

# Perceived Competency in Grief Counseling: Implications for Counselor Education

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Grief is regarded as a critical life event. Unresolved grief issues can interfere with quality of life and can result in emotional, behavioral, physical, and cognitive symptoms. If unresolved, this can result in suicidal ideation. Counselors can be called upon and often do work with grief issues in clients, including U.S. Military veterans. This study examined whether 93 master's-level counselors specializing in rehabilitation counseling reported having been adequately trained to identify and work with clients who are having grief-related issues from loss or disability. Using the Grief Counseling Competency Scale, participants showed a wide range of scores regarding personal competency related to grief. However, scores tended to be low when examining skills and knowledge relating to grief counseling. Implications for further research are discussed.

**Keywords:** *grief, grief and loss, counseling, competency, counselor education, rehabilitation, CORE, CACREP, military veterans, holistic treatment*

## Introduction

In 2010, an estimated 56.7 million individuals had physical, sensory, psychiatric, or cognitive disabilities in the United States, representing about one in five individuals in the nation, or about 18.7% of the noninstitutionalized population (Brault, 2012). Between 2005 and 2010 (the last two times the U.S. Census Bureau reviewed household disability numbers), the number of persons with disabilities had grown by 2.2 million. Disability is a complex process, and being placed into an unforeseen situation, such as acquiring a disability, results in changes in how individuals might perceive themselves and can result in being viewed by society as deviant or unworthy of life (Lutz & Bowers, 2005; Marshall, 2006). Learning to adjust to new life circumstances associated with a disability is one of the most stressful events an individual can experience over a lifetime. It can alter developmental life stages (Falvo, 2014; Smart, 2012) and can destroy an individual's basic assumptions about reality, leaving an individual feeling unsafe and unstable. Coping with traumatic events associated with a disability can often result in negative beliefs concerning how

individuals see themselves and how they believe others perceive them (Livneh, 2012; Livneh & Antonak, 2012; Romanoff, Israel, Tremblay, O'Neil, & Roderick, 1999).

The process of letting go of how life used to be while processing feelings of anger, hurt, disappointment, and bitterness is known as grieving. According to Humphrey (2009), “grief refers to (a) an emotion, generated by an experience of loss and characterized by sorrow and/or distress, and (b) the personal and interpersonal experience of loss” (p. 5), and is unique to the individual, but is not unique to death and dying alone. Grief can be a critical life event that has physical, emotional, behavioral, cognitive, and social consequences (Humphrey, 2009; Kubler-Ross, 2009). Individuals who grieve may experience physical and psychological symptoms such as disbelief, preoccupation, appetite loss, decreased sleep, lethargic behavior, anger, depression, guilt, decreased social interest, loss of pleasure in life experiences, as well as suicidal symptoms and ideation (Freeman & Ward, 1998).

Modern theory on the process of grief can be attributed to Freud (Walter, 1994), and is based in large part on Bowlby's (1980) work in attachment theory. Bowlby and Parkes (1970) posited a deficit model consisting of four stages of grief, having described grief as something one might get over (Silverman, 2002). Other grief theorists, including Rando (1993), Worden (2002), and Kubler-Ross (1993), rejected the deficit model in favor of accommodations for a loss that might change over time. Although many models exist, no single model can be applied universally when examining stages of grief, although an understanding of the history of how societies react to individuals with disabilities can provide a framework for understanding the bias individuals without disabilities have toward individuals with disabilities (Monden, Trost, Scott, Bogart, & Driver, 2016).

