Grief Counseling Competency of Licensed Professional Counselors and School Counselors

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Abstract

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Grief Counseling Competency of Licensed Professional Counselors and School Counselors

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Grief and loss are complex phenomena that everyone experiences at different times during their lives. Counselors are likely to provide counseling services to individuals experiencing grief and loss. However, as grief training is not required, the competency of counselors in addressing grief and loss remains a concern. This study explored the level of competency in grief counseling, experience, and training in grief counseling between licensed professional counselors + (LPCs+), including licensed professional counselors (LPCs), licensed professional clinical counselors (LPCCs), and licensed professional clinical counselors-supervision (LPCCs-S),and licensed school counselors (LSC) in the state of Ohio. A total of 161 randomly selected LPCs+ and 73 LSCs participated in the study. Results revealed that although LPCs+ scored higher in experience and training, neither LPCs+ nor LSCs felt that they received adequate training and experience. However, all participants had encountered at least one client/student presenting with death-related grief and loss. LPCs+ scored higher across all competencies in grief counseling (CGCS), except for professional skills. Regression analysis revealed that experience and training were the strongest predictors of all competencies in grief counseling. This result highlights the importance of supervision in training and experience and indicates that they are inseparable. The results of this study serve as a compelling call to action for counselors, counseling supervisors, counselor educators, and

CACREP to reevaluate and enhance the preparation of counselors in addressing grief and loss issues.

Keywords: counseling, grief, loss, competency, counselors

Dedication

To the cherished memory of my lovely girlfriend

Gülhanım Dilek and our friend Banu Taşdemir

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Chapter 1: Introduction

In this chapter, the author shares various terms related to grief and loss, types of losses, and overall grief responses, as well as how those responses may differ based on emotional and cognitive development. In addition, the author will discuss what is considered typically grief and complicated grief (CG; also known as prolonged grief disorder, PGD) based on how they are defined in the text revision of the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR; American Psychological Association [APA], 2022) and 11th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-11; World Health Organization [WHO], 2019). The grief theories will be shared before discussing the prevalence of prolonged grief disorder. Following that, the author will report on how grief and loss content is covered in the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the competency of counselors based on previous studies. Lastly, the statement of the problem and significance of this study will be discussed.

Understanding Grief

Everyone experiences loss at some point in their lives. The loss can be due to death or non-death. As a result, everyone experiences emotional, physiological, cognitive, and behavioral grief responses to the loss (Parisi et al., 2019; Shear et al., 2011; Zisook et al., 2010). In the research literature, grief, loss, bereavement, and

mourning are common terms that are often used interchangeably. Therefore, in order to understand grief, it is necessary to clarify these terms. To begin, loss is a broad term describing the statement of lacking or having less of something, which includes loss due to death and non-death experiences (Cambridge University Press, n.d.). Bereavement is used only to describe the objective statement of loss due to death (Doka & Chow, 2021; Stroebe, Stroebe, et al., 2001). A person who has experienced bereavement is referred to as bereaved. The emotional, physiological, cognitive, and behavioral responses to a loss can be expressed as grief (Stroebe, Stroebe, et al., 2001). In addition to internal focus, grief also consists of external focuses such as social and cultural. Those cultural, religious, or social norms and behaviors constitute mourning (Stroebe, Stroebe, et al., 2001).

It is a misconception that grief is a response to only the death of a human being. Individuals also experience grief responses to non-death losses, such as job loss, relationship loss, and pet loss. However, grief due to pet loss and non-death losses is mostly unrecognized (Packman et al., 2012; Packman et al., 2017), especially for those who have a pet other than a dog or cat. Individuals whose grief is not acknowledged experience grief responses, but they are less likely to seek support, and their right to grieve is taken away (Doka, 2020). Similarly, those whose death of their loved one is not confirmed (e.g., emotionally present but physically absent), such as missing in a war or a disappearance, or immigrating to another country, tend to experience disenfranchised grief (Boss, 2009).

Some individuals experience grief responses while their loved one is still alive, but their death is anticipated (Fulton et al., 1996; Nielsen et al., 2016). However, since

the grief process starts before the biological death, their grief responses may differ from typical or traditional grief responses, which can play a significant role in the acknowledgment and recognition of grief in their community (Nielsen et al., 2016). In summary, grief is a broad term describing responses to different types of losses, such as the death of a family member, pet, and non-death losses. The circumstances of the loss also have a significant impact on how individuals experience grief, such as ambiguous, disfranchised, or anticipated.

Grief Responses

Loss is a universal experience, but grief as a response to the loss is experienced uniquely. In the literature, adaptive, integrative, normative, acute grief, and non-pathological grief are the most common terms used to describe "normal" grief (De Stefano et al., 2021; Lindemann, 1944; Maciejewski et al., 2016). Individuals who experience those responses are not in need of clinical attention or treatment meant for grieving individuals for this concept of grief, especially for days or weeks following the loss. It is considered a healthy adjustment process to move forward with the reality of the loss and attempt to integrate the reality of the loss into their lives. However, some grief reactions may lead to prolonged grief disorder (PGD) and mental health concerns such as depression and anxiety.

Most grief responses are experienced in physical, emotional, cognitive, spiritual, and behavioral manifestations (Worden, 2018). Common physical grief responses have been reported, including varied forms of physiological pain, such as headache and heartache, tightness, tiredness, and poor appetite (Worden, 2018). Emotional grief reactions include anger, guilt, numbness, longing, yearning, self-blame, and sense of

relief, especially if the death is anticipatory (Worden, 2018). In addition to cognitive responses, such as disbelief, rumination, and difficulty concentrating, bereaved individuals indicated experiencing difficulty finding meaning, struggling with faith, and withdrawal from social life (Doka, 2016; Worden, 2018).

Grief responses are not always typical. Various factors, including psychological development, cultural background, and belief system of the bereaved and circumstance of the death impact these responses. For example, a loss experienced in childhood differs from one experienced in adulthood because the worldview is cognitively perceived differently in each stage. Psychological development, including emotional and cognitive functioning, plays a significant role in individuals' responses to a loss. The developmental stage of grieving individuals offers a frame of reference for their responses to loss (McCoyd et al., 2021).

Prolonged Grief Disorder (PGD)

Although most responses to loss are considered adaptive, grief can become complicated. According to ICD-11 (WHO, 2019), PGD is a persistent and pervasive grief response characterized by preoccupation with intense emotional pain (e.g., difficulty accepting the death, anger, guilt, sadness, blame, emotional numbness) following the death of a close person lasting longer than six months. Grief responses are also expected to exceed religious, cultural, and social norms for the bereaved and result in significant impairment in personal, family, occupational, social, or educational functioning areas (WHO, 2019). In contrast, in the DSM-5-TR, the death must have occurred at least six months ago for children, but at least a year ago for adults in order for PGD to be diagnosed (APA, 2022). Furthermore, individuals must meet at least three specified

symptoms almost every day for at least four weeks. These symptoms include (a) identity disruption, (b) disbelief about the death, (c) avoidance of reminders, (d) intense emotional pain, (e) difficulty reintegrating into one's relationships, (f) emotional numbness, (g) sense of meaningless, and (h) intense loneliness (APA, 2022).

Theories of Grief

Many theories have attempted to explain how individuals experience grief and why they develop PGD. There is a recognizable difference between early and contemporary theories in terms of how they approach grief and loss. In the early 20th century, the main focus was on understanding the differences between depression, trauma, and grief.

Mourning and Melancholia (Freud, 1917/1953) remains the first and most critical paper in terms of understanding depression as a result of a loss to death. According to Freud (1917/1953), melancholia is a challenging task of progressively withdrawing and reinvesting the libido from the lost object or a person to a new or existing object. In the middle of the 20th century, Lindemann (1944) revealed significant findings regarding emotional reactions to the death of a loved one. Later, Bowlby and Parkes (1970) suggested grief could be experienced as chronic, inhibited, and delayed based on bereaved individuals' attachment patterns. These theories increased the attention on how individuals experience grief and loss.

Around the same time, Kübler-Ross (1969) introduced the Stage Model of Grief based on her clinical work and academic studies with terminally ill people and suggested five stages that individuals go through in their grief process: (a) denial, (b) anger, (c) bargaining, (d) depression, and (e) acceptance. However, contemporary models, such as

the Two Track Model of Bereavement (TTMB; Rubin, 1981, 1999), suggest that grieving individuals not only struggle with emotional responses to the death of a loved one, but also attempt to cope with secondary losses, such as increased financial responsibilities following the death of the father in the family and identity change. Moreover, the Dual Process Model (DPM; Stroebe & Schut 1999, 2010) revealed the importance of oscillation between emotions and secondary losses to adapt to the reality of the loss. For example, an individual who focuses on the emotional aspect of the loss and avoids secondary losses tends to develop PGD, whereas an overfocus on secondary losses is an indication of delayed grief.

The evolution of grief models shows a broader understanding of grief, including both emotional responses and coping with secondary losses. These insights underline the complexity of grief, potentially leading to an increase in the number of people seeking grief counseling for diverse and multifaceted reasons.

Issues Increasing The Number of People Seeking Grief Counseling

Professional help is needed for a considerable number of grieving individuals who experience longer-lasting grief responses and difficulty adjusting to life without the deceased (Wilson et al., 2022). Many veterans returning from war seek counseling services due to traumatic loss and experiences of war (Papa et al., 2008). Researchers have predicted that the number of people seeking grief counseling has increased because of the recent deaths due to the pandemic of coronavirus disease (COVID-19; Eisma & Tamminga, 2022; Eisma et al., 2021). More importantly, studies have revealed that those who became bereaved during the pandemic reported higher distress and more severe grief responses compared to others who lost a loved one before or after the pandemic (Akmese

et al., 2024; Breen et al., 2021). In addition, the number of counselors serving older adults is expected to increase significantly following the approval of legislation that allows Medicare reimbursement for counselors (American Counseling Association [ACA], 2022).

Although school shootings are not the only cause of students' death, they can cause traumatic grief for survivors of the shooting as well as teachers and families (Schonfeld & Demaria, 2020). Since 2018, there have been 175 active shootings in schools, resulting in 118 deaths and 311 wounded people (Education Week, 2023). Students in other schools may also experience fear of death and anxiety, although the shooting did not occur in their schools (Schonfeld & Demaria, 2020). Therefore, grief work with survivors of shootings is critically important in schools to improve healthy coping skills and integrate the reality of death.

As a result, it is expected that counselors tend to serve more grieving individuals. However, grief is a universal but complex phenomenon, meaning special training and clinical experiences are required for counselors to support those in need (Dodd et al., 2022; Worden, 2018). Counselors with educational backgrounds in grief and loss are found in diverse settings, including end-of-life facilities and private practice agencies (Worden, 2018). Their work is crucial in providing comprehensive support for the terminally ill and their families, assisting in end-of-life decision-making, emotional coping, and the preparation of death rituals (Overman-Goldsmith, 2019). In private practice, they offer evidence-informed treatments to enhance adaptive coping skills. The psychological development of grieving individuals is pivotal, and counselors must be adept at addressing grief across different age groups. Given that children spend a

significant portion of their time in school and are likely to encounter death for the first time (e.g., death of grandparents and pets), school counselors especially need training in grief and loss to support the school community effectively and to educate students and even families about grief and loss.

Preparing Future Counselors to Be Competent in Grief: CACREP-Accredited Institutions

Loss, grief, death, and dying are not explicitly included in the Council for Accreditation of Counseling and Related Educational Programs 2016 Standards (CACREP, 2016). The most recent standards became effective on July 1, 2024, and include only one grief-related standard. This standard in the foundational counseling curriculum's lifespan development section specifically states, "effects of crises, disasters, stress, *grief,* and trauma across the lifespan (CACREP, 2023, p. 13)." With that change, grief is included in the CACREP standards for the first time. However, it is associated with trauma, which may lead to a misconception among future counselors that grief is essential and needs to be addressed only when it is traumatic. Thus, it is unsurprising that many institutions do not offer standalone grief courses in their curriculum because of the lack of attention to grief and loss in the CACREP standards (Charkow, 2001, Ober et al., 2012).

The lack of standards related to covering loss, grief, and death and dying per the CACREP standards does not change the fact that all counselors will, at some point, work with individuals experiencing loss and grief. However, it is likely these counselors will lack competency in grief and loss. A study examining the grief counseling competency of 147 family counselors (Charkow, 2001) revealed that 98% of participants had seen at

least one client presenting death and grief-related issues. More interestingly, a study sampling counseling students revealed that at least 73 % of future counselors reported they had already seen a client presenting grief (Imhoff, 2015). Therefore, preparing future counselors and enhancing the competency of practicing counselors is essential.

There are still few counseling programs that include grief content in their curriculum, despite the fact that it is not required by CACREP (Wheat et al., 2022). However, research has reported some concerns related to how grief content is covered and the competency of instructors in these programs (Wheat et al., 2022). In these programs, grief and loss are mostly infused in crisis or trauma courses (Wheat et al., 2022). Moreover, almost 87% of counselor educators who participated in the study reported teaching stage and phase models of grief, and less than 25% taught the TTMB while 50% taught DPM (Wheat et al., 2022). However, contemporary models of grief, such as TTMB and DPM, are proven to be evidence-based, whereas the Stage Model does not have a scientific foundation and oversimplifies diverse responses to loss because it suggests linearity in the grief process (Ober et al., 2012; O'Connor, 2023).

Statement of the Problem

Grief and loss are complex phenomena that everyone experiences at different times during their lives, and counselors are likely to provide counseling services to individuals who are experiencing grief and loss. As grief training is not required by CACREP, the most recognized organization providing accreditation to counseling programs in the US, the competency of counselors in addressing grief and loss remains a concern. For example, in studies examining the grief counseling competency of professional counselors (Ober et al., 2012), participants rated themselves with the highest

scores in personal competency, while conceptual skills and knowledge scores were the lowest (Ober et al., 2012). However, researchers also reported that experience and training were responsible for the majority of the variance in predicting grief competency (Imhoff, 2015; Ober et al., 2012).

CACREP mandates a unified core curriculum for all counseling specializations, including school and clinical mental health counseling, to ensure counseling students receive comprehensive training in areas critical to human development, counseling relationships, ethics, and multicultural competence (CACREP, 2024). Therefore, school counselors are expected to have similar official training experiences with clinical mental health counselors. School counselors are also expected to complete the same number of practicum and internship hours under the supervision of a senior member of the counseling profession during their master's level education (CACREP, 2024). However, school counselors are not required to complete any supervision hours after they receive their initial licensure, unlike professional counselors, who are required to complete at least 150 hours of supervision after they receive their initial licensure to be eligible to practice independently (CSWMFT, n.d.-a). Considering that school counselors are likely to encounter students and families who have experienced loss, it remains unclear how school counselors obtain their training to work with people who have experienced grief and loss. In reviewing the literature, there are no studies examining the grief counseling competency of school counselors. Therefore, this study aimed to examine and compare the grief counseling competency of school counselors and professional counselors in the state of Ohio. In this study, the term "licensed professional counselors + (LPCs+)" was used to refer to a combination of licensed professional counselors (LPCs), licensed

professional clinical counselors (LPCCs), and licensed professional clinical counselors with supervision endorsement (LPCCs-S) to avoid potential confusion with LPCs.

Research Questions

The study examined the following research questions:

1. What is the level of grief counseling experience and training as measured by the Grief Counseling Experience and Training Survey (GCETS) of licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) in the state of Ohio?
2. What are the levels of grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) of licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) as measured by the Competency in Grief Counseling Survey (CGCS) in the state of Ohio?
3.
    a. What is the difference in grief counseling experience and training as measured by the GCETS between licensed professional counselors + (LPCS+) and licensed school counselors (LSCs) in the state of Ohio?
    b. What is the difference in the levels of grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) as measured by the CGCS between licensed professional counselors + (LPCS+) and licensed school counselors (LSCs) in the state of Ohio?

4. What is the relationship between grief counseling competencies and the demographic variables of age, gender, specialization (LPCs+ vs. LSCs) professional experience as a licensed counselor (i.e., years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, and completed supervision hours in grief?

Significance of the Study

As evidenced by the critical need to address grief in different settings and the prevalence of PGD, counselors are most likely to work with individuals presenting grief and loss issues. In addition, studies in which respondents were asked to rate life events based on their level of stress using the Social Readjustment Rating Scale (SRRS) revealed that the most stressful two events were the death of a spouse and the death of a family member (Hobson et al., 1998). Although it was reported that death is the most stressful life event for most people, the competency of counselors addressing loss-related issues, especially in conceptual and knowledge skills, was low (Ober et al., 2012). However, more than 90% of professional counselors indicated that grief counseling training should be required or is necessary (Ober et al., 2012).

The significance of this study is unique because it aimed to explore and compare the grief counseling competency of LPCs+ and LSCs. Given that the competency of LSCs remains unknown, this study was one of the first studies shedding light on this topic. Moreover, it was evident that there is a need for counselors who are adequately trained in grief and loss to provide support for grieving individuals across various modalities and settings, including individual, group, and community mental health agencies and schools.

The results of this study revealed that both LPCs+ and LSCs lacked adequate experience and training in grief counseling, despite all counselors having worked with at least one client or student presenting with grief and loss. However, grief counseling experience, training, supervision, and membership in the LPCs+ group were identified as significant predictors of grief counseling competencies. These findings underscore the critical importance of both formal and informal education, along with practice under adequate supervision, to prepare counselors for effectively addressing grief and loss. The results of this study serve as a compelling call to action for counselors, counseling supervisors, counselor educators, and CACREP to reevaluate and enhance the preparation of counselors in addressing grief and loss issues.

Delimitations of the Study

As with any study, there are delimitations to consider in this study, which intends to explore the grief counseling competency of LPCs+ and LSCs. Identifying predictors for grief counseling competencies is challenging due to the scarcity and inconsistency of research in the field (Charkow, 2002). Based on the existing literature, the following variables were explored: age, gender, professional training and experience (as measured by the GCETS), specialty (LPCs+ vs. LSCs), years of experience (i.e., years practicing since obtaining initial licensure), and grief counseling supervision. Inclusion of LSCs and supervision is unique to this study for further exploration, whereas other variables have been included in at least one previous study.

Another delimitation of this study is the inclusion of only LSCs and LPCs+ practicing in Ohio. This decision was made due to the familiarity with Ohio's counseling system and training requirements, as well as the unique nature of licensure systems across

the US. Each state has its own licensure requirements, which can differ significantly regarding education, supervision, and continuing education standards. By narrowing the scope to Ohio, the study benefits from a focused analysis that reflects a deep understanding of the state's specific counseling framework, ensuring accuracy and relevance. However, this delimitation inherently limits the generalizability of the findings to counselors outside of Ohio, as variations in licensure requirements may influence outcomes in other states. Despite this limitation, the state-based focus provides a transparent and manageable context for addressing the research questions.

Definition of Terms

Loss

The fact that an individual no longer possesses something or has a reduced amount of something defines loss.

Bereavement

The experience of losing a loved one to death describes bereavement.

Grief

Grief is the emotional, physiological, cognitive, and behavioral responses to a loss (Stroebe, Stroebe et al., 2001). The loss can be death of a loved one, pet loss, and/or non-death loss, such as loss of a relationship not through death, job loss, loss of identity, etc.

Anticipatory Grief

Anticipatory grief, also known as anticipated grief, describes grief responses before a significant loss actually occurs, particularly in situations in which the loss is expected (Dehpour & Koffman, 2023; Patinadan et al., 2022).

Disenfranchised Grief

Disenfranchised grief is "the grief that results when a person experiences a significant loss where the resultant grief is not openly acknowledged, socially validated, or publicly mourned" (Doka, 2020, p. 26).

Ambiguous Loss

Ambiguous loss refers to the lack of facts surrounding the loss of a loved one (Boss, 2009). Boss (2009) determined two types of ambiguous loss: (a) a loss that the person is physically absent but psychologically present and (b) a loss that the person is physically present but psychologically absent.

Traumatic Grief

Traumatic grief refers to the presence of both trauma and grief symptoms following the death of a loved one (Worden, 2018).

Prolonged Grief Disorder or Complicated Grief

Prior to prolonged grief disorder (PGD) being used in DSM-5-TR, the most common term used to describe the same phenomenon was complicated grief (CG). Throughout this study, PGD and CG may be used interchangeably. In this paper, PGD refers to a persistent and pervasive grief response characterized by preoccupation with intense emotional pain (e.g., difficulty accepting the death or loss, anger, guilt, sadness, blame, emotional numbness) following the death of a close person or a pet or the non-death experience such as divorce at least more than six months at a minimum (APA, 2022). Moreover, grief responses are expected to exceed religious, cultural, and social norms for the bereaved and result in significant impairment in personal, family, occupational, social, or educational functioning areas (APA, 2022).

Grief Counseling

In this study, grief counseling refers to therapeutic work with clients who had an experience of loss to death or non-death loss in individual, group, family, or couples/family settings. Grief counseling can be provided by those who are professional mental health providers specializing and competent in grief and loss. Despite the fact that not all people need grief counseling to adjust to the reality of the loss, grief counseling can be provided to individuals who present with "normal" or prolonged grief responses, regardless of given diagnosis.

Grief Counseling Competency

Grief counseling competency in this study refers to the proficiency of a counselor to provide grief counseling based on personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills (Charkow, 2001).

Licensed Professional Counselor +

In this study, the usage of *Licensed Professional Counselors* + refers to counselors who hold one of the two levels of licensure and licensure with supervision designation: licensed professional counselors (LPCs), licensed professional clinical counselor (LPCCs), and Licensed Professional Clinical Counselors-Supervisor (LPCCs-S).

The Ohio Counselor, Social Worker, Marriage and Family Therapist (CSWMFT) Board establishes licensure standards of practice for counselors. LPC is the initial credential to be eligible to practice as a counselor. To become an LPC, the CSWMFT Board requires a master's degree in clinical mental health, addiction, or rehabilitation counseling from a CACREP-accredited institution or an institution meets the criteria

indicated by CACREP. Based on CACREP standards, counselors-in-training must complete 100 (at least 40 direct) practicum hours and 600 (at least 240 direct) internship hours, which must be completed under the supervision of a counselor who has supervisory credentials from the CSWMFT Board. In addition, counselors-in-training must pass the National Counselor Examination for Certification and Licensure (NCE) to be eligible for LPC (CSWMFT, n.d.-b).

To become an LPCC, in addition to completion of requirements for LPC, counselors must complete 3000 hours of practice over at least a two-year period of time under the supervision of an LPCC who holds a supervisory credential. The clinical experience must include at least 50% of the practice in the diagnosis and treatment of mental and emotional disorders. As of 2023, the LPCC candidate must have previously passed the National Clinical Mental Health Counseling Examination (NCMHCE) (CSWMFT, n.d.-a).

As of 2013, to become an LPCC-S, an LPCC must complete at least twenty-four hours of continuing education in counseling supervision training. In addition, LPCCs must complete at least 1500 hours of clinical experience, including diagnosis and treatment of mental and emotional disorders post obtaining their LPCC. Lastly, LPCCs must observe five supervision sessions conducted by an LPCC-S and spend at least one hour to review and process the observed session (CSWMFT, n.d.-c).

Licensed School Counselor

Similar to LPCs, School counselors must have a master's degree in school counseling in which 100 hours of practicum and 600 hours of internship completed. At

least 40% of practice hours must be direct hours. According to the Ohio Department of Education (ODE, n.d.-a), those practice hours must be completed in a school setting.

Summary

Grief is timeless, non-linear, and a complex phenomenon. Given an increasing number of people seeking grief counseling for events that have global impacts, such as immigration and wars, counselors should be prepared to address grief and loss in their work with clients and students. However, grief and loss are not mentioned or required by CACREP, and only a few counseling programs offer grief and loss content in their curriculum, which is mostly infused in crisis and/or trauma courses or offered as an elective course (Imhoff, 2015; Ober et al., 2012). More importantly, there is little information about professional counselors' grief counseling competencies, and to my awareness, no studies have investigated school counselors' grief counseling competencies. In this introductory chapter, the author shared overall grief terms, responses, theories, prevalence of prolonged grief disorder, and counselors' level of grief counseling competencies, supporting a need for such a study. Lastly, considering the literature gap, the author provided the study's significance, research questions, delimitations, and definitions of terms that will be commonly used in the next chapters. The subsequent chapters will provide a literature review, methodology, results, and discussions of the results for this study.

Grief Is a Journey of Finding New Ways to Express Love,

Accompanied by a Mix of Fear That Our Bond and Love to the Person May Fade.

Ibrahim Akmese

Chapter 2: Literature Review

In this chapter, the author shares both death and non-death-related grief responses and types of grief, such as anticipatory, disenfranchised, traumatic, and complicated grief. Following that, grief theories that have shaped our understanding of the grieving process are discussed. Additionally, an in-depth literature review is provided on how grief and loss training has been delivered from the perspectives of both future counselors and counselor educators. Furthermore, grief counseling competency is defined, and studies investigating grief counseling competency of counselors-in-training and professional counselors are reported. Finally, the author reviews the grief counseling competency of other mental health providers and their grief counseling training background.

Introduction

According to the Centers for Disease Control and Prevention (CDC), over 3.2 million people died in the United States (US) in 2022 (Ahmad et al., 2023). The leading causes of death were heart disease, cancer, unintentional injury, coronavirus disease (COVID-19), stroke, chronic lower respiratory diseases, Alzheimer's, diabetes, and kidney disease, respectively. It is assumed that each death left behind five bereaved individuals (Connor & Rubin, 2021); thus, the number of people grieving after loss of a loved one to death is exceeding 16 million. Although many people heal from their grief experiences over time without the need for counseling, Wilson et al. (2022) suggested

that a significant percentage of bereft individuals experience persistent grief requiring professional intervention.

The demand for grief counseling has risen, partly due to the elevated number of deaths from the global pandemic, which left many bereaved with more intense and prolonged grief, especially those who lost someone during the pandemic (Akmese et al., 2024; Breen et al., 2021). Additionally, as the Baby Boomer generation ages, the demographic of people aged 65 or older is expected to reach 70 million by 2030 and 100 million by 2060, leading to an inevitable increase in the mortality rate (Colvin & Ceide, 2021). The impact of grief is more pronounced in older adults due to their broader network of family and longer life span. Living a longer life leads to more experienced losses, including the death of spouses, siblings, friends, and even children (Colvin & Ceide, 2021; Williams et al., 2007). Given that and the recent enactment of the Mental Health Access Improvement Act (S. 828/ H.R. 432), which allows professional counselors to be reimbursed by Medicare, an increase in counseling services for elderly people is anticipated (American Counseling Association; ACA, 2022). Therefore, competency in grief and loss and end-of-life issues becomes significantly critical for professional counselors.

Many veterans returning from wars are also more likely to seek trauma-related grief services (Papa et al., 2008). Given that, the number of people seeking grief counseling services tends to increase. Additionally, the impact of school shootings extends beyond direct victims to include the psychological trauma experienced by survivors, educators, and other students, exacerbated by the alarming number of such events since 2018 (Education Week, 2023). Given the complexities of grief and its wide-

reaching effects, it is crucial for counselors to be well-trained and prepared to provide effective support in various contexts, including schools.

Loss is one of human beings' biggest stressors. A study asking participants to rate life events based on their perceived stress level revealed that the two most stressful events were the death of a spouse and the death of a family member (Hobson et al., 1998). Moreover, six out of the seven most stressful life events were loss-related, including deaths, illness (loss of health) to self or a close family member, detention in jail (loss of freedom), and divorce (loss of a relationship). Therefore, professional and school counselors should be prepared to address loss. When these professionals are able to competently address loss, they are able to prevent further complications for those who are grieving since most of the biggest life-changing events are rooted in loss.

Loss of a Loved One to Death: Bereavement

Grief Responses to Bereavement

Working with bereaved individuals requires competency in grief and loss. Understanding common reactions to the loss of a loved one is one of the core skills for counselors. Grief responses are largely influenced by a range of elements, such as circumstances surrounding the death, biopsychosocial development, cultural background, and belief system of the bereaved.

Those who suffer a loss may experience emotional responses such as anger, guilt, sadness, self-blame, yearning, and emotional numbness accompanied by somatic symptoms such as chest pain, dizziness, poor appetite, lightheadedness, and sensitivity to noises (Akmese & Foreman, 2024; Doka, 2016; Li et al., 2014; Worden, 2018). A sense of unfairness, survivor guilt (Why him/her and not me?), guilt related to responsibility for

the death, and regret regarding anticipation of the death or missing opportunities are also found to be natural responses to the loss of a loved one to death (Shuchter & Zisook, 2001). A sense of relief is also a common grief response, especially if the death was anticipated and the deceased suffered from illness (Doka, 2016). Experience of a loss may lead to isolation and withdrawal from others. Those whose grief is not acknowledged or stigmatized, such as suicide loss, may experience additional distress and feelings of shame (Dyregrov & Selseng, 2022; Li et al., 2014).

Common cognitive responses to loss include difficulty organizing thoughts, poor concentration, shock, and disbelief, especially if the death is unexpected (Lindemann, 1944; Worden, 2018). In addition, signs of a desire to be with or near the deceased, intrusive images of the deceased, dreams, hallucinations in the form of sensing the presence of the deceased, and symbolic representations, have also been reported by survivors (Ashton, 2020; Lindemann, 1944; Shuchter & Zisook, 2001). Additionally, participants have reported suicidal ideation following the death of a close one (Szanto et al., 2006).

Furthermore, grief has an interpersonal dimension (Stroebe, Stroebe, et al., 2001). For example, following the death of a loved one, the dynamic and the structure of the family may change. After the loss of a spouse, a bereaved may be expected to maintain function in the household and put the emotional dimension of grief on hold (Meichsner et al., 2020). Also, the source of social support may change, expecially when the deceased was the main resource of support. On the other hand, the person may experience a sense of loss in self and self-perception (Bellet et al., 2020). For example, after losing a spouse,

the bereaved may struggle or feel confused due to identity change. The interpersonal dimension of grief impacts individuals differently.

Grief Responses by Developmental Ages

Psychological development, including emotional and cognitive functioning, plays a significant role in individuals' responses to a loss. The developmental stage of a grieving individual offers a frame of reference for one's responses to loss. For example, a loss experienced in childhood differs from one experienced in adulthood because the worldview is cognitively perceived differently in each stage.

Considering the biological development of a fetus, some argue that grief and loss can be experienced even before birth. Despite the fact that the fetus begins to take in and respond to auditory stimulations around week of 27 (Yetkin et al., 2023), it cannot interpret these stimulations because there is no context or experience with the environment (McCoyd et al., 2021). The discussion often pivots to the mother's experience at this point, as her well-being is connected to the fetus. It is within this sphere of maternal health that we encounter the profound effects of loss. Miscarriage, a tragic event for many mothers, not only disrupts the biological process of pregnancy but also introduces a deep psychological component of grief and loss. Mothers navigating this experience often experience a sense of personal failure, and their grief can become disenfranchised (Bennett et al., 2005; Cacciatore, 2010).

Until school age, bereaved children may expect their deceased loved ones to return because they have very little sense of time. At this stage, especially at preverbal ages, children tend to experience behavioral problems following the loss as a grief response (Markese, 2011). For example, exhibiting protest reactions when the living

caregiver leaves similar to a separation from the caregiver observed by Bowlby (1969). Moreover, children may also internalize the reason for death and think that they are the cause of death (American Academy of Pediatrics; AAP, 2000). When looking at the grief responses of parents who experience the death of an infant, they were observed to exhibit guilt and a sense of failure in providing care for the infant, especially if the death was due to an accident (Lichtenthal et al., 2013). Secondary losses for these parents, such as the loss of a dreamed future with the child, are also common among grieving parents.

Children between 6 and 11 years gain a sense of time and understand that the deceased never returns. However, they may verbally express they want to be dead to be with the deceased (Christ, 2000). At this stage in development, the wishful thinking of wanting to be dead is not typically considered suicidal ideation. Some children may consistently want to talk or recall memories about the deceased (Christ, 2000; McCoyd et al., 2021). Although children at this stage tend to socialize and express feelings while playing with peers, they are at risk of social withdrawal. Academically, the experience of a loss may cause decreased school performance (Berg et al., 2014). In addition to the loss of a caregiver, the loss of a sibling, friend, grandparents, pet, or non-death losses, such as parental divorce, are also common at these ages (McCoyd et al., 2021).

Adolescents are able to understand the nature of loss and death. Their grief is not only centered around the loss, but may also affect family structure and future plans because of responsibilities in navigating secondary losses (McCoyd et al., 2021). For example, after the death of a parent, the role of the teen in the family may be reshaped to be more responsible (Cinzia et al., 2014). Considering the speed of development in adolescents between the ages of 12 and 18, grief responses may differ greatly. Balk

(2011) investigated how adolescents in a similar age range respond to loss. He found that those between the ages of 10 and 14 often experience fear and a sense of being overwhelmed when dealing with loss. In contrast, middle adolescents (ages 15–17) are more likely to respond with anger and try to hide their grief. Balk (2011) also noted that older adolescents (ages 18–22) typically feel either a sense of acceptance and love, or a feeling of rejection, with their grieving process heavily centered around their relationships. Encountering the death of a family member or a friend in adolescence also brings awareness of one's own death, which also leads to a need of finding a meaning in life (Fletcher et al., 2013; McCoyd et al., 2021). The most common non-death experiences in adolescence are loss of self-esteem, loss of identity, and loss of a relationship (McCoyd et al., 2021). The first experience of ending a romantic relationship is significantly important because it shapes how the teen may engage in future romantic relationships during adulthood.

In adulthood, grief is expressed through adaptive or maladaptive emotional, cognitive, and behavioral responses. Emotional responses are characterized by anger, guilt, sadness, self-blame, yearning, and/or emotional numbness (Akmese & Foreman, 2024; Doka, 2016; Worden, 2018). Physiological symptoms, including chronic pain, dizziness, loss of appetite, sleep disturbance, and lightheadedness are also commonly reported. In addition to feelings of shock and disbelief, they might experience intrusive thoughts and images of the deceased, dreams, hallucinations, and suicidal ideation (Ashton, 2020; Lindemann, 1944; Shuchter & Zisook, 2001; Szanto et al., 2006; Worden, 2018). Regarding non-death losses, adults typically experience job loss and divorce in

emerging or middle adulthood, and later retirement and empty nest, which describes changes in marriage after the departure of the last child (McCoyd et al., 2021).

Types of Grief

Studies investigating risk factors of PGD reported that the nature of the death is one of the most critical factors (Doka & Chow, 2021). Those who lose a loved one to sudden, unexpected, and/or violent death (i.e., suicide, homicide, overdose, and accident) are more likely to develop PGD (Worden, 2018; Wortman & Pearlman, 2016). These types of deaths, especially violent deaths, can be traumatic and complicated. Additionally, grief following extended illness and losses perceived as preventable may complicate the grief process for the bereaved (Doka & Davidson, 2001). On the other hand, grief can be prolonged or complicated when the loss is ambiguous or not acknowledged by others.

Grief After an Extended Illness: Anticipatory Loss

Anticipatory grief (also known as anticipated) describes grief responses before a significant loss actually occurs, particularly in situations in which the loss is expected (Dehpour & Koffman, 2023; Patinadan et al., 2022). This type of loss is characterized by both the reactions of the caregiver or loved ones of the dying person and the dying person himself/herself. Rando (1984) highlighted that individuals who are terminally ill whose death is foreseen are confronted with the loss of their own lives along with declines in their functionality, autonomy, and meaning of life, including future plans with loved ones. Anticipatory loss includes loss of intimacy and companionship, personal freedom, social or occupational opportunities, and role identity due to the changed dynamic between the love done and the person with illness (Large & Slinger, 2015). Traditional

stages of grief, as articulated by Kübler-Ross (1969), may be observed in patients experiencing this kind of grief (Cheng et al., 2009). However, not every individual will ultimately reach the final stage of acceptance (Avis et al., 2021). Anticipatory grief in the form of non-death loss can manifest emotional detachment. Lindemann (1944) reported that after a prolonged absence, wives of veterans became emotionally unbound from their husbands. The detachment may be present through symptoms of depression, obsessive contemplation of the loved one, and even mental preparation for their passing.

Addressing anticipatory grief often leads to profound psychological benefits. A study by Chunlestskul et al. (2008) revealed that women who were diagnosed with advanced breast cancer reported a sense of peace and personal growth as well as emotional relief. The emotional relief was achieved when they and their families accepted the reality of the death and made end-of-life preparations. Similarly, in a study by Chochinov et al. (2013), those who were encouraged to reflect on their lives and express their end-of-life-related feelings showed improved quality of life.

Disenfranchised Grief

All societies have their own norms that frame the process of grief. These cultural norms shape what losses, when, who, and how grief is acknowledged for social support and sympathy (Doka, 2020). According to Doka (2020), disenfranchised grief is “the grief that results when a person experiences a significant loss where the resultant grief is not openly acknowledged, socially validated, or publicly mourned” (p. 26).

According to Doka (1989, 2002, 2020), disenfranchised grief manifests in several forms. Firstly, disenfranchised grief may occur when the relationship between the deceased and the bereaved is not recognized. Typically, the death of a family member is

recognized and acknowledged by many cultures. However, intense grief responses are also common following the death of a friend, colleague, or neighbor, depending on the relationship between the deceased and bereaved, which may not be recognized prior to the death. Secondly, the loss itself may not be socially validated. Loss of a pet, end of a relationship or friendship not through death are common examples of unacknowledged losses. Thirdly, the bereaved may be seen incapable of grieving. For example, the rights of children, elderly people with dementia, or people with intellectual disabilities to grieve following a loss are mostly taken away because they may be perceived as not capable of grieving.

Additionally, the circumstances of the loss may disenfranchise the grief. For instance, those who lost a loved one to suicide or AIDS may feel a sense of stigma and judgment in disclosing the loss to others (Doka, 1993). Often, the responses of others are unpredictable and may cause isolation. Lastly, the way an individual grieves may not be acknowledged or respected. There are different styles of grieving, such as intuitive and instrumental (Martin & Doka, 1999). Individuals with an intuitive grieving style express grief as deep feelings. On the other hand, those with instrumental grieving style experience grief in physical, cognitive, and/or behavioral reactions. Unfortunately, counselors also tend to disenfranchise instrumental grievers since they mostly value emotional responses (Martin & Doka, 1999). In addition, those who do not meet cultural expectations may tend to experience disenfranchised grief because their grief responses may not be acknowledged or welcomed. For example, a person does not cry after receiving the news of death in a culture where they are expected to show their sadness.

