccupation with the deceased or with the circumstances of the death
- Difficulty engaging in happy memories of the lost person
- Avoidance of reminders of the deceased
- A reduced sense of identity
- Detachment and isolation from surviving friends and family
- Lack of desire to pursue personal interests or plans

The Diagnostic and Statistical Manual (DSM-5) does not classify complicated grief as a clinical condition. Yet it does include diagnostic criteria for “persistent complex bereavement disorder” in the section of conditions requiring further study.

BROKEN HEART SYNDROME



Generally speaking, grief cannot kill a person. That said, there are cases in which severe stress could harm an otherwise healthy person's heart. When a person experiences a shocking event, their body fills with stress hormones. These hormones can cause part of a person's heart to briefly swell and stop

pumping. The rest of the heart continues beating, causing blood to flow unevenly. A person may feel intense chest pain, similar to a heart attack (but unlike a heart attack, the arteries are not blocked). This temporary malfunction is called "broken heart syndrome." As the name suggests, the broken heart syndrome often follows news of loss, such as a divorce or death of a loved one. Yet symptoms can also appear after a good shock, such as winning the lottery. Women are more likely than men to develop the condition. Most people who experience broken heart syndrome recover within weeks. Deaths from the condition are rare. Since the syndrome is prompted by a shocking event, people have a low risk of experiencing it twice.

DEPRESSION AND GRIEF

The DSM-5 does not define bereavement as a disorder. Yet typical signs of grief, such as social withdrawal, can mimic those of depression.

So how can one tell the difference between grief and depression?

- Grief is typically preceded by loss. Depression can develop at any time.
- The sadness present in grief is typically related to the loss or death. Depression is characterized by a general sense of worthlessness, despair, and lack of joy.
- Symptoms of grief may improve on their own with time. Someone with depression often needs treatment to recover.

Despite their differences, depression and grief are not mutually exclusive. If someone is vulnerable to depression, grief has the potential to trigger a depressive episode. If someone already has depression, their condition may prolong or worsen the grieving

process. A therapist can help a person in mourning recognize and manage any depressive symptoms.

BEREAVEMENT AND CULTURE

Certain aspects of grief are virtually universal. Most cultures have rituals of mourning after a death. Crying is common, regardless of a person's origins. However, the bereavement process can vary dramatically depending on one's culture. Cultural values may affect a person's:

- **Attitude toward death:** Many Western cultures display death-denying traits. Death is often depicted as something to fight or resist. Eastern cultures, meanwhile, tend to characterize death to be a part of life. Death is often considered more of a transition than an end. Research suggests people in death-denying cultures tend to have more anxiety around death than people in death-accepting cultures.
- **Remembrance of the deceased:** Some cultures, such as the Hopi or Achuar peoples, grieve by attempting to forget as much of the deceased as possible. It may be taboo for loved ones to say the person's name or to touch their belongings. Rituals are done to sever connections with the dead. Other cultures mourn by sharing memories of the deceased. People in the Akan region of Ghana often hold elaborate funerals which may cost a full year's income. The deceased are typically placed in "fantasy coffins" personalized with symbols of their life.
- **Emotional Displays:** Social norms can differ regarding how much emotion is "appropriate" to show. A 1990 study compared bereavement norms in two Muslim societies. Mourners in Egypt may be encouraged to grieve for an extended period of time. A person might display their love for the deceased through displays of unrestrained emotion. Meanwhile, Balinese culture tends to pathologize overt sorrow. People are encouraged to put on a happy face in front of others and to cut ties with the deceased.

When analyzing grieving behaviors, context matters as much as the symptoms themselves. Bereavement trends which are typical in one culture may be stigmatized in

another. When working with individuals in grief, therapists may need to keep cultural influences in mind.

DISENFRANCHISED GRIEF

Disenfranchised grief occurs when a person's mourning is restricted in some way. Society may stigmatize a person's mourning process or refuse to acknowledge their loss. Grief may be disenfranchised for several reasons:

- **Society devalues the loss.** The loss of a pet often garners less sympathy than the loss of a human relative. Others may say “it was just an animal” and accuse the person of being too emotional. Yet research shows the mourning period for a pet is about the same length as for a human family member.
- **The loss is ambiguous.** An adopted child may grieve the loss of their birth parents, even if said adults are alive. If a loved one has late-stage dementia, family members may feel as if the person they knew is gone.
- **Society stigmatizes the circumstances of the loss.** Pregnancy-related loss is often considered taboo. Women who undergo a miscarriage may feel guilt and shame. They may avoid telling others about the loss to avoid being blamed.
- **Society doesn't recognize the person's relationship to the deceased.** A co-worker or friend may mourn a person, but they will likely receive less support than a family member. The same is true for ex-spouses, even though they used to be family. In societies with systemic homophobia, same-sex partners may also have disenfranchised grief.
- **Others do not consider the person capable of grief.** When young children experience loss, adults may misinterpret signs of bereavement. They may believe the child is not capable of understanding the loss or have prolonged feelings about it. People who have cognitive impairments or intellectual disabilities may also have disenfranchised grief.

Disenfranchised grief can interfere with the bereavement process. If society does not recognize a loss, the person may have trouble accepting it themselves. They may try to repress or deny their emotions. Shame and secrecy can make the symptoms of grief more severe.

Social support is often vital to recovery. A community can provide emotional and financial aid when people are vulnerable. Mourning rituals can offer closure. If a person is forced to grieve alone, they may have a delayed recovery.

If you have lost someone or something precious, you may wish to find a therapist. Therapy can help with any sort of loss, whether society validates the grief or not. Therapy is an opportunity to explore your feelings and memories without judgment. No loss is too big or too small to warrant support. You do not have to endure your grief alone.

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GETTING HELP FOR GRIEF, LOSS, AND BEREAVEMENT



Grief is often painful, but for some people, the emotions can become overwhelming. When a person's grief is severe and unrelenting, a therapist can offer support. In time, a person can recover from their loss and adjust to a new life.

THERAPY FOR GRIEF AND BEREAVEMENT

Each experience of grief is unique, complex, and personal. Grief may concern the death of a loved one, or it could involve a life change such as divorce or job loss. Your

culture, personality, and experience can all affect the grieving process. Therapists will tailor treatment to meet your specific needs.

For example, therapy may help you maintain healthy connections with your lost loved one. Many people find catharsis while talking about their loved ones. Reflection on positive memories can strengthen your bond with the lost person. As you reaffirm your bond, you may feel less sting from your loss.