Grief can be complicated (Shear et al., 2011). There is little consensus on the best description of the term, although the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) has proposed “persistent complex bereavement disorder” under its conditions for further study. Shear (2013) identified that the “clinical picture can be understood as comprised of prolonged and intense acute grief symptoms accompanied by an array of complicating thoughts, feelings, and behaviors” (p. 122). Yet, these symptoms of prolonged, acute grief seem to be a real phenomenon that has also been termed, prolonged grief disorder. There is even an “Inventory of Complicated Grief” (Shear, 2015) that may be used to help in screening for this serious condition. Complicated grief occurs in about 10% of bereaved individuals, although the rates are higher for those who experience disaster or violence, and consequences can result in clinically significant impairment in work and social functioning as well as activities of daily living. Unresolved grief issues also are related to higher vulnerability to physical and mental impairments as well as to an increased risk of death due to lack of personal care and suicide (Lieberman & Jacobs, 1987; Meltzer et al., 2012; Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011). However, if an individual comes to accept the loss and uses the experience for transformative purposes, he or she can experience improved quality of life (Bowlby & West, 1983). Worden (2009) perceived grief to be an active process, consisting of four phases an individual must go through prior to being able to move on from the loss. Worden (2009) identified these tasks as follows: “[t]o accept the reality of the loss . . . to process the pain of grief . . . to adjust to a world without the deceased . . . to find an enduring connection with the deceased while embarking on a new life” (p. 283).

Historically, Dembo, Leviton, and Wright (1956/1975) and Wright (1983) contrasted comparative-status values with asset values. Initially, many individuals with a disability engage in the former in comparing themselves to how they were or to others or some standard of normal. This leads to

judging oneself as less than or deficient, while movement toward asset values suggests looking at oneself as having abilities, skills, and so forth that are independent of one's disability. The latter is often the sine qua non of successful rehabilitation or change efforts. In related fashion, Dembo (1969) noted that there is a difference between the insider view of being disabled that is different than the outsider view; briefly, insiders can view a disability as independent of who they are, while outsiders often view it as all-consuming and defining the person with a disability.

For individuals with disabilities, one potential barrier to effective grief intervention is the lack of understanding of grief in the health service professions (Genevro, Marshall, Miller, & Center for the Advancement of Health, 2004; Ober, Granello, & Wheaton, 2012). A lack of understanding on the part of rehabilitation counselors can result in diminished quality of life for their clients. Although the current study was conducted on rehabilitation counselors in training, rehabilitation practitioners may not be alone in limited knowledge as surveys of medical, nursing, pharmacy, and social work schools have also demonstrated that even though most educational systems presented some information on grief, the course offerings were limited (Dickinson & Field, 2002). This lack of understanding is of particular concern in recent years as increasing numbers of military veterans return home with a variety of physical and mental health concerns, including loss and grief from a disability (Marshall, 2006). Public demand for grief counseling services will likely increase given the existing population of individuals with disabilities and current war veterans returning from overseas who may be grieving a loss, along with an aging population. Doughty Horn, Crews, and Harrawood (2013) described grief and loss as ubiquitous throughout the human experience. These authors pointed to a lack of attention to these issues in the American Counseling Association (ACA) *Code of Ethics* and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards. They stressed the need for additional training in these areas to develop a better understanding of grief and loss subject matter, while highlighting a paucity of research on the topic. Ober et al. (2013) noted a similar lack of requirements by both ACA and CACREP. The recent updates to the ACA *Code of Ethics* (2014) and the CACREP (2016) Standards have not completely addressed these competencies.

Clients who present for counseling bring a variety of multidimensional issues and problems, including those secondary to or associated with loss, disability, or rehabilitation. According to Harris and Winokuer (2016), clients seek counseling in an effort to address significant challenges, such as unresolved childhood issues, personal trauma, divorce, or unresolved grief and seek a safe place to sort out these issues with someone who can be both objective and empathic. Rehabilitation counselors, in particular, focus on working with clients with congenital or acquired disabilities, and those conditions often require a focus on grief issues related to the disability. Issues related to grief and loss following the onset of a disability are complex (Sapey, 2004). According to Livneh (1995), the goals of rehabilitation counseling are to reduce the cause and/or impact of disability on one's life. In addition, rehabilitation counseling utilizes a strengths-based approach to help meet the needs of their clients and promote empowerment, while advocating for those with disabilities (Spornier, 2012). Meeting these objectives when working with a client with a disability requires a multifaceted or holistic treatment approach, which includes "a comprehensive sequence of services, mutually planned by the client and the counselor, to maximize functioning in the environment of the consumer's choice" (Parker, Szymanski, & Patterson, 2005, p. 8).