Ambiguous Loss

Ambiguous loss describes a situation where the facts surrounding the loss are unclear and may also be disenfranchised (Boss, 2009). According to Boss (2009), there are two types of ambiguous loss. The first type describes a loss where the person is physically absent but psychologically present, such as the grief experienced by those whose loved one has been declared missing in a war or a disaster. The second type refers to a loss in which the person is physically present but psychologically absent, such as dementia or Alzheimer's. In this type of loss, although the person is physically present, he or she is not able to perform the expected roles, such as parenthood or the ability to recognize others. The ambiguity of loss forces families to construct their own narratives around the loss (Boss, 2009). Living with such a paradox, families find themselves in a place where they are unable to perform the customary societal rituals that acknowledge loss and facilitate mourning. Ambiguous loss is mostly disenfranchised because typical death rituals are not present (Doka, 202). Consequently, the bereaved are left isolated and in a state of burden from their unresolved grief. A recent study exploring ambiguous loss experiences of relatives of those who are missing in Italy suggested that ambiguous loss was characterized by typical of both prolonged and traumatic grief (Testoni et al., 2020). Participants noted a never-ending wait or posttraumatic growth when their suffering is driven by helping others.

Grief After a Traumatic Loss

Grief following a traumatic loss describes the presence of both trauma and grief symptoms following the death of a loved one (Stroebe, Schut, et al., 2001; Worden, 2018). Those who experience traumatic loss may experience posttraumatic stress disorder

(PTSD) symptoms such as flashbacks, intense fear, avoidance of reminders, and sleep disturbance, as well as typical grief symptoms following a natural loss, such as longing, yearning, and deep sadness (Wortman & Pearlman, 2016). Typically, human beings assume that the world is operated with fairness and justice, and it is safe, secure, predictable, meaningful, and controllable. These assumptions are mostly shattered for individuals who became bereaved following a traumatic experience. One of the most common questions for counselors working with people presenting with traumatic grief is what symptoms should be prioritized- grief or trauma. Another question to consider is whether it is the circumstances surrounding the death or the reactions of the bereaved to the death that defines traumatic grief.

Despite the fact that trauma is not an event, but rather the responses to an event, traumatic grief is likely to be developed after sudden and unexpected death, which mostly involves violence (Wortman & Pearlman, 2016). In situations in which the bereaved witnesses the death of their loved one or experience multiple deaths a traumatic grief response is common. Bereaved individuals believe the death was unfair and unjust. The memories of the deceased are distressing since they are associated with the circumstances surrounding the death, contributing to a traumatic grief response (Wortman & Pearlman, 2016).

Prolonged Grief Disorder (PGD)

Each individual experiences loss, and grief is a "normal" response. However, some people experience persistent and intense grief. Many definitions have been used to define any deviation from "normal" grief, such as *unresolved grief* (UG; Zisook & DeVaul, 1985), *pathological grief* (PG; Horowitz et al., 1993), *complicated grief* (CG;

Prigerson et al., 1995; Sanders, 1989; Shear et al., 2011), *persistent complex bereavement disorder* (PCBD in DSM-5, 2013), and *prolonged grief disorder* (PGD; Prigerson et al., 2009). PGD is the most recent definition used in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR; American Psychiatric Association, APA, 2022) and the World Health Organization (WHO)'s International Classification of Diseases (ICD-11, WHO, 2019). Despite the various terminology that has been used, these terms define the same phenomenon.

In the DSM-5-TR, the definition of prolonged grief differs from the diagnosis in the ICD-11 with some nuances (APA, 2022; WHO, 2019). For example, in the DSM-5-TR, the time required after a death to diagnose (PGD) is set at one year for adults and six months for children. In contrast, the ICD-11 mandates a minimum of six months for the diagnosis, without a specified duration for children (APA, 2022; WHO, 2019). In addition, there is no specified number of symptoms required in the ICD-11, whereas at least three of the following symptoms must be present nearly every day for at least the last month in the DSM-5-TR; (1) identity disruption, (2) disbelief about the death, (3) avoidance of reminders, (4) intense emotional pain, (5) difficulty reintegrating into one's relationships, (6) emotional numbness, (7) sense of meaningless, and (8) intense loneliness (APA, 2022).

A critique of the definition of PGD in the DSM-5-TR and ICD-11 is the limitation to only the death of a loved one. These texts exclude the loss of an animal or a non-death loss. However, in the existing literature, it is indicated that individuals who experience the loss of an animal or a non-death loss can also develop PGD (Adrian et al., 2009).

Prevalence of PGD

A synthesis of recent research highlights the significant variability in the prevalence of Prolonged Grief Disorder (PGD) and Complicated Grief (CG) across different populations and circumstances. Wilson and colleagues (2022) observed that PGD rates fluctuated widely, with one study sampling 551 bereaved parcipants (Boelen et al., 2019) noting a 19.2% diagnosis rate according to ICD-11 criteria, while another reported only 8.2% per the DSM-5 (Persistent Complex Bereavement Disorder, PCBD). The incidence of CG among 823 older bereaved individuals who aged 60 years and older was about 18.6%, and various studies noted an average PGD prevalence of 21.5% (Morowatisharifabad et al., 2020; Parro-Jimenez et al., 2021). In contrast, O'Connor et al. (2019) found that the rate of PGD ranged from 6% and 9% among 206 bereaved elderly participants.

Rates were markedly higher among those who had experienced traumatic or violent deaths (Matthews et al., 2019), 43% among Syrian refugees (Renner et al., 2021), and 62.8% among those who were receiving treatment at a suicide bereavement center (Bellini et al., 2018). The rate of PGD was found to be around one-third among military service members and veterans (Charney et al., 2018; Simon et al., 2018). A recent meta-analysis study reviewing twenty-five studies and a population of 4774 bereaved revealed that 50% of those who became bereaved due to unnatural causes of death developed PGD (Djelantik et al., 2020), and notably, one study found an extraordinary prevalence (71.1%) among earthquake survivors (Li et al., 2015).

A research study conducted by Adrian and colleagues (2009) revealed that the occurrence of Complicated Grief (CG) in individuals grieving the death of a pet was

marginally lower compared to those mourning a human death, yet CG remained significant at a rate of 4.3%. Additionally, the study highlighted that a substantial proportion of participants (31.5%) exhibited enduring grief reactions that extended over six months, with 12.0% experiencing impairment in their daily functioning. Although the prevalence of PGD among those who became bereaved after the loss of a pet is lower, a substantial number experience persistent grief and functional impairment, underscoring the need for clinical attention for those mourning the death of a pet (Adrian et al., 2009).

Impacts of Bereavement

Studies have shown that bereavement is associated with increased physical and mental health issues. In a study exploring the impacts on 7,000 bereaved children and adolescents following the death of their siblings, Bolton et al. (2016) reported that depression was seven times lower among non-bereaved children under 13 and two times lower among non-bereaved participants over 13. Moreover, anxiety, ADHD, and other mental disorders were also higher for both age groups compared to the control group (Bolton et al., 2016). Some studies have shown that bereaved children experience regressive behaviors following the loss, such as bedwetting and thumb-sucking (Cupit, 2017; McCoyd et al., 2021). In addition, fear of losing others, abandonment, and feeling unworthy were common emotional and cognitive responses (Cupit, 2017). Lack of competency in grief and loss among school counselors may cause further complications, such as punishment for “misbehaving” for students, especially for adolescents expressing their grief with anger, health problems also resulting in poor school performance, low self-esteem, and struggles in forming peer relationships (Cupit, 2017). Additionally, unaddressed grief and loss issues may lead to a higher risk of anxiety, depression, post-

traumatic stress, relationship issues, substance abuse, and overall well-being (Griese et al., 2017).

Many studies reported a positive association between spousal bereavement, negative health outcomes, and mortality (Moon et al., 2011; Ennis & Majid, 2021). For example, Young et al. (1963) found that widowers had a 40% higher risk of mortality compared to married men. Similarly, most recent studies reported an increased risk of mortality following the death of a spouse. More importantly, this risk is found to be higher in the short term after the loss, ranging between 90% and %15 (Elwert & Christakis, 2006). Other studies also found a higher risk of cardiovascular disease and chronic pain (Mason & Duffy, 2018). Individuals presenting traumatic grief reported greater depression, decreased job performance, and even higher mortality compared to those who do not have an experience of the death of a loved one (Wortman & Pearlman, 2016). It is also not uncommon to question their faith or even abandon it altogether. Furthermore, rumination around the death and fear of losing someone else are reported. Bereaved individuals who lost a spouse or a child reported more family conflicts and even divorce (Wortman & Pearlman, 2016).

Non-Bereavement Losses

Pet Loss

Pet owners experience grief responses when they lose their pets (Adrian & Stitt, 2019). As of 2023, two-thirds of households in the United States (US) own a pet (Megna, 2023). Considering the potential of more than one person and one pet living in a household, the number of people who may be impacted by the loss of a pet is higher than expected. Almost all pet owners encounter the death of their pets because of the shorter

lifespans of animals (Cleary et al., 2022). However, grief due to pet loss has remained unrecognized (Packman et al., 2012), especially for those who have a pet other than a dog or a cat. Eckerd et al. (2016) noted that being the owner of a pet other than a dog or a cat, such as , is understudied in the literature due to the assumption of association between the loss of a cat or a dog and severe grief following pet loss. Despite pet loss being disenfranchised, it is a fact that those who lost their pets to death experience significant distress and grief complications (Adrian & Stitt, 2019). More importantly, the death of a pet is often the first death experience in a family. This experience opens up the conversation about death and dying to children, which may play a significant role in the way they process the death of a human being (McCoyd et al., 2021). However, when the death of an animal is disenfranchised, the children may be given a message that grief is unacceptable. Regarding grief responses, many studies reported similarities in terms of grief responses between those who lost a pet and a human being. The initial emotional responses are sadness, a sense of loneliness, guilt, disbelief, numbness, rumination, and feeling as if part of oneself is missing (Archer & Winchester, 1994; Packman et al., 2012; Wrobel & Dye, 2003).

Non-Death Losses

All experiences, including the loss of something not due to death, can be considered non-death losses (Harris, 2020). Individuals experience various forms of non-death losses throughout their lives, such as loss of identity, independence, employment, relationships, roles, credibility, status, daily functioning, control, confidence, social connectedness, imagined future, idealized person, freedom, financial security, childhood, family life, and so forth (Breen & Fernandez, 2020). In many qualitative studies,

participants shared non-death loss experiences. Some of those examples are shared below.

> "My biggest issue is coming to terms with the loss of who I am, and that I sometimes feel I cannot be the person I once thought I was" (Proudfoot et al., 2009, p. 125). [Loss of identity]
>
> "I am not able to be there for her when I have gone to hospital. I cannot really be a mother for her. That is a loss for me because she is very important to me, and to not feel that I can be a parent to her—it is difficult" (Fernandez et al., 2014, p. 894). [Loss of roles]
>
> "For me [depression] has always been more than a disease: it has taken my self-esteem, confidence, and pride, heaved them into a swamp of worthlessness, confusion, and frequently, utter hopelessness" (Wisdom et al., 2008, p. 491). [Loss of confidence]
>
> "If I wasn't mentally ill, I believe I would be more into taking care of better of myself. Well because the mind plays tricks on me, and sometimes I get depressed, and I don't wanna do anything. If I didn't have those symptoms, I believe that I would be more active or more motivated to do more" (Borba et al., 2011, p. 290). [Loss of daily functioning]

Non-death losses are mostly disenfranchised. Individuals whose grief is not unacknowledged experience grief responses, but they are not able to seek support, and their right to grieve is taken away. In addition to non-death losses, those with an experience of ambiguous loss also tend to experience disenfranchised grief. Mainly, those who are grieving due to non-death losses cannot seek informal support from their loved

ones, family members, or friends because their grief is not acknowledged. Therefore, that increases the tendency to seek formal support from mental health providers.

Grief Theories

Theories assist counselors in understanding how to provide treatment to the bereaved. The theoretical conceptualization of grief has evolved over time. Earlier theories focused more on understanding grief responses and how they can be differentiated from other mental health disorders, such as depression and trauma. More recently, contemporary theories are evidence-informed compared to earlier theories and focus on how individuals presenting grief and loss develop complications (i.e., DPM; Stroebe & Schut; 1999, 2010). It is critically important to understand grief theories because theories are the foundations of treatment in grief and loss.

Psychoanalytic Theory: Sigmund Freud

Freud (1917/1953), in *Mourning and Melancholia***,** primarily focused on distinguishing normal grief from melancholia, in other words, pathological depression as a result of the loss. Freud (1917/1953) reported that melancholia is a challenging task of progressively withdrawing and reinvesting the libido from the lost object or a person to a new or existing object. The process of withdrawing the energy from the deceased was labeled *decathexis*, characterized by testing the reality of the loss. Freud (1917/1953) recognized that the death of a loved one can be the cause of depression, especially if the deceased has been ambivalently loved.

Acute and Morbid Grief: Erich Lindemann

Lindemann (1944) investigated the grief process of those who lost their loved ones at the Cocoanut Grove fire, where 500 people were killed in Boston. In his

work, *Symptomology and Management of Acute Grief,* he found that those who lost a loved one experience various and broader emotional reactions. In addition, he reported that those who repress their grief and tend to avoid expressing it are likely to encounter difficulty moving forward. Although he suggested that bereaved individuals should express their emotions, he did not investigate individual differences in his study. However, this study is one of the cornerstone studies distinguishing "normal" and "prolonged" grief.

Attachment Theory: John Bowlby and Colin Murray Parkes

Bowlby (1969, 1973, 1980) drew attention to how an infant behaves before, during, and after the separation from the caregiver. In collaboration with Parkes (1970), the similarities between separation from the caregiver and the death of a loved one were identified. Thus, grief was seen as an extension of separation anxiety in response to detachment from the loved one in adulthood. Based on the attachment theory and his clinical observations, Parkes (1964) defined pathological grief by identifying three principal forms: chronic, inhibited, and delayed grief. *Chronic grief* was defined as persistent symptoms of normal grief, which is similar to how a securely attached infant reacts to a separation from the caregiver. On the other hand, *inhibited grief* is defined as the absence of normal grief reactions, whereas *delayed grief* is the avoidance of the emotional pain of grief.

Bowlby (1982) concluded that pathological grief is associated with childhood experiences and attachment patterns. Therefore, Bowlby and Parkes (1970) suggested four mourning phases. The first phase is *Shock and Numbness*, in which bereaved individuals experience difficulty in believing that the death has occurred. The second

phase is *Yearning and Searching*, in which those who lost a loved one to death search for the deceased to ensure they are gone. The third phase is *Disorganization and Despair*, in which bereaved individuals struggle with living without the deceased and question their identity. The final phase is *Reorganization*. The goal is to help bereaved individuals move forward with the new reality and connections. The connection of this theory with Bowlby's attachment model impacted the neuroimaging studies focusing on attachment and bereavement (O'Connor, 2023).

Stage Theory: Kübler-Ross

Kübler-Ross(1969) interviewed 400 terminally ill patients, which is the basis of her influential study, *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy, and Tier Own Families*. According to Kübler-Ross (1969), people go through five stages of grief: denial, anger, bargaining, depression, and acceptance. Along the way, individuals may deny the loss and react with intense anger. Bargaining follows the intense anger because of the unexpectedness of the loss and a desire to be engaged in unfinished tasks. With the awareness of the reality of the loss, intense negative emotions are encountered. Finally, the individual becomes aware that they lack control and move forward with acceptance of the loss.

This model has been criticized due to its limitations. First, the model does not have a scientific foundation, oversimplifies diverse grief reactions, and is considered linear (Ober et al., 2012; O'Connor, 2023). Furthermore, the Kübler-Ross theory was developed based on the experiences working with people who were terminally, which cannot be generalized to bereaved individuals and their grieving process (Worden et al., 2021). These stages seem to reflect the movement from a state of ignorance to awareness

and acceptance. Moreover, Stage Theory fails to identify those at risk of prolonged grief (Stroebe et al., 2016). Perhaps, the linear framework of the Stage Theory aligns with the assumption that all grieving individuals go through the same stages at different time. Despite the facts related to the limits of this theory, it has been popular among mental health providers and even among bereaved individuals due to its popularity in the media for over 40 years (Worden et al., 2021).

Tasks of Mourning: J. William Worden

In contrast to Kübler-Ross, Worden (1982) described four tasks that grieving individuals must address to integrate the reality of the death of a loved one. Those tasks are not linear and can be visited over time. Moreover, Worden (2018) states that grief work is based on individual differences such as relationship with the deceased, death factors, personal and social factors, as well as concurrent stressors, although those tasks apply to all grieving individuals.

The first task is *to accept the reality of the loss*. This includes both cognitive/intellectual and emotional acceptance of the death of the loved one. The second task is *to process the pain of the loss*. According to Worden (1982), grief can be delayed if emotions are suppressed. Therefore, bereaved individuals should actively be engaged actively in processing the pain of the loss. The third task is *to adjust to a world without the deceased.* This task includes adjusting both to the internal and external challenges such as change of identity, core values, and beliefs. The final task is *to find a way to remember the deceased while embarking on the rest of life's journey.* Finding healthy ways to remember the deceased helps them to move forward in life.

Two-Track Model of Bereavement

Rubin (1981, 1999) conceptualized grief as two interdependent tracks. Track I addresses biological, psychological, and interpersonal changes following the death of a loved one, whereas Track II addresses the evolving relationship with the deceased. According to Rubin and colleagues (2017), regardless of whether the existing relationship is enhanced, reshaped, or transformed after the death, the relationship with the deceased should be seen as the central of the grieving process. The change regarding the ongoing relationship with the loved one may also bring a natural change in self-perception and the bereaved individual's personal identity (Rubin et al., 2017).

In a study investigating the grief experiences of Arab Muslim widows,Yasien-Esmael and colleagues (2018) found that bereaved widows dealt with four issues following the death of their husbands. Those four issues include maintaining a positive image of the deceased, reducing their own suffering, adjusting to life without the deceased, and working toward self-efficacy and resilience (Yasien-Esmael et al., 2018). The researchers noted important findings supporting the value of the Two Track Model for cross-cultural comparisons.

Continuing Bonds

In contrast to Freud's (1917/1953) suggestion that bereaved individuals must disengage from the deceased and form new meaningful relationships to adjust and move away from pathological grief, Silverman et al. (1996) propose that bereaved individuals tend to maintain the relationship with the deceased. This relationship is intentional, dynamic, and open to change over time through interaction with others (Silverman &

Klass, 1996). Although the ongoing relationship with the deceased is mostly intrapersonal, it can exist in larger social and cultural contexts (Klass & Steffen, 2018).

Memorial services are one of the biggest opportunities for bereaved individuals to retain their relationship with the deceased by connecting with other grieving individuals and family members (Kalss & Walter, 2001). In addition, annual celebrations and special days are also good resources for sharing stories and maintaining relationships with loved ones (Neimeyer, 2014). Furthermore, the deceased can be seen as a moral guide, role model, and even involved in the decision-making process for the survivor. Moreover, grieving individuals may experience a sense of the presence of the deceased or being watched by the deceased (Epstein et al., 2006; Silverman & Klass, 1996). Overall, bereaved individuals tend to intentionally maintain the bond with the deceased through various ways to be adjust to the loss of their loved ones.

Dual Process Model of Grief

Earlier grief models viewed grieving individuals as passive beings. It was assumed that bereaved people went through a grief process, and their attempt to actively address grief was minimized. The dual process model (DPM) not only addresses how individuals work through their grief but also focuses on secondary losses caused by the reality of the death (Stroebe & Scut, 1999). Furthermore, earlier theories indicated that bereaved individuals should be engaged in processing the emotional and cognitive consequences of the loss. Those who tend to deny the reality of death may be stuck in their grief. However, Stroebe and Schut (1999) indicated that there is a possible benefit of denial to managing the severity of grief because people also need to work through the

reality of secondary losses and stressors following the death, including familial, social, and identity change.

According to Stroebe and Schut (1999, 2010), DPM includes three dimensions: loss orientation, restoration orientation, and oscillation. *Loss orientation* describes various aspects of the loss process itself. That focus includes the relationship with the deceased, rumination about the deceased, and circumstances around the death. Emotional, physical, behavioral, and cognitive reactions are also involved in loss orientation, as explained in the two-track model. However, the dual process model gives special attention to what needs to be dealt with as a secondary source of stress following the loss, which is labeled *restoration orientation.* Although people who experience a significant loss may experience loss-oriented aspects (emotional reactions) more intensely at the initial phase, secondary stressors (i.e., dealing with arrangements to organize their life without the deceased and new identity development) may appear more intensely in the process of time.

The crucial distinguishable element of the DPM from the Two Track Model is *oscillation*, which refers to "the alternation between loss- and restoration-oriented coping, the process of juxtaposition of confrontation and avoidance of different stressors associated with bereavement" (Stroebe & Schut, 1999, p. 215). Oscillation is a dynamic process between loss and restoration-oriented aspects in which bereaved people may avoid emotional stressors and distract themselves by focusing on secondary stressors, which allows them to take time off from the pain of the grief and perform responsibilities as a result of secondary losses (Stroebe & Schut, 1999, 2010). Therefore, oscillation distinguishes the dual-process model from classical stress-coping theory and

acknowledges that emotional avoidance can improve the adaptation to the loss. Based on the concept of the DPM, it can be concluded that lack of oscillation may result in prolonged grief. Bereaved individuals may feel stuck in the loss orientation or focused on restoration orientation too much that they do not allow themselves to experience the pain of the loss. Therefore, either they experience prolonged or delayed grief. On the other hand, the presence of both confronting the reality of the loss (loss orientation) and actively working on secondary losses to adjust to the new reality following the death (restoration orientation) can be interpreted as "normal" grief.

The oscillation between focusing on loss and adjusting to restoration is influenced by various factors, such as the bereaved individual's gender, cultural background, level of attachment or closeness to the deceased, and experiences of multiple losses. In some cultures, bereaved individuals may be expected to express their grief, whereas other cultures may emphasize the importance of expressing emotions within a certain time following the death and expecting the grieving individuals to move forward to take care of the family responsibilities.

People may experience multiple losses or restoration-oriented stressors that can increase the sense of burnout or make them feel it is more than they can deal with. In 2016, Stroebe and Schut added a new concept to the DPM to address that, which is named "overload" and described as "the bereaved person's perception of having more than s/he feels able to deal with— too much or too many activities, events, experiences and other stimuli" (p. 100). This concept is new in the DPM and needs further studies.

Meaning Reconstruction Model

The meaning of life for a bereaved individual is threatened mainly by the reality of the death of their loved one (Neimeyer, 2014). Neimeyer (2001) identified three key processes that bereaved individuals commonly engage in while reconstructing meaning after a loss: *sense-making, benefit finding, and identity change*. These components of meaning reconstruction theory aim to explain how individuals navigate grief by seeking coherence and adjusting to a transformed reality (Hibberd, 2013; Neimeyer, 2001).

The initial way individuals may approach their loss is through sense-making, as they seek to understand what happened, how it occurred, and why it took place (Neimeyer, 2001). The story of the deceased is reshared to create a coherent narrative about life. The second aspect of meaning reconstruction, known as *benefit finding*, involves identifying positive outcomes within the experience of loss (Neimeyer, 2001). For instance, following a loss of a family member, the relationship among the family members may be improved, and the values coming with the changing dynamic in the family may also be reconstructed. The final aspect of meaning reconstruction is *identity change*, which involves the process by which the bereaved individual experiences changes in their own identity (Neimeyer, 2001). The self-perception of grieving individuals tends to evolve through the grief process, which is closely related to reconstructing the meaning of life following the loss.

It may not be easy for each bereaved person to find meaning in their loss, and the time needed to explore the meaning is not equal for everyone (Neimeyer et al., 2010). Many variables, such as the type of death and the grievers' belief system, play a significant role in the meaning-making process. It was found that approximately half of

the parents whose child died to a violent death were unable to find meaning even years later (Armour, 2003). The percentage of participants without meaning in the death goes up to 66% for homicide and 61% for suicide bereavement (Armour, 2003). Additionally, the contradiction between the bereaved parents and their loved ones' belief systems can challenge their worldview to make sense of their experience (Keesee et al., 2008). Therefore, lack of meaning reconstruction may play a significant role in grief complications.

Counselors' Training in Grief and Loss

Over 900 master's and doctoral programs in approximately 450 colleges and universities are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2023). It is not surprising that many counseling students are not offered grief and loss-related courses in their graduate training because CACREP does not require grief and loss-related content in their 2016 standards. The revised CACREP standards, set to come into effect on July 1, 2024, feature a single criterion focusing on grief. This criterion, labeled (m) in the section on lifespan development, emphasizes the "effects of crises, disasters, stress, grief, and trauma across the lifespan, " as stated by CACREP in 2023 (p. 15). This is the first instance that grief is explicitly mentioned in the CACREP standards. However, its association with trauma might create a false perception among counselors that grief is significant only in traumatic contexts. Consequently, the underrepresentation of grief and loss in these standards can explain why many counseling programs do not include standalone grief courses.

Similarly, grief, loss, and bereavement are not explicitly mentioned in the American School Counseling Association (ASCA) School Counselor Professional Standards & Competencies (ASCA, 2019). However, standard B-SS 3.e. indicated that school counselors "respond with appropriate intervention strategies to meet the needs of the individual, group or school community before, during and after crisis response" (ASCA, 2019, p. 5). Given that, grief is perhaps associated with crisis by ASCA, which may also lead to a misconception that school counselors should address grief and loss-related issues only in crisis contexts.

The lack of inclusion in the standards does not change the fact that individuals who have experienced grief and loss seek grief counseling services. Considering the number of people who experience grief and loss, it is likely individuals will present to counseling with grief and loss concerns. Thus, counselors may be providing grief counseling without training, even though it is beyond the competency of practice. Imhoff (2015) reported that 76% of future counselors have already seen at least one client presenting grief and loss in their practicum and internship. In her study investigating family counselors' grief counseling competency, Charkow (2002) reported that the rate of participants who had already worked with clients presenting grief and loss was 98% (Charkow 2002).

Grief is a complex phenomenon. Although the intention of helping clients and students presenting with grief and loss with basic counseling skills is good, counselors may cause harm if they do not receive adequate training in grief and loss. In the following section, the type of grief and loss training that counselors are engaged in and

studies that are conducted to explore future and professional counselors' competencies in addressing grief and loss will be discussed.

Delivery of Grief Counseling Training

Researchers have indicated that the majority of counseling programs do not offer any standalone course related to grief and loss (Charkow, 2002; Cicchetti, 2010; Cicchetti et al., 2016; Imhoff, 2015; Montague et al., 2020; Wood, 2016). The range of participants (counseling students, professional counselors, and rehabilitation counselors) who reported not being offered a specific grief and loss course was between 61% and 71.3% (Charkow, 2002; Cicchetti, 2010; Cicchetti et al., 2016; Imhoff, 2015; Wood, 2016). Concordantly, the majority of participants had not taken any standalone course covering grief and loss content (Charkow, 2002; Cicchetti, 2010; Deffenbaugh, 2008; Imhoff, 2015; Wood, 2016). The rate of counselors-in-training who had not taken any course specifically focusing on grief and loss-related issues (either focusing on theories or interventions) ranged between 76.87% and 92.1% (Cicchetti, 2010; Imhoff, 2015; Wood, 2016). On the other hand, the rate of professional counselors who had not taken any standalone grief and loss course ranged between 54.8% and 65.3% (Deffenbaugh, 2008; Charkow, 2002).

Some studies reported that grief and loss issues were infused into other required courses. For example, Imhoff (2015) reported that 60.2% of counseling students received a course that grief and loss-related issues were integrated. Similarly, Deffenbaugh (2008) found that half of professional counselors completed at least one or two courses infusing grief and loss. Receiving grief counseling training through professional development hours is common among professional counselors, but not future counselors. Imhoff

(2015) reported that over 70% of counselors-in-training had not taken any professional development hours in grief and loss. On the other hand, Deffenbaugh (2008) reported 30.6% professional counselors had obtained grief and loss training through professional development. Considering these results, professional counselors might have encountered grief and loss issues in their work and explored professional development hours as a source of training. Additionally, Charkow (2002) reported that 38.8% of participants were offered at least one standalone grief course, and 34.7% of participants had taken at least one course. In other words, 90% of participants took at least one course when there were available opportunities.

In summary, in their graduate-level training, counselors are mostly offered courses integrating grief and loss content, but not standalone grief and loss courses. Additionally, professional development is also common for training in grief and loss. However, future counselors are not likely to be engaged in professional development activities. This can be a result of financial inability, especially considering the costs of conference attendance. However, there are many ways to enhance professional competency. Counselors can also attend web-based training, webinars, and certification trainings, and read professional books and articles covering grief and loss issues. Charkow (2002) asked participants to report overall articles and books read but did not specify the time frame. Five (3.4%) participants reported that they did not read any books or articles, whereas fifty-four (36.7%) read 1 to 5. Remembering the overall number of articles and books read can be challenging. Participants may recall the most recent ones, but not the ones taken early in their graduate-level training. Given that in this study, a question asking participants to report any types of training, including professional

conferences, web-based training or webinars, professional certification training, and reading books and articles, was added. The researcher decided to restrict the time of books and articles read to the last six months.

Grief Training From Counselor Educators' Perspective

Unfortunately, little is known about how grief and loss-related issues are delivered in graduate training. A recent study with 61 counselor educators investigating how grief content is integrated in CACREP-accredited institutions reported critical results (Wheat et al., 2022). Firstly, in their study, Wheat et al. (2022) revealed that 22% of counselor educators who participated in the study reported that they included grief content in the crisis and/or trauma courses and 31 % in a different course. Secondly, only 14.75% indicated receiving grief-related certification, and only 14.75% noted listed university courses as their training in grief. It can be concluded that most counselor educators receive grief-related training and certification through continuing education but not official training where they received their counseling degree.

Thirdly, when those teaching standalone grief courses were asked how they came to teach the course, both death and non-death-related personal loss experiences were reported as significant but not the only factors. Additionally, only two participants are members of the Association for Death Education and Counseling (ADEC, 2010), which is "the international professional organization dedicated to promoting excellence and recognizing diversity in death education, care of the dying, grief counseling and research in thanatology (no page number)." Teaching a grief course without being involved in the only organization establishing standards in that field may set barriers to following updated evidence-informed approaches.

Unsurprisingly, almost 87% of counselor educators who participated in the study reported teaching stage and phase models of grief, but only less than a quarter taught the Two Track Model of Bereavement, and a half taught the Dual Process Model (Wheat et al., 2022). More interestingly, only 9% reported taking a grief course in their own formal education. Because grief is not mentioned in CACREP standards, counselor educators are forced to take grief training by themselves, which might sometimes be a financial burden. Last but not least, only half of the counselor educators addressed ethics in thanatology (50.82%) and intervention models specific to grief (49.18%). Interestingly, although at least few end-of-life issues are covered in the American Counseling Association (ACA) Code of Ethics (2014) section B.2, half of the counselor educators did not cover ethics in the field of thanatology in their grief courses (Wheat et al., 2022).

Grief Counseling Supervision

Counseling supervision is a structured professional relationship between a more experienced professional and a less experienced colleague aiming to enhance the professional skills of the less experienced counselors, ensure service quality, and uphold standards within the profession (Bernard & Goodyear, 2019). Blueford et al. (2021) reported that counseling supervision plays a significant role in counselors' work with clients/students who present grief and loss, especially when they are less prepared to address these issues in formal education. Counselors in supervision reported that their experiences and challenges were normalized and validated. Moreover, their supervisors provided tools and resources to address grief more effectively (Blueford et al., 2021).

In Ohio, both LSCs and LPCs are required to be engaged in supervised practicum and internship experiences during their master’s level counseling education. However,

school counselors are not required to complete any supervision hours following initial licensure, but LPCs are required to complete one hour of individual or group supervision for every 20 hours of work. In other words, LPCs must be engaged in supervision until they complete the 3,000 hours of clinical work to be independently licensed. LSCs can voluntarily receive supervision at any time to enhance their skills, but the CSWMFT requires supervision for LPCs (CSWMFT, n.d.-a). This difference is one of the most significant differences between the preparation of LPCs+ and LSCs to address grief and loss-related issues.

Grief Counseling Competency

Grief counseling competency refers to the proficiency of a counselor to provide grief counseling based on personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills (Charkow, 2002). The Death Counseling Survey (DCS) has been used in almost all studies measuring the grief counseling competencies of professional counselors or counseling students. In this section, a broad literature review of studies aimed to measure the level of grief counseling competency of counseling students (i.e., Cicchetti, 2010; Imhoff, 2015; Wood, 2016), professional counselors (i.e., Charkow, 2002; Deffenbaugh, 2008), and school counselors will be discussed.

Grief Counseling Competency of Counseling Students

One of the critical studies investigating future counselors' grief counseling competency using the DCS has been conducted by Imhoff (2015) and focused on exploring grief counseling experience and training and self-perceived competency in grief counseling for master's level counseling students (N=154) in CACREP-accredited

universities in the state of Ohio. Participants' professional training and experience was measured using the Grief Counseling Experience and Training Survey (GCETS), which was derived from the Sexual Orientation Counselor Competency Scale (SOCC), with modifications by Deffenbaugh (2008). More specifically, the words *gay, lesbian, and bisexual* were replaced with *clients experiencing grief* to make it suitable for the study. The GCETS was first tested in a preliminary study before being applied in a more extensive research project. Its reliability and validity were confirmed, with a reliability coefficient of 0.86 and a Cronbach's alpha of 0.97 in the larger study.

Imhoff (2015) found that 61% of students noted no grief courses available to them in their programs. Additionally, 79.7% of students stated that they have never taken any standalone grief courses. Even worse, 39.8% of participants indicated that they had not even taken any courses in which grief-related topics were infused into the material (Imhoff, 2015). However, 73.4% of participants noted that they had already worked with a client on grief-related issues in their practicum or internship. It is concerning that many future counselors are expected to work with clients who have experienced a loss without sufficient training in the field. Regarding familiarity with grief theories, over two-thirds indicated "some" or "a lot" of familiarity with the Stage Theory of Kübler-Ross (1969), which they were most familiar with. On the other hand, 85.5% reported "very little" or "no" familiarity with the DPM, 76.3% with Meaning Making, and 88.2% with Continuing Bonds. Half of the participants shared that they were "very" or "somewhat" inadequately prepared through their graduate training to address grief and loss issues.

Participants considered themselves proficient in basic counseling practices relevant to grief, such as self-care and creating a supportive environment, yet they

demonstrated a lower proficiency in specific knowledge and skills associated with grief, such as understanding grief theories, expressing age-appropriate grief responses, and identifying signs of complicated grief. Imhoff (2015) performed regression analyses, investigating the association between self-assessed grief counseling competency and various factors, including age, gender, professional training and experience, and type of grief counseling training received. Age emerged as a significant indicator of personal competencies but not other competencies. Gender was notably predictive of overall competency in grief counseling, conceptual knowledge/skills, treatment skills, and professional skills. Professional training and experience (measured by GCETS) significantly predicted grief counseling competency across all subscales and contributed more substantially to unique variance (standardized beta scores ranging from .19 - .70).

Differently, in this study, Imhoff (2015) compared clinical mental health counseling (N=128), school counseling (N=17), and those who are enrolled in both (N=9) in terms of grief counseling experience and training (GCETS) and levels of self-perceived grief counseling competencies (DCS). The researcher indicated no difference across groups and noted a sample size concern since the majority of participants were mental health counselors.

Cicchetti (2010) examined the grief counseling competency of 93 master's level rehabilitation counseling students enrolled in a Counsil on Rehabilitation Education (CORE) accredited program. An adapted version of the DCS, which is called the Grief Competency Counseling Scale (GCCS) was used in this study (Cicchetti, 2010). GCCS was renamed to avoid the possible bias of DCS's title. Cicchetti (2010) modified this instrument to make it suitable for rehabilitation counselors by adding "disability" in

items. Questions related to death and bereavement were removed from GCCS. Therefore, in contrast to the DCS (Charkow, 2002), GCCS had 9 items for personal competencies, while the second part had 36 items, three subscales: conceptual skills and knowledge, assessment skills, and treatment skills (Cicchetti, 2010). This version of the GCCS was reported as reliable based on Cronbach's alpha, .79 for personal competency (Part I) and .97 for the skills and knowledge (Part II), but the Cronbach's alpha for subscales was lower than the DCS; .52 for conceptual skills and knowledge, .60 for both assessment and treatment skills.

Not surprisingly, participants reported a high score in personal competency, whereas lower in conceptual skills and knowledge, assessment, and treatment skills (Cicchetti, 2010). Results also indicated that gender, age, ethnicity, and practicum and internship setting had no significant impact on perceived grief counseling competency. On the other hand, a personal history of disability had a significant impact on personal competency (η^2=.37) and treatment Skills (η^2=.30), but not on assessment skills, and conceptual skills and knowledge. Surprisingly, the attitude toward disabilities and coursework taken had no main effect on grief counseling competency across all scales.

Another study investigating master's students' preparedness to address grief and loss in their work has been conducted by Wood (2016). The number of counselors-in-training who were enrolled in practicum or internship participated in this non-experimental cross-sectional quantitative study was 153. In this doctoral dissertation, Wood (2016) used Cicchetti's (2010) Grief Competency Counseling Scale (GCCS) to measure participants' grief counseling competency by removing the word disability.

However, the items related to death and bereavement that were removed in GCCS were not added back.

Results from this study indicated that two-thirds of participants are not offered a course related to grief theories in their CACREP-accredited institutions, and 80.26% reported they had not taken any such courses. However, it was found that the status of taking a grief course had a significant effect on Professional Skills, including Assessment, Treatment, and Conceptual Skills and Knowledge, but not Personal Skills. Lastly, age had a significant impact on only personal skills, whereas no significant effect of race, gender, and ethnicity on any competencies was found.

Grief Counseling Competency of Professional Counselors

Only a few studies investigating counselors' grief counseling competency have been conducted. One of the earlier studies, conducted by Charkow (2002), assessed 147 family counselors' specialized training and the level of competency in grief and identified variables predicting counselors' competencies.

Charkow (2002) conducted one of the most comprehensive studies on grief counseling competencies. These competencies included personal, conceptual skills and knowledge, assessment, treatment, and professional skills. This dissertation study focused on members of the International Association of Marriage and Family Counselors (IAMFC) and the American Association of Marriage and Family Therapy (AAMFT). In this study, Bugen's Coping with Death Scale (BCDS; Bugen, 1980), which assesses counselors' abilities to cope with death, both personally and professionally, was used. Thereafter, a demographic information form and the Death Counseling Survey (DCS),

developed by the author, were used to measure self-perceived grief counseling competency.

The DCS was developed as a result of a pilot study aimed to create standards in grief counseling from the literature and contributions of 34 experts in grief loss who had at least five years of experience on the topic. Results from the pilot study indicated high reliability, as shown by an overall Cronbach's alpha of .97. The Cronbach's alpha for subscales are as follows: personal competency .72, conceptual skills and knowledge .93, assessment skills .80, treatment skills .95, and professional skills .84. The concurrent validity of the instrument was supported based on the correlation between DCS and Burgen's Coping with Death Scale (BCDS), which was .73.