That said, some people may become overly attached to the deceased. In complicated grief, a person may feel hopeless and desire to join the lost loved one in death. A therapist can help you adjust to life without your loved one. They may also help you strengthen bonds with surviving friends and family.

Another common goal in therapy is to process your feelings. Society may stigmatize you for grieving a certain way. But in therapy, you can express your feelings without judgment. A therapist can help you address any guilt or regret you have regarding the deceased.

Joint therapies are also available for people in grief. In group therapy, you may find solace in sharing thoughts and feelings with other mourners. Recovery results are often rapid in this setting. Family therapy may be suitable for a family who is struggling to adapt to the loss of a member.

HELPING CHILDREN GRIEVE



Children may not understand their loss at first. Young kids may believe the deceased will come back. They may also believe they are in danger of dying. However, children are capable of understanding death, so long as adults explain it to them in simple and direct terms.

In some cases, a death may change a child's daily routine. For instance, a widowed parent may need to hire a babysitter while they are at work. Adults can help children feel

less anxious by letting them know what to expect. Children often feel more secure in a predictable environment.

Children often look to their guardians for how to grieve. If an adult hides their sadness, a child will likely try to do the same. When adults talk about their emotions, children can learn to recognize and accept the feelings in themselves. Adults can teach healthy ways to cope with strong feelings, as opposed to withdrawing or lashing out.

Children may have trouble verbalizing their thoughts at first. The immediate nature of their grief may overwhelm them. Certain activities, such as storytelling or play, can help them talk about loss from a mental distance. Children often find it easier to speak about a sad character than about themselves.

A child counselor can help children grieve in a healthy manner. Children who have lost a caregiver or sibling may benefit from family therapy.

SELF-CARE FOR GRIEF

Bereavement can involve a lot of vulnerability and pain. Like a physical injury, the emotional wounds of loss often take time to recover. If you are grieving, it is vital that you take care of yourself.

Self-care can take different forms. During the grieving process, there are five aspects of yourself that may need healing.

1. The Physical Aspect

Stress from grief can cause changes in your body. You may feel unexplained aches, sleep issues, or changes in appetite. Fatigue is especially common. Don't be surprised if you need more rest than usual.

During this time, routine can provide a sense of stability. A nutritious diet can reduce stress, so try to eat three meals a day, even if you are not hungry. A set sleep schedule can help stabilize energy levels as well. That said, be gentle with yourself. A nap or a snack can go a long way to providing comfort.

2. The Cognitive Aspect

Your mental state may be compromised during bereavement. You may have trouble focusing or making decisions. Like the rest of your body, your brain may need a bit of a break.

You may wish to restrict or avoid alcohol use during this time. Although alcohol may make you feel temporarily better, it is not a long-term solution to grief.

3. The Emotional Aspect

You may be overwhelmed with emotion, or you may feel completely numb. There are no “bad” feelings during grief. Remember to be patient and have self-compassion. During this time, you may need to be proactive about pursuing happiness. If you know you have an activity to look forward to, you may find it easier to get out of bed in the morning. That activity could be eating lunch with friends, watching a favorite show, or relaxing in a warm bath.

Many mourners find comfort in listening to music. Happy music may cheer a person up. Sad music can be cathartic. You may prefer different music at different stages of the grieving process. A song tied to the deceased may be too painful to listen to at first but grow nostalgic as time passes.

4. The Spiritual Aspect

When a loved one dies, it often sparks questions about death and life. People who have strong spiritual beliefs may find comfort in talking to their religious leaders. Rituals of mourning can provide validation.

Some people have no defined belief system, yet they may still seek to clarify their relationship with death and find meaning in life. Some may join a support group for people with existential questions. Others may find their own answers through meditation. Nurturing one’s spiritual self can be as vital as self-care in any other realm.

5. The Social Aspect

Grief is a difficult process to go through alone. Social support can make recovery easier. Friends and family can help you with daily responsibilities as you recover. They can also offer emotional support.

When a person dies, the dynamics between their loved ones may change. You may find yourself growing closer to some people and further from others. Different people can fill distinct needs. One friend may offer a shoulder to cry on. Another may be more suited for days when you need cheering up. Being honest about your needs can help prevent misunderstandings.

Your surviving loved ones cannot replace the deceased. However, they can help you recover from the loss.

Therapy can also be an important part of self-care. A licensed therapist can offer assistance with any of the aspects above. There is no shame in seeking help.

CASE EXAMPLE OF THERAPY FOR BEREAVEMENT

- **Mourning multiple losses:** Rhonda, 57, had a sudden breakdown after her sister passed away. She stopped working, becoming anxious and depressed. A month after her breakdown, Rhonda decides to seek therapy. A full history reveals she had been the sole caretaker for her sister, who had been ill for years and required constant assistance. During the time of the illness, Rhonda's parents had both died of natural causes. Rhonda says she never had the time or emotional energy to mourn her parents' death. In therapy, Rhonda realizes she resented her sister, explaining why Rhonda had not mourned her death either, even though she felt guilty about it. Also, she been so caught up in her family duties that she'd had little time to develop her own hobbies. The therapist helps Rhonda face her intense feelings of sadness and loss. Her anxiety slowly dissolves. After a time of rest to fully grieve, Rhonda feels ready to return to work. With the support of a therapist and a close friend, she finds the strength to build a new life.

References:

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3. Goldman, L. (2015). What complicates grief for children: A case study [PDF]. *Healing Magazine*. Retrieved from <https://bit.ly/2xuXNGW>
4. Nurturing yourself when you're grieving. (2016, December 14). Center for Loss & Life Transition. Retrieved from <https://www.centerforloss.com/2016/12/nurturing-youre-grieving>

Appendix F

Eligibility Checklist

[Please note that the eligibility for the current study was different than the eligibility for the general study. Current study sample consisted only of the U.S.-based doctoral students in the counseling and clinical Psychology programs]

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

1. Are you currently enrolled in a Masters or doctoral program in a mental health field (e.g., counseling or clinical psychology, counselor education)?

- ☐ Yes
- ☐ No

2. Are you currently working as a therapist or counselor who received your degree in counseling or clinical psychology or counselor education?