When applying a holistic treatment approach to counseling, rehabilitation counselors assist clients with managing both the physical and emotional manifestations of their disability. Individuals with disabilities may grieve a loss of function due to a disability in the same way that individuals may

grieve the loss of a loved one (Bailey & Gregg, 1986). Wald and Alvaro (2004) conducted a literature review pertaining to the various challenges and grief-related problems that arise in individuals with work related amputations, to include but not limited to grief, suicidal ideation, posttraumatic stress disorder, or depression. Wald and Alvaro (2004) emphasized the importance of assessment and intervention in rehabilitation counseling, especially when disability or amputation are a factor. Thus, rehabilitation counselors may assist clients who are struggling with unresolved grief issues associated with a disability. Rehabilitation counselors, therefore, should be trained in grief theories and grief counseling strategies as a means of better serving their clients.

The establishment of rehabilitation counseling competencies is an important development for promoting self-regulation and training within the profession (Ebener, 2007). In 1971, the Council on Rehabilitation Education (CORE) was created to oversee the improvement of professional education in rehabilitation counseling, including the assurance that counseling competencies are met by accredited programs. Recently, they signed a “Plan of Merger Agreement” to combine CORE and the CACREP accrediting bodies (CACREP, 2015) to initiate this process. The merger of the organizations could have ramifications on competency standards for rehabilitation counselors, as well as mental health counselors, and is thus related to the present study. CORE-accredited rehabilitation counseling programs have conventionally prepared counselors for certification as certified rehabilitation counselors via the certified rehabilitation counselor exam, although, more recently, many programs have prepared rehabilitation counselors for licensure as well, overlapping with CACREP accreditation guidelines.

Ober et al. (2012) suggested that counselors would benefit from additional training in the following domains:

theories of grief counseling, terms and definitions, crisis intervention for grief, community-based psychoeducational grief programming, methods for working on interdisciplinary teams to reduce grief, counselor peer support, and identification of clients’ effective and ineffective coping skills. (p. 156)

The purpose of the present study was to examine whether master’s-level rehabilitation counselor trainees reported having been adequately trained to identify and work with clients who are having grief-related issues from a loss or disability. Such a focus allowed for the examination of perceptions of training based on CORE education requirements, rather than knowledge one may have obtained in the field if the focus had been on practitioners. Data from a more extensive empirical study by Cicchetti (2010) were used in the present study. The original Cicchetti study (2010) was designed to analyze the perceived competencies of rehabilitation counselors ( $N = 93$ ). The following research questions were examined in the present study:

1. How do rehabilitation counselor trainees rate themselves on perceived skills and knowledge competency as measured by the Conceptual Skills and Knowledge, Assessment Skills, and Treatment Skills scale on the GCCS?
2. How do demographic variables of gender, age, presence, or history of disability, and race/ethnicity relate to perceived grief counseling competency?
3. Controlling for course offerings, what is the relationship between coursework and grief counseling competency?

## Method

The research design used in this study was a quantitative, nonexperimental, single observation survey design of master's-level students attending a CORE-accredited rehabilitation counseling program. A convenience sampling method was used for this study. In order to compute results addressing the three research questions, different approaches were employed. The first question used descriptive statistics to report the demographic characteristics of the participants as well as self-perceived skill and knowledge competencies. For the second and third questions, multiple analysis of variance and co-variance methods, respectively, were applied in conjunction with correlational statistics to determine differences between independent groups on the variables described above.