The study revealed interesting facets in terms of the preparedness of family counselors working with individuals presenting grief and loss. Participants reported a high level of personal competency and were adept at fundamental counseling techniques like active listening and providing emotional support. However, they indicated lower competency in knowledge and conceptual skills, particularly in implementing creative arts in their work. A concerning finding was the minimal exposure to graduate-level, standalone grief and loss courses. Half of the respondents had taken only one such course, with the majority acquiring less than ten hours of professional development in this area.

Despite the lack of formal education, 98% of these counselors had already worked with clients dealing with grief. This disconnect between training and practice may lead to ethical concerns, as counselors are practicing in areas where they have not been adequately trained. The perceived adequacy of the training in their graduate programs

was reported as low, whereas the level of adequacy of the external training, such as professional development hours, was rated as somewhat adequate to adequate. Interestingly, personal experience with death and grief did not directly influence their competency or knowledge in the field, but there was an indirect effect on their personal death experiences. Professional training and experience were the key predictors of knowledge and conceptual skills in dealing with grief-related issues, more so than the number of years in practice. Additionally, a stronger positive correlation was observed between the number of standalone death and grief-related graduate courses completed and the enhancement of both personal and professional skills when compared to courses that infused grief and loss content. Furthermore, professional development hours and engagement with death and grief-related literature through reading books and articles were more influential in bolstering competence-related variables than graduate-level coursework alone.

Another significant study was conducted by Deffenbaugh (2008). This dissertational study was published as an article by Ober et al. in 2012. For clarity in literature and published work, “Deffenbaugh” and “Ober” are the same author. This study aimed to measure practicing counselors’ grief counseling competency and to explore the relationship between demographic characteristics and the competency of counselors. Although there were counselors working in a school setting, all counselors held mental health counseling licenses: licensed professional counselors (43.9%) and licensed professional clinical counselors (56.1%).

Results from this study indicated that participants felt generally competent in addressing grief and loss, but they lacked specific training in grief counseling methods

and a range of experiences, particularly in group settings. Surprisingly, despite the reported lack of formal training, many had completed professional development in grief counseling. In comparison between groups, the study reported that those who completed 1-10 professional development hours on grief and loss indicated higher scores across all competency scales compared to those who had no professional development hours. Similarly, the difference was observed between those who had completed no course and those who had completed at least one course where grief and loss content were integrated.

More than 90% of participants reported that they were “some” or “a lot” familiar with Stage Theory. On the other hand, only 15% indicated “some” or “a lot” familiarity with the Dual Process Model (DPM). Given that DPM is evidence-informed, but Stage Theory is considered linear and was developed based on the work with dying people and not grieving individuals, these results were concerning (Hansson & Stroebe, 2007). The study highlighted that training and experience in grief counseling, professional experience as a licensed counselor, and gender significantly impacted grief counseling competencies, whereas age, personal grief experiences, and practice setting did not. The predominant contributors to the variation in each of the regression models were professional training and experience in four of the five models assessing competencies in grief counseling. Regarding years of experience, interestingly, counselors with professional experience over 20 years had lower average competency scores in conceptual knowledge and assessment compared to those with less experience. Lastly, over 90% indicated that grief counseling training should be required or is necessary.

In summary, studies investigating counselors' grief counseling competency included age, gender, professional training and experience, type of training, personal experience with death and grief, and years of experience. Professional training and experience (GCETS), type of training, and gender were found to be the most notable predictors of grief counseling competency. Age was found to be either a predictor of only personal competency or had no impact on grief counseling competency at all. Similarly, the number of years in practice was less predictive of knowledge and conceptual skills compared to professional training and experience. Interestingly, the impact of receiving supervision hours on grief counseling competency has not been investigated. Considering that grief and loss are not required to be included in the graduate-level counseling curriculum by CACREP, counselors-in-training, and new professionals may rely on their supervisors to promote their competencies. Counselors, especially those who recently graduated and are still working for their independent licensure under supervision, may need additional support in addressing grief and loss in their therapeutic work. It is also known that school counselors are not required to be supervised after they receive their initial licensure, whereas LPCs+ are required to complete at least 150 hours of training supervision with an LPCC-S after their initial licensure (CSWMFT, n.d.a). The differences during the training process for school and mental health counselors may be a factor impacting grief counseling competency. Therefore, the number of supervision hours received was added as an independent variable in this study. Participants were asked whether they received grief counseling supervision, how many hours, and what setting they received their supervision in (group or individual). They were also asked to rate the level of adequacy of their supervision experience.

Grief Counseling Competency of School Counselors

Grief and loss manifest in various forms within school settings, significantly impacting students' academic, social, and emotional well-being. Common manifestations of grief include the death of a parent, ambiguous loss, such as parental incarceration, and disenfranchised grief, such as moving away from a friend or the death of a pet (Ellis et al., 2016; Jenkins et al., 2014). In early childhood, students may encounter death for the first time, often through the loss of a grandparent or a companion animal. This early exposure to grief is crucial, as beliefs and coping mechanisms established during these formative years can persist into adulthood (Howell, 2016). Furthermore, experiences of grief and loss can escalate into crises within school environments, necessitating proactive measures from school counselors. Counselors are often expected to inform students and families about grief and employ psychoeducation to help students understand and process their experiences (Donohue et al., 2015; Greenidge et al., 2023). Therefore, it is essential for school counselors to be equipped with the knowledge and skills to address these issues effectively, as they play a vital role in supporting students through their grief (Ellington et al., 2023; , O'Brien et al., 2022).

Although the role of school counselors is significantly important, not only for students but also for school administrators and families, the level of grief counseling competency of school counselors remains unknown due to a lack of research studies. Similarly, the type and content of the graduate-level training in grief and loss for school and clinical mental health counseling students have not been differentiated. A decade ago, Imhoff (2015) attempted to compare the grief counseling competency among clinical mental health counseling (N=128), school counseling (N=17), or both clinical mental

health and school counseling students (N=9) who were enrolled in field experience (i.e., practicum or internship). In this study, those who were enrolled only in a school counseling program scored the lowest scores in conceptual skills and knowledge (M=2.78), assessment skills (M=2.91), and treatment skills (3.02) compared to the other two groups of students. Additionally, school counseling students reported a lower grief counseling experience and training score than clinical mental health students. However, there was no statistically significant difference among the three groups. Considering the distribution of the sample size, the results may not be reliable. Therefore, this study is critically important in shedding light on the grief counseling competencies of LSCs as well as comparing these competencies of LPCs+ and LSCs.

Grief Counseling Competency in Other Helping Professions

Grief and loss are not a unique practicing area for counselors. Psychologists and social workers also provide services for clients presenting grief and loss. Recent studies have shown that non-counselor mental health providers are not prepared to address grief and loss better than counselors. In a study with 437 social workers, whose majority had a master's level degree (92.64%), Pomeroy et al. (2021) reported that only 8% of participants indicated feeling prepared to work with grief and loss issues when they started practicing. However, over 80% of participants "often" or "sometimes" encountered end-of-life and grief issues in their practice. Participants reported a lack of preparedness in their bachelor's and master's level education to assist their clients in end-of-life and grief-related issues (Pomeroy et al., 2021). Supporting that, a study revealed that 61% of social workers had never taken any courses focusing on grief and loss (Mitchell & Murillo, 2016). Those who reported not feeling prepared and somewhat

prepared noted that master's level end-of-life and grief courses and the inclusion of the topic in supervision could have helped them to promote their preparedness (Pomeroy et al., 2021).

Very little is known about the grief counseling competency of mental health providers who graduate from a psychology program and how grief education is delivered in these psychology programs. In 2009, a study with 161 psychology program representatives found that only 20.5% (33) had offered a class on death, dying, and bereavement in the previous five years (Eckerd, 2009). Looking forward, less than half of the institutions that had offered such a course indicated no plans to offer such a course in the next five years, with 28% unsure and only 18% confirming they would. This study also explored reasons for not offering any death, dying, and grief courses. Fifty-four responders reported greatly varying reasons, including faculty limitations (either in number or expertise), content overlap with other psychology courses or departments, curriculum constraints, and a lack of interest or demand by students. Similar to counseling programs, psychology programs integrated aspects of death, dying, and bereavement into other courses, particularly those focused on aging and lifespan development (Eckerd, 2009). In summary, grief and loss is not commonly offered as a standalone course in helping professions. It is primarily infused in other classes.

Ethical Issues in Grief Counseling Competency

Counselors' lack of training in grief may cause irreversible results for clients. ACA Code of Ethics (2014) and ASCA Ethical Standards for School Counselors (2022) explicitly share requirements regarding practicing within a personal and professional competency manner. The professional responsibility section (Section 2) in the ACA Code

of Ethics (2014) indicates a need for education, training, supervision, and professional experience to be competent within competency boundaries. Furthermore, counselors are required to provide techniques grounded in empirical foundation (Section C.7.a; ACA, 2014). Similarly, ASCA Ethical Standards for School Counselors (2022) emphasizes the importance of professional development through training, professional organization membership, and following current research in relation to school counseling. Further supporting this concern, many studies showed that most counselors are familiar with grief theories (Stage Theory; Kübler-Ross, 1969) that are not empirically based more than those that are proven to be up-to-date and evidence-based (Ober et al., 2012; O'Connor, 2023; Stroebe et al., 2016; Worden et al., 2021). Kübler-Ross's (1969) model was drawn from studies with terminally ill people and not those who are grieving after the death of a loved one. Moreover, it is not empirically supported (Bonanno & Kaltman, 1999; Hansson & Stroebe, 2007; Payne et al., 2002; Stroebe & Schut, 1999; Wortman & Silver, 2001). In contrast to how it is proposed in the Stage Theory, which is a linear model in which all grieving individuals go through the same five stages, grief is a unique and non-linear experience.

Summary

Loss is beyond bereavement after the death of a loved one and includes non-death losses as well as pet loss. Considering the complexity of grief and loss due to factors impacting the grief process, such as types of grief and circumstances surrounding the loss, counselors are expected to be well-prepared to work with clients/students presenting grief and loss in different settings. This chapter reviewed studies examining counselors' grief counseling competency reported concerns because of low competency levels in

conceptual skills and knowledge. Not surprisingly, future and professional counselors are less familiar with contemporary and evidence-informed grief theories. Previous studies have shown that grief counseling experience and training is a significant predictor of grief counseling competency, as well as gender. On the other hand, age was reported as a predictor of personal grief counseling competency but had no relationship with other types of competencies. Despite the valuable contributions from the literature, research gaps have been observed. The grief counseling competency of LSCs remains unknown. Interestingly, the relationship between supervision experience and grief counseling competency has also never been investigated, even though counselors may rely more on their supervisors due to a lack of official grief training in their graduate programs. Subsequent chapters will detail the research methodology, results, and discussion.

Biliyorsun Ölüm, Mavi Boş Bir Kafestir Kimi Zaman

(You Know, Death Is Sometimes a Blue Empty Cage)

Didem Madak

Chapter 3: Methodology

This chapter presents a comprehensive overview of the research design and methodology employed in this study. It outlines the research questions and hypotheses that form the foundation of the investigation, along with detailed definitions of the variables involved. The chapter further elaborates on the targeted population and the strategic plan for sampling, including the determination of the sample size. Essential to the research process, the instruments used for data collection are described, providing insights into their selection and application. Lastly, the chapter delves into the methods of data analysis, detailing the techniques and procedures employed to interpret the gathered data, ensuring a thorough and systematic approach to the research.

Research Design

This study utilized a non-experimental research design using quantitative research methodology. The purpose of the study was to explore and compare the self-perceived grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) of licensed professional counselors + (LPCs+), including licensed professional counselors (LPCs) licensed professional clinical counselors (LPCCs), and licensed professional clinical counselors-supervision (LPCCs-S) and licensed school counselors (LSC) using the Competency in Grief Counseling Survey (CGCS), which is a revised version of the Death Counseling Survey (DCS; Charkow, 2002). Additionally, the relationship between grief

counseling competency, demographic characteristics, and professional training and experience in grief and loss using the Grief Counseling Experience and Training Survey (GCETS) was explored. Demographic information included age, gender, specialization (professional counseling and school counseling), professional experience as a licensed counselor (i.e., years practicing since obtaining initial licensure), and number of received grief supervision hours.

Previous studies have explored the relationship between age, gender, years of practice, practice setting, number of courses taken, professional experience and training in grief counseling, and personal experience with grief and grief counseling competency of practicing counselors (i.e., Ober et al., 2012), marriage and family therapists (i.e., Charkow, 2002), and future counselors specializing in rehabilitation and clinical mental health counseling (i.e., Cicchetti, 2010; Imhoff, 2015). However, little is known about the grief counseling competency of licensed school counselors. Therefore, licensed school counselors were added to the sample to explore their grief counseling competency and professional training and experiences in order to compare school counselors and professional counselors. Also, the researcher included additional variables in this study: supervision hours and hours spent in various types of professional development related to grief and loss (i.e., professional conferences, web-based training and webinars, etc.).

Specifically, the researcher attempted to answer the following research questions;

1. What is the level of grief counseling experience and training as measured by the Grief Counseling Experience and Training Survey (GCETS) of licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) in the state of Ohio?

2. What are the levels of grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) of licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) as measured by the Competency in Grief Counseling Survey (CGCS) in the state of Ohio?
3.
    a. What is the difference in grief counseling experience and training as measured by the GCETS between licensed professional counselors + (LPCS+) and licensed school counselors (LSCs) in the state of Ohio?

        H_03_a: There is no statistically significant difference between LPCS+ and LSCs in terms of grief counseling experience and training.

        H_13_a: There is a statistically significant difference between LPCs+ and LSCs in terms of grief counseling experience and training.

    b. What is the difference in the levels of grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) as measured by the CGCS between licensed professional counselors + (LPCS+) and licensed school counselors (LSCs) in the state of Ohio?

        H_03_b: There is no statistically significant difference between LPCs+ and LSCs in terms of grief counseling competencies.

        H_13_b: There is a statistically significant difference between LPCs+ and LSCs in terms of grief counseling competencies.

4. What is the relationship between grief counseling competencies and the demographic variables of age, gender, specialization (LPCs+ vs. LSCs) professional experience as a licensed counselor (i.e., years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, and completed supervision hours in grief?

   $H_0$4: There is no relationship between age, gender, specialization (LPCs+ vs. LSCs), professional experience as a licensed counselor (years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, completed supervision hours in grief, and the grief counseling competencies.

   $H_1$4: There is a significant relationship between age, gender, specialization (LPCs+ vs. LSCs) professional experience as a licensed counselor (years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, completed supervision hours in grief, and the grief counseling competencies.

Definitions of Variables

Age

Age is a continuous ratio variable. Participants were asked to report their age in years as a response to an open-ended question in the demographic information form. Studies that recruited future counselors reported that age was a significant predictor of personal competencies but not overall grief counseling competency or other subscales in the DCS (Imhoff, 2015; Wood, 2016). Given the various findings, this variable was included for further investigation.

Gender

Gender is a categorical variable with four options: male, female, transgender, and other. Participants were asked to choose one of the given options in the demographic information form. Gender was found to be a significant predictor of overall grief counseling competency, conceptual skills and knowledge, treatment skills, and professional skills, but not the assessment skills of practicing counselors (Imhoff, 2015). A study investigating practicing counselors reported females scored higher on personal competencies, treatment skills, and assessment skills. On the other hand, gender was found to have no significant relationship with the grief counseling competency of counselors-in-training (Wood, 2016). Given the contradicting findings, gender was included to be investigated further.

Specialization (Type of Licensure)

Specialization is a categorical variable and describes participants' current type of licensure. Counselors who hold LPC (Licensed Professional Counselor), LPCC (Licensed Professional Clinical Counselor), LPCC-S (Licensed Professional Clinical Counselor-Supervision), and LSC (Licensed School Counselor) in the state of Ohio were asked to report their current licensure in the demographic information form. Those who have LPC, LPCC, and LPCC-S were in one group, which were named licensed professional counselors + (LPCs+). To my awareness, licensed school counselors' grief counseling competency has not been investigated yet, except for a recent study aimed to validate an instrument measuring school counselors' grief counseling competency (Wood, 2023). Moreover, there is no comparative study recruiting licensed counselors. Therefore, this

variable was included to explore school counselors' grief counseling competency as well as compare them with licensed professional counselors.

Years of Practice

Years of practice is a continuous ratio variable and describes the time that has passed since a participant received their initial licensure. Participants were asked to report for how long they have been licensed via an open-ended question in the demographic information form. Ober et al. (2012) reported that counselors who have a practicing experience more than 20 years had lower average scores than counselors with less practicing experience on conceptual knowledge and skills and assessment skills. Given those interesting results, this variable was included for further exploration. It was anticipated that counselors with more experience would have increased grief counseling competency scores.

Grief Counseling Training Received

Grief counseling training received describes what type of training participants received and the number of hours spent on the training. This was collected via six questions. The first question asked participants to indicate the number of standalone grief and loss courses taken during their graduate-level training. The second question asked the number of standalone elective courses offered in their graduate-level training. The third question asked participants to report the number of standalone elective courses taken during their graduate-level training. The fourth question asked participants to share the number of taken courses that integrated grief and loss content. The fifth question asked participants to indicate what type of additional training they received (i.e., professional conferences, web-based training or webinars, personal certification training) and report

the number of hours spent on that training. The last question asked participants to report the number of books and articles they have read in the last six months.

Studies found different results regarding the impact of the number of standalone grief courses and the number of courses integrated grief and loss on grief counseling competencies of counselors. Wood (2016) indicated a positive relationship between coursework taken and conceptual skills and knowledge, assessment skills, and treatment skills in DCS. Similarly, Ober et al. (2012) reported that those who completed more courses focusing solely on grief and loss or integrated grief and loss scored higher than those who had no such courses on all subscales. Also, participants who had a higher number of professional development hours scored higher than those who had no professional development hours on all subscales. On the other hand, Imhoff (2015) found that the number of standalone grief courses and the number of courses that infused grief and loss content did not predict any subscales of grief counseling competency. Therefore, this variable was included with changes regarding the type of training for further investigation.

Supervision Hours Received

Supervision hours received is a continuous variable and describes the number of hours spent in received supervision in grief and loss. Participants are asked to answer this question in the demographic information form. The role of supervision in predicting grief counseling has not been explored yet but was added to this study for exploration.

Grief Counseling Experience and Training

Counselors' grief counseling experience and training was measured using the Grief Counseling Experience and Training Survey (GCETS), which consists of 12 items

(5 Likert-type) and measures participants' formal education, supervision, experience, and clinical training. Minor revisions were made to make it inclusive of school counselors (see instrument section in this chapter). Previously, GCETS was used in two studies (Imhoff, 2015; Ober et al., 2012). Both studies found that professional training and experience was a significant predictor of all grief counseling competencies.

Grief Counseling Competency

Grief counseling competency of licensed professional counselors and school counselors was measured using a revised version of the Death Counseling Survey (DCS) (Charkow, 2002), which was named the "Competency in Grief Counseling Survey (CGCS)" to avoid the possible bias of the title of the DCS. Simply, death counseling may result in a misconception that grief is only related to death, which minimizes the non-death loss experiences and related grief responses. Changes in DCS was minor and aimed to make it inclusive of school counselors and non-death loss experiences. For example, item 17 in part II ("I can teach clients how to obtain support and resources in the community") was replaced with "I can teach clients/students how to obtain support and resources in the community pertaining to grief and loss." The CGCS has 58 items measuring overall grief counseling competency on five scales: personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills. Participants were asked to report on a 5 Likert-type scale, from one ("This does not describe me") to five ("This describes me very well").

Population, Sample Size, and Sampling

The target population of this study was LPCs+ and LSCs in the state of Ohio. LPCs+ refers to those who hold LPC (Licensed Professional Counselor), LPCC

(Licensed Professional Clinical Counselor), and LPCC-S (Licensed Professional Clinical Counselor-Supervision; LPCC-S). The study was approved by the Institutional Review Board (IRB, 23-X-137).

The required sample size to run an analysis of variances (One-way ANOVA) to answer research question 3a is calculated using G*Power (Faul et al., 2009). Using two groups, an effect size of .25, α=.05, and power=.80, the minimum number of participants was determined to be at least a total of 128. Ideally, the sample size was expected to be equal for both LPCs+ (N=64) and LSCs (N=64). Similarly, the required sample size to run a multivariate analysis of variance (MANOVA) to answer research question 3b is calculated using G*Power (Faul et al., 2009). Using five dependent factors, two groups, an effect size of .15, α=.05, and power=.80, the minimum number of participants was determined to be at least a total of 156. Ideally, the sample size was expected to be equal for both LPCs+ (N=64) and LSCs (N=64).

The required sample size to run the regression analysis to answer research question 4 is calculated by using Brooks and Barcikowski's (2012) Precision Efficacy Analysis for Regression (PEAR) method. Using the desired precision efficacy (PE) of .80, an expected medium effect size (ρ^2) of .25, and six variables, the minimum number of participants was determined to be at least 198. Because the regression analysis requires a larger sample size, the target sample size for the study was determined to be 198.

The author used random sampling to recruit LPCs+ by obtaining a list of counselors licensed by the Ohio Counselor, Social Worker, and Marriage and Family Therapist (CSWMFT) Board. This list has information, such as license number and when the initial license was obtained, which is public information. From the total LPCs+

population in Ohio (N=12,891; CSWMFT, personal communication, September 5, 2023), 1,000 LPCs+ were randomly selected using the Statistical Package for Social Sciences (SPSS, Version 29) obtained from CSWMFT. The response rate for the first random sample was 2%. The researcher submitted a request to the Institutional Review Board (IRB) to draw another sample to meet the minimum sample size required for the statistical analyses. The request was granted by IRB, and the researcher drew a new sample consisting of 4,000 professional counselors distributed equally between LPCs, LPCCs, and LPCCs-S from an updated list of LPCs+ in Ohio (N = 11,587) on March 25, 2024. Those who were selected in the first draw were eliminated from the updated list. The response rate for the second random sample was approximately 3.5%. The average response rate was 3.22%. A total of 161 professional counselors participated in the study, which represents approximately 1.4% of the total number of LPCs+ in Ohio.

A total of 1,574 licensed school counselors (LSCs) in Ohio were asked to participate in the study via an email from the Ohio School Counseling Association (OSCA). Potential participants did not receive a follow-up email. The response rate was approximately 1%. The researcher submitted a request to the IRB to extend the initial contacts to faculty members at institutions that have school counseling master's programs and a few school counselors. The request was granted, and over 50 new licensed school counselors participated in the study. A total of 73 LSCs participated in the study. The number of LSCs that participated in the study represents approximately 1.4% of the total number of LSCs in Ohio, which was 5,282 in September 2024 (Ohio Department of Education [ODE], 2023).

Instrumentation and Data Collection Procedures

The data was collected via an online survey using Qualtrics. Before accessing informed consent and other surveys, participants completed the Captcha to avoid digital survey completions. Following that, participants were asked to read the informed consent form. Those who read the informed consent and agree to participate in the study were asked to select "Yes, I consent and agree to participate." Those who did not consent had the right to leave the survey with no further answer needed. After giving consent to participate, respondents answered the following surveys, respectively: the Demographic Information Form (See Appendix A), the Grief Counseling Experience and Training Survey (GCETS, see Appendix B), the Competency in Grief Counseling Survey (CGCS, see Appendix C), and the Attitudes Towards Training in Grief Counseling (ATTGC, see Appendix D). Permission from developers of these instruments can be found in Appendix E and F.

Demographic Information Form

The researcher developed the demographic information form based on previous studies. Participants were asked to answer demographic questions regarding age, gender, race, highest earned educational degree, major field of study, current licensure and certification held, time since the initial licensure was obtained, and current work setting.

Participants were also asked to answer questions regarding their grief and loss training in the demographic information form. These questions included the approximate number of clients/students presenting grief and loss, the number of required standalone grief courses, the number of elective standalone grief courses offered, the number of elective standalone grief courses taken, the number of taken courses that integrate grief

and loss content, and the source of additional training in grief and loss if ever taken, such as professional conferences, web-based training or webinars, personal certification training. Also, participants were asked to report the number of supervision hours in grief and loss if ever received and the adequacy of the supervision received on a 5-Likert type scale, where 1 indicates inadequate and 5 indicates adequate. Finally, participants were asked to rate their familiarity with six grief and loss theories, including Stage Theories (i.e., Kubler-Ross), Task Theories (i.e., Worden), Two-Track Model (i.e., Rubin), Continuing Bonds (i.e., Bonanno & Klass), Dual-Process Theory (i.e., Stroebe & Schut), and Meaning Making Theory (i.e., Neimeyer).

Competency in Grief Counseling Survey (CGCS)

The Competency in Grief Counseling Survey (CGCS) is a revised version of the Death Counseling Survey (DCS), which was developed by Charkow (2002). The DCS was developed to assess the grief counseling competency of counselors in two parts (personal grief counseling competencies and skills and knowledge grief counseling competencies) divided into five different subscales: personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills (Charkow, 2002). The psychometric properties of this instrument indicate high reliability and validity. Results from the pilot study indicated high reliability, as shown by an overall Cronbach's alpha of .97. The Cronbach's alpha for subscales are as follows: personal competency .72, conceptual skills and knowledge .93, assessment skills .80, treatment skills .95, and professional skills .84. The original doctoral study revealed similar results as evidenced: overall .97, personal competency .79, conceptual skills and knowledge .92, assessment skills .87, treatment skills .94, and professional skills .83

(Charkow, 2002). The most recent two studies also reported similar results of Cronbach's alpha, ranging between .72 and .95 (Deffenbaugh, 2008; Imhoff, 2015).

Charkow's (2002) research included the application of the DCS alongside Bugen's (1981) Coping with Death Scale. It was revealed that the DCS demonstrated concurrent validity, evidenced by a correlation coefficient (r) of .73. Content validity of DCS was indicated by the contribution and feedback of twenty-seven grief counseling experts who participated in the three-round Delphi study.

Only minor changes were made to the DCS, and it was renamed to avoid the bias associated with the DCS's title, which may cause a misconception that grief is only about death. Changes are explained in detail in each subscale below. Similar to the DCS, CGCS contains a total of 58 items that participants were asked to rate each item from 1 ("This does not describe me") to 5 ("This describes me very well"). A higher total grief counseling competency score, which ranges between 58 and 290, indicates higher overall competency in grief counseling. Scores on each subscale offer a better understanding of participants' perceived competency in each specific skill.

Part I contains 11 items related to personal grief counseling competencies, which define the counselors' ability to utilize self-care, personal beliefs surrounding grief, humor, and spirituality. Two items from CGCS are shared as following: "I practice personal wellness and self-care" and "I view grief as a systemic as well as an individual experience." The total score of personal competency ranges from 11 to 55. An example of the change made in DCS includes the replacement of "I have experienced the death(s) of a family member and can verbalize my own grief process" with "I have experienced loss and can verbalize my own grief process." Another example includes the replacement

of “I can articulate my own philosophy and attitudes regarding death” with “I can articulate my own philosophy and attitudes regarding loss, including death.”

Part II contains a collective total of 47 items associated with skills and knowledge of grief counseling competencies. Part II is divided into four subscales: conceptual skills and knowledge, treatment skills, assessment skills, and professional skills.

The conceptual skills and knowledge subscale defines and evaluates the participants’ ability to define complicated and normal grief, theoretical knowledge, recognize effective and ineffective coping skills, and understand the development of death with nine items. An example of the change made in this subscale includes the removal of “bereavement” from item 5.

The assessment skills subscale evaluates whether counselors are able to assess unresolved grief, suicidality, spirituality, and the need for medical treatment and recognize the influences of culture on grief with nine items. An example of the change made in this subscale is the replacement of “bereavement, according to DSM-IV” with “Prolonged Grief Disorder (PGD), according to DSM-5-TR” in item 6.

The treatment skills subscale evaluates if counselors are able to facilitate grief counseling sessions in different settings, including individual, group, and family, provide psychoeducation related to grief, build rapport with grieving individuals, utilize active listening and creative arts, and identify roles of culture and morning rituals on grief with 22 items. Examples of the change made in this subscale are that “to grieving individuals” was added to item 47, and “clients” was replaced with “clients/students” in item 17.

The professional skills subscale assesses counselors’ ability to provide activities and interventions related to grief in different settings, crisis intervention, perform

teamwork, follow the most recent updates on the literature of grief, and participate in professional support grief with seven items. No change is made in this subscale.

Grief Counseling Experience and Training Survey (GCETS)

The Grief Counseling Experience and Training Survey (GCETS) measures participants' grief counseling training, supervision, experience, and formal education (i.e., workshops and conferences). GCETS contains a total of 12 items that participants were asked to rate each item from 1 ("Not at all true") to 5 ("Totally true"). Deffenbaugh (2018) adapted the GCETS from the Sexual Orientation Counselor Competency Scale (SOCC), and the results were published by Ober et al. (2012). SOCC was originally developed to measure the competency of counselors in working with gay, lesbian, and bisexual clients. In addition to revised items, Deffenbaugh (2018) added one item to the GCETS, "I have sufficient knowledge of grief counseling theories and models." A pilot study was conducted with 21 counselors before using it in her dissertation study, which indicated a high reliability based on the Cronbach's alpha (.86). The validity was evaluated by asking participants if the survey effectively measured their experience and training in grief counseling. Out of the respondents, thirteen affirmed its effectiveness, none found it ineffective, and the remaining participants chose not to answer the question. Later, in the dissertation study, Deffenbaugh (2018) reported a higher Cronbach's alpha (.93). Except for question number 10, which was reverse scored, a rating of "1" indicates that the participant has no experience or training and "5" indicates that the participant has significant training or experience.

In this study, one minor change was made to promote the inclusiveness of both groups, professional counselors and school counselors. In item 8 ("I feel competent to

assess the mental health needs of a person who presents with grief in a therapeutic setting"), "in a therapeutic setting" part was removed.

Ober et al. (2012) raised a concern about two items of the GCETS because they include statements about overall grief counseling competency rather than grief counseling experience and training. Those items are "At this point in my professional development, I feel competent, skilled, and qualified to counsel clients/students who present with grief" and "I feel competent to assess the mental health needs of a person who presents with grief in a therapeutic setting."The same study reported that grief counseling experience and training was the primary factor influencing the outcomes in the regression models, explaining 50% to 69% of the variance in four out of the five models related to grief counseling competencies.

Considering this result, the researcher included all 12 items to gather information from participants. The correlation between each of these two items and overall grief counseling competency and each subscale were reported to shed light on the relationship between these two items and grief counseling competencies. Results indicated a moderate to high correlation between item 4 and CGCS (r=.66, p<.00) and between item 8 and CGCS (r=.64, p<.001). Therefore, these two items were removed and 10-item version of the GCETS was used (see Chapter 4, CFA section).

Attitudes Towards Training in Grief Counseling (ATTGC)

This brief survey contains four questions to explore counselors' attitudes towards education in grief counseling, and was developed by the researcher. More specifically, one question asked participants' opinions on whether education in grief counseling "is necessary" or "is not necessary." The second question asked participants' opinions on

whether education in grief counseling "should be required" or "should not be required." In a previous study, the first two questions were combined, and only three options were given; "are not necessary," "are necessary," and "should be required" (Deffenbaugh, 2008). Considering that some participants may think education in grief counseling should not be required, this option was added, and the question was split in two questions.

The third question examined the level of participants' willingness to learn more about grief counseling on a 3-Likert type scale ("Yes" or "No" or "Uncertain"), which was also adapted from a previous study examining professional counselors' grief counseling competency (Deffenbaugh, 2008). The final question required participants to report their preferred type of education for grief counseling training from given options: (1) required course(s) in master's or doctoral level counseling programs, (2) elective course(s) in master's or doctoral level counseling programs, (3) professional development through conferences, (4) professional development through web-based training or webinars, (5) professional development through personal training and certifications, and (6) personal development, such as through books and articles.

Data Analysis

The data analysis process began with the closure of surveys in Qualtrics. The researcher conducted descriptive, inferential, and regression analysis methods using the Statistical Package for Social Sciences (SPSS, Version 29) following the data screening procedure, including identifying missing or invalid data, screening for outliers and normality tests. Thereafter, the demographics of participants (age, gender, race, highest earned educational degree, major field of study, current licensure and certification held, and time since the initial licensure obtained) were reported using descriptive statistics.

Before moving to the statistical analyses to answer the research questions, CFA was conducted to determine the best fit for GCETS. Following that, to answer the first research question (the level of grief counseling experience and training as measured by the Grief Counseling Experience and Training Survey (GCETS) of LPCs+ and LSCs in Ohio), the researcher calculated and reported the means, median, mode, standard deviation, and range for both groups using descriptive statistics.

To answer the second research question (the levels of grief counseling competencies (personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) of LPCs+ and LSCs in Ohio), the researcher calculated the overall competency in grief counseling score and each subscale scores to a scale of 1-5, and report the mean, median, mode, standard deviation, and range for both groups using descriptive statistics.

To answer the first part (a) of the third research question (the difference in the areas of grief counseling experience and training between licensed professional counselors and licensed school counselors), the researcher conducted One-Way Analyses of Variance (ANOVA) to compare mean scores in grief counseling experience and training (GCETS) across two groups.

To answer the second part (b) of the third research question (the difference in the levels of self-perceived grief counseling competencies (personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) between licensed professional counselors and licensed school counselors, the researcher conducted a multivariate analysis of variances (MANOVA).

To answer the last research question (the relationship between grief counseling competencies and the following selected demographic variables of age, gender, specialization (professional counseling and school counseling), professional experience as a licensed counselor (years practicing since obtaining initial licensure), grief counseling experience and training (as measured by the GCETS), and completed supervision hours in grief), the researcher conducted regression analyses after testing assumptions, such as normality, linearity, homoscedasticity, multicollinearity, and outliers. Following the assumptions test, the researcher conducted linear regression analyses to investigate the relationship between the dependent variable and independent variables. Six regression analyses were performed, one per subscale of CGCS and one for overall competency in grief counseling.

Lastly, the researcher performed two supplemental exploratory analyses. The first was used to determine the relationship between grief counseling supervision and GCETS. The other was used to examine the predictors of GCETS since it was found to be the strongest predictor of all grief competencies.

Summary

This chapter outlined the methodology of the study. It described the research design, which includes the research questions and hypotheses foundational to the investigation. The chapter then clarified the definitions of key variables, ensuring clarity in the terms used throughout the study. It also provided a detailed description of the population, sample size, and sampling plan. The instruments selected for data collection were then discussed. Following this, the data collection procedures were explained, detailing the step-by-step process of gathering data. Finally, the chapter concluded by

presenting the methods of data analysis, describing how statistical tests were used to analyze the data. Subsequent chapters will include the presentation of the data screening, results, discussion, implications, and limitations and suggestions for future researchers.

Death Is an Empty Cage.	*Ölüm Boş Bir Kafestir*
Watch it, If You Can.	*İzle İzleyebilirsen*
Fill It Again, If You Can.	*Yeniden Doldur, Doldurabilirsen*
Or Get Rid of It, If You Feel Brave Enough	*Ya da Kurtul Ondan Çok Cesursan*
Take a Look Back at the Cage	*Dön Bir Bak Kafese*
It Might Be Locked on You, too.	*Üstüne Kilitlenmiş Olabilir Senin de.*

Ibrahim Akmese

Chapter 4: Results

This chapter presents a comprehensive overview of the statistical results. It outlines research questions, data screening, participants' demographic information, and the results of the statistical analyses for each research question, including three supplemental exploratory analyses. The analyses performed include descriptive statistics, Confirmatory Factor Analysis (CFA), One-way ANOVA, One-way MANOVA, and Multiple Regression Analyses. The Statistical Package for Social Sciences (SPSS) was used for all statistical analyses, except for CFA, which was conducted through Jamovi.

Research Questions

1. What is the level of grief counseling experience and training as measured by the Grief Counseling Experience and Training Survey (GCETS) of licensed professional counselors + (LPCs+) and licensed school counselors (LSCs)?
2. What are the levels of grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) of licensed professional counselors + (LPCs+) and licensed

school counselors (LSCs) as measured by the Competency in Grief Counseling Survey (CGCS)?

3.

a. What is the difference in grief counseling experience and training as measured by the GCETS between licensed professional counselors + (LPCs+) and licensed school counselors (LSCs)?

$H_0 3_a$: There is no statistically significant difference between licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) in terms of grief counseling experience and training.

$H_1 3_a$: There is a statistically significant difference between licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) in terms of grief counseling experience and training.

b. What is the difference in the levels of grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) as measured by the CGCS between licensed professional counselors + (LPCs+) and licensed school counselors (LSCs)?

$H_0 3_b$: There is no statistically significant difference between licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) in terms of grief counseling competencies.

$H_1 3_b$: There is a statistically significant difference between licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) in terms of grief counseling competencies.

4. What is the relationship between grief counseling competencies and the demographic variables of age, gender, specialization (i.e., professional counseling and school counseling), professional experience as a licensed counselor (i.e., years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, and completed supervision hours in grief?

    $H_0$4: There is no relationship between age, gender, specialization (professional counselors and school counselors), professional experience as a licensed counselor (years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, completed supervision hours in grief, and the grief counseling competencies.

    $H_1$4: There is a significant relationship between age, gender, specialization (professional counselors and school counselors), professional experience as a licensed counselor (years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, completed supervision hours in grief, and the grief counseling competencies.

Data Screening

A total of 1,000 licensed professional counselors (LPC, N=333), licensed professional clinical counselors (LPCC, N=334), and licensed professional clinical counselors with supervision endorsement (LPCC-S, N=333) were randomly selected using the Statistical Package for Social Sciences (SPSS, Version 29) from a list of 11,587 licensed professional counselors in the state of Ohio, obtained from the Ohio Counselor, Social Worker, and Marriage and Family Therapist (CSWMFT) Board. The response rate

for the initial and follow-up contact was 2%. The researcher submitted a request to the Institutional Review Board (IRB) to draw another sample to meet the minimum sample size required for the statistical analyses. The request was granted by IRB, and the researcher drew a new sample consisting of 4,000 professional counselors distributed equally between LPCs, LPCCs, and LPCCs-S. The response rate for the second random sample was approximately 3.5%. The average response rate was 3.22%. A total of 161 professional counselors participated in the study, which represents approximately 1.4% of the total number of licensed professional counselors in Ohio.

A total of 1,574 licensed school counselors (LSCs) in Ohio were asked to participate in the study via an email from the Ohio School Counseling Association (OSCA). Potential participants did not receive a follow-up email. The response rate was approximately 1%. The researcher submitted a request to the IRB to extend the initial contacts to faculty members at institutions that have school counseling master's programs and a few school counselors. The request was granted, and over 50 new licensed school counselors participated in the study. A total of 73 LSCs participated in the study. The number of LSCs that participated in the study represents approximately 1.4% of the total number of LSCs in Ohio, which was 5,282 in September 2024 (Ohio Department of Education [ODE], 2023).