- ☐ Yes
- ☐ No

3. Do you currently reside in the United States?

- ☐ Yes
- ☐ No

4. Do you currently reside in Korea?

- ☐ Yes
- ☐ No

Appendix G

Grief and Grief Counseling Knowledge Assessment

Please choose your level of knowledge regarding the following concepts and terms using the following scale:

- 0 = Not at all knowledgeable
- 1 = Slightly knowledgeable
- 2 = Somewhat knowledgeable
- 3 = Moderately knowledgeable
- 4 = Extremely knowledgeable

1. Definition of grief
2. Common grief reactions
3. Symptoms of prolonged grief disorder
4. Assessment of prolonged grief disorder
5. Protective factors in grieving
6. Risk factors that might predict challenges with grieving
7. Five Stages of Grief theory (i.e., Kübler-Ross)
8. Four Tasks of Grief model (i.e., Worden)
9. Grief Integration theory (i.e., Jung et al.)
10. Dual Process Model of Grief (i.e., Stroebe & Schut)
11. Meaning Reconstruction Model (i.e., Neimeyer et al.)
12. Continuing Bonds Theory (i.e., Klass, Silverman, & Nickman)
13. Waves of Mourning Theory (i.e., Lee)
14. Post traumatic growth following loss
15. Grieving styles (i.e., Doka)
16. Disenfranchised grief (i.e., Doka)
17. Salient cultural or generational considerations in grief
18. Important components of grief counseling
19. The specific components of the 3-Factor Grief Counseling Model
20. Helpful grief counseling techniques (e.g., empty chair, two chair, journaling)

Appendix H

Grief Counseling Knowledge: Case Vignette

Kim is a 50-year old woman who comes in to see you for support after her husband's death 7 months ago. Kim's husband had advanced lung cancer and had undergone extensive treatment consisting of multiple surgeries, many rounds of chemotherapy and radiation. Kim was struggling with intense anxiety throughout her husband's treatment and had a particularly hard time seeing the various invasive medical procedures that he received. Toward the end of his illness, Kim's husband wanted to stop chemotherapy, but Kim disagreed and with the help of their doctor convinced him to try another round of treatment. Unfortunately, her husband developed an adverse reaction to the treatment and died in the Intensive Care Unit (ICU) after spending almost 4 months in the hospital. Kim was by his side at the time of his death.

Since the loss, Kim has been struggling and reports feeling like a part of herself has died. She really misses her husband and feels lonely, withdrawn, and guilty about encouraging another round of treatment. Kim has little desire to teach anymore; previously, her work as a teacher was a meaningful and rewarding part of her life. Kim resides in an apartment alone with her beloved dog. She is hesitant to discuss her feelings with her son who is attending college and lives in another city.

1. Now, we would like you to imagine yourself as Kim's therapist. What would you want to assess as you conceptualize her case and plan her treatment? What specific assessment questions would you ask her directly or consider indirectly? List the four most important assessment questions/domains that you would focus on – please list **only** the top four most important questions/domains:

Assessment question/domain #1: _____

Assessment question/domain #2: _____

Assessment question/domain #3: _____

Assessment question/domain #4: _____

2. Next, think about a possible treatment plan for your work with Kim. How will you structure your treatment and what will you focus on when trying to address her grief? What are the four most important treatment plan steps or treatment domains that you would focus on throughout your work? Please list **only** the top four most important steps/domains:

Treatment plan step/domain #1: _____

Treatment plan step/domain #2: _____

Treatment plan step/domain #3: _____

Treatment plan step/domain #4: _____

3. Describe four ways that you could use the 3-Factor Grief Counseling Model with this client:

#1: _____

#2: _____

#3: _____

#4: _____

Appendix I

Grief Counseling Self-Efficacy

(This measure was based on the DCS Part II: Skills and Knowledge Grief Counseling Competencies [Charkow, 2001] measure and was then edited by the authors for the purposes of the current study. See the Method section for details.)

Please rate your confidence in your ability to currently perform the following skills on this scale:

- 1 = Very low confidence
- 2 = Low confidence
- 3 = Some confidence
- 4 = Moderate confidence
- 5 = Very high confidence

Conceptual skills and knowledge
1. Define and articulate the nature of “normal” bereavement and grief as detailed by theoretical models.
2. Describe general differences in the grief experience as determined by different status and process variables (i.e. personality, relationship to the deceased).
3. Define and articulate the nature and symptoms of prolonged/unresolved grief.
4. Describe common functional coping styles of bereaved persons.
5. Describe common dysfunctional coping styles of bereaved persons.
6. Describe how various individual counseling theories can be applied to grief counseling with individuals and families.
7. Consider the limitations of grief-related theories when conducting grief counseling.
8. Articulate the problems associated with Kübler Ross Five Stage model.
9. Respect the client’s unique process of grieving.
10. Identify which of the grief-related tasks the client is working on.
11. Describe the oscillating aspect of the grieving process.
12. Recognize the specific areas of posttraumatic growth in the client.
13. Describe the differences between externalized and internalized continuing bonds.
14. Articulate the diagnostic criteria for Prolonged Grief Disorder.
Assessment skills
1. Assess for unresolved losses that may not be stated as a presenting problem.
2. Assess the client’s beliefs related to death and grieving.
3. Assess the client’s progress on theoretically defined grief tasks.
4. Identify cultural or generational differences that affect assessment of the client’s grief.
5. Identify symptoms that warrant medical evaluation and referral to a physician.
6. Assess the client’s current functioning (e.g., sleep, nutrition, concentration, motivation).
7. Assess the client’s relationship with the deceased.
8. Conduct an assessment for Prolonged Grief Disorder
9. Assess the client’s existing social support.
Treatment skills

1. Provide grief-related psycho-education to the client.
2. Facilitate individual grief counseling sessions.
3. Use concrete terms regarding death.
4. Teach a grieving client how to obtain support and resources in the community.
5. Provide a safe therapeutic environment for a grieving client.
6. Identify cultural or generational differences that affect treatment for a grieving client.
7. Exhibit effective active listening skills with a grieving client.
8. Explain the 3-Factor Grief Counseling Model to a grieving client.
9. Provide hope without giving false reassurance to a grieving client.
10. Support the client as they create ways to remember the deceased (if desired).
11. Provide a supportive presence for a grieving client in difficult times.
12. Assist a grieving client in completing necessary life tasks (e.g., working, socializing).
13. Support a client to identify and deal with new responsibilities that they may have after loss.
14. Validate the client's feelings related to grieving.
15. Support the client to engage in life without the deceased.
16. Facilitate areas of growth that the client may experience after loss.
17. Facilitate meaning making that the client may experience after loss.
18. Notice any unfinished business that may be associated with the loss.
19. Use counseling techniques (e.g., empty chair, journaling) with a grieving client based on their needs.
20. Help the client find their own way to maintain continuing bonds with the deceased (if desired).
Professional skills
1. Apply current research and literature related to grief and effective treatment interventions.
2. Use the 3-Factor Grief Counseling Model when working with a grieving client.
3. Accurately assess your readiness to provide grief counseling.
4. Seek support when providing grief therapy becomes challenging.