### Rationale

*Q1:* The first question was analyzed using descriptive statistics. Trainees were hypothesized to demonstrate a range of perceived personal competency related to grief. This question was investigated using descriptive statistics (e.g., central tendency measures such as mean, median, mode, and variability measures such as standard deviation, interquartile range, and range).

*Q2:* There will be a significant interaction effect among the demographic variables and perceived grief counseling competencies. This question was investigated using a four-way multiple analysis of variance (MANOVA), where the demographic variables were the independent variables and the four grief competency subscales on the GCCS were the outcome variables.

*Q3:* The third question was investigated using a multiple analysis of variance (MANCOVA), where the independent variable was coursework, the four grief competency subscales on the GCCS were the outcome variables, and the covariate was course offering.

### Variables

For this study, the dependent variables from the GCCS were personal competencies, conceptual skills and knowledge, assessment skills, and treatment skills. The independent variables for this study included demographic variables, clinical setting, and coursework; and the covariate for this study was whether institutions offered courses in grief theories and interventions. These independent variables explored their relationship to perceived grief competency. Demographic variables included gender, age, relationship status, race/ethnicity, and if a participant had ever had a disability. The covariate used for this study, refers to whether the institution the participant attended offered any course work in grief interventions and theories. The covariate was held constant to examine the relationship between coursework and perceived grief counseling competency, and was measured by the four subscales on the GCCS.

### Participants

Using Cohen's (1992) formula, with alpha level set at .05, it was determined that a minimum of 64 students were needed for this study. To take advantage of the diverse populations afforded by states with rural and urban backgrounds, as well as established relationships with faculty, the participants

for this study were recruited from CORE accredited master's-level rehabilitation counseling programs in Illinois, Michigan, Wisconsin, and Indiana. Twelve accredited schools across four states agreed to participate in the study. Department chairs from the 12 accredited schools in the four states were contacted via telephone or email to explain the purpose of the study. After follow-up, all agreed to participate. Students in their clinical practica or internship courses in each of these schools were provided the website address of the survey and asked to participate voluntarily. The website remained open for 45 days, at which point 93 students ( $N = 93$ ) had completed the survey.

### **Demographic Data Sheet**

Each participant completed a demographic data sheet, which included information about gender, age, ethnicity, relationship status, and practica/internship setting. In addition, information regarding the number of courses in grief interventions and grief theories offered at the university and whether the student took any of those was solicited. Finally, each student participant was asked if she or he had a disability.

### **Instrumentation**

The GCCS was chosen for the study. The GCCS is a redesigned version of the Death Competency Scale (DCS; Charkow, 2002), which is a survey designed to measure a marriage and family counselor's interpretations of her or his related training and ability to treat clients experiencing grief or loss due to disability. The DCS has been shown to be a reliable and valid instrument for measuring grief related to death as indicated by an overall Cronbach's alpha of .87, with subscales ranging from .79 to .94. Content validity of the original survey was indicated by both the demographic composition of the 27 family grief experts who rated and provided feedback regarding the importance of the competency items and the utilization of the adapted Delphi procedure for identification of competency items (Charkow, 2002). All experts reported a minimum of 5 years in death and grief counseling, with 20 experts reporting between 10 or more years of experience in this area. Content validity was indicated by the large percentage of participants (93.4%) within the final survey of the modified Delphi study. Participants agreed that the competency items either adequately or completely covered counselor characteristics and competencies needed for effective grief counseling.

For the present study, the original DCS was examined by three experts in grief education and grief counseling and one expert in assessment. The grief education and grief counseling experts had a minimum of 5 years teaching either grief theories or grief interventions in a CACREP or CORE-accredited counseling program. These experts also had a minimum of 5 years clinical experience working with clients who had grief-related issues or clients who had rehabilitation counseling issues. The assessment expert had 30 years of teaching testing and assessment and has written a national textbook on testing and assessment. The purpose of the expert review was to determine whether or not the DCS was appropriate for this study. After the experts reviewed the DCS, it was recommended that seven questions specific to the topic of death and bereavement be removed by the researcher, and an additional seven questions reframed so as to not focus exclusively on death or to increase readability. The final version was renamed the GCCS. Following the revisions, the GCCS was redistributed to the expert reviewers and was determined to be appropriate.