The total sample for professional counselors and school counselors was 235 counselors; however, one participant did not report their type of licensure. Although the LPCs+ and LSCs groups were not equally distributed, the minimum required sample size (N=198) was met. The data was examined to identify valid, invalid, and missing data. This examination was concluded with the identification of 34 invalid surveys due to the

completion of only a few demographic questions. These cases were investigated to determine specific patterns of incompletion. Although there were no particular pattern raising concerns about the data collection, the majority were White (N=28), Women (N=33), school counselors (N=20), and held master's degrees (N=32). All 34 cases were eliminated from the data set. A total of 201 participants remained.

A few grounding approaches were followed in the data screening and cleaning process. First, counselors with both school and professional counseling licensure were further examined in terms of the major field of study and years since obtaining licensure. Those whose longest years of experience and major field of study were under the same licensure were grouped based on the dominant licensure. For example, if a participant with both school and professional counseling licensure indicated the major field of study as school counseling and also indicated that they have worked under their school counseling licensure significantly longer than professional counseling licensure, they were added to the LSCs group (n=1). Second, some participants did not report a specific number for demographic questions asking to report in numbers (e.g., "Approximately, how many clients/students presenting death-related grief and loss have you worked with?"). The researcher recorded these numbers with the minimum number that fits the definition of the responses. For example, 24 was replaced with "dozens," 101 with "over 100," and 51 with "+50" (n=5).

Participant Demographics

Age, Gender, Race/Ethnicity, and Major Field of Study

Of the 52 LSCs that participated in the study, the majority were women (90.4%) who identified as White/Caucasian (92.3%) and held a master's degree (96.2%) with a

specialization in school counseling (98.1%). Similarly, of the 148 LPCs+ that participated in the study, the majority were women (83.8%) who identified as White/Caucasian (83.8%) and held a master's degree (89.9%) with a specialization in clinical mental health counseling (91.9%).

Table 1
Demographic Characteristics of Participants

	Licensed School Counselors (LSCs)		Licensed Professional Counselors + (LPCs+)		Total	
	n	%	n	%	n	%
Gender						
Woman	47	90.4	124	83.8	172	85.6
Man	4	7.7	20	13.5	24	11.9
Non-binary	0	0	4	2.7	4	2.0
Other	1	1.9	0	0	1	.5
Ethnicity						
White/Caucasian	48	92.3	124	83.8	173	86.1
Black/African American	2	3.8	12	8.1	14	7.0
Hispanic/Latinx	0	0	7	4.7	7	3.5
Native American	0	0	1	.7	1	.5
Multiracial	2	3.8	2	1.4	4	2.0
Other	0	0	2	1.4	2	1.0
Highest education level						
Master's	50	96.2	133	89.9	184	91.5
Doctorate	2	3.8	14	9.5	16	8.0
Other	0		1	.7	1	.5
Major field of study						
CMHC	0	0	136	91.9	137	68.5
SC	51	98.1	2	1.4	53	26.5
CRC	0	0	2	1.4	2	1.0
Other	1	1.9	7	4.7	8	4.0

Note. One participant did not indicate their type of licensure (LSC vs. LPC+); therefore, the total column is not equal to n for LSCs + n for LPCs+.
CMHC: clinical mental health counseling; SC: school counseling; CRC: clinical rehabilitation counseling.

Age and Years of Experience

The mean age for LSCs (N=52) was 42.15 years, with a range between 25 and 67 and a standard deviation of 9.65 years. Of the 148 LPCs+, on the other hand, the mean age of participants for LPCs+ was 45.61 years, with a range between 25 and 91 and a

standard deviation of 13.72 years. LSCs had an average of 11.08 years since they obtained their initial licensure, with a range of 1 and 40 years and a standard deviation of 8.64. LPCs+ had an average of 11.04 years since they obtained their initial licensure, with a range of .33 and 55 years and a standard deviation of 10.29.

Table 2

Descriptive Statistics of Age and Years of Experience for Licensed School Counselors (LSCs)

		Range				
	n	min	max	M	SD	Skew
Age	52	25	67	42.15	9.65	.42
Years of Experience	50	1	40	11.08	8.64	1.04

Table 3

Descriptive Statistics of Age and Years of Experience for Licensed Professional Counselors + (LPCs+)

		Range				
	n	min	max	M	SD	Skew
Age	148	25	91	45.61	13.72	.43
Years of Experience	148	.33	55	11.04	10.29	1.43

Number of Clients/Students Presenting Grief and Loss

Participants were asked to report how many students/clients presented both death-related and non-death-related grief and loss that they have worked with. The scale variables were recoded into grouping variables using the values of the 33rd and 67th percentiles of the sample distribution. Of the 50 LSCs who reported the number of

students presenting death-related grief that they provided counseling services for, 30% reported seeing 1 to 15 students, 38% reported seeing 16 to 50 students, and 32% reported seeing more than 50 students. Similarly, 38.4% of LPCs+ noted that they had seen 1 to 15 clients presenting death-related grief and loss, 35.5% reported seeing 16 to 50 clients, and 26.1% reported seeing more than 50 clients. There were no participants who reported seeing no clients presenting death-related grief and loss.

Among the 47 LSCs who reported the number of students presenting with death-related grief for whom they provided counseling services, only 2.1% indicated that they had seen 'zero' students. The percentages of LSCs reporting the number of students they had seen presenting with non-death-related grief and loss issues were as follows: 21.3% saw between 1 and 35 students, 31.9% saw between 36 and 101 students, and 44.7% saw more than 101 students. Similarly, of the 133 LPCs+ who reported the number of clients presenting with non-death-related grief and loss issues, only 3.8% indicated that they had seen 'zero' clients. The percentages of LPCs+ reporting the number of clients they had seen presenting with non-death-related grief and loss issues were as follows: 33.1% saw between 1 and 35 students, 37.6% saw between 36 and 101 students, and 25.6% saw more than 101 students.

Table 4

Descriptive Statistics of Experiences with Clients/Students Presenting Death and Non-death Related Grief

	Licensed School Counselors (LSCs)		Licensed Professional Counselors + (LPCs+)		Total	
	n	%	n	%	n	%
Number of students/clients presenting death related grief						
1-15	15	30.0	53	38.4	68	36.0
16-50	19	38.0	49	35.5	69	36.5
>50	16	32.0	36	26.1	52	27.5
Number of students/clients presenting non-death related grief						
0 (zero)	1	2.1	5	3.8	6	3.3
1-35	10	21.3	44	33.1	54	29.8
36-101	15	31.9	50	37.6	65	35.9
>101	21	44.7	34	25.6	56	30.9

Note. One participant did not indicate their type of licensure (LSC vs. LPC+); therefore, the total column is not equal to n for LSCs + n for LPCs+.

Formal Training in Grief Counseling

Of the LSCs, 88.5% had not taken a standalone required grief course in their graduate counseling programs. Over two-thirds of LSCs were not offered a standalone grief course. 80% of those who were offered one or two standalone elective grief courses had taken at least one of those courses. The majority of LSCs had taken at least one or two courses in which grief and loss content was integrated. Similarly, of the LPCs+, 77.9% had not taken a standalone required grief course in their graduate counseling programs. Among the LPCs+, 66% were not offered a standalone elective grief course; however, 79.2% of those who were offered one or two standalone elective grief courses

had taken at least one of those courses. Among the LPCs+, 67.6% had taken at least one course in which grief and loss content was integrated.

Table 5

Descriptive Statistics of Formal Education (Formal Training) Received and Offered

	Licensed School Counselors (LSCs)		Licensed Professional Counselors + (LPCs+)		Total	
	n	%	n	%	N	%
Number of standalone required grief courses taken						
No courses	46	88.5	113	77.9	159	80.3
One course	5	9.6	23	15.9	29	14.6
Two or more courses	1	1.9	9	6.2	10	5.1
Number of standalone elective grief courses offered						
No courses	36	69.2	93	66.0	129	68.6
One course	7	13.5	40	28.4	47	25.0
Two or more courses	3	5.8	8	5.7	12	6.4
Number of standalone elective grief courses taken						
No courses	44	84.6	107	73.8	151	76.3
One course	6	11.5	30	20.7	37	18.7
Two or more courses	2	3.8	8	5.5	10	5.1
Number of taken courses integrates grief and loss						
No courses	6	12.2	46	32.4	52	27.2
One course	16	32.7	47	33.1	63	33.0
Two or more courses	27	55.1	49	34.5	76	39.8

Informal Training in Grief Counseling: Professional Development

Participants were asked to report the number of professional development hours (i.e., conferences, web-based training, certification, reading books, and reading articles in the last six months) they had earned in numbers. The scale variables were recoded into

grouping variables using the values of the 33rd and 67th percentiles of the sample distribution. Of the LSCs participants, 40% had earned “zero hours” of professional development hours through conferences, 42.1% had earned “zero hours” of professional development hours through web-based training, and 70% had earned “zero hours” of professional development hours through certification programs. Of the LSCs, 75% had read “zero books” and 39.1% had read “zero articles” in the last six months. The percentage of LPCs+ who had earned “zero hours” of professional development hours through conferences (50.5%) and certification training programs (79.1%) was higher than LSCs. In other words, the likelihood of earning at least one professional development hour through conferences and certification training programs was higher for LSCs than LPCs+. On the other hand, LPCs+ were more likely to earn professional development hours through web-based training, and are more likely to read grief and loss-related books and articles in the last six months.

Table 6

Descriptive Statistics of Professional Development (Informal Training)

	Licensed School Counselors (LSCs)		Licensed Professional Counselors + (LPCs+)		Total	
Number of Professional Development hours	n	%	n	%	n	%
Conference Hours						
Zero hours	14	40.0	46	50.5	60	47.6
1-5 hours	14	40.0	12	13.2	26	20.6
6-12 hours	3	8.6	16	17.6	19	15.1
>12 hours	4	11.4	17	18.7	21	16.7
Web-based Training						
Zero hours	16	42.1	36	32.4	52	34.9
1-3 hours	13	34.2	21	18.9	34	22.8
4-10 hours	7	18.4	30	27.0	37	24.8
>10 hours	2	5.3	24	21.6	26	17.4
Certification Training						
Zero hours	19	70.4	53	79.1	72	76.6
1-5 hours	3	11.1	6	9.0	9	9.6
6-15 hours	1	3.7	2	7.5	6	6.4
>15 hours	4	14.8	6	4.5	7	7.4
Reading Books						
Zero books	24	75.0	59	56.2	84	60.9
1 Book	6	18.8	19	18.1	25	18.1
2 books	1	3.1	17	16.2	18	13.0
>2 books	1	3.1	10	9.5	11	8.0
Reading Articles						
Zero articles	18	39.1	41	33.9	59	35.1
1-2 articles	12	26.1	44	27.3	46	27.4
3-5 articles	9	19.6	25	24.8	39	23.2
>5 articles	7	15.2	11	14.0	24	14.3

Certifications

Zero LSCs were Certified in Thanatology (CT), Fellow in Thanatology (FT), Certified in Death Education (CDE), Certified in Grief Counseling (CGC), and Certified

in Grief Therapy (CGT). Similarly, zero LPCs+ were Fellow in Thanatology (FT), Certified in Death Education (CDE), and Certified in Grief Therapy (CGT). On the other hand, the percentage of LPCs+ who held National Counseling Certification (NCC) (22.3%) and "other certifications" related to grief and loss (12.2%) was much higher than LSCs held NCC (1.9%) or other certifications" related to grief and loss (1.9%).

Table 7

Descriptive Statistics of Certifications Received

	Licensed School Counselors (LSCs)		Licensed Professional Counselors + (LPCs+)		Total	
	n	%	n	%	n	%
Certifications						
National Certified Counselor (NCC)	1	1.9	33	22.3	34	16.9
Not National Certified Counselor	51	98.1	115	77.7	167	83.1
Certified in Thanatology (CT)	0	0	1	.7	1	.5
Not Certified in Thanatology	52	100.0	147	99.3	200	99.5
Fellow in Thanatology (FT)	0	0	0	0	0	0
Not Fellow in Thanatology	52	100	148	100.0	201	100
Certified in Death Education (CDE)	0	0	0	0	0	0
Not Certified in Death Education	52	100	148	100.0	201	201
Certified in Grief Counseling (CGC)	0	0	1	.7	1	.5
Not Certified in Grief Counseling	52	100.0	147	99.3	200	99.5
Certified in Grief Therapy (CGT)	0	0	0	0	0	0
Not Certified in Grief Therapy (CGT)	52	100	148	100.0	201	100
Other Certifications						
Holds certification different than listed ones	1	1.9	18	12.2	20	10.0
Does not Holds certification different than listed ones	51	98.1	130	87.8	181	90.0

Supervision

Participants were asked to report whether they had grief counseling supervision and the number of supervision hours as well as rating the adequacy of the supervision experience. The scale variable of number of supervision hours was recoded into grouping variables using the values of the 33rd and 67th percentiles of the sample distribution. Only 13.5% of LSCs had received grief counseling supervision, whereas 46.3% of LPCs+ had received at least one hour of grief counseling supervision. Of those who had received grief counseling supervision, the percentage of LPCs+ who received 1-3 hours (17.2%), 4-10 hours (15.2%), and more than 10 hours (13.1%) was higher than LSCs. The majority of LSCs and LPCs+ indicated that their supervision experience was either somewhat adequate or adequate.

Table 8

Descriptive Statistics of Grief Counseling Supervision

	Licensed School Counselors (LSCs)		Licensed Professional Counselors + (LPCs+)		Total	
	n	%	n	%	n	%
Grief Counseling Supervision Status						
Received	7	13.5	68	46.3	76	38.0
Not Received	45	86.5	79	53.7	124	62.0
Grief-related Supervision Hours Received						
Zero hours	45	86.5	79	54.5	124	62.9
1-3 hours	2	3.8	25	17.2	27	13.7
4-10 hours	4	7.7	22	15.2	26	13.2
> 10 Hours	1	1.9	19	13.1	20	10.2
Adequacy of Supervision						
Inadequate	0	0	3	4.3	3	3.9
Somewhat Inadequate	1	14.3	4	5.8	6	7.9
Neutral	2	28.6	14	20.3	16	21.1
Somewhat Adequate	3	42.9	23	33.3	26	34.2
Adequate	1	14.3	25	36.2	25	32.9

Familiarity With Grief Theories

Participants were asked to rate their familiarity with six grief and loss theories, including Stage Theories (i.e., Kubler-Ross), Task Theories (i.e., Worden), Two-Track Model (i.e., Rubin), Continuing Bonds (i.e., Bonanno & Klass), Dual-Process Theory (i.e., Stroebe & Schut), and Meaning Making Theory (i.e., Neimeyer). Responses ranged between “none,” “very little,” “some,” or “a lot” of familiarity with the listed theories.

The majority of LSCs were “some” (51%) or “a lot” (15.7%) familiar with the Stage Theories. However, of the 51 LSCs, 90.2% reported “none” “or very little” level of familiarity with the Task Theories, 98% reported “none” “or very little” level of

familiarity with the Dual-Process Theory, 98% reported “none” “or very little” level of familiarity with the Two-Track Model, 89.2% reported “none” “or very little” level of familiarity with the Meaning Making Theory, and 98.1% reported “none” “or very little” level of familiarity with the Continuing Bonds Theory.

Similarly, the majority of LPCs+ were “some” (41.8%) or “a lot” (47.9%) familiar with the Stage Theories. However, of the 146 LPCs+, 65.8% reported “none” “or very little” level of familiarity with the Task Theories, 76.8% reported “none” “or very little” level of familiarity with the Dual-Process Theory, 88.3% reported “none” “or very little” level of familiarity with the Two-Track Model, 56.9% reported “none” “or very little” level of familiarity with the Meaning Making Theory, and 79.5% reported “none” “or very little” level of familiarity with the Continuing Bonds Theory.

In summary, the Stage Theories are the most known theories for both LSCs and LPC+. Although Task Theories, Dual-Process Theory, Two-Track Model, Meaning Making Theory, and Continuing Bonds were the least known grief counseling theories for both groups, the percentage of LPCs+ who are familiar with these theories was higher than LSCs.

Table 9

Descriptive Statistics of Familiarity with Grief Counseling Theories

	Licensed School Counselors (LSC)		Licensed Clinical Counselors (LCC)		Total	
Familiarity with Grief Counseling Theories	n	%	n	%	n	%
Stage Theories						
None	6	11.8	3	2.1	9	4.5
Very Little	11	21.6	12	8.2	23	11.6
Some	26	51.0	61	41.8	88	44.4
A lot	8	15.7	70	47.9	78	39.4
Task Theories						
None	30	58.8	53	36.3	83	41.9
Very Little	16	31.4	43	29.5	60	30.3
Some	5	9.8	37	25.3	42	21.2
A lot	0	0	13	8.9	13	6.6
Two Track Model						
None	40	78.4	85	58.2	126	63.6
Very Little	10	19.6	44	30.1	54	27.3
Some	1	2.0	14	9.6	15	7.6
A lot	0	0	3	2.1	3	1.5
Continuing Bonds						
None	40	76.9	68	46.6	109	54.8
Very Little	11	21.2	48	32.9	59	29.6
Some	0	1.9	23	15.8	24	12.1
A lot			7	4.8	7	3.5
Dual Process Theory						
None	36	70.6	63	43.2	99	50.0
Very Little	14	27.5	49	33.6	64	32.3
Some	1	2.0	27	18.5	28	14.1
A lot	0	0	7	4.8	7	3.5
Meaning Making						
None	25	49.0	34	23.3	59	29.8
Very Little	20	39.2	49	33.6	69	34.8
Some	6	11.8	51	34.9	58	29.3
A lot	0	0	12	8.2	12	6.1

Attitudes Towards Training in Grief Counseling

Four questions investigated participants' attitudes towards education in grief counseling, including whether education in grief counseling is or is not necessary, whether it should be or should not be required, willingness to learn more about grief counseling, and preferred type of education for grief counseling training. Almost all LSCs (97.8%) and LPCs+ (99.2%) indicated that education in grief counseling is necessary. Similarly, almost all LSCs (95.6%) and LPCs+ (93.9%) reported that education in grief counseling should be required. Moreover, 82.2% of LSCs and 91.7% of LPCs+ noted that they are willing to participate and learn more about grief counseling.

All types of education in grief counseling were selected by the majority of LSCs and LPCs+ as the preferred way of training, except for elective courses (24.4% and 43.3%, respectively).

Table 10

Descriptive Statistics of Attitudes Towards Training in Grief Counseling

	Licensed School Counselors (LSCs)		Licensed Professional Counselors + (LPCs+)		Total	
	n	%	n	%	n	%
Education in grief counseling						
Is necessary	44	97.8	131	99.2	175	98.9
Is not necessary	1	2.2	1	.8	2	1.1
Education in grief counseling						
Should be required	43	95.6	123	93.9	166	94.3
Should not be required	2	4.4	8	6.1	10	5.7
Willingness to participate and learn more about grief counseling						
Yes	37	82.2	121	91.7	158	89.3

No	0	0	4	3.0	4	2.3
Uncertain	8	17.8	7	5.3	15	8.5
Preferred type of education in grief counseling						
Required courses	34	75.6	79	59.0	113	63.1
Elective courses	11	24.4	58	43.3	69	38.6
Conferences	33	73.3	88	65.7	121	67.6
Web-based training	37	82.2	105	78.5	142	79.3
Training for Certification	36	80.0	79	59.0	115	64.3
Book and articles	32	71.1	87	64.9	119	66.5

Univariate Distribution of Normality

A normality test has been conducted to test the univariate normality of the variables included in the analyses. Histogram graphs for each variable are also shared below in the figures.

Table 11

Univariate Normality Test Results for Continuous Variables

	Licensed School Counselors (LSCs)		Licensed Professional counselors + (LPCs+)	
	W	p-value	W	p-value
Overall CGCS	.910	.002	.983	.094
PC	.950	.046	.971	.005
CSK	.962	.133	.970	.004
AS	.950	.046	.980	.044
TS	.928	.007	.989	.317
ProS	.954	.066	.987	.246
GCETS	.942	.023	.981	.055

CGCS: competencies in grief counseling survey; PC: personal competencies; CSK: conceptual skills and knowledge; AS: assessment skills; TS: treatment skills; ProS: professional skills.

Figure 1

Distribution of the Grief Counseling Experience and Training (GCETS) for LSCs

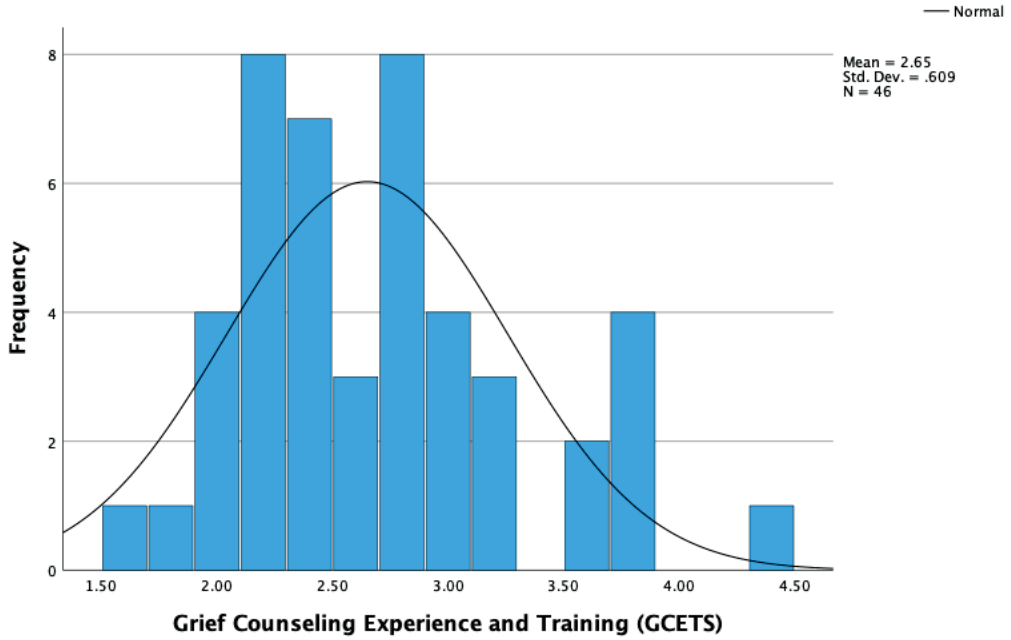


Figure 2

Distribution of the Grief Counseling Experience and Training (GCETS) for LPCs+

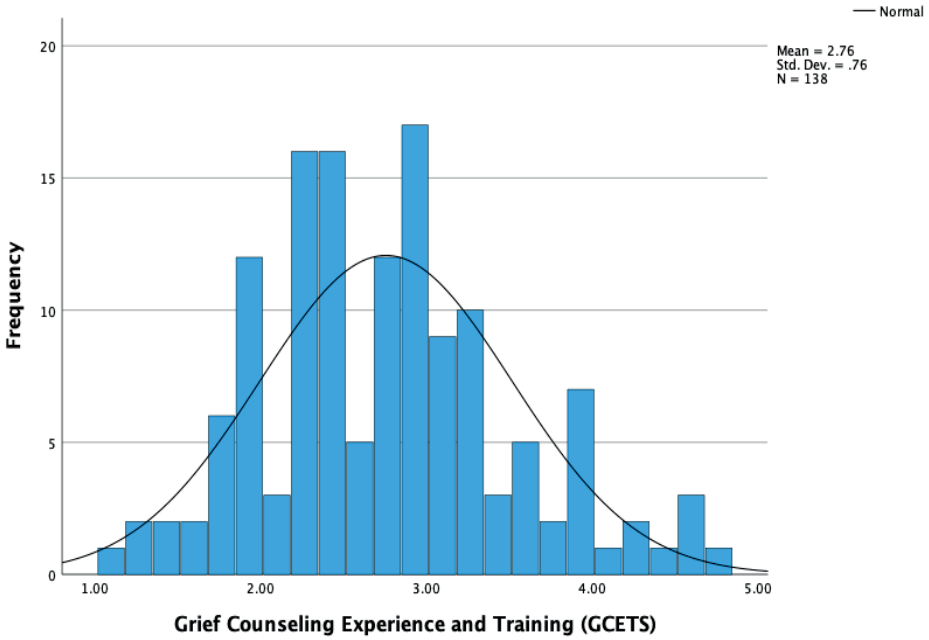


Figure 3

Distribution of the Overall Competency in Grief Counseling (CGCS) for LSCs

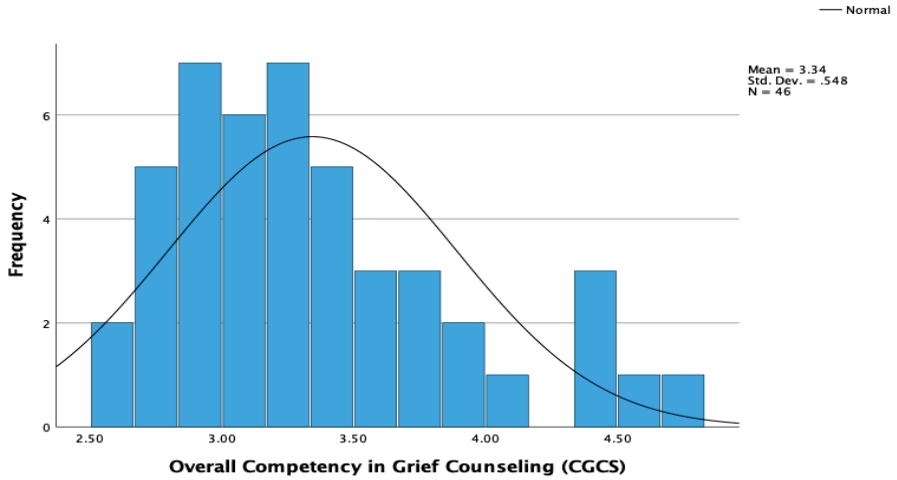


Figure 4

Distribution of the Overall Competency in Grief Counseling (CGCS) for LPCs+

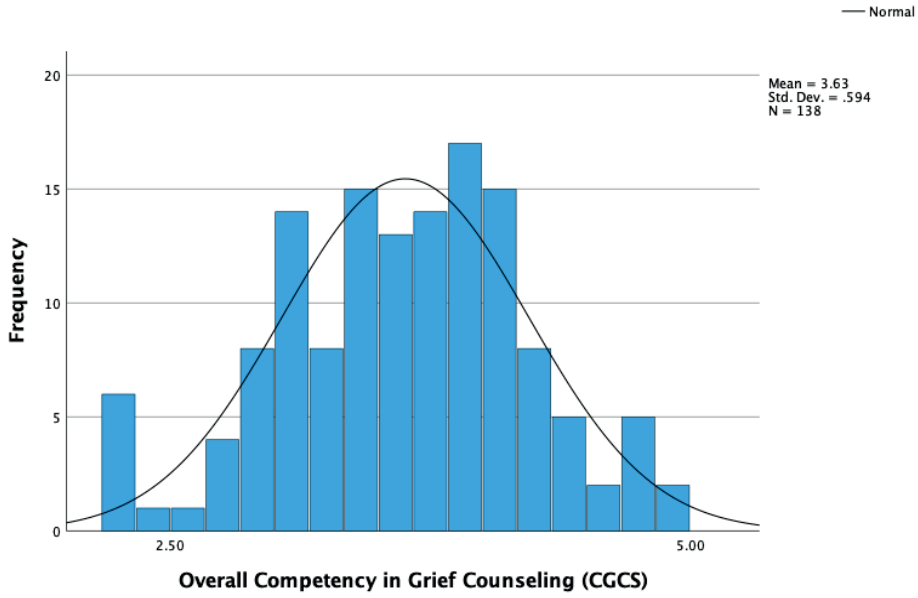


Figure 5

Distribution of Personal Competencies (PC) in Grief Counseling for LSCs

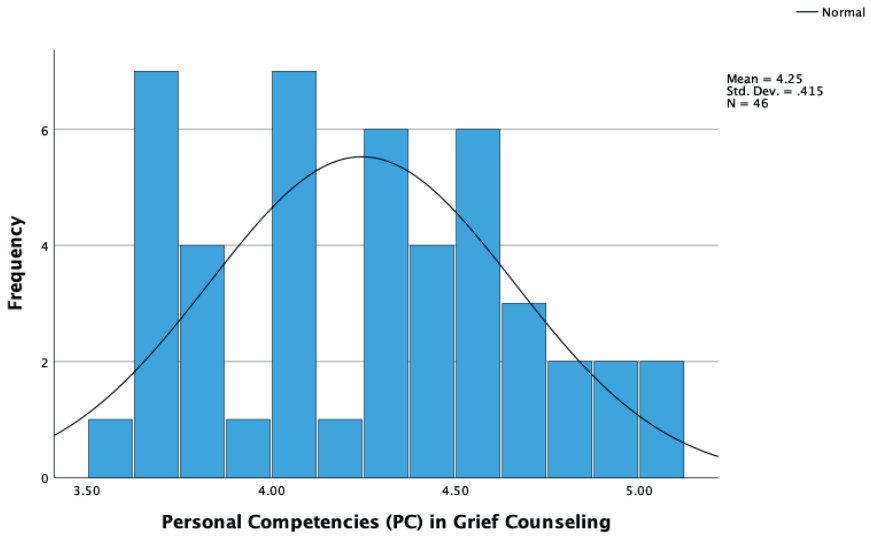


Figure 6

Distribution of Personal Competencies (PC) in Grief Counseling for LPCs+

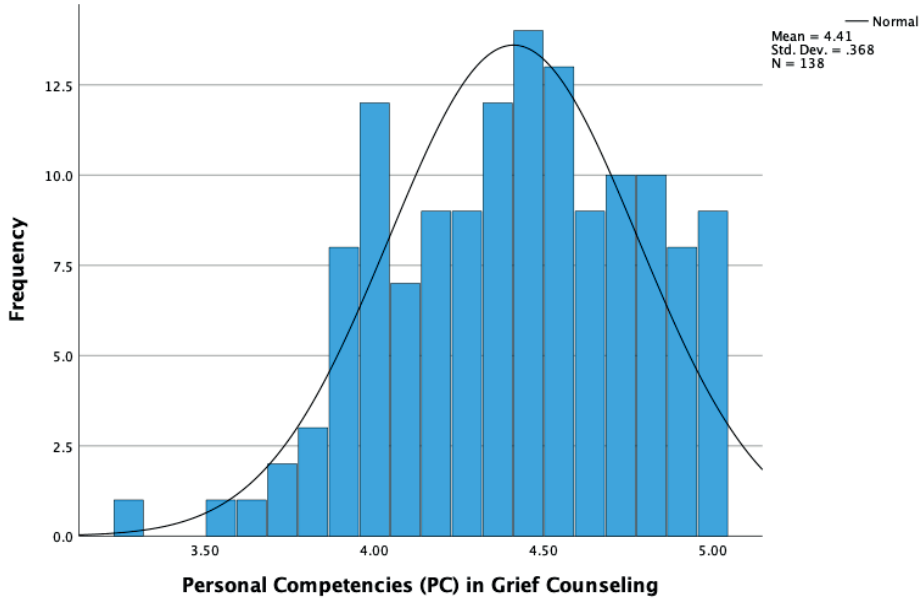


Figure 7

Distribution of Conceptual Skills and Knowledge (CSK) in Grief Counseling for LSCs

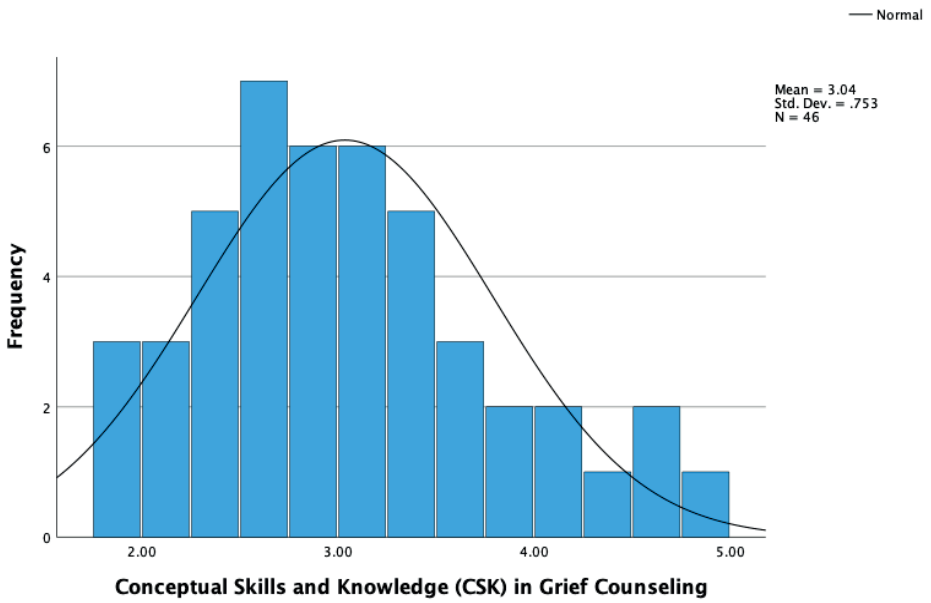


Figure 8

Distribution of Conceptual Skills and Knowledge (CKS) in Grief Counseling for LPCs+