Appendix J

Grief Counseling Experience and Training

Grief Counseling Experience and Training Survey (GCETS; Ober, 2012)

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. At this point in my professional development, I feel competent, skilled and qualified to counsel clients who present with grief.
5. I have a great deal of experience counseling persons who experienced loss of a loved one to suicide.
6. I have a great deal of experience counseling children who present with grief.
7. I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling.
8. I feel competent to assess the mental health needs of a person who presents with grief in a therapeutic setting.
9. I have a great deal of experience with facilitating group counseling focused on grief concerns.
10. Currently, I do not have sufficient skills or training to work with a client who presents with grief.
11. I have done many counseling role-plays (as either the client or counselor) involving grief concerns.
12. I have sufficient knowledge of grief counseling theories and models.

Appendix K

Evaluation of Intervention

You are almost done! Now, we would like to ask you to evaluate the intervention. Please answer the following questions honestly:

1. I learned new information about **grief** from the intervention.
 - 1- Strongly disagree
 - 2- Disagree
 - 3- Neither agree or disagree
 - 4- Agree
 - 5- Strongly agree
2. I learned new information about **grief-related models** from the intervention.
 - 1- Strongly disagree
 - 2- Disagree
 - 3- Neither agree or disagree
 - 4- Agree
 - 5- Strongly agree
3. I learned new information about **the 3-Factor Grief Counseling Model** from the intervention.
 - 1- Strongly disagree
 - 2- Disagree
 - 3- Neither agree or disagree
 - 4- Agree
 - 5- Strongly agree
4. I plan to apply the **3-Factor Grief Counseling Model** to my work with grieving clients.
 - 1- Strongly disagree
 - 2- Disagree
 - 3- Neither agree or disagree
 - 4- Agree
 - 5- Strongly agree
5. What was most helpful about this intervention?
6. How could this intervention be improved?

Appendix L

Demographics

1. Your age (in years): _____
2. Gender:
☐ Woman ☐ Man
☐ Non-binary or gender queer ☐ Prefer to self-describe _____
3. Do you identify as transgender?
☐ Yes ☐ No
4. In which country are you currently residing?
☐ Korea
☐ United States
☐ Other, please specify _____
5. Race/Ethnicity (please check all that apply):
☐ American Indian or Alaska Native
☐ Biracial/Multiracial
☐ Black or African
☐ Chinese
☐ Filipino
☐ Hispanic/Latinx
☐ Indian
☐ Japanese
☐ Korean
☐ Middle Eastern
☐ Mongolian
☐ Native Hawaiian or Pacific Islander
☐ Vietnamese
☐ White or European
☐ Other (please specify: _____)
6. Sexual orientation:
☐ Bisexual ☐ Heterosexual ☐ Lesbian, Gay, or Homosexual
☐ Prefer to self-describe _____
7. What is your highest educational degree?

- ☐ Associate of Arts (A.A.) or Associate of Science (A.S.)
- ☐ Bachelor of Arts or Science (B.A./B.S.)
- ☐ Master of Arts (M.A.) or Master of Science (M.S.)
- ☐ Doctoral degree (e.g., Ph.D., Psy.D.)

8. Are you currently a graduate student?

- ☐ Yes ☐ No

9. If you are a graduate student, year in your current graduate program:

- ☐ Completed graduate study
- ☐ First year
- ☐ Second year
- ☐ Third year
- ☐ Fourth year
- ☐ Fifth year
- ☐ Sixth year
- ☐ Seventh year or beyond

10. What is your area of study and degree sought?

- ☐ Counseling Psychology Ph.D.
- ☐ Counseling Psychology Psy.D.
- ☐ Counseling Psychology Masters M.A./M.S.
- ☐ Clinical Psychology Ph.D.
- ☐ Clinical Psychology Psy.D.
- ☐ Clinical Psychology Masters M.A./M.S.
- ☐ Other, please specify: _____

11. Approximate number of direct counseling/clinical hours accrued to date (e.g., these might be counseling/clinical hours received while providing treatment/assessment in your work, practica, externship, internship): _____

12. Have you obtained licensure for the practice of counseling/psychotherapy?

- ☐ Yes
☐ No

13. Please choose all the counseling/clinical training sites where you are currently working or worked previously (select all that apply):

- ☐ University Counseling Center
 - ☐ Current
 - ☐ Previously
- ☐ University training clinic
 - ☐ Current
 - ☐ Previously
- ☐ Community clinic/center
 - ☐ Current
 - ☐ Previously
- ☐ Hospital or medical center
 - ☐ Current
 - ☐ Previously
- ☐ VA or other military medical center
 - ☐ Current
 - ☐ Previously
- ☐ Other, please specify: _____
 - ☐ Current
 - ☐ Previously

14. Typically what percentage of your caseload are clients presenting with grief issues/bereavement?

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

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

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

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

- ☐ Took grief counseling or death education courses in graduate program
 - ☐ Was this a required course?
- ☐ 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) or 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
- ☐ Facilitated a grief counseling group

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

- ☐ Yes ☐ No

18. To what degree do any of these deaths feel unresolved or unfinished?

- 1- Extremely unresolved/unfinished
- 2 - Very unresolved/unfinished
- 3 - Slightly unresolved/unfinished
- 4 - Mostly resolved
- 5 - Completely resolved

19. Rate the following: For *therapists in training (i.e., graduate students)*, education in grief counseling is:

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

20. Rate the following: For *psychologists*, ongoing/continuing education in grief counseling is:

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

21. 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

22. Would you like to share any comments with the researchers? _____

Appendix M

Validity Check Questions

1. Please select “not at all knowledgeable” for this item.
2. Please select “very high confidence” for this item.

Table 1*Demographics (n =169)*

Variable	Total	
	%	<i>n</i>
Race/Ethnicity		
White or European	59.8	101
Asian/ Asian American	17.7	30
Biracial/Multiracial	9.5	16
Black/African American	6.5	11
Hispanic/Latinx	2.9	5
Middle Eastern	2.4	4
Other	1.2	2
Gender		
Woman	79.9	135
Man	16.0	27
Non-binary/Gender queer/Gender flexible	4.1	7
Transgender		
No	98.8	167
Yes	1.2	2
Sexual orientation		
Straight (Heterosexual)	69.8	118
Bisexual	14.8	25
Lesbian, Gay, Homosexual	6.5	11
Queer	3.5	6
Asexual	2.4	4
Other (Prefer to self-describe)	1.8	3
Did not answer	1.2	2
Have you experienced any significant deaths in your life?		
Yes	71.0	120
No	29.0	49
To what degree do any of these losses feel unresolved or unfinished?		
Mostly resolved	43.3	52
Completely resolved	30.0	36
Slightly unresolved/unfinished	19.2	23
Very unresolved/unfinished	6.7	8
Extremely unresolved/unfinished	0.8	1