The GCCS contains a 46-item Likert-type scale that assesses perceived knowledge and skills related to grief counseling and interventions if treating a client dealing with loss or grief from a disability. The instrument contains a section that assesses perceived personal competencies (nine items) and a separate section that assesses perceived skills and knowledge competencies (37 items). This section

is divided into three subsections: conceptual skills (nine items), assessment skills (nine items), and treatment skills (19 items).

Response choices on the GCCS include 1 (*this does not describe me*), 2 (*this barely describes me*), 3 (*this somewhat describes me*), 4 (*this describes me*), and 5 (*this describes me very well*). Cronbach's alpha for the Personal Competency and for the Skills and Knowledge Competencies sections of the GCCS were .79 and .97, respectively. Alphas for the three subscales were .59 for Conceptual Skills and Knowledge, .60 for Assessment Skills, and .60 for Treatment Skills.

To assess for a relationship between respondents' attitudes towards individuals with disabilities and perceived competency, the Attitudes Toward Disabled Persons (ATDP) scale (Yuker & Block, 1966) was used. Cronbach's alpha for the ATDP has been found to be .59 for this study. To establish convergent validity, ATDP scores were correlated with other measures of attitudes towards disabled people with range of medians for similar measures being 0.54 to 0.98. If 10% of the items were left blank, the survey was considered not scorable.

## Results

### Participant Demographics

Of the master's-level rehabilitation counselor trainees who participated in the study ( $N = 93$ ), 59 were female and 34 male. The demographic breakdown with associated percentages based on ethnicity can be seen in Table 1. Approximately 38 participants were of White/Caucasian descent, 22 were African American, 19 Hispanic, six Asian American, four identified as Native American, and four fell within the categories of multiracial or other. Participants ranged from 22 to 58 years of age, with a mean age score of 33.55 ( $SD = 8.09$ ).

Sixteen participants reported as currently having a disability, with an additional 12 noting they once had a disability, but no longer have a disability. Reporting on their clinical practica or internship settings, respondents indicated they were at the following settings: community/mental health facilities: 27 (28.7%), rehabilitation facility: 22 (23.4%), state agency: 15 (16%), hospital setting: 10 (10.6%), school setting: nine (9.6%), "other": six (7.5%), residential setting: two (2.1%), participants did not respond: two (2.1 %).

### Course Offerings in Grief Theories and Interventions

Twenty-seven participants (28.7%) reported their universities offered courses in grief theories while 66 (71.3%) reported no such offerings. Similarly, 17 (18.1%) reported their universities offered courses in grief interventions, while 75 (80.8%) reported no such offerings, and one (1.1%) did not respond. Eighty-three participants (89.3%) reported not having taken any courses in grief theories, five (5.3%) reported having taken one course in grief theories, one (1.1%) reported he or she had taken two courses in grief theories, and four (4.3%) did not answer the question. Eighty-six participants (92.1%) reported not having taken any courses in grief interventions, three (3.2%) reported having taken one course in grief interventions, and four (4.3%) did not respond to the question.

## Research Question 1 Results

Question 1 (“How do rehabilitation counselor trainees rate themselves on perceived skills and knowledge competency as measured by the Conceptual Skills and Knowledge, Assessment Skills, and Treatment Skills scale on the GCCS?”) was investigated using descriptive statistics.

Nine questions on Section 1 of the GCCS survey pertain to personal competency and grief. The scores for each question ranged from 1 (*This does not describe me*) to 5 (*This describes me very well*). The higher the total score, the higher perceived personal competency related to grief.