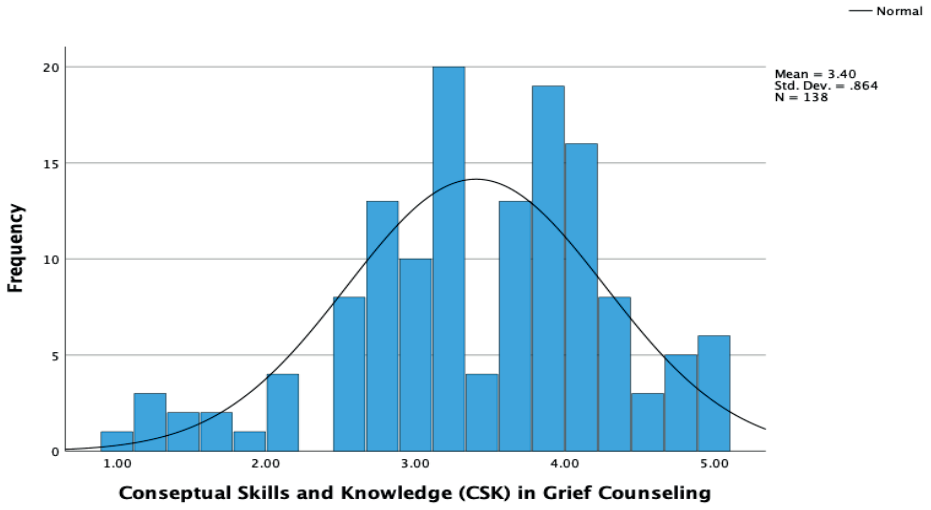


Figure 9

Distribution of Assessment Skills (AS) in Grief Counseling for LSCs

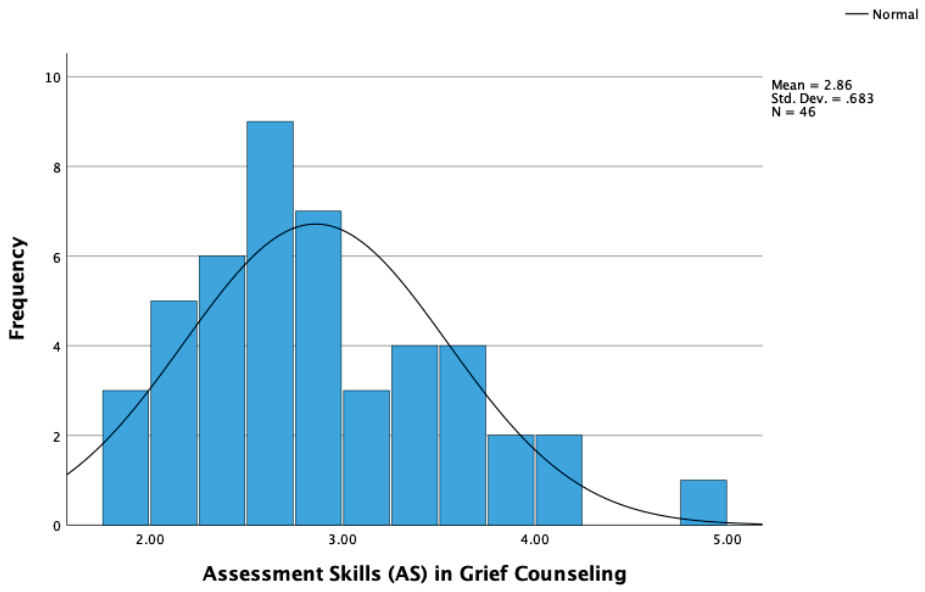


Figure 10

Distribution of Assessment Skills (AS) in Grief Counseling for LPCs+

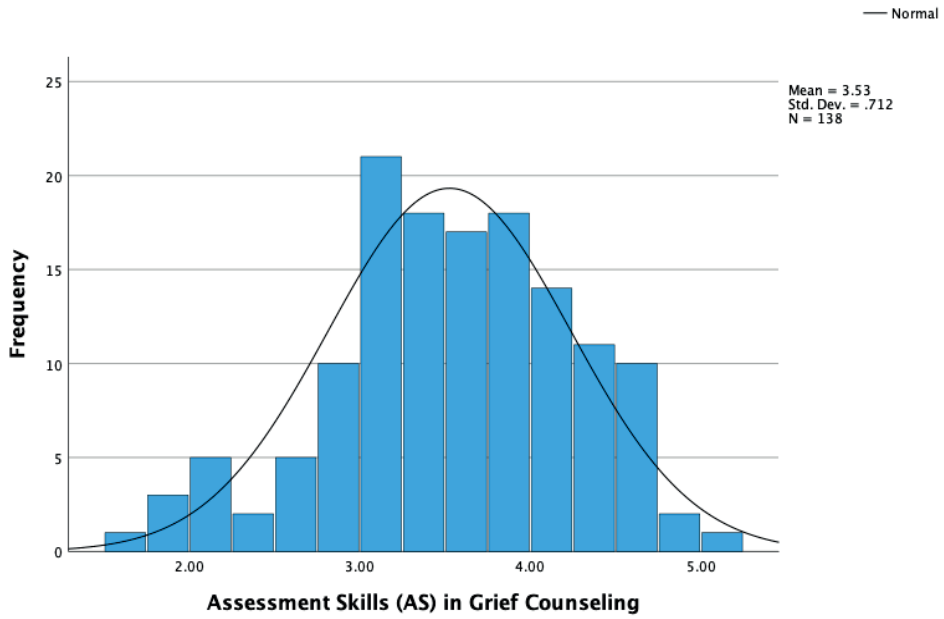


Figure 11

Distribution of Treatment Skills (TS) in Grief Counseling for LSCs

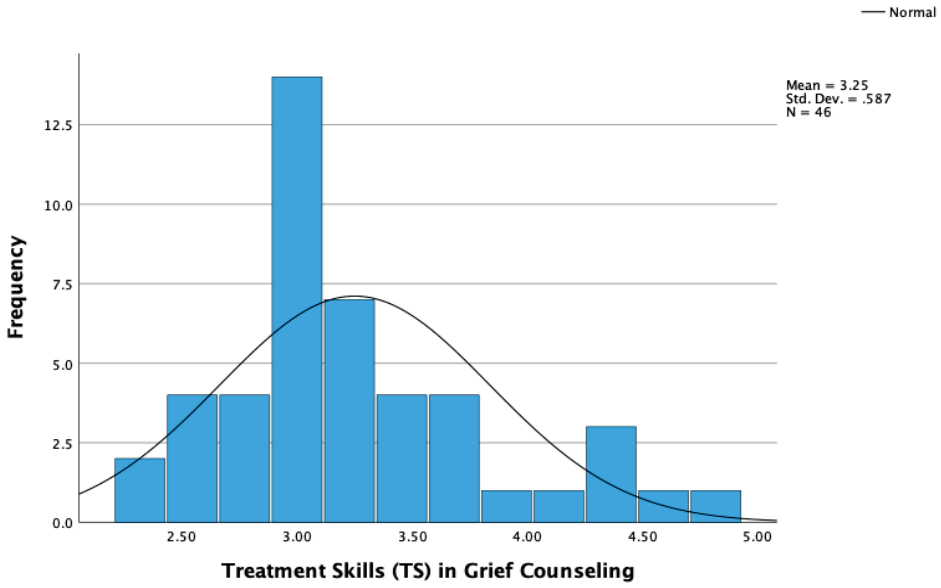


Figure 12

Distribution of Treatment Skills (TS) in Grief Counseling for LPCs+

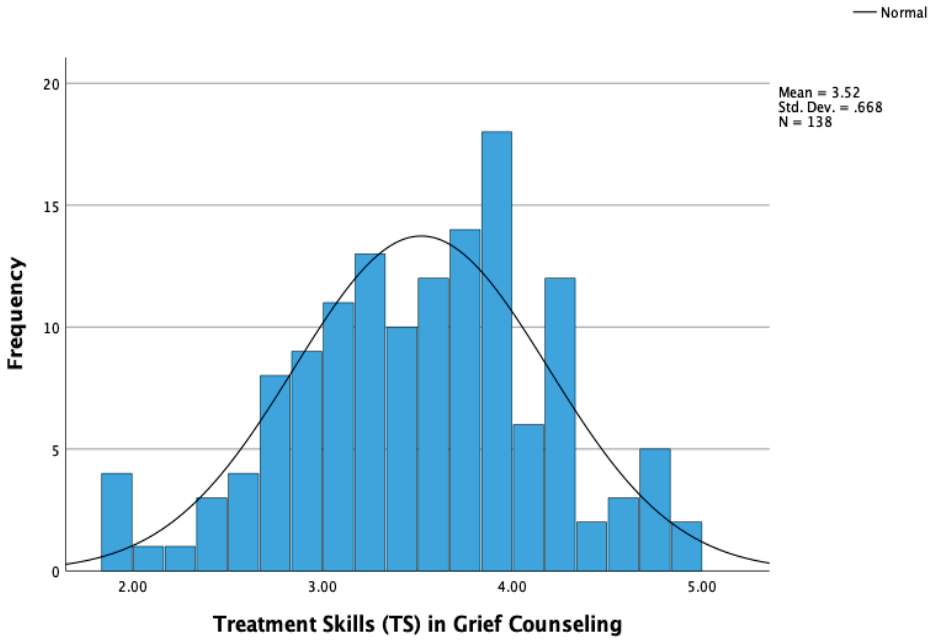


Figure 13

Distribution of Professional Skills (PS) in Grief Counseling for LSCs

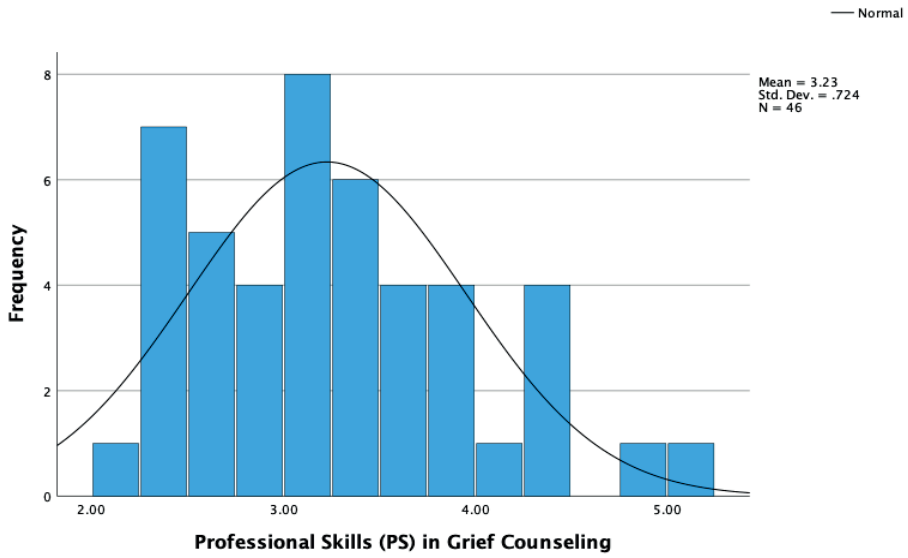


Figure 14

Distribution of Professional Skills (PS) in Grief Counseling for LPCs+

Confirmatory Factor Analysis: Grief Counseling Experience and Training Survey (GCETS)

The original version of the Grief Counseling Experience and Training Survey (GCETS) contains a total of 12 items measuring participants' grief counseling experience and training. GCETS was adapted from a subscale of the Sexual Orientation Counselor Competency Scale (SOCC) by Ober et al. (2012). SOCC was originally developed to measure the competency of counselors in working with gay, lesbian, and bisexual clients. In addition to revised items, Deffenbaugh (2008) added one item to the GCETS, "I have sufficient knowledge of grief counseling theories and models." Ober et al. (2012) raised a concern about two items of the GCETS because they include statements about overall grief counseling competency rather than grief counseling experience and training.

GCETS clearly has items measuring experience and training separately, but it has been adapted to measure experience and training with one total score as one single factor. For example, item 5 ("I have a great deal of experience counseling persons who experienced loss of a loved one to suicide") and item 6 ("I have a great deal of experience counseling children who present with grief") measure experience of working with suicide loss survivors and children, and item 9 ("I have a great deal of experience with facilitating group counseling focused on grief concerns") measures grief counseling experience in a group setting. On the other hand, item 7 ("I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling") specifically measures training. Therefore, there is a possibility that GCETS may measure experience and training separately as two factors.

Considering that GCETS was not originally adapted to measure grief counseling experience and training, there is still room for improvement. To contribute to the evolution of the GCETS, the researcher examined the correlation between overall grief counseling competency measured by the Competency in Grief Counseling Survey (CGCS) and the two items that researchers (Ober et al., 2012) reported potential concerns about. Results indicated a moderate to high correlation between item 4 and CGCS (r=.66, p<.00) and between item 8 and CGCS (r=.64, p<.001). Following that, the researcher conducted four Confirmatory Factor Analyses (CFA) using Jamovi (Version 2.6) to test the best model fit among a 12-item version of GCETS with one factor, a 12-item version of GCETS with two factors, a 10-item version of GCETS with one factor, and 10-items version of GCETS with two factors. The researcher conducted two Exploratory Factor Analyses (EFA) to confirm that the items, which were explicitly designed to measure either training or experience, appropriately grouped into two distinct factors for subsequent Confirmatory Factor Analysis (CFA). This step was necessary to ensure that the items were accurately categorized according to their respective constructs before moving forward with the CFA.

Table 12

Results of Confirmatory Factor Analysis (CFA) for the Grief Counseling Experience and Training Survey (GCETS)

Model	χ^2 (df)	RMSEA 90% CI	CFI	TLI	SRMR	AIC
One factor, 12 items	177 (54)***	.108 (.090-.125)	.886	.861	.062	5958
One factor, 10 items	101 (35)***	.098 (.076-.120)	.908	.881	.055	5185
Two factor, 12 items	137 (53)***	.090 (.071-.108)	.922	.903	.055	5920
Two factor, 10 items	77.6 (34)***	.081 (.057-.105)	.939	.919	.047	5164

Note: χ^2 = Chi-square, df = Degree of freedom; RMSEA = Root-mean-square error of approximation; CI = Confidence interval; CFI = Comparative fit index; TLI = Tucker-Lewis index; SRMR = Standardized root mean square residual; AIC = Akaike information criterion.
*** $p<.001$

Results have shown that the two-factor, 10-item model demonstrated the best overall fit among the models tested as evidenced by the lowest chi-square (χ^2 =77.6, df (34)), The RMSEA was .081 (90% CI: .057 - .105]), which is within the acceptable range for model fit, with values below .08 generally considered indicative of a reasonable fit (Kline, 2016). The CFI was .939, exceeding the conventional threshold of .90 for a good fit (Bentler, 1990). The TLI was .919, further supporting a robust model fit, as values above .90 are typically considered acceptable (Hu & Bentler, 1999). Additionally, the SRMR was .047, well below the recommended cutoff of .08, indicating a well-fitting model (Byrne, 2013). The AIC for the two-factor, 10-item model was 5164, the lowest of all models, suggesting that this model strikes the best balance between fit and parsimony (Akaike, 1974). Taken together, these indices demonstrate that the two-factor, 10-item

model provides the best fit for the data. Factor Loadings for the two-factor, 10-item model is reported in Table 13.

Based on the results from the CFA, the two-factor, 10-item version of the GCETS demonstrates good construct validity. In addition, this version of the GCETS appears to be reliable, with Cronbach's alpha values indicating acceptable internal consistency for the Training subscale (α = .80), the Experience subscale (α = .81), and the overall score (α = .87). Although results indicate that GCETS can be used with two subscales, in this study the overall score was used for because the use of both subscales separately was beyond the focus of this research study and should be tested in future studies.

Table 13

Factor Loading from the Confirmatory Factor Analysis (CFA) of the Grief Counseling Experience and Training Survey (GCETS)

GCETS items	Factor Loading	
	1	2
Factor 1: Training		
1. I have received adequate clinical training and supervision to counsel clients/students who present with grief.	**.652**	
2. I consistently check my grief counseling skills by monitoring my functioning and competency via consultation, supervision, and continuing education.	**.667**	
7. I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling.	**.653**	
10. Currently, I do not have sufficient skills or training to work with a client/student who presents with grief.	**.619**	
12. I have sufficient knowledge of grief counseling theories and models.	**.741**	
Factor 2: Experience		
3. I have a great deal of experience counseling clients/students who present with grief.		**.814**
5. I have a great deal of experience counseling persons who experienced loss of a loved one to suicide.		**.693**

6. I have a great deal of experience counseling children who present with grief.	**.541**
9. I have a great deal of experience with facilitating group counseling focused on grief concerns.	**.709**
11. I have done many counseling role- plays (as either the client/student or counselor) involving grief concerns.	**.586**

Note: N = 197
The reversed version of item 10 was included in the analysis.

Research Question One: Grief Counseling Experience and Training

What is the level of grief counseling experience and training as measured by the Grief Counseling Experience and Training Survey (GCETS) of licensed professional counselors + (LPCs+) and licensed school counselors (LSCs)?

The original version of GCETS contains a total of 12 items. Participants were asked to rate each item from 1 ("Not at all true") to 5 ("Totally true") except for item 10, which was scored reversely. However, following the CFA results and concerns from previous studies, the researcher decided to use the 10-item version in this study (see the Confirmatory Factor Analysis Section in Chapter 4). The researcher investigated the reliability of the 10-item version of GCETS and found Cronbach's alpha to be .87. To answer the first research question, descriptive statistics for the overall GCETS score were calculated for both groups, and it was found that the mean score for GCETS was higher for LPCs+ (M = 2.78, SD= .76) than LSCs (M = 2.63, SD = .59) (see Table 14).

Table 14

Descriptive Statistics for Grief Counseling Experience and Training Survey (GCETS)

	N	Mean	Median	Mode	Standard Deviation	Range (1-5)
LSCs	50	2.63	2.50	2.10	.59	2.70
LPCs+	146	2.78	2.70	3.00	.76	3.70

Research Question Two: Competency in Grief Counseling

What are the levels of grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) of licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) as measured by the Competency in Grief Counseling Survey (CGCS)?

To answer the second research question, the descriptive statistics of the Overall Competency in Grief Counseling (CGCS) and sub-scores were calculated for both LSCs and LPCs+. The Competency in Grief Counseling Survey (CGCS) is a revised version of the Death Counseling Survey (DCS), which was developed by Charkow (2002). CGCS contains a total of 58 items, and participants were asked to rate each item from 1 (“This does not describe me”) to 5 (“This describes me very well”). A higher mean score of CGCS indicates higher overall competency in grief counseling. Results from the descriptive statistics have shown that LPCs+ (M = 3.63, SD = .59) have a higher mean of CGCS than LSCs (M= 3.34, SD = .54). The overall Cronbach’s alpha for CGCS was found to be .96.

Table 15

Descriptive Statistics for Overall Competency in Grief Counseling (CGCS)

	N	Mean	Median	Mode	Standard Deviation	Range (1-5)
LSCs	47	3.34	3.21	3.05	.54	2.10
LPCs+	139	3.63	3.64	3.97	.59	3.62

Personal Competency (PC) defines the counselors' ability to utilize self-care and personal beliefs surrounding grief, humor, and spirituality with eleven items. The mean score of personal competency ranges from 1 (low personal competency) to 5 (high personal competency). Results have indicated that LPCs+ (M = 4.40, SD= .37) have a higher mean score of PC than LSCs (M = 4.25, SD = .43). Moreover, the mean score of PC was higher for both groups than overall and all other competencies. The Cronbach's alpha for PC was found to be .73.

Table 16

Descriptive Statistics for Personal Competency (PC)

	N	Mean	Median	Mode	Standard Deviation	Range (1-5)
LSCs	50	4.25	4.27	4.00	.43	1.55
LPCs+	145	4.40	4.46	4.45	.37	1.73

'The Conceptual Skills and Knowledge (CSK) subscale defines and evaluates the participants' ability to define complicated and normal grief, theoretical knowledge, recognize effective and ineffective coping skills, and understand the development of death with nine items. A higher mean score indicates a higher competency in CSK.

Results have shown that LPCs+ (*M* = 3.40, *SD* = .86) have a higher mean score of CSKs than LSCs (*M* = 3.04, *SD* = .75). The Cronbach's alpha for CSKs was found to be .90.

Table 17

Descriptive Statistics for Conceptual Skills and Knowledge (CSK)

	N	Mean	Median	Mode	Standard Deviation	Range (1-5)
LSCs	47	3.04	2.89	2.67	.75	3.00
LPCs+	139	3.40	3.56	3.78[a]	.86	4.00

Note: [a] indicates that more than one mode exists. The smallest one was reported.

The Assessment Skills (AS) subscale evaluates whether the counselor is able to assess unresolved grief, suicidality, spirituality, and the need for medical treatment and recognize the influences of culture on grief with nine items. A higher mean score indicates a higher competency in AS. Results have shown that LPCs+ (*M* = 3.53, *SD* = .71) have a higher mean score of AS than LSCs (*M* = 2.86, *SD* = .68). The mean difference between LSCs and LPCs+ for AS was the highest among other competencies. The Cronbach's alpha for AS was found to be .85.

Table 18

Descriptive Statistics for Assessment Skills (AS)

	N	Mean	Median	Mode	Standard Deviation	Range (1-5)
LSCs	47	2.86	2.78	2.56	.68	3.00
LPCs+	139	3.53	3.56	3.78	.71	3.44

The Treatment Skills (TS) subscale evaluates if a counselor is able to facilitate grief counseling sessions in different settings, including individual, group, and family, provide psychoeducation related to grief, build rapport with grieving individuals, utilize active listening and creative arts, and identify roles of culture and morning rituals on grief with twenty-two items. A higher mean score indicates a higher competency in TS. Results have shown that LPCs+ (*M* = 3.52, *SD* = .67) have a higher mean score of TS than LSCs (*M* = 3.23, *SD* = .59). The Cronbach's alpha for TS was found to be .92.

Table 19

Descriptive Statistics for Treatment Skills (TS)

	N	Mean	Median	Mode	Standard Deviation	Range (1-5)
LSCs	47	3.23	3.09	3.00	.59	2.45
LPCs+	139	3.52	3.59	3.86	.67	3.09

The Professional Skills (ProS) subscale assesses counselors' ability to provide activities and interventions related to grief in different settings, crisis intervention, perform teamwork, follow the most recent updates on the literature of grief, and participate in professional support grief with seven items. A higher mean score indicates a higher competency in ProS. Results have shown that LSCs (*M* = 3.23, *SD* = .72) have a higher mean score of ProS than LPC+ (*M* = 3.18, *SD* = .75). ProS is the only competency in which LSCs reported a higher mean score than LPCs+. The Cronbach's alpha for ProS was found to be .74.

Table 20

Descriptive Statistics for Professional Skills (ProS)

	N	Mean	Median	Mode	Standard Deviation	Range (1-5)
LSCs	46	3.23	3.14	2.29	.72	2.86
LPCs+	139	3.18	3.14	2.71[a]	.75	3.43

Note: [a] indicates that more than one mode exists. The smallest one was reported.

Research Question Three

Research Question 3.a

Research question 3.a. was "What is the difference in grief counseling experience and training as measured by the GCETS between licensed professional counselors and licensed school counselors?"

$H_0 3_a$: There is no statistically significant difference between licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) in terms of grief counseling experience and training.

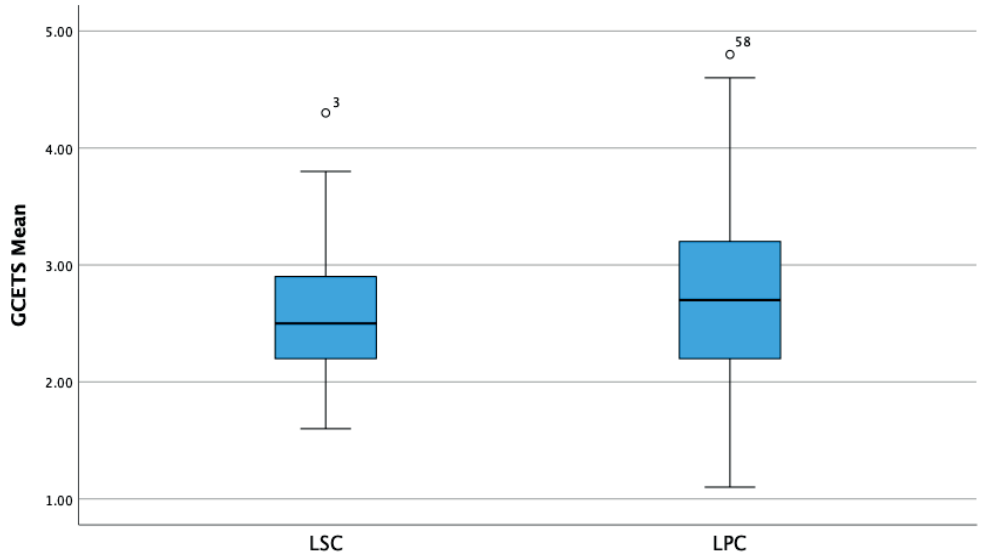
$H_1 3_a$: There is a statistically significant difference between licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) in terms of grief counseling experience and training.

A one-way analysis of variance (ANOVA) was performed to compare the mean differences between Licensed School Counselors (LSCs) and Licensed Professional Counselors + (LPC+) on the Grief Counseling Experience and Training (GCETS) scores. The assumptions of ANOVA were checked before the analysis. Results indicated that the GCETS scores were not normally distributed within each group (W (194) = .98, p = .004), group sizes were not equal for LSCs (N = 50) and LPC+ (N = 146), and the

homogeneity of variances assumption was violated as assessed by Levene's Test for Equality of Variances $F(1, 194) = 3.98$, $p = .047$. Therefore, a Welch's ANOVA test was used. The results revealed that there were no statistically significant differences in GCETS by type of licensure (LSCs vs. LPCs+) for Welch's $F(1, 108.84) = 2.03$, $p = .157$, suggesting that the alternative hypothesis was rejected. Although two outliers (one per group) were determined, the results did not change after removing the outliers.

Figure 15

Boxplot of GCETS scores for LPCs and LPC+



Research Question 3.b

Research question 3.b. was "What is the difference in the levels of grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge,

assessment skills, treatment skills, and professional skills) as measured by the CGCS between licensed professional counselors and licensed school counselors?"

H_03_b: There is no statistically significant difference between licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) in terms of grief counseling competencies.

H_13_b: There is a statistically significant difference between licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) in terms of grief counseling competencies.

A one-way multivariate analysis of variance (MANOVA) was used to test the second hypothesis using CGCS subscales as dependent variables (personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) and type of licensure (LSCs vs. LPC+) as the independent variable with a two-tailed significance test. Before conducting the analysis, multivariate outliers were checked using Mahalanobis distance. No outliers were detected for any of the groups. The Box's Test of Equality of Covariance Matrices results indicated that the assumption of homogeneity of covariance matrices was met, $M = 21.46$, F (15, 28924.44) = 1.37, p = .153. In addition, Levene's Test of Equality indicated that the assumption of homogeneity of variances was met for each independent variable.

The results of the MANOVA have shown that there is a significant multivariate effect of being LSC vs. LPC+ on the combined dependent variables, Pillai's Trace = 0.284, $F(5,178)=14.086$, $p<0.001$, $\eta^2=.284$, suggesting that overall combination of personal competencies, conceptual skills and knowledge, assessment skills, treatment

skills, and professional skills differentiate both groups of LSCs vs LPCs+. Therefore, the null hypothesis was rejected.

The partial eta squared value of .284 indicates that being an LSC or LPC+ has a large impact on the overall combination of personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills, explaining 28.4% of the variance in competencies. Univariate ANOVAs indicated that AS is the most useful variable in the discrimination of groups, with 14.4% of the variance in competencies in grief counseling. Although PC, CSK, and TS were also found to be significant at the univariate level of ANOVA, ProS was not significant (see Table 21).

Table 21

The effect of Type of Licensure (LSCs vs. LPCs+) on Subscales of Competency in Grief Counseling (CGCS)

Univariate Tests			
	F (1, 182)	*p*	η^2
PC	6.449	.012	.034
CSK	6.666	.011	.035
AS	30.634	<.001	.144
TS	5.935	.016	.032
ProS	.176	.675	.001

A multivariate follow-up analysis was conducted using discriminant analysis to determine the importance of each variable in distinguishing between groups. The Standardized Canonical Discriminant Function Coefficients results revealed that AS had the highest positive contribution (β = 1.650), followed by Personal Competencies (β=0.047). Conceptual Skills and Knowledge (β = -.232) and Treatment Skills (β = -.220)

made smaller negative contributions. On the other hand, Professional Skills (β = -.879) showed a moderate negative contribution to group separation, which was found to be non-significant at the univariate level of ANOVA. Results suggested that ProS is not useful on its own, but it becomes useful when it is considered in the context of other variables. In other words, ProS plays a secondary role in enhancing group discrimination when combined with other variables, but it is not powerful enough to show significance by itself. Moreover, the components of competency in grief counseling are reasonably and highly correlated, which indicates a complex relationship between subscales and might be leading to ProS not being useful on its own while it is the second useful in the context of other variables.

Research Question Four: Prediction of Competency in Grief Counseling

Research question four was stated as "What is the relationship between grief counseling competencies and the demographic variables of age, gender, specialization (i.e., professional counseling and school counseling), professional experience as a licensed counselor (i.e., years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, and completed supervision hours in grief?" Six regression models were tested: for each five sub-competency and overall competencies in grief counseling.

> $H_0$4: There is no relationship between age, gender, specialization (professional counselors and school counselors), professional experience as a licensed counselor (years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, completed supervision hours in grief, and the grief counseling competencies.

$H_1$4: There is a significant relationship between age, gender, specialization (professional counselors and school counselors), professional experience as a licensed counselor (years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, completed supervision hours in grief, and the grief counseling competencies.

Assumptions

The researcher examined the data set and tested the assumptions before conducting the multiple regression analysis. The assumptions included normality, linearity, homoscedasticity, and multicollinearity.

Normality. The normality assumption was visually tested using a P-P Plot for each of the predicted variables. Results indicated that the normality assumption was met for all six regression models.

Figure 16

Normal P-P Plot for Personal Competency (PC) (N=186)

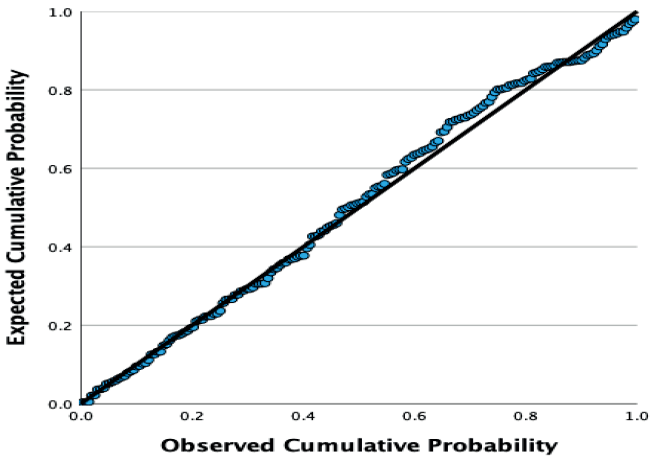


Figure 17

Normal P-P Plot for Conceptual Skills and Knowledge (CSK) (N=174)

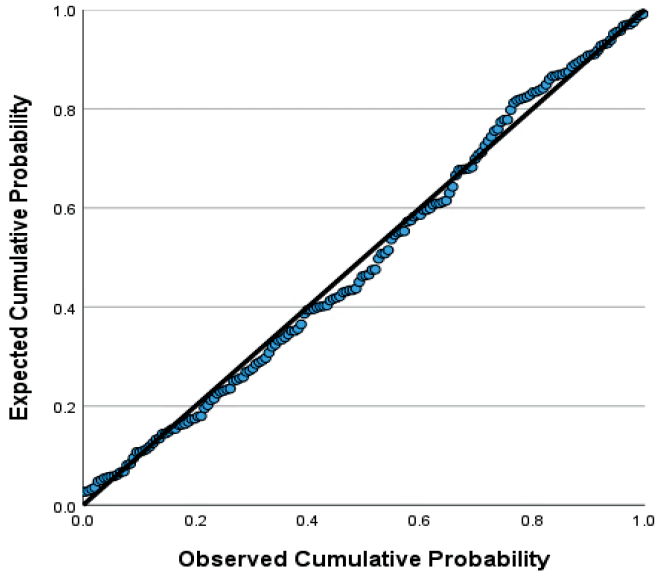


Figure 18

Normal P-P Plot for Assessment Skills (AS) (N=178)

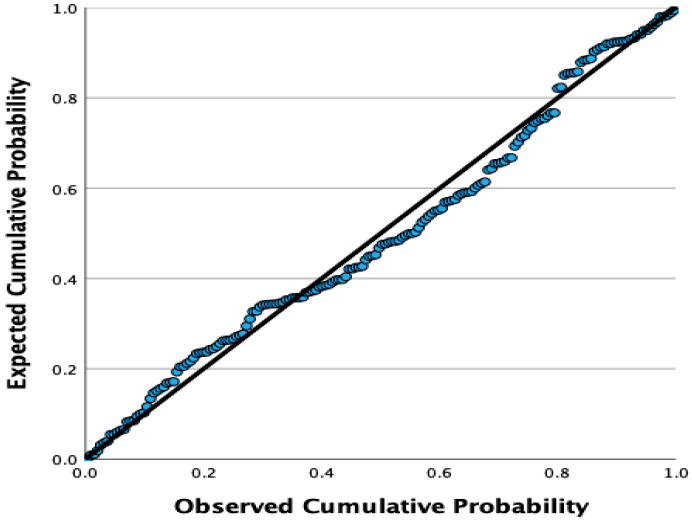


Figure 19

Normal P-P Plot for Treatment Skills (TS) (N=178)

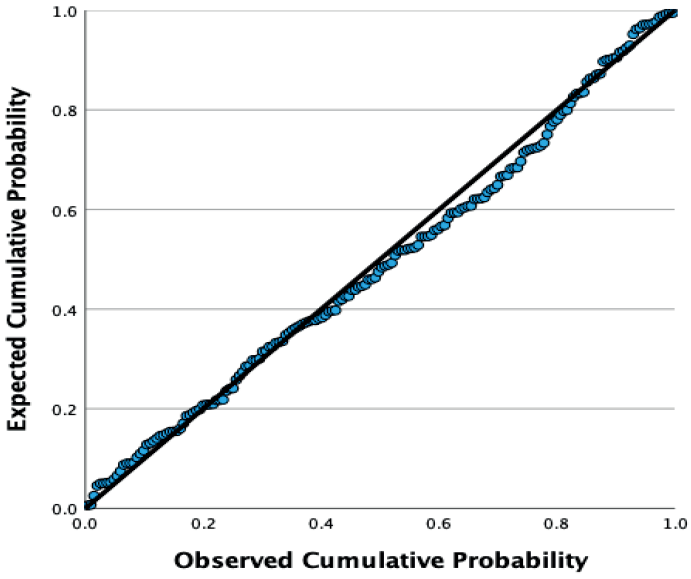


Figure 20

Normal P-P Plot for Professional Skills (ProS) (N=178)

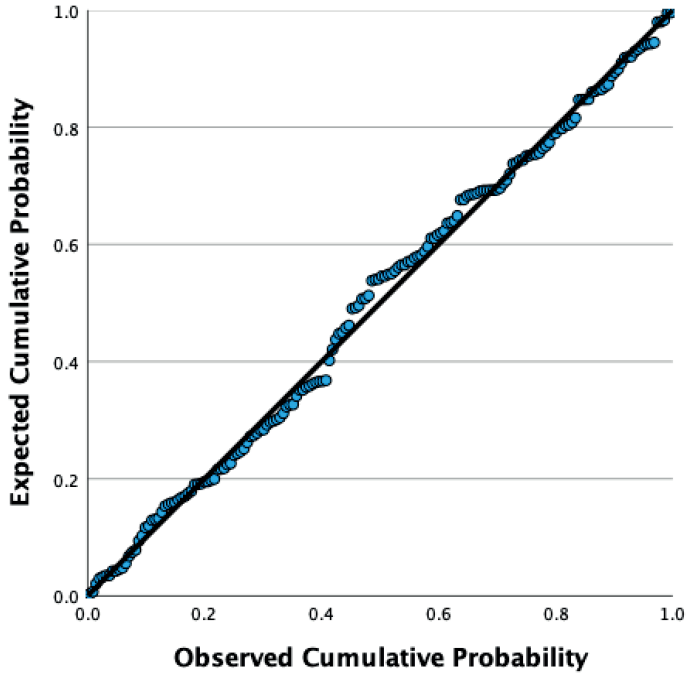
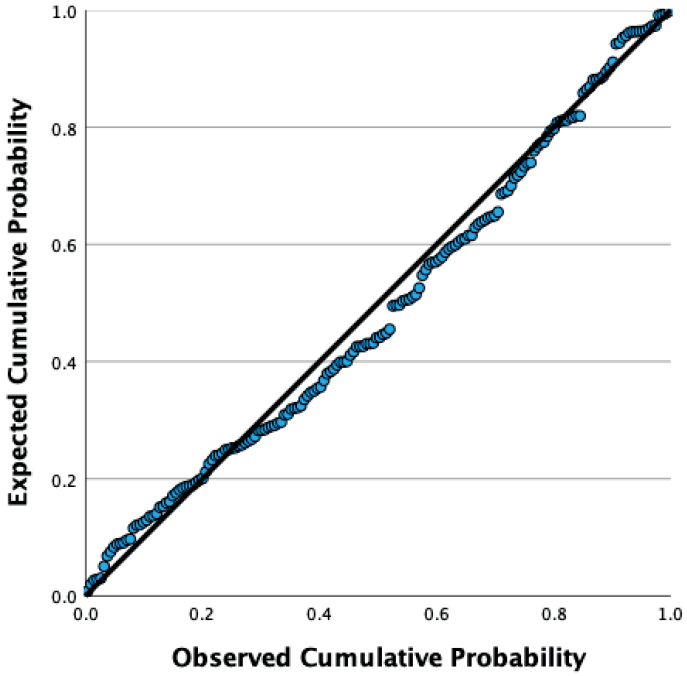


Figure 21

Normal P-P Plot for Overall Competency in Grief Counseling (CGC) (N=178)



Linearity. The assumption of linearity between the dependent and independent variables was examined using a visual inspection of a scatterplot. Linearity between all subscales of competency in grief counseling (PC, CSK, AS, TS, and ProS) and OCGC and continuous independent variables (age, years of experience, and GCETS) were investigated, and no concerns have been identified. Only the linearity between OCGC and independent variables was reported due to a high number of graphs (see Figures 22-25).