Table 2*Professional Background and Education (n =169)*

Variable	Total	
	%	<i>n</i>
Highest educational degree		
Master of Arts (M.A.) or Master of Science (M.S.)	67.5	114
Bachelor of Arts (B.A.) or Bachelor of Science (B.S.)	26.0	44
Doctoral degree (e.g., Ph.D., Psy.D.)	6.5	11
Area of study and degree sought		
Counseling Psychology Ph.D.	50.3	85
Clinical Psychology Ph.D.	23.7	40
Clinical Psychology Psy.D.	19.5	33
Counseling Psychology Psy.D.	6.5	11
Year in current graduate program		
2 nd Year	24.9	42
3 rd Year	20.1	34
4 th Year	18.3	31
5 th Year	16.0	27
1 st Year	15.4	26
6 th Year	3.0	5
7 th Year and beyond	2.4	4
Have you obtained licensure for the practice of counseling/psychotherapy?		
No	95.3	161
Yes	4.7	8
Typically what percentage of your caseload are clients dealing with grief issues/bereavement?		
1-5%	30.8	52
0%	20.7	35
6-10%	17.1	29
11-20%	16.6	28
21-40%	8.9	15
41-70%	3.5	6
71-100%	1.2	2
Did not answer	1.2	2
In all of your years of doing therapy, how often have you worked with bereaved clients?		
Rarely	56.8	96
Fairly often	18.9	32
Never	17.8	30
Often	3.0	5
Very often	1.8	3
Did not answer	1.8	3

Counseling/clinical training sites where you are currently working or worked previously:

University training clinic	53.2	90
Community clinic/center	49.1	83
University counseling center	47.9	81
Hospital or medical center	31.4	53
VA or other military medical center	13.0	22
Other	13.0	22

Have you done any of the following?

Read books or other educational material on grief counseling	42.6	72
Received grief counseling experience/training in practica/externship/internship	23.7	40
Worked with terminally-ill clients	9.5	16
Volunteered/worked in hospice	8.9	15
Took grief counseling or death education courses in graduate program	5.9	10

Was this a required course?

No	100.0	10
Facilitated a grief counseling group	5.9	10
Were/are a primary caregiver to someone critically ill	5.3	9
Attended professional conferences that focused on grief counseling or death education	4.7	8
Took continuing education courses in grief counseling or death education	4.1	7
Received other certification in grief counseling	0.6	1

For therapists in training (i.e., graduate students), education in grief counseling is:

Very important	62.1	105
Important	36.1	61
Moderately important	1.8	3

For psychologists, ongoing/continuing education in grief counseling is:

Very important	57.4	97
Important	33.7	57
Moderately important	7.1	12
Did not answer	1.8	3

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

Very interested	58.6	99
Interested	33.1	56
Moderately interested	5.9	10
Slightly interested	2.4	4

Table 3*Means, Standard Deviations, Reliability Estimates, and Intercorrelations (n = 169)*

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Grief and Grief Counseling Knowledge (Pre)	1												
2. SE: Conceptual Skills and Knowledge (Pre)	.87**	1											
3. SE: Assessment Skills (Pre)	.64**	.74**	1										
4. SE: Treatment Skills (Pre)	.55**	.62**	.78**	1									
5. SE: Professional Skills (Pre)	.56**	.66**	.66**	.70**	1								
6. Grief and Grief Counseling Knowledge (Post)	.46**	.41**	.29**	.22**	.19**	1							
7. SE: Conceptual Skills and Knowledge (Post)	.51**	.55**	.41**	.38**	.35**	.86**	1						
8. SE: Assessment Skills (Post)	.49**	.54**	.68**	.59**	.48**	.68**	.76**	1					
9. SE: Treatment Skills (Post)	.47**	.50**	.54**	.66**	.45**	.64**	.74**	.82**	1				
10. SE: Professional Skills (Post)	.40**	.38**	.32**	.33**	.44**	.70**	.74**	.67**	.72**	1			
11. GCETS: Grief Counseling Experience and Training Survey	.65**	.67**	.42**	.45**	.39**	.32**	.42**	.38**	.42**	.32**	1		
12. Evaluation of Intervention (Learning about Grief and Grief Models)	-.11	-.06	-.03	-.08	-.11	.44**	.41**	.24**	.19**	.32**	-.10	1	
13. Evaluation of Intervention (Learning about 3-Factor Grief Counseling Model)	.02	-.00	-.06	-.11	-.03	.34**	.34**	.19**	.20**	.47**	.04	.43**	1
Mean	.98	2.11	2.86	3.24	2.55	2.20	3.31	3.69	3.80	3.32	1.77	4.46	3.27
(SD)	(.56)	(.69)	(.80)	(.73)	(.66)	(.70)	(.74)	(.73)	(.63)	(.76)	(.50)	(.61)	(1.40)
Actual Range	0-3.22	1-4.14	1-4.44	1-4.60	1-4.25	.17-4	1.21-5	1.56-5	1.60-5	1-5	1-3.17	2-5	1-5

Possible Range	0-4	1-5	1-5	1-5	1-5	0-4	1-5	1-5	1-5	1-5	1-5	1-5	1-5
Cronbach Alpha	.90	.92	.90	.95	.58	.93	.94	.91	.95	.67	.83	.83	.90

Note: ** $p < .01$.

Table 4*Results of Post Hoc Tests for Pre- to Post-test Grief and Grief Counseling Knowledge**(n = 169)*

Dependent Variable	Full Intervention M (n = 43)	Partial Intervention M (n = 58)	Control M (n = 68)
Grief and Grief Counseling Knowledge	2.62 _a	2.19 _b	1.93 _c

Note. Estimated marginalized means that do not share subscripts within the same row differ, $p < .02$.

Results of Post Hoc Tests for Pre- to Post-test Grief Counseling Self-Efficacy (n = 169)

Dependent Variable	Full Intervention M (n = 43)	Partial Intervention M (n = 58)	Control M (n = 68)
1. Self-Efficacy: Conceptual Skills and Knowledge	3.70 _a	3.36 _b	3.03 _c
2. Self-Efficacy: Assessment Skills	4.00 _a	3.59 _b	3.58 _b
3. Self-Efficacy: Treatment Skills	4.13 _a	3.66 _b	3.73 _b
4. Self-Efficacy: Professional Skills	3.93 _a	3.15 _b	3.08 _b

Note. Estimated marginalized means that do not share subscripts within the same row differ, $p < .004$.