The median score for this section was 36.00 with two mode scores of 38 and 40 ( $N = 93$ ). The distribution of scores was approximately mesokurtic, suggesting a wide range of scores on the Personal Competence and Grief section of the GCCS while the majority of scores falling between “this somewhat describes me” and “this describes me.”

There are 37 questions on Subsection 2 of the GCCS survey pertaining to Skills and Knowledge of Grief Counseling Competency. The section has three areas of concentration: Conceptual Skills and Knowledge, Assessment Skills, and Treatment Skills. The scores for each question ranged from 1 (*This does not describe me*) to 5 (*This describes me very well*). The higher the total score, the higher perceived skills and knowledge of grief counseling competency. The total score can range from 37 to 185.

Participants ( $N = 93$ ) reported in this section of the GCCS, a mean score of 92.60 ( $SD = 26.67$ ). The median score for this section was 87.00 with a mode score of 81.00, appearing 17 times, and the total scores ranging from a low of 52 with a frequency of 6 to a high of 165 with a frequency of 2. The score distribution was approximately mesokurtic. This data shows there was a wide range of scores on the Skills and Knowledge subsection of the GCCS while the majority of scores fell between “this barely describes me” and “this somewhat describes me.”

This portion of the survey was further studied by individual examination of the three subsections of the GCCS. The first subsection examined was perceived Conceptual Skills and Knowledge, which had nine questions. Once again, scores for each question ranged from 1 (*This does not describe me*) to 5 (*This describes me very well*). The higher the total score, the higher perceived conceptual skills and knowledge. The scoring range in this section is from 9 to 45. Results of the descriptive computation for this subsection of the GCCS survey revealed a mean score equal to 21.31 ( $SD = 7.24$ ). The median score for this section was 20.00 with a mode score of 19, appearing 13 times, and the total scores ranging from a low of 9 with a frequency of 1 to a high of 40 with a frequency of 1. The score distribution was also approximately mesokurtic. An interquartile range was completed to examine the distribution of 50% of the scores around the median and it was found that scores ranged from 1.8 to 2.7 (out of a possible 5). This data shows there was a wide range of scores on the Conceptual Skills subsection of the GCCS, while the majority of scores fell between “this barely describes me” and “this somewhat describes me.” The second subsection examined was Assessment Skills, which had nine questions. Scores for each question ranged from 1 (*This does not describe me*) to 5 (*This describes me very well*). The higher the total score, the higher perceived assessment skills on the GCCS survey. The scoring range in this section is from 9 to 45. Results of this computation showed a mean score of 22.46 ( $SD = 6.95$ ). The median score for this section was 22.00 with a mode score of 22, appearing 15 times, and the total scores ranging from a low of 9 with a frequency of 2 to a high of 40 with a frequency of 1. This score distribution, once again, was approximately

mesokurtic. This data shows there was a wide range of scores on the Assessment Skills subsection of the GCCS while the majority of scores fell between “this barely describes me” and “this somewhat describes me.”

### **Frequency Distribution for Assessment Skills**

The last subsection examined was the Treatment Skills section, which consisted of 19 questions. Again, scores for each question ranged from 1 (*This does not describe me*) to 5 (*This describes me very well*). The higher the total score, the higher perceived treatment skills. The total score range is from 19 to 95. A mean score of 48.82 ( $SD = 13.54$ ) for this section was computed. The median score for this section was 45 with a mode score of 34, appearing 12 times, and the total scores ranging from a low of 29 with a frequency of 2 to a high of 86 with a frequency of 2. This score distribution was also approximately mesokurtic (see Figure 5). This data shows a wide range of scores on the Treatment Skills subsection of the GCCS, while the majority of scores fell between “this barely describes me” and “this somewhat describes me.”