Figure 22

Scatterplot of Overall Competency in Grief Counseling (OCGC) and Age (N=201)

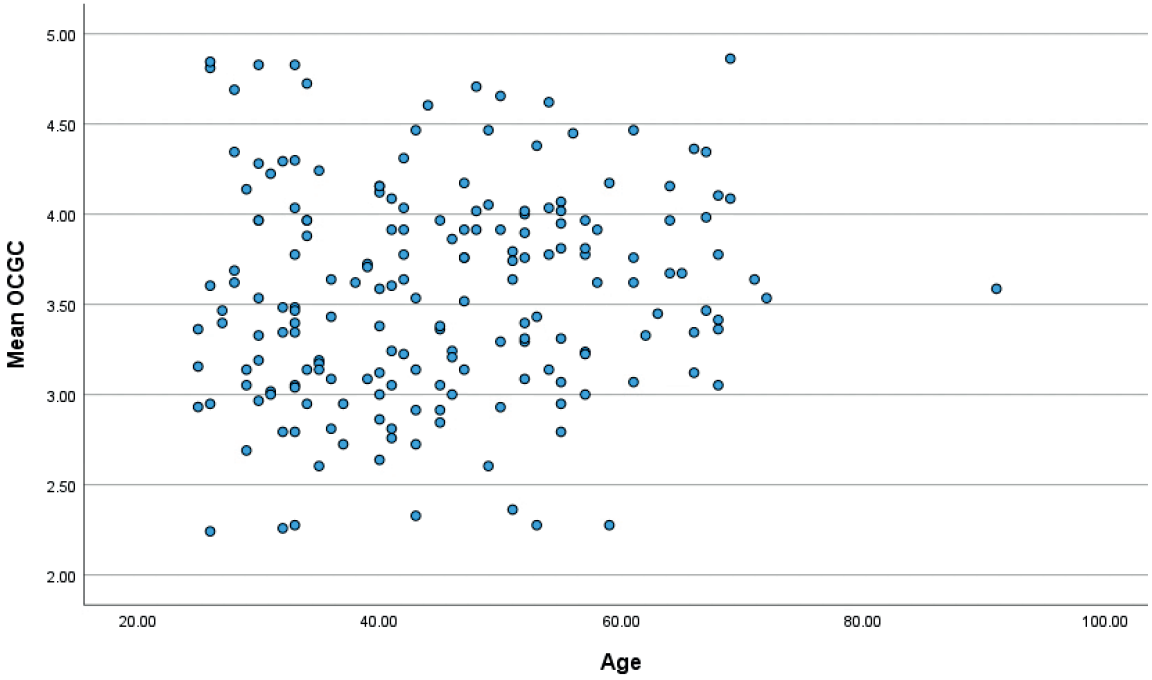


Figure 23

Scatterplot of Overall Competency in Grief Counseling (OCGC) and Years of Experience (N=199)

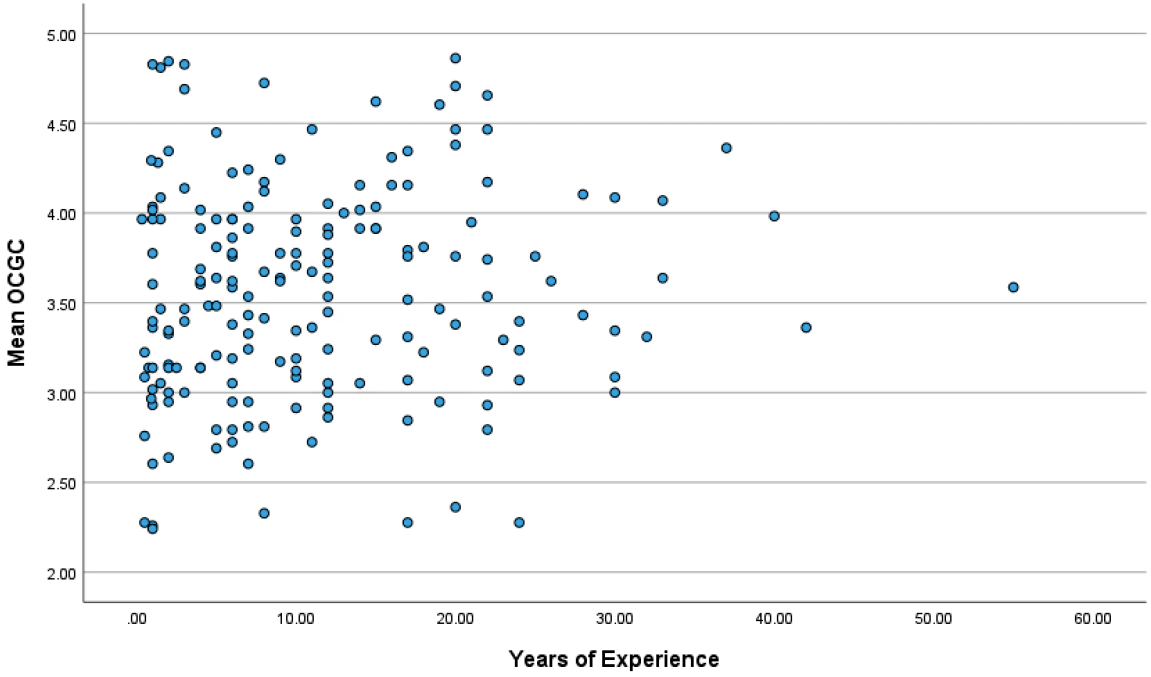


Figure 24

Scatterplot of Overall Competency in Grief Counseling (OCGC) and Grief Counseling Experience and Training (GCETS) (N=197)

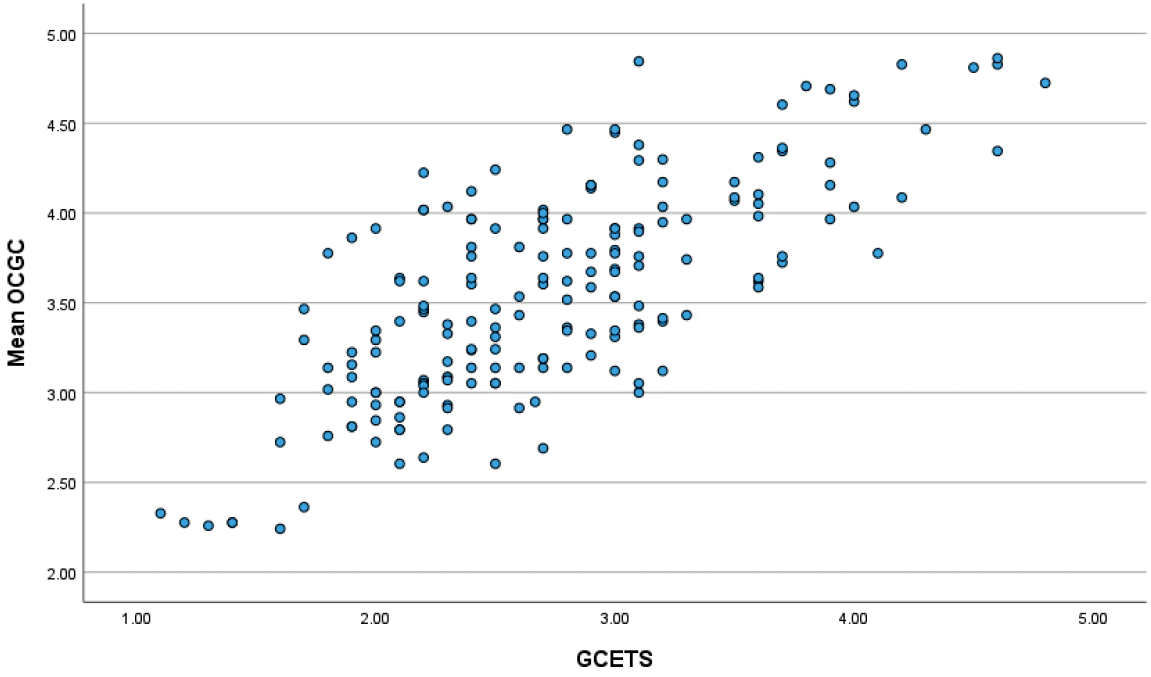
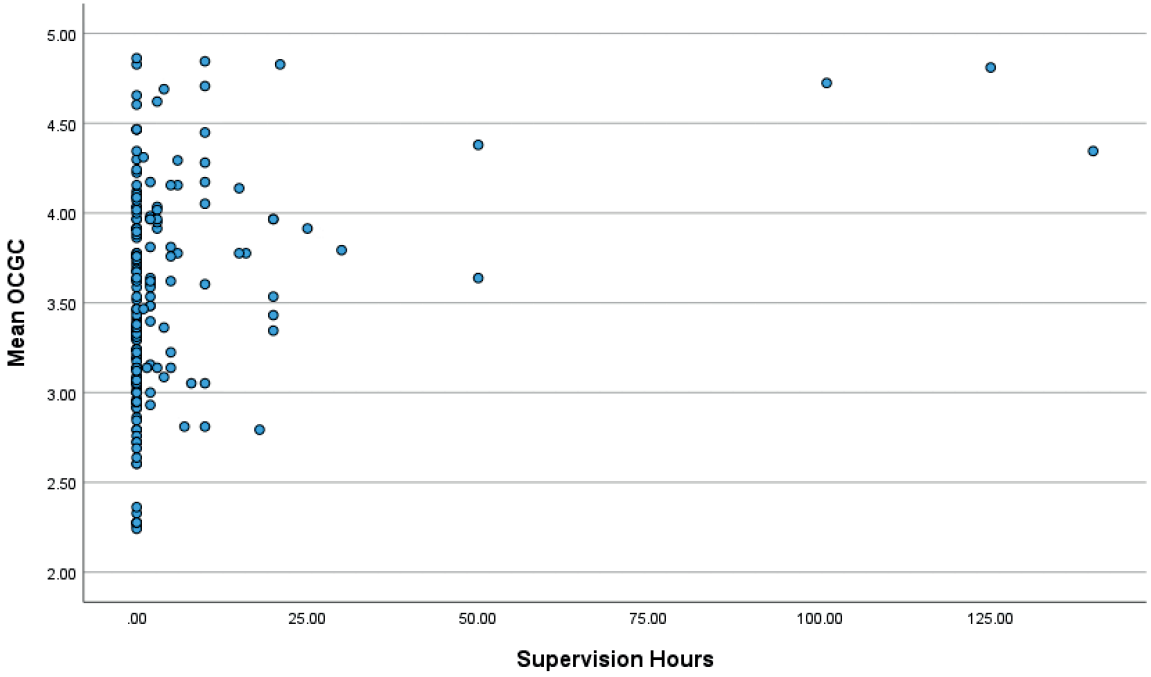


Figure 25

Scatterplot of Overall Competency in Grief Counseling (OCGC) and Grief Supervision Hours (N=197)



Homoscedasticity. The assumption of homoscedasticity for each regression model was examined using visual inspection of residual plots. Results have shown that the residuals were scattered randomly without any observable pattern, indicating that the variance of the residuals remained constant (See Figures 22-27).

Figure 26

Residual Plot of Personal Competencies (PC) (N=186)

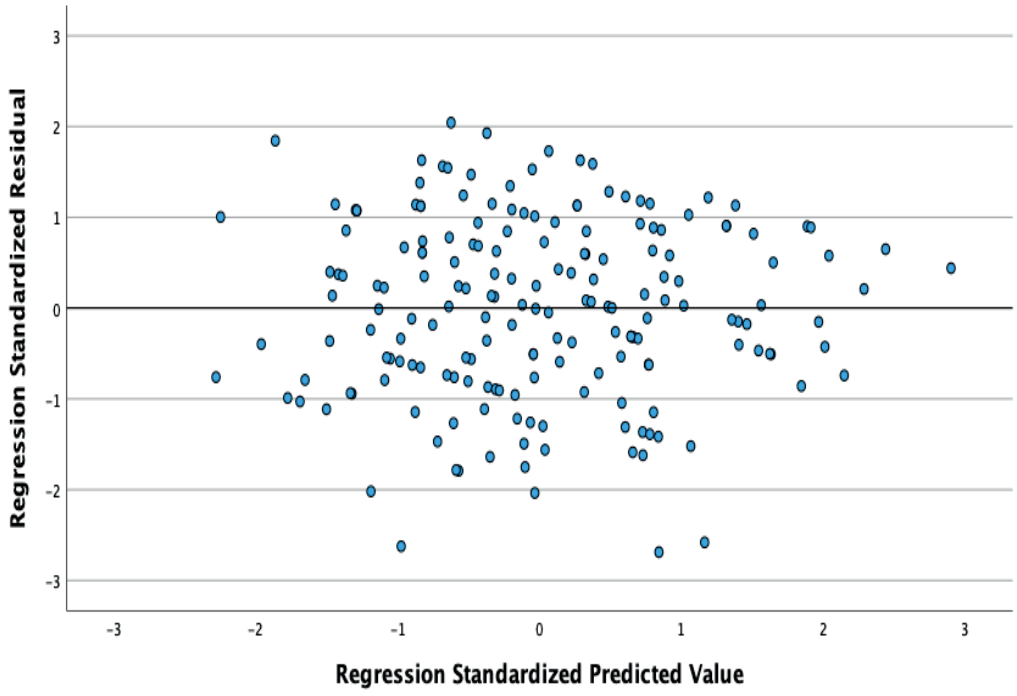


Figure 27

Residual Plot of Conceptual Skills and Knowledge (CSK) (N=174)

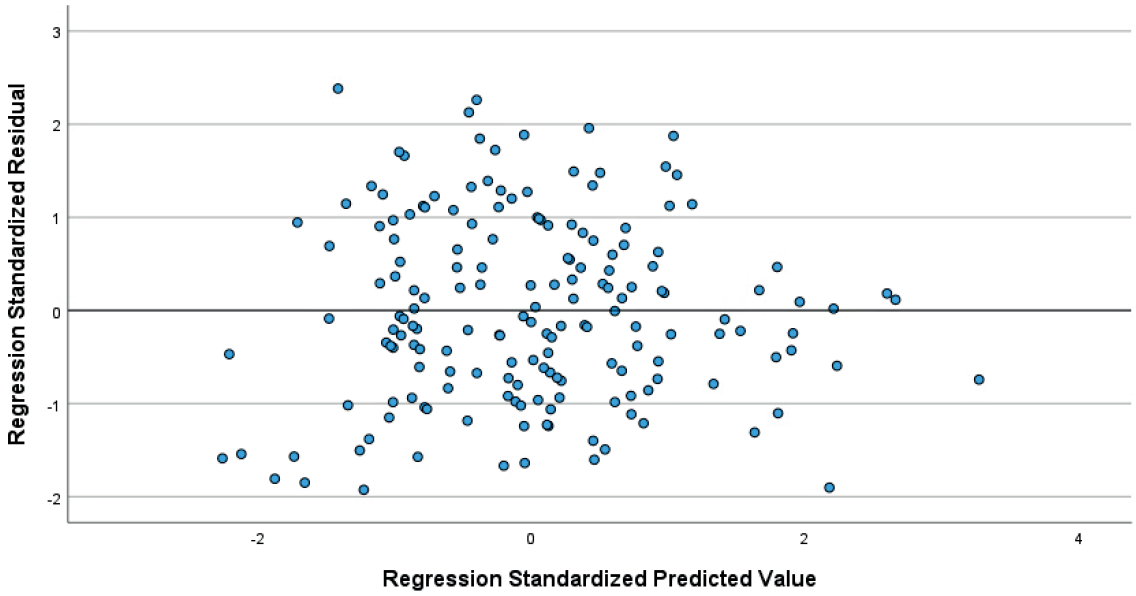


Figure 28

Residual Plot of Assessment Skills (AS) (N=178)

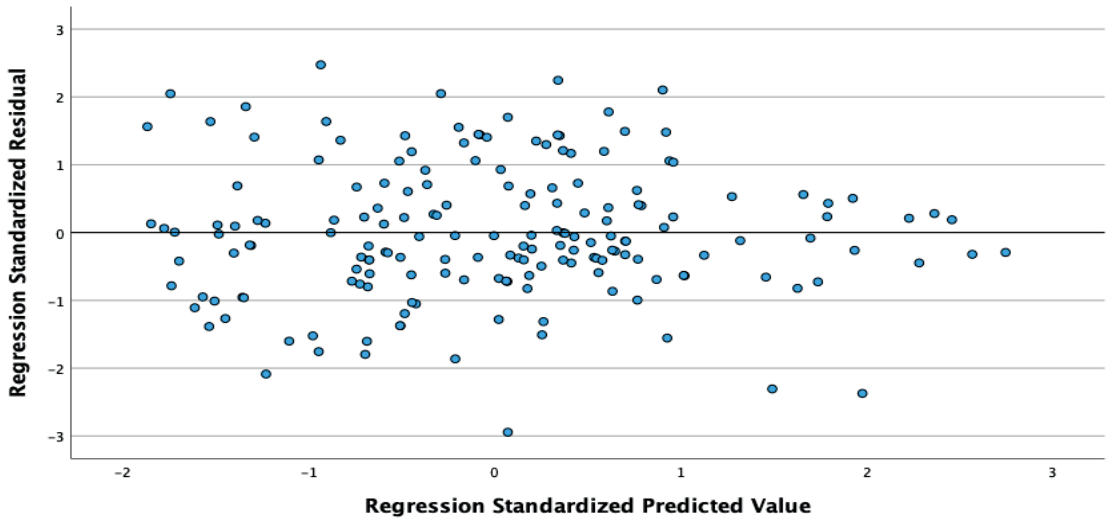


Figure 29

Residual Plot of Treatment Skills (TS) (N=178)

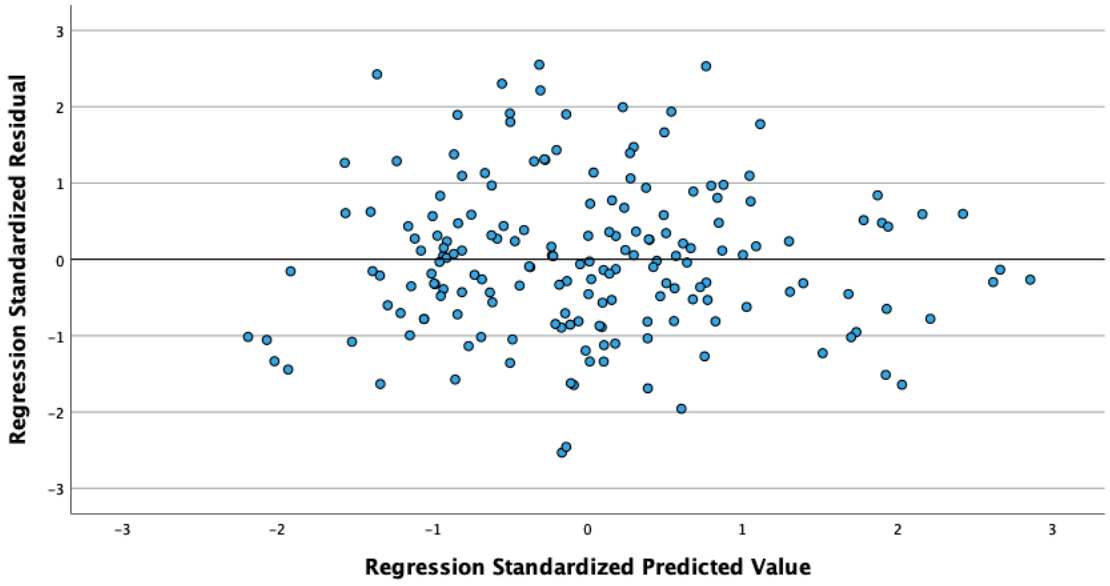


Figure 30

Residual Plot of Professional Skills (ProS) (N=178)

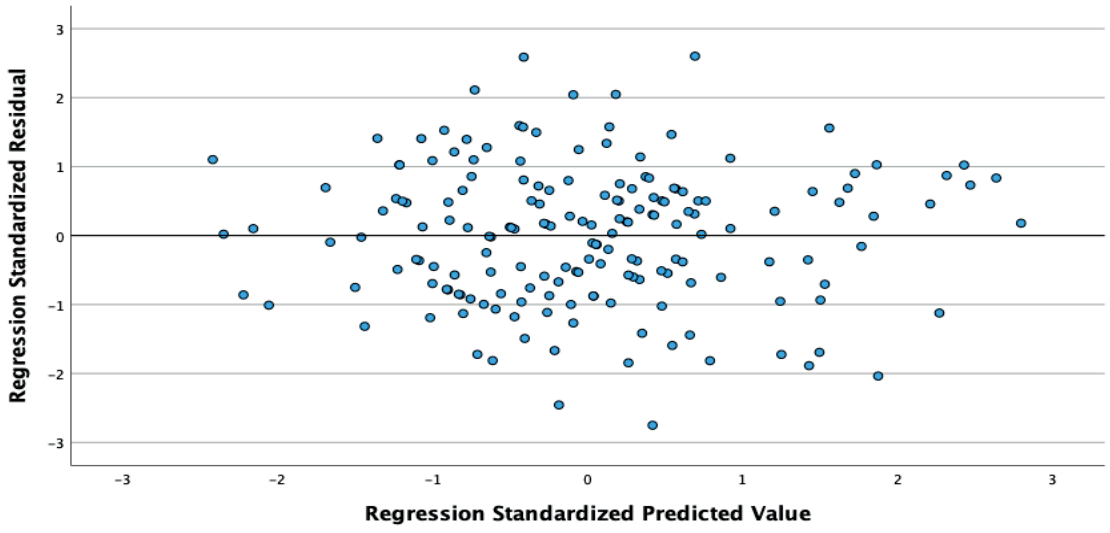
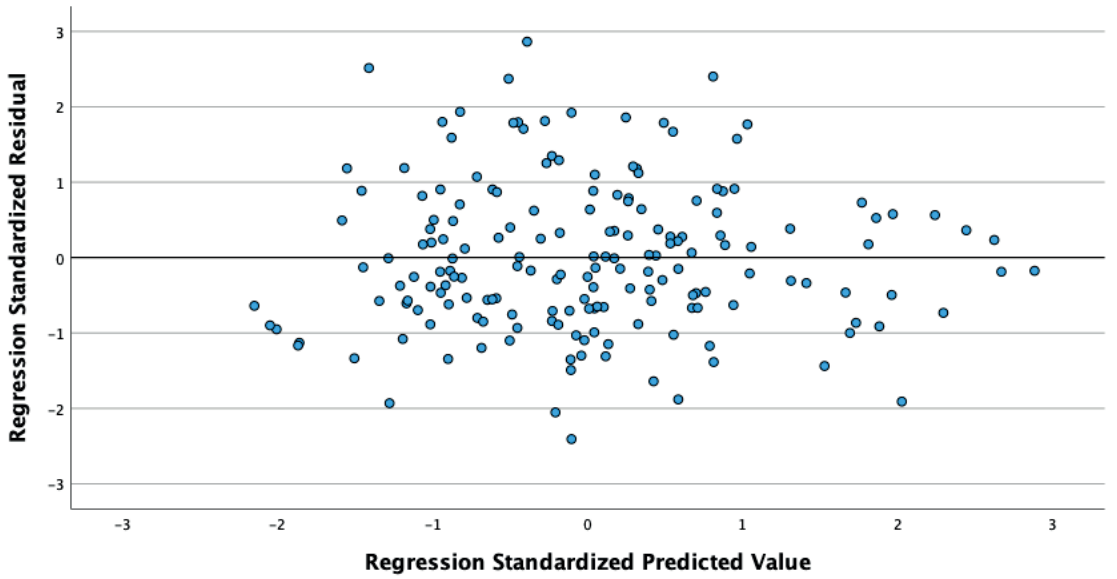


Figure 31

Residual Plot of Overall Competency in Grief Counseling (N=178)



Multicollinearity. The multicollinearity assumption was explored using the Variance Inflation Factor (VIF) and examination of correlations between independent variables. Results have shown a lack of multicollinearity, as evidenced by a lack of VIF score over 10 in all regression models (see Table 22).

Table 22

Correlations Between Independent Variables in Regression Analyses

Variables	1	2	3	4	5
1. Age					
2. Gender	-.17**				
3. Type of licensure	.12	-.08			
4. Years of Experience	.68***	-.17*	-.02		
5. GCETS	.24***	.04	.08	.29	
6. Supervision hours	-.09	.01	.15	-.02	.44***

Outliers. Four outliers were identified through Mahalanobis distance analysis with a critical value of $\chi 2(6) = 22.46$, $p<.001$, as each model included six predictors. The inclusion or exclusion of these outliers did not significantly affect the overall model outcomes, except for the model predicting Conceptual Skills and Knowledge (CSK). Specifically, in the third model, which aimed to predict CSK, years of experience ceased to be a significant predictor after the removal of outliers. Consequently, the decision was made to exclude the outliers in the CSK model. However, the outliers were retained in other models to increase the generalizability, as their removal did not result in any substantial changes to the results.

Regression Models

The relationship between Competency in Grief Counseling and age, gender, type of licensure (LSCs vs. LPCs+), years of experience, grief counseling experiences and training (GCETS), and completed supervision hours in grief was examined using multiple regression. Six regression analyses were conducted – predicting each sub-grief counseling competency and overall competency in grief counseling.

Regression Model One. The variables in the first model included Personal Competency (PC) as the dependent variable and age, gender, type of licensure (LSCs vs. LPCs+), years of experience, grief counseling experiences and training (GCETS), and completed supervision hours as independent variables. The result of the regression analysis indicated that the first model was statistically significant, $F(6,179)=6.378$, $p<.001$, and explained approximately 18% of the variance in PC, $R^2 = .18$. Regarding individual variables, GCETS was the only independent variable significantly predicted the dependent variable, $b = .21$ ($SE =. 04$), $\beta = .40$, $p < .001$. Results have shown that

higher professional training and experience scores in grief counseling were associated with higher competency in PC.

Table 23

|*Regression Analysis Predicting Personal Competency (PC)*

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
1. Age	.00	.00	-.00	.01	.06	.532
2. Gender	.10	.08	-.06	.25	.08	.235
3. Type of licensure	.11	.06	-.01	.23	.12	.080
4. Years of Experience	-.00	.00	-.01	.01	-.04	.701
5. GCETS	.21	.04	.13	.30	.40	<.001
6. Supervision hours	-.00	.00	-.00	.00	-.06	.423

Note. N = 186. CI = confidence interval; LL = lower limit; UL = upper limit.

Regression Model Two. The variables in the second model included Conceptual Skills and Knowledge (CSK) as the dependent variable and age, gender, type of licensure (LSCs vs. LPCs+), years of experience, grief counseling experiences and training (GCETS), and completed supervision hours as independent variables. The result of the regression analysis indicated that the model was statistically significant, $F(6,167)=33.886$, $p<.001$, and explained approximately 55% of the variance in CSK, R2 = .55. Regarding individual variables, GCETS was a significant predictor of CSK, b = .93 (*SE* =. 07), β = .77, $p < .001$, indicating that higher professional training and experience scores in grief counseling were associated with higher competency in CSK. In addition, the type of licensure was also a significant predictor of CSK, b = .24 (*SE* =. 10), β = .13, $p = .022$. Being LPCs+ was associated with higher CSK scores than being LSCs. On the other hand.

Table 24

Regression Analysis Predicting Conceptual Skills and Knowledge (CSK)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
1. Age	-.01	.01	-.01	.00	-.07	.303
2. Gender	.01	.14	-.26	.28	.00	.971
3. Type of licensure	.24	.10	.05	.44	.13	.022
4. Years of Experience	-.01	.01	-.03	.00	-.14	.052
5. GCETS	.93	.07	.80	1.07	.80	<.001
6. Supervision hours	.00	.01	-.01	.00	-.06	.917

Note. N = 174. CI = confidence interval; LL = lower limit; UL = upper limit.

Regression Model Three. The variables in the third model included Assessment Skills (AS) as the dependent variable and age, gender, type of licensure (LSCs vs. LPCs+), years of experience, grief counseling experiences and training (GCETS), and completed supervision hours as independent variables. The result of the regression analysis indicated that the model was statistically significant, $F(6,171)=27.830$, $p<.001$, and explained approximately 49% of the variance in AS, $R^2 = .49$. Regarding individual variables, GCETS was a significant predictor of AS, b = .68 (*SE* =. 07), β = .65 $p < .001$, indicating that higher professional training and experience scores in grief counseling were associated with higher competency in AS. Type of licensure was also a significant individual predictor of AS, b = .57 (*SE* =. 10), β = .32, $p < .001$. Being an LPC+ was associated with higher AS compared to LSCs. However, age, gender, years of experience, and grief supervision hours did not predict AS.

Table 25

Regression Analysis Predicting Assessment Skills (AS)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
1. Age	.00	.00	-.01	.01	-.00	.961
2. Gender	.01	.13	-.25	.27	.00	.944
3. Type of licensure	.57	.10	.38	.76	.32	<.001
4. Years of Experience	-.01	.01	-.02	.00	-.14	.064
5. GCETS	.68	.07	.58	.81	.65	<.001
6. Supervision hours	-.00	.00	-.01	.00	-.05	.429

Note. N = 178. CI = confidence interval; LL = lower limit; UL = upper limit.

Regression Model Four. The variables in the fourth model included Treatment Skills (TS) as the dependent variable and age, gender, type of licensure (LSCs vs. LPCs+), years of experience, grief counseling experiences and training (GCETS), and completed supervision hours as independent variables. The result of the regression analysis indicated that the model was statistically significant, $F(6,171)=44.889$, $p<.001$, and explained approximately 61% of the variance in TS, $R^2 = .61$. Regarding individual variables, GCETS was a significant predictor of TS, b = .75 (*SE* =. 05), β = .82, $p < .001$, indicating that higher professional training and experience scores in grief counseling were associated with higher competency in TS. Type of licensure was also a significant individual predictor of TS, b = .18 (*SE* =. 08), β = .12, $p = .016$. Being a LPC+ was associated with higher TS compared to LSCs. However, age, gender, years of experience, and grief supervision hours did not predict TS.

Table 26

Regression Analysis Predicting Treatment Skills

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
1. Age	-.00	.00	-.01	.01	-.01	.872
2. Gender	.08	.10	-.12	.28	.04	.433
3. Type of licensure	.18	.08	.04	.33	.12	.016
4. Years of Experience	-.01	.01	-.02	.00	-.12	.076
5. GCETS	.75	.05	.64	.85	.82	<.001
6. Supervision hours	-.00	.00	-.01	.00	-.08	.172

Note. N = 178. CI = confidence interval; LL = lower limit; UL = upper limit.

Regression Model Five. The variables in the fifth model included Professional Skills (ProS) as the dependent variable and age, gender, type of licensure (LSCs vs. LPCs+), years of experience, grief counseling experiences and training (GCETS), and completed supervision hours as independent variables. The result of the regression analysis indicated that the model was statistically significant, $F(6,171)=24.397$, $p < .001$, and explained approximately 46% of the variance in ProS, $R^2 = .46$. Regarding individual variables, GCETS was a significant predictor of TS, b = .75 (*SE* =. 07), β = .71, $p < .001$, indicating that higher professional training and experience scores in grief counseling were associated with higher competency in ProS. However, age, gender, type of licensure, years of experience, and grief supervision hours did not predict ProS.

Table 27

Regression Analysis Predicting Professional Skills (ProS)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
1. Age	-.00	.01	-.01	.01	-.05	.523
2. Gender	.16	.14	-.11	.43	.07	.246
3. Type of licensure	-.13	.10	-.33	.08	-.07	.209
4. Years of Experience	-.01	.01	-.02	.01	-.08	.328
5. GCETS	.75	.07	.61	.88	.71	<.001
6. Supervision hours	-.00	.00	-.01	.00	-.05	.402

Note. N = 178. CI = confidence interval; LL = lower limit; UL = upper limit.

Regression Model Six. The variables in the last model included Overall Competency in Grief Counseling (OCGC) as the dependent variable and age, gender, type of licensure (LSCs vs. LPCs+), years of experience, grief counseling experiences and training (GCETS), and completed supervision hours as independent variables. The result of the regression analysis indicated that the model was statistically significant, $F(6,171)=43.966$, $p < .001$, and explained approximately 61% of the variance in OCGC, $R^2 = .61$. Regarding individual variables, GCETS was a significant predictor of OCGC, b = .75 (*SE* =. 07), β = .71, $p < .001$, indicating that higher professional training and experience scores in grief counseling were associated with higher competency in OCGC. Type of licensure was also a significant individual predictor of OCGC, b = .20 (*SE* =. 07), β = .15, $p = .003$. Being a LPC+ was associated with higher OCGC compared to LSCs. However, age, gender, years of experience, and grief supervision hours did not predict OCGC.

Table 28

Regression Analysis Predicting Overall Competency in Grief Counseling (OCGC)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
1. Age	-.00	.00	-.01	.01	-.02	.744
2. Gender	.07	.09	-.11	.25	.04	.464
3. Type of licensure	.20	.07	.07	.34	.15	.003
4. Years of Experience	-.01	.00	-.02	.00	-.12	.066
5. GCETS	.66	.05	.57	.76	.81	<.001
6. Supervision hours	-.00	.00	-.01	.00	-.07	.214

Note. N = 178. CI = confidence interval; LL = lower limit; UL = upper limit.

In summary, grief training and experience (GCETS) is the most useful predictor of all grief counseling competencies, including overall competency in grief counseling. In addition, the type of licensure was also a significant individual predictor of CSK, AT, TS, and OCGC when other independent variables were controlled. However, age, gender, years of experience, and supervision hours did not add unique variance to any regression models.

Supplemental Exploratory Analysis One: Grief Supervision

The number of completed grief supervision hours was not a significant predictor of any competencies in grief counseling, however, its correlation with competencies in grief counseling was moderate, except for with PC (see Table 29). Moreover, the total of completed supervision hours is moderately correlated with GCETS ($r = .44$, $p < .001$). These results from the correlations raise a concern regarding a potential suppressing relationship between the number of completed grief supervision hours and GCETS. To investigate the suppressing relationship, a set of hierarchical regression analyses was performed to predict each subscale and overall competency in grief counseling. The first

step was performed with age, gender, type of licensure (LSCs vs. LPCs+), years of experience, and completed supervision hours. In the second step, GCETS was added in addition to the existing independent variables.

Table 29

Correlation between Supervision Hours and Competency in Grief Counseling and Its Subscales

Variables	1	2	3	4	5	6
1. Supervision hours						
2. PC	.13					
3. CSK	.30***	.45***				
4. AS	.27***	.49***	.85***			
5. TS	.29***	.52***	.91***	.86***		
6. ProS	.24***	.33***	.77***	.65***	.82***	
7. OCGC	.30***	.59***	.95***	.91***	.98***	.84***

*** $p < .001$. PC: personal competencies; CSK: conceptual skills and knowledge; AS: assessment skills; TS: treatment skills; ProS: professional skills; OCGC: Overall competency in grief counseling.

Hierarchical Regression One. In the first step, age, gender, type of licensure, years of experience, and completed supervision hours were entered into the model to predict PC. The result of the regression analysis indicated that the model was statistically significant, $F(5,180) = 2.530$, $p = .031$, and explained approximately 7% of the variance in Personal Competency (PC), $R^2 = .07$. Supervision was not a significant predictor of PC ($\beta = .117$, $p = .113$). In the second step, GCETS was added in addition to the existing independent variables. The result of the regression analysis indicated that the model was statistically significant, $F(6,179) = 6.378$, $p < .001$, and explained approximately 18% of the variance in PC, $R^2 = .18$. Supervision remained as a non-significant predictor of PC ($\beta = -.06$, $p = .423$).

Table 30

Hierarchical Regression Predicting Personal Competency (PC)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
Step 1						
1. Age	.00	.00	-.00	.01	.12	.236
2. Gender	.14	.09	-.03	.31	.12	.096
3. Type of licensure	.11	.07	-.02	.24	.13	.089
4. Years of Experience	.00	.00	-.01	.01	.05	.632
5. Supervision hours	.00	.00	-.00	.01	.12	.113
Step 2						
1. Age	.00	.00	-.00	.01	.06	.532
2. Gender	.01	.08	-.06	.25	.08	.235
3. Type of licensure	.11	.06	-.01	.23	.12	.080
4. Years of Experience	-.00	.00	-.01	.01	-.04	.701
5. Supervision hours	-.00	.00	-.01	.00	-.06	.423
6. GCETS	.21	.04	.13	.30	.40	<.001

Note. N = 186. CI = confidence interval; LL = lower limit; UL = upper limit.

Hierarchical Regression Two. In the first step, age, gender, type of licensure, years of experience, and completed supervision hours were entered into the model to predict CSK. The result of the regression analysis indicated that the model was statistically significant, $F(5,168) = 2.561$, $p = .029$, and explained approximately 7% of the variance in CSK, $R^2 = .07$. Supervision was the only statistically significant predictor of CSK when controlling for the other independent variables ($\beta = .19$, $p = .016$). In the second step, GCETS was added in addition to the existing independent variables. The result of the regression analysis indicated that the model was statistically significant, $F(6,167) = 33.886$, $p < .001$, and explained approximately 55% of the variance in CSK $R^2 = .55$. Supervision became a non-significant predictor, whereas GCETS ($\beta = .77$, $p < .001$) and type of licensure ($\beta = .13$, $p = .022$) were significant predictors of CSK.

Table 31

Hierarchical Regression Predicting Conceptual Skills and Knowledge (CSK)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
Step 1						
1. Age	.00	.01	-.01	.02	.04	.719
2. Gender	.22	.20	-.17	.61	.08	.266
3. Type of licensure	.24	.15	-.05	.53	.127	.102
4. Years of Experience	.00	.01	-.02	.02	.03	.779
5. Supervision hours	.02	.01	.00	.04	.19	.016
Step 2						
1. Age	-.01	.01	-.01	.00	-.07	.303
2. Gender	.01	.14	-.27	.28	.00	.971
3. Type of licensure	.24	.10	.04	.44	.13	.022
4. Years of Experience	-.01	.01	-.03	.00	-.14	.052
5. Supervision hours	.00	.01	-.01	.01	.01	.917
6. GCETS	.93	.07	.80	1.07	.77	<.001

Note. N = 174. CI = confidence interval; LL = lower limit; UL = upper limit.

Hierarchical Regression Three. In the first step, age, gender, type of licensure, years of experience, and completed supervision hours were entered into the model to predict AS. The result of the regression analysis indicated that the model was statistically significant, $F(5,172) = 8.346$, $p < .001$, and explained approximately 20% of the variance in AS, $R^2 = .20$. Supervision ($\beta = .23$, $p = .001$) and type of licensure ($\beta = .33$, $p < .001$) were statistically significant predictors of AS when controlling for the other independent variables. In the second step, GCETS was added in addition to the existing independent variables. The result of the regression analysis indicated that the model was statistically significant, $F(6,171) = 27.830$, $p < .001$, and explained approximately 49% of the variance in AS $R^2 = .49$. Supervision became a non-significant predictor ($\beta = -.05$, $p =$

.429), whereas type of licensure (β = .32, $p < .001$) remained as a significant predictor. GCETS (β = .65, $p < .001$) was also a significant predictor of AS in the second step.

Table 32

Hierarchical Regression Predicting Assessment Skills (AS)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
Step 1						
1. Age	.00	.01	-.01	.02	.09	.363
2. Gender	.17	.17	-.16	.50	.07	.313
3. Type of licensure	.58	.12	.33	.82	.33	<.001
4. Years of Experience	.00	.01	-.02	.02	.00	.984
5. Supervision hours	.01	.00	.00	.02	.23	.001
Step 2						
1. Age	.00	.00	-.01	.01	-.00	.961
2. Gender	.01	.13	-.25	.27	.00	.944
3. Type of licensure	.57	.10	.38	.76	.32	<.001
4. Years of Experience	-.01	.01	-.02	.00	-.14	.064
5. Supervision hours	-.00	.00	-.01	.00	-.01	.429
6. GCETS	.68	.07	.55	.81	.65	<.001

Note. N = 178. CI = confidence interval; LL = lower limit; UL = upper limit.

Hierarchical Regression Four. In the first step, age, gender, type of licensure, years of experience, and completed supervision hours were entered into the model to predict TS. The result of the regression analysis indicated that the model was statistically significant, $F(5,172) = 5.302$, $p < .001$, and explained approximately 13% of the variance in TS, $R^2 = .13$. Supervision was the only significant predictor of TS when controlling for other independent variables (β = .28, $p < .001$). In the second step, GCETS was added in addition to the existing independent variables. The result of the regression analysis indicated that the model was statistically significant, $F(6,171) = 44.889$, $p < .001$, and

explained approximately 61% of the variance in TS, $R^2 = .61$. Supervision became a non-significant predictor (β = -.08, $p = .172$), whereas the type of licensure (β = .12, $p = .016$) and GCETS (β = .82, $p < .001$) were significant predictors of AS in the second step.

Table 33

Hierarchical Regression Predicting Treatment Skills (TS)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
Step 1						
1. Age	.01	.01	-.01	.02	.10	.294
2. Gender	.25	.15	-.04	.55	.12	.092
3. Type of licensure	.19	.11	-.03	.41	.13	.084
4. Years of Experience	.00	.01	-.01	.02	.06	.519
5. Supervision hours	.01	.00	.01	.02	.28	<.001
Step 2						
1. Age	-.00	.00	-.01	.01	-.01	.872
2. Gender	.08	.10	-.12	.28	.04	.433
3. Type of licensure	.18	.08	.04	.33	.12	.016
4. Years of Experience	-.01	.01	-.02	.00	-.12	.076
5. Supervision hours	-.00	.00	-.01	.00	-.08	.172
6. GCETS	.75	.05	.64	.85	.82	<.001

Note. N = 178. CI = confidence interval; LL = lower limit; UL = upper limit.

Hierarchical Regression Five. In the first step, age, gender, type of licensure, years of experience, and completed supervision hours were entered into the model to predict ProS. The result of the regression analysis indicated that the model was statistically significant, $F(5,172) = 3.622$, $p = .004$, and explained approximately 10% of the variance in ProS, $R^2 = .10$. Supervision was the only significant predictor of ProS when controlling for other independent variables (β = .26, $p < .001$). In the second step, GCETS was added in addition to the existing independent variables. The result of the regression analysis indicated that the model was statistically significant, $F(6,171) =$

24.397, $p < .001$, and explained approximately 46% of the variance in ProS, $R^2 = .46$. Supervision became a non-significant predictor ($\beta = -.05$, $p = .402$), whereas GCETS ($\beta = .71$, $p < .001$) was the only significant predictor of ProS in the second step.

Table 34

Hierarchical Regression Predicting Professional Skills (ProS)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
Step 1						
1. Age	.01	.01	-.01	.01	.05	.621
2. Gender	.33	.17	-.01	.67	.14	.059
3. Type of licensure	-.12	.13	-.37	.14	-.07	.371
4. Years of Experience	.01	.01	-.01	.02	.08	.412
5. Supervision hours	.01	.00	.01	.02	.26	<.001
Step 2						
1. Age	-.00	.01	-.01	.01	-.05	.523
2. Gender	.16	.14	-.11	.43	.07	.246
3. Type of licensure	-.13	.10	-.33	.08	-.07	.209
4. Years of Experience	-.01	.01	-.02	.01	-.08	.328
5. Supervision hours	-.00	.00	-.01	.00	-.05	.402
6. GCETS	.75	.07	.61	.88	.71	<.001

Note. N = 178. CI = confidence interval; LL = lower limit; UL = upper limit.

Hierarchical Regression Six. In the first step, age, gender, type of licensure, years of experience, and completed supervision hours were entered into the model to predict OCGC. The result of the regression analysis indicated that the model was statistically significant, $F(5,172) = 5.600$, $p < .001$, and explained approximately 14% of the variance in OCGC, $R^2 = .14$. Supervision ($\beta = .28$, $p < .001$) and type of licensure ($\beta = .15$, $p = .036$) were significant predictors of OCGC when controlling for other independent variables. In the second step, GCETS was added in addition to the existing independent variables. The result of the regression analysis indicated that the model was

statistically significant, $F(6,171) = 43.966$, $p < .001$, and explained approximately 61% of the variance in OCGC, $R^2 = .61$. Supervision became a non-significant predictor ($\beta = -.07$, $p = .214$), whereas type of licensure remained as a significant predictor of OCGC ($\beta = .15$, $p = .003$). GCETS ($\beta = .81$, $p < .001$) was also a significant predictor of OCGC in the second step.