Note. Estimated
marginalized
means that do
not share
subscripts
within the same
row differ, $p < .001$.

Evaluation of Intervention (Learning about Grief and Grief Models)	4.80 _a	4.61 _a	4.12 _b
Evaluation of Intervention (Learning about 3-Factor Grief Counseling Model)	4.66 _a	3.36 _b	2.32 _c

Table 7*Pre-Intervention: Assessment Questions/Domains in Vignette Responses (n = 169)*

Theme	Total (757)	
	%	n
1. Social support/relationships	15.2	115
2. Emotional state/mood assessment	11.8	89
3. Risk assessment (i.e., suicidal ideation, self-harm)	10.4	79
4. Symptoms of mental health disorder (e.g., depression, anxiety, PTSD, adjustment)	8.7	66
5. Coping strategies/selfcare/pleasurable activities	5.8	44
6. Daily physical functioning (i.e., sleep, eating)	3.6	27
7. Meaning in life, values	3.3	25
8. Relationship with son	2.9	22
9. Engagement in daily life/activities/tasks	2.8	21
10. Relationship with husband before his death	2.6	20
11. Goals in therapy	2.4	18
12. Areas of life affected by husband's death	2.4	18
13. Cognitions around loss experience	2.2	17
14. Circumstances of husband's death	2.0	15
15. Previous loss history	1.8	14
16. Changes in identity	1.7	13
17. Future goals/motivation/hopes for self	1.7	13
18. Previous mental health history and/or use of therapy	1.5	11
19. Culture and important identities	1.5	11
20. Her spiritual/religious beliefs and coping	1.2	9
21. Existential concerns, beliefs about death/afterlife	1.2	9
22. Resilience factors/protective factors/strengths	1.1	8
23. Mourning behaviors (e.g., grief expression, rituals)	1.1	8
24. Duration of symptoms since the loss	0.9	7
25. Meaning making of the loss	0.9	7
26. Kübler-Ross 5 Stages of Grief model assessment	0.8	6
27. Avoidant behaviors (e.g., avoiding reminders of loss)	0.7	5
28. Current work situation	0.7	5
29. Prolonged grief disorder (or complicated grief)	0.5	4
30. Relationship with husband after his death (e.g., continuing bonds, legacy)	0.5	4
31. Financial situation/concerns	0.4	3
32. Other	4.9	37
0. I don't know/NA	0.9	7

Table 8*Post-Intervention: Important Assessment Questions/Domains in Vignette Responses**(n = 169)*

Theme	Total (812)	
	%	n
1. Social support/relationships	12.4	101
2. Culture and important identities	7.5	61
3. Emotional state/mood assessment	7.1	58
4. Daily physical functioning (i.e., sleep, eating)	6.5	53
5. Risk assessment (i.e., SI, self-harm)	6.5	53
6. Relationship with husband before his death	5.8	47
7. Coping strategies/selfcare/pleasurable activities	4.7	38
8. Areas of life affected by husband's death	3.6	29
9. Symptoms of mental health disorder (e.g., depression, anxiety, PTSD, adjustment)	3.4	28
10. Prolonged grief disorder (or complicated grief)	3.3	27
11. Relationship with husband after his death (e.g., continuing bonds, legacy)	3.1	25
12. Grief style (e.g., intuitive, instrumental)	2.6	21
13. Her spiritual/religious beliefs and coping	2.5	20
14. Existential concerns, beliefs about death/afterlife	2.1	17
15. Engagement in daily life/activities/tasks	2.0	16
16. Previous loss history	2.0	16
17. Relationship with son	1.8	15
18. Circumstances of husband's death	1.7	14
19. Goals in therapy	1.6	13
20. Cognitions around loss experience	1.5	12
21. Mourning behaviors (e.g., grief expression, rituals)	1.2	10
22. Resilience factors/protective factors/strengths	1.0	8
23. Future goals/motivation/hopes for self	1.0	8
24. Meaning in life, values	1.0	8
25. Previous mental health history	1.0	8
26. Duration of symptoms since the loss	0.7	6
27. Changes in identity	0.6	5
28. Kübler-Ross 5 Stages of Grief Model assessment	0.6	5
29. New responsibilities, roles, etc. due to husband's death	0.6	5
30. Post-traumatic growth	0.6	5
31. Current work situation	0.5	4
32. Loss- and restoration-oriented activities (i.e., Dual Process Model)	0.5	4
33. Therapist's readiness to work with client, countertransference	0.5	4
34. Avoidant behaviors (e.g., avoiding reminders of loss)	0.4	3

35. Other	5.3	43
36. I don't know/NA	0.7	6

Table 9*Pre-Intervention: Important Treatment Plan Steps/Domains in Vignette Responses**(n = 169)*

Theme	Total (763)	
	%	n
1. Explore/help process her emotions (i.e., guilt, sadness, loneliness)	13.8	105
2. Explore social supports and/or relationships	12.2	93
3. Explore coping skills/selfcare/hobbies and/or behavioral activation	10.1	77
4. Cognitive Behavioral Therapy (CBT) principles	5.5	42
5. Process grief, narrate her loss story	5.0	38
6. Help her find meaning in her life	3.7	28
7. Address any suicidality/risk concerns	3.0	23
8. Explore her relationship with her son	2.9	22
9. Meaning making of the loss	2.9	22
10. Provide general grief psychoeducation	2.9	22
11. Acceptance Commitment Therapy (ACT) principles	2.8	21
12. Explore ways to maintain a continuing bond with her husband	2.4	18
13. Build rapport/trust/working alliance/therapy relationship	2.1	16
14. Explore Kim's hopes/aspirations for herself	2.1	16
15. Provide bereavement-related resources	1.8	14
16. Explore relationship (e.g., closeness) with husband before his death	1.7	13
17. Kübler-Ross 5 Stages of Grief model application	1.7	13
18. Address therapy process (identify goals, therapy progress)	1.6	12
19. Help her adjust to the new normal without her husband	1.4	11
20. Explore Kim's post-loss identity	1.4	11
21. Process death circumstances (e.g., treatment, trajectory)	1.4	11
22. Mindfulness, experiential or reflective exercises (e.g., journaling, writing a letter, empty chair)	1.4	11
23. Help her accept that the loss has happened	1.3	10
24. Normalize her grief reactions	1.2	9
25. Vocational help (e.g., reconnecting with her work)	1.0	8
26. Allow/help her feel positive emotions (e.g., joy)	1.0	8
27. Address symptoms of mental health disorder (e.g., prolonged grief disorder, depression, anxiety, PTSD, adjustment)	0.9	7
28. Address daily physical functioning (e.g., sleep, appetite)	0.9	7
29. Dialectical Behavioral Therapy (DBT) principles	0.7	5
30. Explore multicultural considerations (e.g., culture, identities, spiritual/religious beliefs, beliefs in afterlife)	0.4	3
31. Explore strengths, protective factors, her resiliency	0.4	3