### **Research Question 2 Results**

In answer to Question 2 (“How do demographic variables of gender, age, presence, or history of disability and race/ethnicity relate to perceived grief counseling competency?”), using a four-way MANOVA, a significant main effect was found between presence or history of a disability as a function of personal competency and for treatment skills. No significance was found for age or gender difference. However, a significant relationship was found for history of a disability as a function of combined skills ( $r = .395$ ,  $p < .001$ ) and a main effect was noted for presence or history of a disability and perceived assessment skills,  $F(1,11) = 4.63$ ,  $p = .05$ .

### **Research Question 3 Results**

Question 3 (“What is the relationship between coursework and grief counseling competency?”) was examined using a MANCOVA on the independent variable *coursework*. The four grief competency subscales on the GCCS were used as outcome variables, with the covariate *course offerings*. Controlling for course offerings, no significant relationship was found between having course work in either grief theories, or grief interventions, and competency in the four grief counseling scales; Hypothesis 3 was not supported. However, Research Question 3 may not have been supported due possibly to the limited number of grief theory courses offered, or due to confounding factors, even though *course offerings* was a controlling factor.

## **Discussion**

Overall results suggested students as having perceived themselves with only a limited amount of competency for working with individuals, as measured on the Personal Competency section of the GCCS. However, on all three of the subscales of the Conceptual Knowledge and Skills section of the GCCS, students’ scores resulted in what could be considered at the low end of the scale, with scores ranging between a 1.8 to 2.9 on the 5-point Likert-type scale (ranging from the high end of *this does not describe me* to the low end of *this somewhat describes me*).

Demographic data and scores on the GCCS showed no significant relationships in gender, age, race/ethnicity, number of courses taken in grief counseling, type of practicum/internship setting, or attitudes towards disabilities related to perceived grief counseling competency, nor was any

significance found in attitudes toward people with disability scores on the GCCS. However, a main effect was found between presence or history of a disability as a function of perceived grief counseling competency as measured by the Personal Competency scale of the GCCS. A main effect was also found between presence or history of a disability as measured by the Treatment Skills subscale of the Skills and Knowledge Competency section of the GCCS. Although no relationship was found between presence or history of a disability with assessment skills and conceptual skills and knowledge, a significant relationship was found between presence or history of a disability with combined scores of the three subscales of the Skills and Knowledge subsection. Clearly, students who have had or have a disability feel more competent about their personal competency and their treatment skills as compared to other students. Such students may feel as if they have an increased sense of personal competency and of skill competency due to the fact that they know, “first-hand,” what is needed to work with a person with a disability.

Unfortunately, students do not seem to perceive themselves as having learned grief competencies in the process of their education experiences. Very few students (about 1 out of 10) are exposed to courses in grief counseling or grief interventions. Also, there was no significant relationship between practica/internship setting with scores on the GCCS and when controlling for course offerings, there was no significant relationship between having course work in either grief theories, or grief interventions, and scores on the GCCS. This last result, however, should be taken tentatively as few students had actually taken any courses in these areas.

The results in this study are similar to the few studies found in the literature. For example, one study by Allen and Miller (1988) revealed rehabilitation counselors as having felt they needed additional training and education on the topics of both bereavement and grief. More recent research by Ober et al. (2012) furthered Allen and Miller’s (1988) research by identifying the need for training in grief for counselors in general. Ober and colleagues (2012) assessed grief counseling competencies in counselors, and found that counselors lacked training in grief counseling, recommending greater levels of competency in grief counseling as a standard in counseling programs. In addition, the work of Doughty Horn et al. (2013) supported the hypothesis. Apparently, rehabilitation programs are not the only ones not treating this topic adequately as surveys of American and British medical, nursing, pharmacy, and social work schools have demonstrated that although most educational systems presented some information on grief, such information was limited at best (Dickinson & Field, 2002).