Table 35

Hierarchical Regression Predicting Overall Competency in Grief Counseling (OCGC)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
Step 1						
1. Age	.00	.00	-.01	.01	.09	.355
2. Gender	.22	.13	-.04	.49	.12	.100
3. Type of licensure	.21	.10	.01	.41	.15	.036
4. Years of Experience	.00	.01	-.01	.02	.06	.568
5. Supervision hours	.01	.00	.01	.02	.28	<.001
Step 2						
1. Age	-.00	.00	-.01	.01	-.02	.744
2. Gender	.07	.09	-.11	.25	.04	.464
3. Type of licensure	.20	.07	.07	.34	.15	.003
4. Years of Experience	-.01	.00	-.02	.00	-.12	.066
5. Supervision hours	-.00	.00	-.01	.00	-.07	.214
6. GCETS	.66	.05	.57	.76	.81	<.001

Note. N = 178. CI = confidence interval; LL = lower limit; UL = upper limit.

Supplemental Exploratory Analysis Two: Prediction of Grief Counseling Experience and Training (GCETS)

GCETS was the most significant and consistent predictor of competency in grief counseling. Therefore, demographic variables related to experience and training were used to predict GCETS. These variables include grief supervision hours, number of professional development hours, number of grief courses taken, number of

clients/students presenting death-related grief, number of clients/students presenting non-death-related grief, number of books read in the last six months, number of articles read in the last six months, and years of experience. The variable of professional development hours consisted of total hours of professional development hours through conferences, web-based training, and certification hours. Similarly, the number of grief-related courses taken consisted of required standalone, elective standalone, and courses integrated grief and loss-related content.

First, the correlation between the independent variables and the dependent variables was investigated. All variables were significantly correlated with the dependent variable, except for the number of clients/students presenting non-death-related grief, which was removed from the model. The last model consisted of six independent variables.

Table 36

Correlations Between Grief Counseling Experience and Training (GCETS) and Independent Variables

Variables	1	2	3	4	5	6	7	8
1. GCETS								
2. Grief supervision hours	.44***							
3. Professional development hours	.45***	.30**						
4. Grief courses taken	.35***	.20***	.32***					
5. Number of death-related clients/students seen	.38***	.21**	.71***	.34***				
6. Number of non-death-related clients/students seen	.13	.08	.47***	.14	.47***			
7. Number of books	.40***	.16	.36***	.10	.33***	.11		
8. Number of articles	.34***	.10	.71***	.16*	.74***	.56***	.47***	

9. Years of experience	.31***	-.01	.17*	.06	.18*	.28***	.05	.05

*** p < .001, ** p < .01, and * p < .05

Assumptions

The researcher examined the data set and tested the assumptions before conducting the regression analysis. The assumptions included normality, linearity, homoscedasticity, multicollinearity, and outliers. Assumptions were not violated. However, a few outliers were determined using Mahalanobis distance analysis with a critical value of $\chi 2(7) = 24.32$, $p<.001$. Seven outliers were omitted due to extreme high scores and extreme low scores in other variables. The final data set consisted of 194 participants.

The result of the regression analysis indicated that the model was statistically significant, $F(7,92) = 13.263$, $p<.001$, and explained approximately 50% of the variance in GCETS, $R^2 = .50$. Regarding individual variables, grief supervision hours ($\beta = .18$, $p= .030$), professional development hours ($\beta = .37$, $p < .001$), number of grief courses taken ($\beta = .15$, $p= .046$), and number of clients/students presenting death-related grief and loss ($\beta = .23$, $p = .011$) were statistically significantly individual predictors of GCETS. On the other hand, the number of books and articles that have been read in the last six months and years of experience were not significant predictors.

Table 37

Regression Predicting Grief Counseling Experience and Training (GCETS)

			95% CI			
Variables	Beta	*SE*	*LL*	*UL*	*β*	*p*
1. Grief Supervision hours	.02	.01	.00	.03	.18	.030
2. Professional development hours	.02	.01	.01	.03	.37	<.001
3. Grief courses taken	.07	.03	.00	.13	.15	.046
4. Number of death-related clients/students seen	.00	.00	.00	.01	.23	.011
5. Number of books	.11	.07	-.04	.25	.14	.153
6. Number of articles	.02	.03	-.04	.07	.07	.482
7. Years of experience	.01	.01	-.01	.02	.09	.312

Note. N = 100. CI = confidence interval; LL = lower limit; UL = upper limit.

Supplemental Exploratory Analysis Three: Grief Counseling Experience and Training

Results from research question three (a), investigating the difference in grief counseling experience and training as measured by the GCETS between licensed professional counselors and licensed school counselors, revealed that there were no statistically significant differences in GCETS by type of licensure (LSCs vs. LPCs+). However, descriptive statistics have shown that the percentages of LPCs+ who received standalone required and elective courses were higher than LSCs. In addition, the percentages of LPCs+ who received web-based training and read books and articles in the last six months were also higher than those of LSCs. These descriptive statistics results were expected to represent participants' scores on GCETS, which measures individuals' experience and training in grief counseling.

To explore the discrepancy between descriptive statistics, which indicated that LPCs+ were more likely to receive training in grief counseling, and GCETS scores, which measure counselors' experience and training in grief counseling, item scores for the GCETS were reviewed. The results showed that LPCs+ scored higher on almost all items, except for item 6 ("I have a great deal of experience counseling children who present with grief.") and item 9 ("I have a great deal of experience with facilitating group counseling focused on grief concerns."). The mean difference between LSCs and LPCs+ for item 6 was .92 and .09 for item 9. It is not surprising that LSCs have more experience with counseling children who present with grief because children are the primary focus of LSCs. Results were reexamined without item 6.

A one-way analysis of variance (ANOVA) was performed to compare the mean differences between Licensed School Counselors (LSCs) and Licensed Professional Counselors + (LPC+) on the Grief Counseling Experience and Training (GCETS) scores. The assumptions of ANOVA were checked before the analysis. Results indicated that the GCETS scores were normally distributed within each group, group sizes were not equal for LSCs (N = 50) and LPC+ (N = 146), and the homogeneity of variances assumption was not violated as assessed by Levene's Test for Equality of Variances $F(1, 194) = 1.192$, $p = .167$. A Welch's ANOVA test was used because group sizes were not equal. The result revealed that there is a statistically significant difference in GCETS by type of licensure (LSCs vs. LPCs+) for Welch's $F(1, 104.912) = 19.922$, $p < .001$, suggesting that LPCs+ had significantly higher experience and training in grief counseling. The means score for LSCs was 2.32 with a standard deviation of .69 and 2.86 with a standard deviation of .86 for LPCs+. The Cronbach's alpha for GCETS with nine items was .87.

Summary

This chapter presented a comprehensive overview of the results, including demographic information for participants and the statistical analyses for each research question. A total of 235 counselors participated in the study. Following the data screening process, 201 participants remained for the analyses. The mean age for LSCs was 42.15 years, and for LPCs+ it was 45.61 years. LSCs had an average of 11.08 years since obtaining their initial licensure, and LPCs+ had an average of 11.04 years.

Of the 52 LSCs who participated in the study, the majority were women (90.4%) who identified as White/Caucasian (92.3%) and held a master's degree (96.2%) with a specialization in School Counseling (98.1%). Of the 148 LPCs+ who participated in the study, the majority were women (83.8%) who identified as White/Caucasian (83.8%) and held a master's degree (89.9%) with a specialization in Clinical Mental Health Counseling (91.9%).

All participants had seen at least one client presenting with death-related grief and loss issues, and almost all participants had at least one client presenting with non-death grief and loss. Among the LSCs, 88.5% had not taken a standalone required grief course in their graduate counseling programs, compared to 77.9% of LPCs+. Of those who were offered one or two standalone elective grief courses, 80% of LSCs and 79.2% of LPCs+ had taken at least one of those courses. The likelihood of earning at least one professional development hour through conferences and certification training programs was higher for LSCs than for LPCs+. Conversely, LPCs+ were more likely to earn professional development hours through web-based training and to have read grief and loss-related books and articles in the last six months. Only 13.5% of LSCs had received grief

counseling supervision, whereas 46.3% of LPCs+ had received at least one hour of grief counseling supervision.

The Stage Theories were the most well-known theories for both LSCs and LPCs+. Although Task Theories, the Dual-Process Theory, the Two-Track Model, Meaning Making Theory, and Continuing Bonds were among the least known grief counseling theories for both groups, the percentage of LPCs+ familiar with these theories was higher than that of LSCs. A total of 97.8% of LSCs and 99.2% of LPCs+ indicated that education in grief counseling is necessary. Similarly, almost all LSCs (95.6%) and LPCs+ (93.9%) reported that education in grief counseling should be required.

Results showed that the two-factor, 10-item version of GCETS demonstrated the best overall fit among the models tested. The mean score for GCETS was higher for LPCs+ ($M = 2.78$, $SD = .76$) than for LSCs ($M = 2.63$, $SD = .59$). There was a statistically significant difference in GCETS scores by type of licensure (LSCs vs. LPCs+). Descriptive statistics revealed that LPCs+ had a higher mean score in all competencies in grief counseling except for professional skills. The results of the MANOVA showed a significant multivariate effect of being an LSC versus an LPC+ on the combined dependent variables. Regression analysis results revealed that GCETS was the strongest predictor across all competencies in grief counseling. Type of licensure was also a significant predictor of conceptual skills, knowledge, assessment skills, treatment skills, and overall competency. Supervision was found to be significant when GCETS was not included in the model. The following chapter will discuss and interpret the findings in light of the results, exploring their implications, relevance to existing literature, and potential contributions to the field.

What Do You Think Happens When We Die, Keanu Reeves?

I Know That the Ones Who Love Us Will Miss us!

(Reeves & Colbert, 2020)

Chapter 5: Discussion

This chapter presents a detailed discussion of the study's findings. The descriptive statistics highlight key data points, including the number of clients/students experiencing grief and loss, the level of formal and informal grief and loss training received, the prevalence of grief counseling supervision, and participants' familiarity with grief counseling theories. Each research question is examined in light of the findings. The implications of the results are explored for counselors, counseling supervisors, counselor educators and counseling programs, and the Council for Accreditation of Counseling and Related Educational Programs (CACREP). Additionally, the chapter addresses the study's limitations and offers recommendations for future research.

Summary of the Study

This study explored and compared the level of competency in grief counseling, as well as training and experience in grief counseling, between licensed professional counselors (LPCs, LPCCs, and LPCCs-S) and school counselors (LSCs) in the state of Ohio. Random sampling was used to recruit licensed professional counselors (LPCs+), and purposeful snowballing sampling was used to recruit LSCs. As of March 2024, a total of 11,587 LPCs+ were licensed through the Ohio Counselor, Social Worker, and Marriage and Family Therapist (CSWMFT) Board (CSWMFT, personal communication, March, 25, 2024). A total of 5,000 LPCs+ were randomly selected in two steps; 1,000 in step one

and 4,000 in step 2 (see Chapter 3, population, sample size, and sampling section). The average response rate for LPCs+ was 3.22%. A total of 161 LPCs+ participated in the study, representing approximately 1.4% of the total number of LPCs+ in Ohio. On the other hand, as of April 2024, the total of school counselors licensed through the Ohio Department of Education [ODE] was 5,282. A total of 73 LSCs participated in the study, representing approximately 1.4% of the population (ODE, 2023).

The Competency in Grief Counseling Survey (CGCS), which is a revised version of the Death Counseling Survey (DCS), developed by Charkow (2002), was used to measure participants' grief counseling competency in two parts (personal grief counseling competencies and skills and knowledge of grief counseling competencies). CGCS is divided into five different subscales: personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills. The goals of the study included (1) exploring the level of grief counseling experience and training of LPCs+ and LSCs, (2) exploring the level of competencies in grief counseling (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) of LPCs+ and LSCs, (3) investigating the difference in grief counseling experience and training and competencies in grief counseling between LPCs+ and LSCs, and (4) exploring the predictive relationship between the competencies in grief counseling and the demographic variables of age, gender, specialization (LPCs+ and LSCs), professional experience as a licensed counselor (i.e., years practicing since obtaining initial licensure), grief counseling experiences and training.

Significant Findings

Number of Clients/Students With Grief and Loss Issues

Results indicated that all LPCs+ who participated in this study have seen at least one client presenting with death-related grief and loss, with 61.6% reporting that they have seen more than 15 such clients. Similarly, all LSCs have seen at least one student with death-related grief and loss, and 70% have seen more than 15 students in this context. A study with 147 family counselors investigating the level of death-related grief counseling revealed that 98% of participants had seen at least one client presenting death and grief-related issues (Charkow, 2001). Another study examining 156 master's level counseling students' (both clinical mental health and school) counseling training and competencies indicated that 73.5% had worked with a client on grief issues (Imhoff, 2015).

Furthermore, over 96% of LPCs+ have seen at least one client presenting with non-death-related grief and loss, with 63.2% having seen at least 35 clients. Similarly, more than 97% percent of LSCs have seen at least one student with non-death-related grief and loss, and more than 76.7% have seen more than 35 students in this category. These findings clearly suggest that both LSCs and LPCs+ are highly likely to provide services to individuals grieving the loss of a loved one and/or a non-death loss. Therefore, the quality of the experience and training is significantly important for both LPCs+ and LSCs in providing grief counseling services. To my awareness, there is no study investigating the frequency or likelihood of seeing a client or a student with non-death grief and loss experiences. Thus, this study adds a significant contribution to the literature on grief counseling with a special focuse on non-death-related issues.

Formal and Informal Training in Grief Counseling

Results have shown that 88.5% of LSCs and 77.9% of LPCs+ had not taken a standalone required grief course in their graduate counseling programs. 69.2% of LSCs and 66% of LPCs+ were not offered a standalone grief course. Similarly, Charkow (2001) reported that 88.46% of family counselors were not offered any specific death-related grief courses in their graduate programs, and 92.31% had not taken any such courses. On the other hand, Ober et al. (2012) also indicated that 54.8% (N=369) of randomly selected professional counselors in the state of Ohio had not taken any grief and/or death-related courses. For school counselors, the percentage of those who have never received a standalone grief course was reported as 89 in a previous study (Low, 2004).

The current study is similar to results in previous studies (Charkow, 2001), in which the majority of LSCs and LPCs+ were not offered any standalone elective grief courses in their graduate programs. Not surprisingly, 84.6% of LSCs and 73.8% of LPCs+ had not taken any elective grief courses in this study. However, 80% of LSCs and 79.17% of LPCs+ who were offered one or two standalone elective grief courses had taken at least one of those courses. Nearly all of the LSCs and more than half of the LPCs+ in this study had taken at least one or two courses in which the content of grief and loss was integrated. However, most counselors took stand alone grief-related courses in their graduate programs when available. Considering that grief and loss are not included in the CACREP standards, it is unsurprising that required or even elective grief-related courses are inaccessible in graduate counseling programs. On the other hand, most LSCs and LPCs+ had taken other courses in which grief and loss-related content was

integrated. Results from an exploratory supplemental analysis in this study revealed that the number of grief and loss courses taken, either required or elective, were associated with higher grief counseling experience and training (GCETS).

Participants were asked to report the number of professional development hours in grief and loss that they have received. Results have shown that 40% of LSCs and 50.5% of LPCs+ had earned "zero hours" of professional development hours through conferences, whereas 42.1% of LSCs and 32.4% of LPCs+ had earned "zero hours" of professional development hours through web-based training. Moreover, 70.4% of LSCs and 79.1% of LPCs+ had earned "zero hours" of professional development hours through certification programs. Similarly, 75% of LSCs and 56.2% of LPCs+ had not read any books, and 39.1% of LSCs and 33.9% of LPCs+ had not read any articles related to grief and loss in the last six months. In other words, the percentage of LSCs who have earned at least one professional development hour through conferences and certification training programs was higher than LPCs+. The percentages of LPCs+ who have earned at least one professional development hour through web-based training and read grief and loss-related books and articles in the last six months were higher than LSCs. Although the type of professional development hours was not specified, Ober et al. (2012) found that at least 30% of professional counselors in Ohio had not received any professional development hours related to grief and loss. However, this study's results from the exploratory supplemental analysis revealed that the number of professional development hours was associated with higher grief counseling experience and training (GCETS).

In summary, although the percentage of LPCs+ who received standalone required and elective courses was higher than LSCs, overall, the percentage of counselors who

received standalone grief counseling courses (required or elective) was low for both groups. It can be predicted that the lack of accessibility to formal training in graduate counseling programs has led professionals to seek professional development hours through conferences, web-based training, and reading articles. The percentages of LPCs+ who received web-based training and read books and articles in the last six months were also higher than those of LSCs. However, there is still a relatively high number of both LSCs and LPCs+ who were not engaged in any professional development resources related to grief and loss issues.

Certification programs and reading books are the less preferred ways for professional development hours for both groups. Interestingly, no LSCs received specific certification in grief and loss from the Association for Death Education and Counseling (ADEC) or any other professional organizations. On the other hand, only one LPC had received such certification (Certified in Thanatology) from ADEC, which is "one of the first interdisciplinary organizations in the field of dying, death and bereavement" (n.d.). Certifications could be perceived as a resource for those who want to specialize in grief and loss and not for all counselors, especially by LSCs. Moreover, similar to other professional development sources, the cost of certifications could significantly impact the decision-making about engagement with those resources.

Counselors' Preferences of Grief Counseling Training and Education

All participants were asked to share their attitudes about grief counseling education and training. Almost all LSCs (97.8%) and LPCs+ (99.2%) indicated that education in grief counseling is necessary. Similarly, almost all LSCs (95.6%) and LPCs+ (93.9%) reported that education in grief counseling should be required. Moreover, 82.2%

of LSCs and 91.7% of LPCs+ noted that they are willing to participate and learn more about grief counseling. These results align with the only existing study in the literature (Ober et al., 2012), which revealed that 91% of LPCs+ believed grief counseling education is necessary or should be required. Counselors were also asked to share their preferred ways of receiving training in grief and loss. Despite the slight differences among groups, all types of education and training in grief counseling were chosen; however, elective courses were the least preferred. These results clearly indicated that there would be a high demand for standalone grief-related courses and professional development hours among LPCS+ and LSCs.

Grief Counseling Supervision

This study showed that only 13.5% of LSCs in Ohio had received at least one hour of grief counseling supervision. On the other hand, 46.3% of LPCs+ had received at least one hour of supervision, specifically focusing on grief and loss. Of those who received grief counseling supervision, only 1.9% of LSCs and 13.1% of LPCs+ received more than 10 hours of supervision. Regarding the adequacy of the grief counseling supervision received, most LSCs and LPCs+ indicated that their supervision experience was either somewhat adequate or adequate. Due to state licensure board supervision requirements, LPCs+ were perhaps more likely to discuss grief and loss issues presented by their clients with their supervisors. However, the amount of supervision time dedicated to grief and loss for even LPCs+ was very limited. These findings raise an important question about why grief is less frequently addressed in supervision, particularly given that all participants have encountered clients presenting with grief and loss issues.

Familiarity With Grief Theories

Participants were asked to rate their familiarity with six grief and loss theories, including Stage Theories (i.e., Kubler-Ross), Task Theories (i.e., Worden), Dual-Process Theory (i.e., Stroebe & Schut), Two-Track Model (i.e., Rubin), Meaning Making Theory (i.e., Neimeyer), and Continuing Bonds (i.e., Bonanno & Klass). Responses ranged between "none," "very little," "some," or "a lot" of familiarity with the listed theories. A total of 51 LSCs and 146 LPCs+ responded to this demographic question. Similar to previous studies (Imhoff, 2015; Ober et al., 2012), Stage Theories (i.e., Kubler-Ross) were the most known grief theories among LSCs and LPCs+. In contrast, the Dual-Process Theory (i.e., Stroebe & Schut), Two-Track Model (i.e., Rubin), and Continuing Bonds (i.e., Bonanno & Klass) theories were the least known ones among both LSCs and LPCs+. However, LPCs+ are more familiar with contemporary and evidence-based grief counseling theories than LSCs.

The popularity of Stage Theories (i.e., Kubler-Ross) among counselors is significantly concerning due to the oversimplification of the grief process and diverse responses to a loss (Ober et al., 2012; O'Connor, 2023). Moreover, this theory is rooted in research with terminally ill individuals and fails to generalize the results to the loss of a loved one or non-death loss (Worden et al., 2021). Stage Theories also do not address how to assess or identify complications in grief (Stroebe et al., 2016). Worden et al. (2021) claimed that media has a significant role in the popularity of the Kubler-Ross Model, which also raises a question about whether the familiarity of counselors with this theory is associated with formal or informal training or only related to its popularity in media.

Research Question One: Grief Counseling Experience and Training

Research question one examined the level of experience and training in grief counseling for both LPCs+ and LSCs as measured by the Grief Counseling Experience and Training Survey (GCETS).

The original version of the Grief Counseling Experience and Training Survey (GCETS) contains 12 items measuring participants' grief counseling experience and training. Deffenbaugh (2008) adapted GCETS from a subscale of the Sexual Orientation Counselor Competency Scale (SOCC), which was originally developed to measure counselors' competency in working with gay, lesbian, and bisexual clients. Ober et al. (2008) reported a concern about two items that could be measuring overall grief counseling competency instead of experience and training. Moreover, GCETS had one factor measuring training and experience altogether.

In this study, the researcher performed four Confirmatory Factor Analyses (CFA) to test the best model fit among a 12-item version of GCETS with one factor, a 12-item version with two factors, a 10-item version with one factor, and 10-item version with two factors. The researcher conducted two Exploratory Factor Analyses (EFA) to confirm that the items, which were explicitly designed to measure either training or experience, appropriately grouped into two distinct factors for subsequent CFA. Results have shown that the 10-item version of GCETS with the two-factor model demonstrated the best overall fit among the models tested. This version of the GCETS appears to be reliable, with Cronbach's alpha values indicating acceptable internal consistency for the training subscale ($\alpha = .80$), the experience subscale ($\alpha = .81$), and the total score ($\alpha = .87$). Although the 10-item, two-factor model demonstrated the best fit based on the CFA

results, the decision was made to use the 10-item, one-factor model, as the one-factor model aligns more closely with previous research, consistently using a one-factor structure (Deffenbaugh, 2008; Imhoff, 2015; Ober et al., 2012). This continuity allows for comparison with the existing research studies.

In this study, the mean score on the GCETS was 2.63 for LSCs; and 2.78, for LPCs+. The results indicate that LPCs+ have slightly more training and experience in grief counseling than LSCs. Both groups scored below the midpoint of 3, suggesting that neither group felt they had sufficient experience and training in grief counseling. Similarly, Deffenbaugh (2008) reported an average GCETS score of 2.7 among randomly selected LPCs+ in Ohio, while Imhoff (2015) reported an average score of 2.11 among counseling students.

Item scores have shown that LPCs+ scored higher in eight items, including clinical training and supervision, consultation, supervision, and continuing education, conference workshops, knowledge of grief counseling theories, the experience of counseling individuals with grief, counseling suicide loss survivors, and role play in clinical training. In contrast, LSCs scored higher than LPCs+ only in two items, including counseling children who present with grief and facilitating grief group counseling. These results align with the results from the descriptive statistics showing that LPCs+ had more training across various types of training in grief counseling, including standalone grief courses, web-based training, reading books and articles, and supervision. The lowest item scores (items 9 and 11) suggest that both LSCs and LPCs+ may feel unprepared to address grief in a group counseling setting. Moreover, the lack of experience with role-plays involving grief concerns indicates that the training received by both groups may

have lacked practicum experiences and might have relied heavily on knowledge-based training.

Table 38

Comparison of GCETS Scores Between This Study and Previous Studies

	This Study (2024)				Ober et al. (2012)		Imhoff (2015)	
	LSCs in Ohio		LPCs+ in Ohio		LPCs+ in Ohio		Counseling Students	
	M	SD	M	SD	M	SD	M	SD
GCETS	2.63	.59	2.78	.76	2.7	.9	2.11	.64

Note: Reported as given in the original studies with the original decimal numbers.

Research Question Two: Competency in Grief Counseling

Research question two aimed to investigate the levels of grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) of licensed professional counselors + (LPCs+) and licensed school counselors (LSCs) as measured by the Competency in Grief Counseling Survey (CGCS).

The competency of LSCs and LPCs+ in grief counseling was measured using the Competency in Grief Counseling (CGCS), a revised version of the Death Counseling Survey (DCS) developed by Charkow (2001). Similar to DCS, CGCS contains 58 items, and participants were asked to rate each item from 1 (“This does not describe me”) to 5 (“This describes me very well”). CGCS contains two parts of competency (personal grief counseling competencies and skills and knowledge grief counseling competencies) divided into five different subscales: personal competencies, conceptual skills and

knowledge, assessment skills, treatment skills, and professional skills (Charkow, 2001). A higher mean score of CGCS indicates higher overall competency in grief counseling.

First, both LPCs+ and LSCs scored the highest in personal competencies. Similarly, in all studies using the original version of DCS (Charkow, 2001; Imhoff, 2015; Ober et al., 2012), participants reported the highest scores in personal competencies, which measures the ability to utilize self-care, personal beliefs surrounding grief, humor, and spirituality. Considering that self-care, humor, and spirituality are related to general counseling skills and not only grief-related, counselors were expected to score the highest in personal competency. Despite the fact that personal skills are more related to general counseling skills and beliefs surrounding grief, it is interesting that LPCs+ have scored higher than LSCs. Specifically, LPCs+ scored higher than LSCs in practicing wellness, self-care, self-awareness related to personal grief, and articulating personal philosophy and attitudes regarding loss, which was one of the largest differences between LPCs+ and LSCs. These results highlight the importance of self-care and awareness in personal experiences related to grief and loss to avoid burnout (Worden, 20128), especially for LSCs. Furthermore, this difference may be associated with training and supervision experiences, where self-care and self-awareness are usually highlighted.

Second, this study's results revealed notable differences in conceptual skills and knowledge as well as assessment skills between LSCs (M = 3.04 and 2.86, respectively) and LPCs+ (M = 3.40 and 3.53, respectively). Specifically, LPCs+ scored higher than LSCs in knowledge related to “the nature and symptoms of prolonged/complicated/unresolved grief,” “normal (adaptive) grief,” and “theoretical models of grief.” Additionally, the largest differences between LPCs+ and LSCs were

observed in assessing complications in grief, identifying Prolonged Grief Disorder (PGD), and evaluating spirituality, even when grief was not the primary reason for seeking help. Conversely, LSCs scored higher than LPCs+ in their ability to "articulate appropriate developmental levels of death understanding for children."

Third, LPCs+ rated themselves higher than LSCs in treatment skills (M = 3.52 and 3.23, respectively). Specifically, LPCs+ scored higher in "providing psychoeducation to clients/students related to the grief experience," "working with grief-related client/student resistance and denial," and "providing hope to grieving individuals without giving false reassurance." In contrast, LSCs rated themselves higher in "articulating a grief consultation model for parents, teachers, and other adults about how to talk to children about death, grief, and loss," "facilitating group grief counseling sessions," and "teaching clients/students how to obtain support and resources in the community pertaining to grief and loss."

Last but not least, LSCs scored higher than LPCs+ in professional skills (M = 3.23 and 3.18, respectively), encompassing the ability to deliver grief-related activities and interventions across different settings, perform crisis intervention, and work effectively within a team. Specifically, LSCs scored higher in "providing crisis intervention services to schools and/or community settings" and "working on an interdisciplinary team by interacting with staff from different professions." In contrast, LPCs+ rated themselves higher in "reading and applying current research and literature related to grief and effective treatment interventions."

These results seem to be consistent with the populations and the nature of grief counseling that LSCs provide. School counselors, as part of the school system, often

engage in multiple roles when addressing loss, especially in cases involving death. Grief interventions in schools are typically delivered immediately after a loss occurs, in collaboration with other staff, such as teachers and administrators (DeMuth et al., 2020; Haugen et al., 2023). For instance, following a student's death, school counselors are involved in notifying other students and families, as well as facilitating access to mental health services (Haugen et al., 2023). The immediate and collaborative nature of these interventions may reflect the emphasis on professional skills within a limited time frame.

In contrast, LPCs+ are more likely to work with individuals experiencing grief after the initial response period, often addressing more complex grief-related issues. In these cases, assessing for Prolonged Grief Disorder (PGD) may be necessary, particularly when working with insurance providers. This assessment process requires not only strong conceptual knowledge and assessment skills but also the ability to address client/student concerns surrounding complications in their grief journey. Consequently, it is not unexpected that LPCs+ scored higher in conceptual skills, assessment, and treatment competencies, while LSCs scored relatively higher in professional skills. This difference aligns with the unique demands and contexts within which each type of counselor provides grief counseling.

Not surprisingly, all grief counseling competency scores across all subscales for LPCs+, except for conceptual skills and knowledge, were almost identical to the results from a previous study randomly sampling LPCs+ in Ohio (Ober et al., 2012). Considering that both studies used random sampling methods, these results were expected. However, Ober et al. (2012) collected the data in 2008. In other words, despite the 16 years between the two studies, the level of competencies of LPCs+ from the same

state and licensure board has increased only in conceptual skills and knowledge areas. LPCs+ perhaps became slightly more competent in their ability to define and evaluate complicated and adaptive grief and theoretical knowledge, recognize effective and ineffective coping skills, and understand the development of death. However, their competencies have remained the same, including personal, assessment, treatment, and professional competencies, within the last 16 years, indicating that there has been no progress in preparing LPCs+ to address grief and loss issues.

Table 39

Comparision of Competency Scores Between This Study and Previous Studies

	This Study (2024)				Ober et al. (2012)		Charkow (2001)		Imhoff (2015)	
	LSCs in Ohio		LPCs+ in Ohio		LPCs+ in Ohio		MIAMFC		Counseling Students	
	M	SD	M	SD	M	SD	M	SD	M	SD
Personal Competencies	4.25	.43	4.40	.37	4.41	.43	4.46	.68	4.26	.43
Conceptual Skills & Knowledge	3.04	.75	3.40	.86	3.07	.91	3.74	.78	2.82	.79
Assessment Competencies	2.86	.68	3.53	.71	3.56	.73	3.91	.62	3.19	.68
Treatment Competencies	3.23	.59	3.52	.67	3.47	.71	4.01	.61	3.13	.63
Professional Competencies	3.23	.72	3.18	.75	3.19	.83	3.85	.72	2.77	.65
Overall Competency	3.34	.54	3.63	.59	NU	NU			3.27	.53

NU: Not used in the study; MIAMFC: Members of International Association of Marriage and Family Counselors.
Note: Reported as given in the original studies with the original decimal numbers.

Research Question Three

Research Question 3.a

Research question three (a) aimed to examine the difference in grief counseling experience and training as measured by the GCETS between licensed professional counselors (LPCs+) and licensed school counselors (LSCs).

Results have indicated no statistically significant differences between LPCs+ and LSCs in terms of grief counseling experience and training. This result suggests that both types of counselors possess comparable skills and preparedness to support individuals through grief and loss. However, descriptive statistics revealed that the percentages of LPCs+ who completed standalone required and elective courses were higher than those of LSCs. Similarly, LPCs+ were more likely to have participated in web-based training and to have read books and articles on grief counseling within the past six months.

The further examination of the discrepancy between descriptive statistics related to grief counseling training and GCETS scores through supplemental exploratory analysis has shown that item 6 (“I have a great deal of experience counseling children who present with grief.”) was a potential explanation for the discrepancy. After removing this item and reanalyzing the data, a significant difference between the groups emerged, suggesting that LPCs may possess a broader range of grief counseling training and experience compared to LSCs.

The results suggest that both LPCs+ and LSCs felt inadequately trained to address grief and loss in their work with grieving clients or students, as indicated by low mean scores on the GCETS. This aligns with previous research showing that school counselors (Dougherty, 2016), professional counselors (Ober et al., 2012), and college counselors

(Jankauskaite et al., 2021) were not sufficiently prepared to address issues of grief and loss. However, this study contributes significantly to the literature, suggesting that LPCs+ have more experience and training in grief counseling. The preparedness of each group reflects their unique roles as counselors. LSCs+ seemed to be building their experiences through their work with children presenting grief and loss and providing group counseling. On the other hand, LPCs+ reported significantly higher training via clinical training, consultation, supervision, continuing education, and knowledge related to grief counseling theories and more experiences with clients presenting grief and loss and suicide loss survivors.

Research Question 3.b

Research question three (b) aimed to examine the difference in the levels of grief counseling competencies (i.e., personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills) as measured by the CGCS between licensed professional counselors (LPCs+) and licensed school counselors (LSCs).

The results of the MANOVA analysis indicated a significant multivariate effect, indicating that the competencies in grief counseling between LSCs and LPCs+ differ across combined personal competencies, conceptual skills and knowledge, assessment skills, and treatment skills. This finding suggests that potential differences in training, experience, roles, and the served population may lead to distinct proficiency levels in grief counseling, specifically in areas such as personal competencies, conceptual skills and knowledge, assessment skills, and treatment skills. The univariate analyses further specify that assessment skills (AS) most strongly differentiate the groups, explaining

14.4% of the variance in competencies. This may suggest that LPCs+ are more competent at assessing unresolved grief, suicidality, spirituality, and cultural influences.

Interestingly, although personal competencies (PC), conceptual skills and knowledge (CSK), and treatment skills (TS) also show significant differences, professional skills (ProS) did not significantly distinguish the groups. This non-significant finding for ProS may indicate that both groups are similar in providing grief-related interventions, such as crisis intervention.

The significant differences observed in competencies may be attributed to differences in training and experience. In addition, these results might reflect variations in the practical application and emphasis of grief counseling skills within their respective work settings rather than in their foundational preparation. For example, LPCs+ may be more likely to work in settings that prioritize assessing and treating grief-related issues, which could naturally enhance their skills in these areas over time. On the other hand, school counselors may focus more on educational and developmental support and providing grief-related activities and interventions regardless of assessing or treating PGD. These results could also imply that LSCs and LPCs+ might be engaged in role-specific training to address the unique demands they face in their respective professional environments following the completion of their formal master's level education.

Research Question Four: Prediction of Competency in Grief Counseling

Research question four aimed to examine the relationship between grief counseling competencies and the demographic variables of age, gender, specialization (i.e., professional counseling and school counseling), professional experience as a licensed counselor (i.e., years practicing since obtaining initial licensure), grief

counseling experiences and training as measured by the GCETS, and completed supervision hours in grief. It was hypothesized that age, gender, specialization (LPCS+ vs. LSCs), professional experience as a licensed counselor (years practicing since obtaining initial licensure), grief counseling experiences and training as measured by the GCETS, and completed supervision hours in grief would predict grief counseling competencies. Six regression analyses were conducted to predict each sub-grief counseling competency and overall competency in grief counseling.

Grief Counseling Experience and Training (GCETS)

The results showed that the GCETS was the strongest significant predictor across all six models, based on standardized beta values, predicting personal competencies (β = .40, R^2 = .18), conceptual skills and knowledge (β = .80, R^2 = .55), assessment skills (β = .65, R^2 = .49), treatment skills (β = .82, R^2 = .61), professional (β = .71, R^2 = .46), and overall competencies (β = .81, R^2 = .61). Results indicate that experience and training were the most significant factors in developing overall competency in grief counseling. More specifically, training and experience was a strong predictor of personal competencies, which involve self-care practices and personal beliefs surrounding grief. Similarly, counselors who have efficient experience and training were more competent in differentiating adaptive grief from PGD, assessing unresolved grief, suicidality, and cultural influences on grief, which also enhances treatment skills in various settings, including individual, group, and family settings. These results emphasize the need for either or both formal and informal training through professional development and experience for counselors, as experience and training directly impact the perceived competency in grief counseling.

Previous studies using the 12-item version of the GCETS reported similar results, implying that the GCETS was the strongest significant predictor of all competencies (Ober et al., 2012) and overall grief counseling competencies (Imhoff, 2015). Ober et al. (2012) reported the following standardized beta coefficients for the GCETS in each model: personal competencies (β =.35), conceptual skills and knowledge β =.84), assessment skills (β =.72), treatment skills (β =.84), and professional skills (β =.78). In this study, a 10-item version was used based on CFA results. Although the GCETS remained the strongest significant predictor across all models, the standardized beta coefficients were smaller than those in the previous study. Ober et al. (2012) noted that the results were unusual, suggesting that the two removed items might have been measuring overall competency rather than experience and training. The results showed that with the use of the 10-item GCETS after removing two problematic items, the unique contribution of GCETS in each model was slightly lower and reasonable.

Type of Licensure: Specialization

Type of licensure was the only significant predictor, rather than GCETS, contributing to the conceptual skills and knowledge (β = .24), assessment skills (β = .57), treatment skills (β = .18), and overall competency in grief counseling (β = .20) models uniquely when controlling for other variables. Results indicated that LPCs+ were likely to have a solid foundation in understanding the theories of grief, distinguishing between adaptive grief and PGD, and recognizing effective versus ineffective coping strategies. This difference in conceptual skills and knowledge is vital for the assessment of unresolved grief, risk assessment, and cultural influences of a loss and the development of treatment plans for clients presenting grief and loss in which LPCs+ also were

associated with higher skills in assessment skills. The significant contribution of the type of licensure (LPCs+ vs. LSCs) was present when experience and training (GCETS) was controlled. In other words, the difference in conceptual skills and knowledge, assessment skills, treatment skills, and overall competency in grief counseling between LSCs and LPCs+ is likely to be rooted in other factors beyond experience and training measured by GCETS.

Supervision

The number of completed grief supervision hours did not explain a significant variance in any grief counseling competencies despite its moderate correlation with all competencies in grief counseling but personal competencies. Additionally, the number of completed grief supervision hours was moderately correlated with GCETS ($r = .44$, $p < .001$), which raised a concern regarding potential suppressing relationships between independent variables. Six hierarchical regression analyses predicting grief counseling competencies were conducted to investigate the suppressing relationship.

The results of the hierarchical regression analyses revealed that grief counseling experience and training, as measured by the GCETS, emerged as the strongest and most consistent predictor across all models for professional competencies (PC), conceptual skills knowledge (CSK), assessment skills (AS), treatment skills (TS), professional skills (ProS), and overall competencies in grief counseling. In five of the six models, supervision hours, while significant in the first step, became non-significant after GCETS was added, indicating that grief counseling experience and training might be a stronger or more comprehensive measure of the same underlying construct that supervision partially captures. In other words, GCETS captures most and almost all of the variance that would

otherwise be explained by supervision hours. In addition, in the exploratory supplemental analysis investigating the predicting relationship between various variables and GCETS, supervision was a significant predictor of GCETS.