32. Explore Kim's existential concerns (e.g., own mortality)	0.3	2
33. Other	4.8	37
34. I don't know/NA	3.3	25

Table 10*Post-Intervention: Important Treatment Plan Steps/Domains in Vignette Responses**(n = 169)*

Theme	Total (823)	
	%	n
1. Explore social supports and/or relationships	10.1	83
2. Explore/help process her emotions (i.e., guilt, sadness, loneliness)	8.7	72
3. Explore ways to maintain a continuing bond with her husband	8.7	72
4. Explore coping skills/selfcare/hobbies and/or behavioral activation	7.3	60
5. Help her adjust to the new normal without her husband	6.2	51
6. Provide general grief psychoeducation	6.1	50
7. Process grief, narrate her loss story	6.1	50
8. Meaning making of the loss	4.4	36
9. Help her accept that the loss has happened	2.7	22
10. Normalize her grief reactions	2.6	21
11. Explore multicultural considerations (e.g., culture, identities, spiritual/religious beliefs, beliefs in afterlife)	2.6	21
12. Explore relationship (e.g., closeness, memories/reflections) with husband before his death	2.4	20
13. Mindfulness, experiential or reflective exercises (e.g., journaling, writing a letter, empty chair)	2.3	19
14. Help her find meaning in her life	2.2	18
15. Address daily physical functioning (e.g., sleep, appetite)	2.1	17
16. Cognitive Behavioral Therapy (CBT) principles	1.9	16
17. Build rapport/trust/working alliance/therapy relationship	1.8	15
18. Explore possible post-traumatic growth	1.8	15
19. Explore her relationship with her son	1.7	14
20. Apply the Dual Process Model of Grief	1.7	14
21. Provide psychoeducation about specific grief models	1.2	10
22. Provide bereavement-related resources	1.1	9
23. Acceptance Commitment Therapy (ACT) principles	1.1	9
24. Explore Kim's post-loss identity	0.9	7
25. Address symptoms of mental health disorder (e.g., prolonged grief disorder, depression, anxiety, PTSD, adjustment)	0.9	7
26. Process death circumstances (e.g., treatment, trajectory)	0.7	6
27. Address any suicidality/risk concerns	0.7	6
28. Explore Kim's hopes/aspirations for herself	0.7	6
29. Address any "unfinished business"	0.7	6
30. Address therapy process (identify goals, therapy progress)	0.7	6
31. Kübler-Ross 5 Stages of Grief model application	0.6	5
32. Vocational help (e.g., reconnecting with her work)	0.6	5

33. Other	5.7	47
34. I don't know/NA	1.0	8

Table 11*Pre-Intervention: 3-Factor Grief Counseling Model Application in Vignette**Responses (n = 169)*

Theme	Total (681)	
	%	n
1. Accompany the client on their grief journey (ACCOMPANY)	9.0	61
2. Assist the client in engaging in life and constructing a life without the deceased (ASSIST)	6.0	41
3. Assist the client in identifying the need for and sources of social support (ASSIST)	5.6	38
4. Helpful tools/techniques for grief counseling	2.1	14
5. Educate the client (ACCOMPANY)	1.8	12
6. Assist client in completing necessary life tasks (ASSIST)	1.6	11
7. Assist the client in facilitating reflection regarding areas of change/ progress/growth (ASSIST)	1.6	11
8. Assess the client's current functioning (ASSESS)	0.7	5
9. Embrace the client's grieving traditions/practices (ACCOMPANY)	0.6	4
10. Assess therapist readiness to provide grief counseling (ASSESS)	0.1	1
11. Assess for prolonged grief disorder (PGD; ASSESS)	0.1	1
12. Other	4.6	31
13. I don't know/NA/blank	66.2	451

Table 12*Post-intervention: 3-Factor Grief Counseling Model Application in Vignette**Responses (n = 169)*

Theme	Total (696)	
	%	n
1. Accompany the client on their grief journey (ACCOMPANY)	19.0	132
2. Assist the client in engaging in life and constructing a life without the deceased (ASSIST)	17.1	119
3. Assist the client in identifying the need for and sources of social support (ASSIST)	8.0	56
4. Educate the client (ACCOMPANY)	5.3	37
5. Assist the client in facilitating reflection regarding areas of change/ progress/growth (ASSIST)	4.3	30
6. Assess the client's current functioning (ASSESS)	3.4	24
7. Assist client in completing necessary life tasks (ASSIST)	3.3	23
8. Embrace the client's grieving traditions/practices (ACCOMPANY)	3.2	22
9. Helpful tools/techniques for grief counseling	2.2	15
10. Assess therapist readiness to provide grief counseling (ASSESS)	1.9	13
11. Assess for prolonged grief disorder (PGD; ASSESS)	1.3	9
12. Other	5.9	41
13. I don't know/NA/blank	25.1	175