Additionally, while not significant in the first model, the type of licensure became significant only in the second step in models predicting CSK and TS, suggesting a unique interaction between the type of licensure and grief counseling experience and training. Adding GCETS seems to highlight that type of licensure becomes more relevant in the prediction of CSK and TS when grief counseling experience and training are taken into account. In other words, supervision hours likely account for most of the variance in the type of licensure when GCETS is not included. However, when GCETS accounts for most of the variance in supervision hours, the type of licensure explains a unique variance that cannot be explained once other variables are controlled.

Considering that GCETS captures almost all of the variance in supervision hours, some items could be measuring the same components with supervision. For example, item 1 (“I have received adequate clinical training and *supervision* to counsel clients/students who present with grief”) and item 2 (“I consistently check my grief counseling skills by monitoring my functioning and competency via consultation, *supervision,* and continuing education”) explicitly mention supervision as a part of training in grief counseling. Thus, supervision in grief counseling is a way of training, and by itself, without training or experience, it may not be useful in predicting grief counseling competency.

Age, Gender, and Years of Experience

Age, gender, and years of experience (time since the initial licensure) were not unique significant predictors of any grief counseling competencies. Ober et al. (2012) reported that women scored higher than men in personal competencies, assessment skills, and treatment skills. However, the difference in scores for both genders ranged between .15 and .26 on a five-point scale. On the other hand, Imhoff (2015) found that female counseling students have significantly higher scores than men on conceptual skills and knowledge, treatment skills, professional skills, and overall competency in grief counseling. The results show that both studies reported significant differences in different competencies between women and men. Therefore, the relationship between gender and competency in grief counseling cannot be concluded.

Similar to the results from this study, Ober et al. (2012) and Imhoff (2015) noted that age was not a significant predictor of any grief counseling competencies, except personal competencies for master's level counseling students. Personal competencies include foundational counseling skills, such as self-care, but not competencies specifically capturing grief and loss. Therefore, the results of this study mostly align with the literature and indicate that overall counseling skills are not likely to be associated with competencies in grief counseling.

Last but not least, years of experience were not found to be a significant predictor of any competencies in grief counseling. Ober et al. (2012) grouped years of experience into three categories: new, experienced, and master practitioners. They reported that, interestingly, master practitioners scored lower in conceptual skills and knowledge and assessment competencies. These results indicate that grief counseling requires special

training and experience and does not simply rely on general experiences in counseling. Therefore, counselors should intentionally be prepared to address grief and loss in their work with their clients/students and students instead of being expected to develop competency over time without training and experience.

Implications

Implications for Counselors

Results have shown that seeing clients and students presenting both death and non-death-related grief and loss is inevitable for both LPCs+ and LSCs. However, both groups indicated that they did not have adequate experience and training preparing them to work with individuals presenting grief and loss issues. In addition, all counselors scored higher in personal competencies than competencies specifically related to grief and loss. These results indicated that counselors may believe that overall counseling skills can be transferred to their work with clients/students presenting grief and loss. Moreover, although LPCs+ were more familiar with evidence-based contemporary grief models, most counselors in both groups reported a lack of familiarity with these models, indicating a potential discrepancy between self-perceived grief counseling competency and actual competency evidenced by training and experience. In addition, most counselors indicated that grief counseling training was not incorporated into their formal education, and they tended to receive professional development hours in grief and loss to fill the gap from their formal education and provide the best services for their clients and students. Supervision was found to be an important component of experience and training, which is a significant difference between LPCs+ and LSCs regarding requirements following the obtaining of the initial licensure.

In light of this study's outcomes, both LPCs+ and LSCs are suggested to seek continuing education hours, especially if they were not required to take any required or elective standalone grief and loss courses. Moreover, considering the impact of supervision on experience and training, LSCs are suggested to continue seeking supervision after obtaining their initial licensure. On the other hand, LPCs+ is also suggested to bring grief and loss-related issues into their clinical supervision since more than half of LPCs+ had not received grief counseling supervision despite the fact that all of them had clients presenting grief and loss issues. Professional counselors who have already completed their supervision requirements can also maintain supervision and consultation with a counselor demonstrating high competency in grief and loss. Lastly, counselors should shift their focus from solely knowledge-based training to participating in training programs that incorporate supervised role-playing to enhance their grief counseling skills.

Implications for Counseling Supervisors

The findings that all counselors have encountered clients or students experiencing grief and loss, yet not all have received grief-related supervision, highlight a significant question regarding the potential reasons why grief and loss are not addressed in supervision. Counseling supervisors play a pivotal role in shaping the professional development of their supervisees. Therefore, it is imperative that they actively encourage discussions surrounding grief-related issues during supervision. By fostering an environment where grief can be openly discussed, supervisors can help counselors process their experiences and enhance their competencies in dealing with grief in their clients (Breen, 2011; Cicchetti et al., 2016). The integration of grief-related supervision

into counseling practices can lead to improved outcomes for clients. Research indicates that effective supervision can enhance counselors' skills and confidence in managing grief, ultimately benefiting their clients (Blueford et al., 2021; Currier et al., 2008).

Implications for Counselor Educators and Counseling Programs

Results have shown that the percentage of counselors who had not taken any required or elective standalone grief-related courses ranged between 73.8% and 88.5%. However, most counselors took a grief course when it was available to them. Moreover, the percentage of counselors who indicated that education in grief counseling is necessary ranged between 97.8% and 99.2%. Similarly, the percentage of counselors who indicated that they were willing to participate and learn more about grief counseling ranged between 82.2% and 91.7%.

Results demonstrate a significant result and play a significant role as a call for counselor educators to have elective or required grief-related courses in their curriculum. Considering the demand for grief-related courses, offering such a course can distinguish counseling programs from other programs and address the needs of future counselors. In addition, counselor educators are leaders and advocates. Therefore, they should consider the demands of counselors and advocate for including grief and loss issues in the counseling curriculum, both mental health and school counseling programs. Lastly, the content of the grief counseling courses and professional development hours is critically important in helping counselors build grief counseling competency. Counselor educators and professional development hours providers should include evidence-based models rather than traditional stage models. Lastly, considering the potential differences in the

nature of services provided by LPCs+ and LSCs, counselor educators should address the unique needs of both groups in their courses.

Implications for the Council for Accreditation of Counseling and Related Educational Programs (CACREP)

Results have shown that at least 95% of LSCs and 93% of LPCs+ indicated that education in grief counseling should be required. However, grief is not included in the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards (2016, 2024). Results demonstrate a recognition of the prevalence of grief and loss issues in therapeutic settings, suggesting that current standards may not adequately prepare counselors to address these complex issues. The findings call for CACREP to consider incorporating grief and loss education into its accreditation standards for school counseling and mental health counseling programs. Such a move would not only align educational practices with the expressed needs of practitioners but also enhance the overall competency of future counselors in managing grief-related issues effectively (Crunk et al., 2017; Hill et al., 2018). As the demand for grief counseling continues to rise, it is imperative that counselor education evolves to meet these pressing needs (Bradley et al., 2021; Jacobson & Butler, 2013).

Limitations and Implications for Future Research

As with any study, this study is not without limitations. First, the data was collected using self-report surveys, which rely on participants' ability to accurately remember and recall specific experiences and objectively assess their skills. This method also inherently carries the risk of intentional or unintentional bias or misrepresentation. To improve the reliability of the data, future research could incorporate feedback from

clients/students and supervisors, providing additional perspectives and reducing the potential for inaccuracies.

Second, the scale measuring competency in grief counseling and the grief counseling experience and training survey (GCETS) has been used in only a few studies. Two items were deleted from the GCETS following a suggestion from the originally study adapted GCETS. Thus, a 10-item version with one single factor was used in this study. Although results from a CFA have shown a good fit for this version, the 10-item version with two factors (training and experience) should be tested in the future studies across diverse groups of counselors. Moreover, the reliability and validity of GCETS should be tested across different groups, particularly school counselors, given that this study marks its first use with this population.

Third, the study population consisted of LPCs+ and LSCs in the state of Ohio, so the findings are generalizable only to this specific group. However, the majority of the LSCs (92.3%) and LPCs+ (83.8%) were White/Caucasian counselors, which limits the generalizability of the results to all counselors in the state of Ohio. Researchers are encouraged to replicate the study with a more ethnically diverse sample. Last but not least, two different sampling methodologies were used due to uncontrollable restriction and accessibility to the population. Therefore, future researchers are suggested to replicate the study using the same recruitment plan and methodology.

Conclusion

This study explored and compared the level of competency in grief counseling, as well as training and experience in grief counseling, between licensed professional counselors (LPC, LPCC, and LPCC-S) and school counselors (LSCs) in the state of Ohio.

Descriptive statistical results revealed that all participants had encountered at least one client/student presenting with death-related grief and loss, and almost all had also worked with at least one client/student experiencing non-death-related grief and loss issues. Despite this, there was a significant lack of accessibility and availability of grief and loss-related courses in master's level formal education, even though there was high demand and a widespread belief that grief counseling education is both necessary and should be required. The percentage of LPCs+ who had received grief-related standalone and elective courses was higher than that of LSCs. However, both groups reported limited experience with role-plays involving grief concerns, suggesting that their training may have lacked practicum components and relied heavily on knowledge-based instruction. Supporting this, although LPCs+ were more familiar with contemporary evidence-based grief counseling models than LSCs, most counselors were more familiar with traditional stage models of grief and less acquainted with evidence-based contemporary approaches. This finding raises concerns about the quality of grief counseling training received by counselors. Furthermore, only a few LSCs had received grief counseling supervision, and, more notably, the majority of LPCs+ did not discuss grief-related issues with their supervisors, despite having worked with clients experiencing grief and loss.

The results from statistical analyses have shown no significant difference between LPCs+ and LSCs in terms of grief counseling experience and training (GCETS), although LPCs+ scored slightly higher than LSCs. However, LPCs+ scored higher in all competencies in grief counseling (CGCS), except for professional skills. Regression analysis results revealed that GCETS was the strongest predictor of all competencies in grief counseling, and it captures supervision. This result highlights the importance of

supervision in training and experience and indicates that they are inseparable. Supplemental exploratory analysis results also indicated that supervision, the number of standalone grief courses, professional development hours, and the number of clients/students presenting death-related grief and loss were associated with higher GCETS scores. Moreover, being LPCs+ was associated with higher conceptual skills and knowledge, assessment skills, treatment skills, and overall competency in grief counseling. Results indicate potential work-related factors, such as diagnosis for insurance purposes, might be somehow be associated with higher competencies for LPCs+.

Based on these results, several recommendations were identified for counselors, counseling supervisors, counselor educators, and the accreditation body, CACREP. Counselors are encouraged to engage in training and supervised experiences to enhance their competencies. Supervisors should work closely with their supervisees when addressing grief and loss issues with clients. The concerning gaps in the curriculum regarding grief counseling education should be revisited, and counselor educators and professional development providers are urged to incorporate evidence-based, contemporary models into their training. Finally, the inclusion of grief and loss content in counseling standards by CACREP is deemed essential.

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Part II: Treatment Skills

	LSCs		LPCs+		M_1-M_2
	M	SD	M	SD	
2. I can provide psychoeducation to clients/students related to the grief experience for themselves and others.	3.10	1.10	3.87	.86	-.77
3. I can facilitate family grief counseling sessions.	1.85	1.03	2.52	1.25	-.67
7. I can facilitate individual grief counseling sessions.	3.17	1.00	3.88	1.06	-.71
8. I can use concrete terms regarding death to address the reality of death and convey the ability to discuss death-related issues.	3.27	.94	4.00	1.03	-.73
10. I can facilitate group grief counseling sessions.	2.77	1.13	2.59	1.37	.18
13. I can facilitate multi-family group grief counseling sessions.	1.60	1.01	2.03	1.21	-.43
14. I can articulate a grief consultation model for parents, teachers, and other adults about how to talk to children about death, grief, and loss.	2.65	1.21	2.37	1.27	.28
17. I can teach clients/students how to obtain support and resources in the community pertaining to grief and loss.	3.81	.96	3.66	1.20	.15
19. I can establish rapport with clients/students of all ages.	4.67	.60	4.42	.84	.25
21. I can identify cultural differences related to grief and loss that affect treatment.	3.50	.77	3.79	1.01	-.29
24. I can provide appropriate crisis debriefing services.	3.31	1.19	3.54	1.14	-.23
25. I can exhibit effective active listening skills.	4.81	.45	4.83	.37	-.02
27. I can facilitate a reframe of loss experience and grief reactions for client/student empowerment.	3.43	1.19	3.80	1.04	-.37
30. I can facilitate reconnection between a dying client/student and distant/estranged family members.	1.94	1.09	2.73	1.30	-.79

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Appendices

Appendix A: Demographic Information Form

Please take the time to read and answer the following demographic questions carefully. Remember that your answers are confidential. They will be used only for group analysis and not to track you individually.

What is your age? _____

1. What is your sex assigned at birth? _____Male _____Female ____ Other
2. What is your race/ethnicity?

___Black/African-American

___Asian-American

___White/Caucasian

___Hispanic/Latino

___Native American

___Pacific Islander

___Multiracial

___Other (pleas explain)

3. What is your highest earned educational degree?

   ___Bachelors (to end of survey)

   ___Masters

   ___PhD

   ____Other (explain): _____

4. Major field of study as a master student?

   ___Clinical Mental Health Counseling (CMHC)

   ___School Counseling (SC)

   ___Addiction Counseling (AC)

   ___Clinical Rehabilitation Counseling (CRC)

   ___Other (please explain):_____

5. I am currently licensed as a

   ___Licensed School Counselor (LSC)

   ___Professional Counselor (LPC)

   ___Professional Clinical Counselor (LPCC)

   ___Professional Clinical Counselor-Supervision (LPCC-S)

   ___Other (explain)_____

6. Which of the following professional certifications do you hold? (Check all that apply)

   ___National Certified Counselor (NCC)

   ___Certified in Thanatology (CT), ADEC

   ___Fellow in Thanatology (FT), ADEC

   ___Certified in Death Education (CDE), ADEC

___Certified in Grief Counseling (CGC), ADEC

___Certified in Grief Therapy (CGT), ADEC

___Other (if grief counseling related please explain)_____

7. How long have you been licensed? _____

Grief Counseling Questions

8. Approximately, how many clients/students presenting death related grief and loss have you worked with? _____
9. Approximately, how many clients/students presenting non-death related (i.e. loss of a relationship or friendship or job) grief and loss have you worked with? _____
10. During your graduate educational training in counseling, how many required standalone grief and loss courses have you taken? (Put "0" if none)_____
11. During your graduate educational training in counseling, how many standalone elective grief and loss courses were offered? (Put "0" if none)_____
12. During your graduate educational training in counseling, how many standalone elective grief and loss courses did you take? (Put "0" if none).
13. During your graduate educational training in counseling, how many courses where grief and loss were integrated did you take? (Put "0" if none)____
14. How many hours of professional development hours have you spent on the additional training on grief and loss listed below?

Put the number of earned professional development hours related to grief and loss for each type of training. (Put "0" if you have not received related training hours.)

___Professional Conferences

___Web-based trainings or webinars

___Personal Certification Training

15. In the last six months, how many books or articles have you read on grief and loss? (Put 0 if you have not read any.)

___Reading Books

___Reading Articles

16. Have you ever received grief and loss supervision?

___Yes ___No

17. Approximately, how many <u>supervision hours</u> have you received on the topic(s) of death and dying and/or grief? Put "0" if you have not received any grief and loss supervision. _____

18. How did you receive your supervision in? (Leave empty if you have not received any grief and loss supervision.)

___Group ____ Individual ____Both

19. How would you rate the adequacy level of your grief and loss supervision experience?

__Inadequate

__Somewhat inadequate

__Neutral

__Somewhat adequate

__Adequate

20. Please indicate your level of familiarity with the following Grief Counseling Theories by circling the appropriate answer below. [The authors of the models are included for your reference].

(a) Stage Theories (i.e. Kubler-Ross, Bowlby, & Parkes)

None Very Little Some A Lot

(b) Task Theories (i.e. Worden)

None Very Little Some A Lot

(c) Two-Track Model (i.e. Rubin)

None Very Little Some A Lot

(d) Continuing Bonds (i.e. Bonanno & Klass)

None Very Little Some A Lot

(e) Dual-Process Theory (i.e. Stroebe & Schut)

None Very Little Some A Lot

(f) Meaning Making Theory (i.e. Neimeyer)

None Very Little Some A Lot

Appendix B: Grief Counseling Experience and Training Survey (GCETS)

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

1	2	3	4	5
Not at All True		Somewhat True		Totally True

---

1. I have received adequate clinical training and supervision to counsel clients/students who present with grief.

   1 2 3 4 5

2. I consistently check my grief counseling skills by monitoring my functioning and competency via consultation, supervision, and continuing education.

   1 2 3 4 5

3. I have a great deal of experience counseling clients/students who present with grief.

   1 2 3 4 5

4. I have a great deal of experience counseling persons who experienced loss of a loved one to suicide.

   1 2 3 4 5

5. I have a great deal of experience counseling children who present with grief.

   1 2 3 4 5

6. I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling.

   1 2 3 4 5

7. I have a great deal of experience with facilitating group counseling focused on grief concerns.

   1 2 3 4 5

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

   1 2 3 4 5

9. I have done many counseling roleplays (as either the client/student or counselor) involving grief concerns.

   1 2 3 4 5

10. I have sufficient knowledge of grief counseling theories and models.

    1 2 3 4 5

11. I feel competent to assess the mental health needs of a person who presents with grief.

    1 2 3 4 5

12. At this point in my professional development, I feel competent, skilled and qualified to counsel clients/students who present with grief.

    1 2 3 4 5

Appendix C: Competency in Grief Counseling Survey (CGCS)

Part I: Personal Grief Counseling Competencies

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

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

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

Part ***II: Skills and Knowledge Grief Counseling Competencies***

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

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

1. I can assess for unresolved grief that may not be stated as a presenting problem.
2. I can provide psycho-education to clients/students related to the grief experience for themselves and others.
3. I can facilitate family grief counseling sessions.
4. I can provide educational workshops and activities to community members about grief.
5. I can define and articulate the nature of "normal" grief as detailed by theoretical models.
6. I can articulate the diagnostic criteria for Prolonged Grief Disorder (PGD), according to DSM-5-TR, and how to distinguish this diagnosis from related diagnoses.
7. I can facilitate individual grief counseling sessions.
8. I can use concrete terms regarding death to address the reality of death and convey the ability to discuss death-related issues.

9. I can provide developmentally appropriate programs about grief and loss issues in schools.
10. I can facilitate group grief counseling sessions.
11. I can describe general differences in the grief experience as determined by different status and process variables (i.e. personality, relationship to the deceased).
12. I can conduct suicide assessments.
13. I can facilitate multi-family group grief counseling sessions.
14. I can articulate a grief consultation model for parents, teachers, and other adults about how to talk to children about death, grief, and loss.
15. I can provide crisis intervention services to schools and/or community settings.
16. I can define and articulate the nature and symptoms of prolonged/complicated/unresolved grief situations.
17. I can teach clients/students how to obtain support and resources in the community pertaining to grief and loss.
18. I can assess a client/student's sense of spirituality.
19. I can establish rapport with clients/students of all ages.
20. I can work on an interdisciplinary team by interacting with staff from different professions.
21. I can identify cultural differences related to grief and loss that affect treatment.

22. I can describe common functional coping styles of grieving persons.
23. I can utilize family assessment techniques to examine interaction patterns and roles.
24. I can provide appropriate crisis debriefing services.
25. I can exhibit effective active listening skills.
26. I can read and apply current research and literature related to grief and effective treatment interventions.
27. I can facilitate a reframe of loss experience and grief reactions for client/student empowerment.
28. I can describe common dysfunctional coping styles of grieving persons.
29. I can assess individuals' progress on theoretically defined grief tasks.
30. I can facilitate reconnection between a dying client/student and distant/estranged family members.
31. I can use the creative arts in counseling to facilitate grief expression.
32. I can appropriately self-disclose related to my own grief and loss experiences.
33. I maintain an updated library of grief and loss resources for clients/students.
34. I can articulate appropriate developmental levels of death understanding for children.
35. I can identify cultural differences that affect assessment pertaining to grief and loss.
36. I can recognize and work with grief-related client/student resistance and denial.

37. I can participate in informal or formal support groups for professionals who work with issues of grief and loss to prevent burnout and vicarious traumatization.
38. I can describe how various individual counseling theories can be applied to grief counseling with individuals and families.
39. I can recommend helpful articles and books for grieving individuals and families.
40. I can identify symptoms that warrant medical evaluation and refer to a physician.
41. I can describe how various family counseling theories can be applied to grief counseling with individuals and/or families.
42. I can advocate for the needs of the dying client/student and the family.
43. I can define and differentiate between the terms of grief, loss, bereavement, and mourning.
44. I can determine appropriate treatment modality for grieving client/student (i.e. individual or group) as a result of assessment.
45. I can co-create and participate in mourning rituals for individuals and/or families.
46. I can provide supportive presence for clients/students in difficult times.
47. I can provide hope to grieving individuals without giving false reassurance.

Appendix D: Attitudes Towards Training in Grief Counseling (ATTGC)

The following questions are examining your beliefs and attitudes about education and training in grief and loss. Please read each question carefully and choice the best answer describing your attitude and beliefs.

1. I think education in grief counseling:

   ____Is Necessary ____Is Not Necessary

2. I think education in grief counseling:

   ____Should Be Required ___Should Not Be Required

3. I would be willing to participate in and learn more about grief counseling.

   _____Yes _____No _____Uncertain

4. My preferred type of education for grief counseling training is through… (you can check more than one.)

   ____Required course(s) in master's or doctoral level counseling programs.

   ____Elective course(s) in master's or doctoral level counseling programs.

   ____Professional Development through conferences.

   ____Professional Development through web-based training or webinars.

   ____Professional Development through personal training and certifications.

   ____Personal Development, such as through books and articles.

Appendix E: Permission to Revise and Use the Death Counseling Survey (DCS)

From: Bordeau, Wendy <wbordeau@franklinboe.org>
Sent: Thursday, November 16, 2023 13:43
To: Akmese, Ibrahim <ia345219@ohio.edu>
Subject: Re: [External] Re: Death Counseling Survey - request

This looks great! Thanks for sharing and yes, you have my approval to use and move forward. Good luck!
Sincerely,

Dr. Wendy Bordeau, School Counselor
Franklin High School
500 Elizabeth Ave.
Somerset, NJ 08873
732.302.4200 x5311
wbordeau@franklinboe.org

Hello Dr. Charkow-Bordeau,

I completed the changes in DCS. I attached the last version of DCS that I will use in my dissertation. Death Counseling Survey (DCS) is named Competency in Grief Counseling Survey (CGCS) to avoid the possible bias of DCS's title since the study I am conducting includes both death and non-death losses.
For example, question 2 in DCS part I is, "I have experienced the death(s) of a family member and can verbalize my own grief process" vs. "I have experienced loss and can verbalize my own grief process" in CGCS.

Please let me know if you have any questions. I am looking forward to your approval before I proceed to submit the study for Institutional Board Review.

Best regards,
Ibrahim

Ibrahim Akmese, LPC (Ohio)
Doctoral Student, Counselor Education and Supervision (CES)
Ohio University (OU) | Athens, OH 45701
Clinical Counselor Graduate Assistant, LPC | Counseling and Psychological Services (OU)
Pronouns: he/him/his (هو)

From: Bordeau, Wendy <wbordeau@franklinboe.org>
Sent: Wednesday, September 27, 2023 15:18
To: Akmese, Ibrahim <ia345219@ohio.edu>
Subject: [External] Re: Death Counseling Survey - request

Use caution with links and attachments.
Hello! Yes, you have my permission. Please share a copy of. your results with me and let me know if you have any questions!
Sincerely,

Dr. Wendy Bordeau, School Counselor
Franklin High School
500 Elizabeth Ave.
Somerset, NJ 08873
732.302.4200 x5311

wbordeau@franklinboe.org

From: Akmese, Ibrahim
Sent: Wednesday, September 27, 2023 14:35
To: wbordeau@franklinboe.org <wbordeau@franklinboe.org>
Subject: Death Counseling Survey – request

On Wed, Sep 27, 2023 at 2:35 PM Akmese, Ibrahim <ia345219@ohio.edu> wrote:
Greetings Dr. Charkow-Bordeau

I, Ibrahim Akmese, am a third-year doctoral student in Counselor Education at Ohio University. I am currently working on my dissertation proposal and am interested in using the Death Counseling Survey (DCS) in my dissertation. I aim to explore licensed mental health and school counselors' grief competency and its relationship with professional training and experience. Although revised versions of the DCS exist, it is still the most used tool in assessing grief competency. I would like your permission to use the assessment tool and make small changes before I use it in my study. The changes I anticipate are minors to ensure both bereavement and non-death-related grief are included. I am looking forward to hearing from you and learning what steps I need to take to acquire this permission. Thank you in advance for your consideration.
From: Bordeau, Wendy <wbordeau@franklinboe.org>
Sent: Thursday, November 16, 2023 13:43
To: Akmese, Ibrahim <ia345219@ohio.edu>
Subject: Re: [External] Re: Death Counseling Survey - request

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Sincerely,

Dr. Wendy Bordeau, School Counselor
Franklin High School
500 Elizabeth Ave.
Somerset, NJ 08873
732.302.4200 x5311
wbordeau@franklinboe.org

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I completed the changes in DCS. I attached the last version of DCS that I will use in my dissertation. Death Counseling Survey (DCS) is named Competency in Grief Counseling Survey (CGCS) to avoid the possible bias of DCS's title since the study I am conducting includes both death and non-death losses.
For example, question 2 in DCS part I is, "I have experienced the death(s) of a family member and can verbalize my own grief process" vs. "I have experienced loss and can verbalize my own grief process" in CGCS.

Please let me know if you have any questions. I am looking forward to your approval before I proceed to submit the study for Institutional Board Review.

Best regards,
Ibrahim
Ibrahim Akmese, LPC (Ohio)
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Appendix F: Permission to Revise and Use Grief Counseling Experience and Training Survey (GCETS)

From: Anne Ober (she/her/hers) <aober@wooster.edu>
Sent: Saturday, September 23, 2023 15:14
To: Akmese, Ibrahim <ia345219@ohio.edu>
Subject: [External] Re: [EXT]Grief Counseling Experience and Training Survey (GCETS)-Request

Use caution with links and attachments.
Hi Ibrahim -

You have my permission to use the assessment. Good luck to you with your dissertation and I hope the instrument is useful to you in your work.

Take care
Anne

Anne M. Ober, PhD, LPCC-S
Director of Wellbeing and Counseling Services
Longbrake Student Wellness Center
The College of Wooster
570 E Wayne Avenue
Wooster, OH 44691
330.263.2319
330.263.2369 (fax)

My pronouns: she/her

From: Akmese, Ibrahim <ia345219@ohio.edu>
Sent: Monday, September 18, 2023 11:36 AM
To: Anne Ober (she/her/hers) <aober@wooster.edu>
Subject: [EXT]Grief Counseling Experience and Training Survey (GCETS)-Request

Greetings Dr. Ober,

I, Ibrahim Akmese, am a third-year doctoral student in Counselor Education at Ohio University. I am currently working on my dissertation proposal and am interested in using the Grief Counseling Experience and Training Survey (GCETS), which was derived from the Sexual Orientation Counselor Competency Scale (SOCC) by Dr. Bidell in 2005 and used in your doctoral dissertation. I aim to explore licensed mental health and school counselors' grief competency and its relationship with grief counseling

experience and training. I would like your permission to use the assessment tool. I am looking forward to hearing from you and learning what steps I need to take to acquire this permission. Thank you in advance for your consideration.

Best regards,
Ibrahim

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From: Anne Ober (she/her/hers) <aober@wooster.edu>
Sent: Tuesday, October 10, 2023 09:34
To: Akmese, Ibrahim <ia345219@ohio.edu>
Subject: Re: [EXT]Re: [EXT]Re: [External] Re: [EXT]Grief Counseling Experience and Training Survey (GCETS)-Request

This sounds like a good plan.

take care

Anne

****
From: Akmese, Ibrahim <ia345219@ohio.edu>
Sent: Monday, October 9, 2023 11:40 AM
To: Anne Ober (she/her/hers) <aober@wooster.edu>
Subject: [EXT]Re: [EXT]Re: [External] Re: [EXT]Grief Counseling Experience and Training Survey (GCETS)-Request

Hello,

It can also be helpful to keep them while collecting data. Then, I can test the reliability without them and report both results (with and without).

Best,
Ibrahim

****

From: Anne Ober (she/her/hers) <aober@wooster.edu>
Sent: Monday, October 9, 2023 11:35
To: Akmese, Ibrahim <ia345219@ohio.edu>
Subject: Re: [EXT]Re: [External] Re: [EXT]Grief Counseling Experience and Training Survey (GCETS)-Request

Hello Ibrahim -

My initial thought is that by removing items - the scale's validity and reliability would need to be recalculated without these items.

Let me know if you want to proceed with this change and the needed exploration into the scale's properties.

take care

Anne

****
From: Akmese, Ibrahim <ia345219@ohio.edu>
Sent: Thursday, September 28, 2023 13:23
To: Anne Ober (she/her/hers) <aober@wooster.edu>
Subject: Re: [External] Re: [EXT]Grief Counseling Experience and Training Survey (GCETS)-Request

Hello Dr. Ober,

Thank you for your permission to use the survey in my study.

After reading your studies in depth, I am asking permission to make a change to the survey based on your results and suggestion in the article entitled "Grief Counseling: An Investigation of Counselors' Training, Experience, and Competencies"

You indicated that,
"Although the majority of the questions on the GCETS ask about specific experiences and training, two of the 12 items did ask about general competence in grief counseling ("At this point in my professional development, I feel competent, skilled, and qualified to counsel clients who present with grief " and "I feel competent to assess the mental health

needs of a person who presents with grief in a therapeutic setting") (Ober et al., 2012, p. 156).

I need your permission to delete these two items measuring general competency in grief counseling to avoid confusion between competency and professional experience and training.

Thank you for your consideration.

Best,
Ibrahim

Appendix G: Item Scores on the Grief Counseling Experience and Training (GCETS)

	LSCs		LPCs+		M_1-M_2
	M	SD	M	SD	
Training					
1. I have received adequate clinical training and supervision to counsel clients/students who present with grief.	2.48	.91	2.92	1.04	-.44
2. I consistently check my grief counseling skills by monitoring my functioning and competency via consultation, supervision, and continuing education.	2.86	.95	3.18	1.09	-.32
7. I regularly attend in-services, conference sessions, or workshops that focus on grief issues in counseling.	2.50	.86	2.53	1.09	-.03
10. Currently, I do not have sufficient skills or training to work with a client/student who presents with grief.	3.60	.78	3.81	.99	-.21
12. I have sufficient knowledge of grief counseling theories and models.	2.16	.84	2.80	.90	-.64
Experience					
3. I have a great deal of experience counseling clients/students who present with grief.	2.98	1.02	3.18	1.15	-.20
5. I have a great deal of experience counseling persons who experienced loss of a loved one to suicide.	2.30	.97	2.69	1.09	-.39
6. I have a great deal of experience counseling children who present with grief.	3.36	.90	2.44	1.24	.92
9. I have a great deal of experience with facilitating group counseling focused on grief concerns.	2.12	1.14	2.03	1.29	.09

11. I have done many counseling role- plays (as either the client or counselor) involving grief concerns.	1.92	.85	2.19	.96	-.27
Deleted Items					
4. At this point in my professional development, I feel competent, skilled and qualified to counsel clients/students who present with grief.	2.84	.89	3.36	1.06	-.52
8. I feel competent to assess the mental health needs of a person who presents with grief.	3.18	.80	3.76	.83	-.58

Appendix H: Item Scores on Competency in Grief Counseling Survey (CGCS)

Part I: Personal Competency

	LSCs		LPCs+		M_1-M_2
	M	SD	M	SD	
1. I practice personal wellness and self-care.	3.82	.85	3.98	.73	-.16
2. I have experienced loss and can verbalize my own grief process.	3.92	.88	4.25	.88	-.33
3. I have self-awareness related to my own grief issues and history.	4.00	.90	4.36	.67	-.36
4. I view death as a natural part of the experience of living.	4.28	.64	4.48	.61	-.20
5. I believe that grief is a result of a variety of loss experiences, which include but are not limited to death.	4.62	.53	4.78	.43	-.16
6. I display therapeutic attributes of empathy, unconditional positive regard, and genuineness in interactions with others.	4.71	.50	4.79	.41	-.08
7. I view grief as a systemic as well as an individual experience.	4.22	.76	4.32	.82	-.10
8. My spirituality is important to my understanding of grief and loss.	3.76	1.27	3.75	1.39	.01
9. I believe that there is no one right way to grieve or deal with grief.	4.68	.55	4.74	.55	-.06
10. I have a sense of humor.	4.62	.49	4.59	.61	.03
11. I can articulate my own philosophy and attitudes regarding loss, including death.	4.08	.75	4.39	.68	-.31

Part II: Conceptual Skills and Knowledge

	LSCs		LPCs+		M_1-M_2
	M	SD	M	SD	
5. I can define and articulate the nature of "normal" grief as detailed by theoretical models.	2.56	1.05	3.14	1.13	-.58
11. I can describe general differences in the grief experience as determined by different status and process variables (i.e. personality, relationship to the deceased).	3.00	1.07	3.46	1.11	-.46
16. I can define and articulate the nature and symptoms of prolonged/ complicated/unresolved grief situations.	2.81	1.00	3.47	1.08	-.66
22. I can describe common functional coping styles of grieving persons.	3.60	.79	3.77	1.05	-.17
28. I can describe common dysfunctional coping styles of grieving persons.	3.47	.91	3.92	.93	-.45
34. I can articulate appropriate developmental levels of death understanding for children.	3.37	1.10	2.75	1.32	.62
38. I can describe how various individual counseling theories can be applied to grief counseling with individuals and families.	3.59	1.13	3.13	1.24	.46
42. I can advocate for the needs of the dying client/student and the family.	3.51	1.60	3.55	1.24	-.04
44. I can determine appropriate treatment modality for grieving client/student (i.e. individual or group) as a result of assessment.	2.30	1.11	3.52	1.03	-.22

Part II: Assessment Skills

	LSCs		LPCs+		M_1-M_2
	M	SD	M	SD	
1. I can assess for unresolved grief that may not be stated as a presenting problem.	3.04	.97	3.86	.94	-.82
6. I can articulate the diagnostic criteria for Prolonged Grief Disorder (PGD), according to DSM-5-TR, and how to distinguish this diagnosis from related diagnoses.	1.79	1.07	3.37	.15	-1.58
12. I can conduct suicide assessments.	4.29	.82	4.48	.70	-.19
18. I can assess a client/student's sense of spirituality.	3.00	1.20	3.80	.98	-.80
23. I can utilize family assessment techniques to examine interaction patterns and roles.	2.25	1.00	2.89	1.30	-.64
29. I can assess individuals' progress on theoretically defined grief tasks.	2.32	1.07	3.05	1.22	-.73
35. I can identify cultural differences that affect assessment pertaining to grief and loss.	2.85	.97	3.17	1.17	-.32
40. I can identify symptoms that warrant medical evaluation and refer to a physician.	3.55	1.10	4.04	.84	-.49
45. I can co-create and participate in mourning rituals for individuals and/or families.	2.59	1.28	3.21	1.25	-.62

Part II: Treatment Skills

	LSCs		LPCs+		M_1-M_2
	M	SD	M	SD	
2. I can provide psychoeducation to clients/students related to the grief experience for themselves and others.	3.10	1.10	3.87	.86	-.77
3. I can facilitate family grief counseling sessions.	1.85	1.03	2.52	1.25	-.67
7. I can facilitate individual grief counseling sessions.	3.17	1.00	3.88	1.06	-.71
8. I can use concrete terms regarding death to address the reality of death and convey the ability to discuss death-related issues.	3.27	.94	4.00	1.03	-.73
10. I can facilitate group grief counseling sessions.	2.77	1.13	2.59	1.37	.18
	1.60	1.01	2.03	1.21	-.43
14. I can articulate a grief consultation model for parents, teachers, and other adults about how to talk to children about death, grief, and loss.	2.65	1.21	2.37	1.27	.28
17. I can teach clients/students how to obtain support and resources in the community pertaining to grief and loss.	3.81	.96	3.66	1.20	.15
19. I can establish rapport with clients/students of all ages.	4.67	.60	4.42	.84	.25
21. I can identify cultural differences related to grief and loss that affect treatment.	3.50	.77	3.79	1.01	-.29
24. I can provide appropriate crisis debriefing services.	3.31	1.19	3.54	1.14	-.23
25. I can exhibit effective active listening skills.	4.81	.45	4.83	.37	-.02
27. I can facilitate a reframe of loss experience and grief reactions for client/student empowerment.	3.43	1.19	3.80	1.04	-.37
30. I can facilitate reconnection between a dying client/student and distant/estranged family members.	1.94	1.09	2.73	1.30	-.79

31. I can use the creative arts in counseling to facilitate grief expression.	3.28	1.14	3.26	1.26	.02
32. I can appropriately self-disclose related to my own grief and loss experiences.	3.93	.68	4.06	.83	-.13
36. I can recognize and work with grief-related client/student resistance and denial.	3.02	1.00	3.50	1.03	-.48
39. I can recommend helpful articles and books for grieving individuals and families.	3.32	1.07	3.36	1.30	-.04
41. I can describe how various family counseling theories can be applied to grief counseling with individuals and/or families.	2.11	1.01	2.73	1.26	-.62
43. I can define and differentiate between the terms of grief, loss, bereavement, and mourning.	2.91	1.00	3.60	1.10	-.69
46. I can provide supportive presence for clients/students in difficult times.	4.55	.62	4.66	.56	-.11
47. I can provide hope to grieving individuals without giving false reassurance.	4.02	.97	4.41	.76	-.39

Part II: Professional Skills

	LSCs		LPCs+		M_1-M_2
	M	SD	M	SD	
4. I can provide educational workshops and activities to community members about grief.	1.98	1.01	2.42	1.27	-.44
9. I can provide developmentally appropriate programs about grief and loss issues in schools.	3.29	1.01	2.26	1.33	.03
15. I can provide crisis intervention services to schools and/or community settings.	3.79	1.10	3.09	1.45	.70
20. I can work on an interdisciplinary team by interacting with staff from different professions.	4.50	.72	4.39	.83	.11
26. I can read and apply current research and literature related to grief and effective treatment interventions.	3.45	1.20	4.09	.89	-.64
33. I maintain an updated library of grief and loss resources for clients/students.	2.76	1.27	2.88	1.16	-.12
37. I can participate in informal or formal support groups for professionals who work with issues of grief and loss to prevent burnout and vicarious traumatization.	2.65	1.23	3.17	1.23	-.52

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