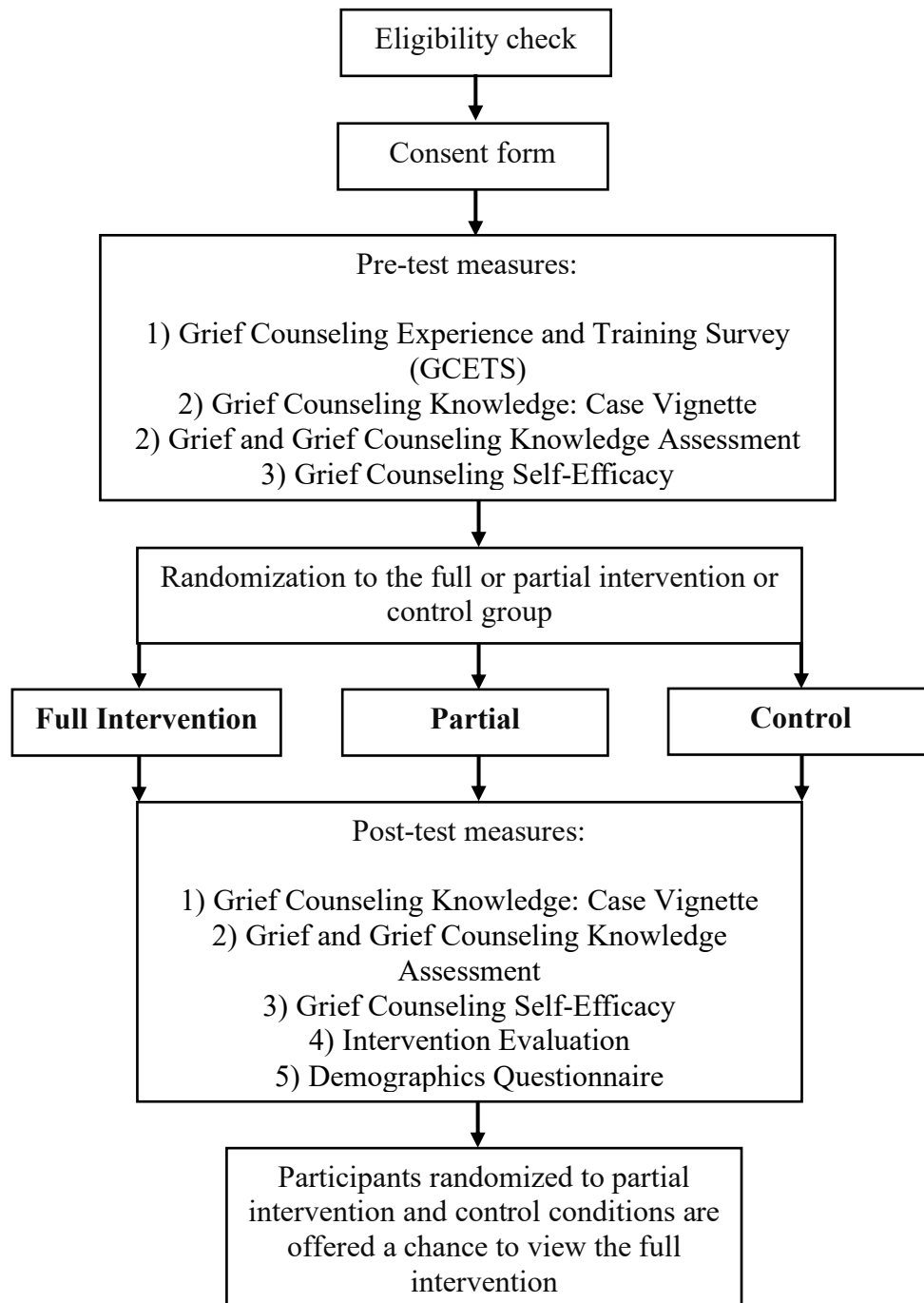
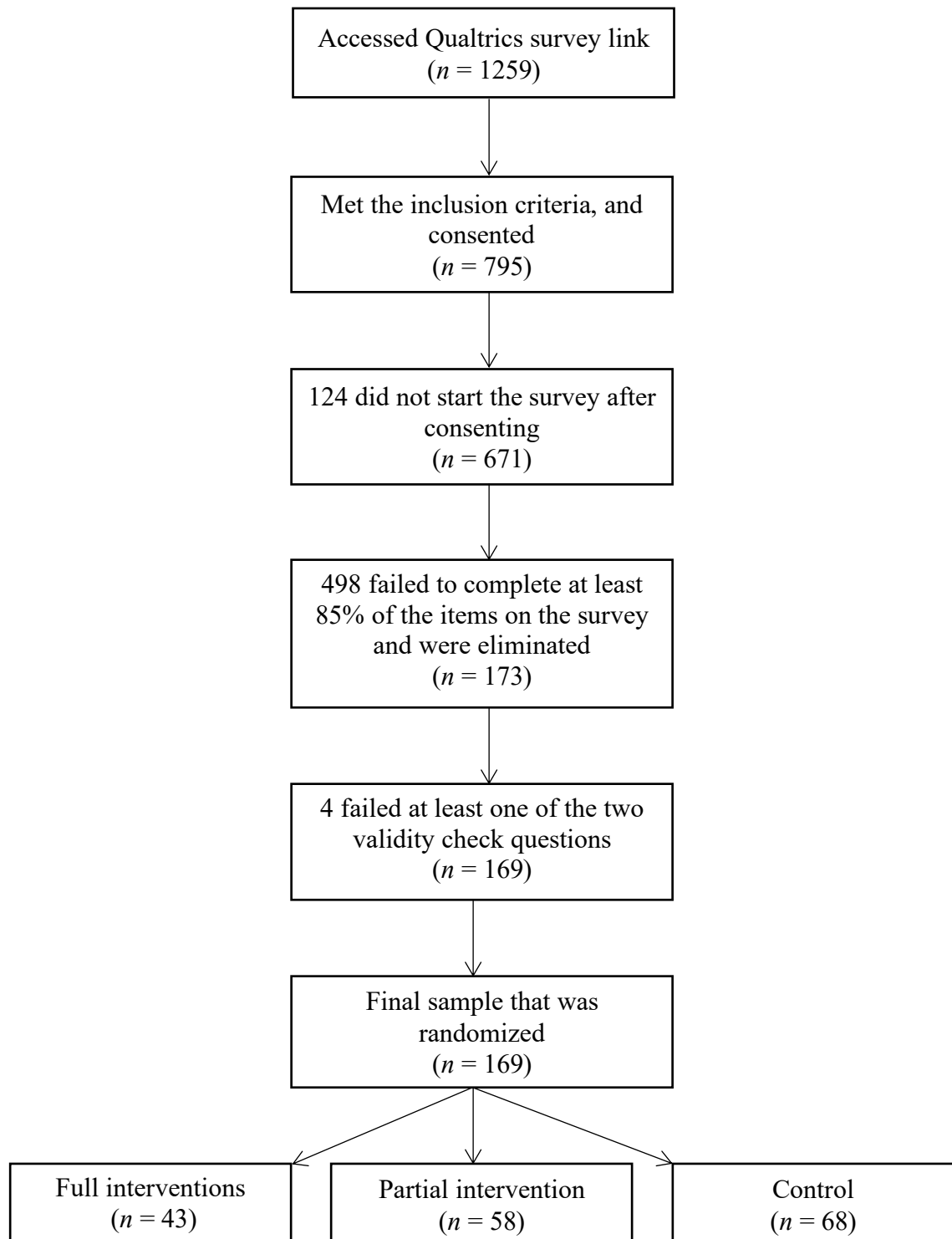
Figure 1*Study Flow Diagram*

Figure 2*Final Sample*

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