Counselors in training and counseling professionals have a moral and ethical obligation to facilitate client growth and development. Client is paramount (American Counseling Association, 2014). If appropriate grief education is not being taught in rehabilitation counseling programs, then it is difficult to understand how counselors in training and counseling professionals can adequately serve their clients. In addition, counselors in training and counseling professionals also must “. . . acquire and maintain a reasonable level of awareness and current scientific and professional information in their fields of activity . . . [and] maintain their competence in the skills they use” (p. 9). If cutting-edge knowledge is not being taught in schools, then counselors may not be well prepared to serve their clients with the most up-to-date knowledge. Lack of knowledge can lead to misdiagnosis, mistreatment, and incorrect medication use.

CORE (2009) noted under Section C of their General Curriculum Requirements, Knowledge Domains, and Educational Requirements that “The required curriculum for graduate study shall provide for obtaining essential, knowledge, skills, and attitudes necessary to function effectively as a professional rehabilitation counselor, responding to the culture and rights of people with disabilities”

(p. 2). The results of the present study corroborate master's-level counseling trainees in CORE accredited rehabilitation counseling programs as perceiving themselves as having minimal adequacy in personal competencies, and particularly poor perceptions of the adequacy in assessment skills, conceptual skills and knowledge and treatment skills, in relation to grief theories and interventions. As far back as the late 1980s, Miller (1988) found that 98% of the certified rehabilitation counselors felt they needed additional training in the area of bereavement and grief counseling. Although, over 20 years later, this study finds the same. The alarmingly high rate of participants from this study who had not taken any courses in grief theory and intervention reflects a need for CORE to reevaluate its curriculum requirements. To assure competency in these areas, CORE should mandate coursework in grief theory and grief intervention. In addition, just as rehabilitation programs teach experiential exercises in living with a disability, experiencing grief might help to better understand the grieving process.

Currently, programs who wish to meet the standards for Clinical Rehabilitation Counseling must offer a 60-credit-hr degree program, whereas CORE programs who wish to maintain their current rehabilitation counseling status can continue to offer a 48-credit-hr program (CACREP, 2014). The results of the present study support the need for additional training in grief theories and interventions. In addition, it is incumbent on CORE and rehabilitation counseling programs to assure that when students are in their practicum and internship sites, they receive the proper training in working with clients who have grief related issues. Finally, more research on this important area is critical if we are to know how effectively students, who eventually become practitioners, work with individuals with disabilities.

### **Limitations**

There are a number of limitations and potential confounds to this study. First, because the recruitment location for this study was narrowly focused, this study's generalizability may be limited. In addition, since this study measured perceptions, whether knowledge and skills are actually being taught or learned is not adequately assessed. Intuitively, it makes sense that if students do not perceive themselves as having had training in a specific area, they would not work as effectively in that area. However, the actuality of these assumptions may be wrong. In any event, it behooves educators to address students' perceptions with more focused training and feedback on skill acquisition. Further research and subsequent education and practice guidelines are needed to address these various concerns. Confounding variables may have had an effect on the results. For example, due to a limited availability of participants and schools, although a controlling factor of course offerings was entered into the equation, confounds may still exist.

### **Conclusion**

Students may say they have not learned as much as may be needed in the work they will encounter, they might be responding more to the enormity of the task that lay ahead, to actually do the "surgery" of working with the clients with specific needs. Few studies exist on this topic, suggesting a need for attention to the inclusion of grief counseling education in the curriculum. According to Machin (1998), in programs where grief-counseling education is offered, the curriculum usually is included with other related health care disciplines, consisting of mostly short lectures at best.

Overall, 98% of the certified rehabilitation counselors in the study stated they felt they needed training in the area of bereavement and grief counseling. Because grief from disability can present

similar symptoms as grief from death, these findings are significant and demonstrate a clear and unarguable need for grief counseling competency. Achieving entry-level competence means a counselor in training has met the requirements of the program of study and has complied with the standards of the accrediting agency, which oversees the discipline of study (Charkow, 2002). Therefore, it is incumbent upon accrediting agencies to align the curriculum with current counseling demands and client needs as well as to provide the necessary opportunities for graduate students to obtain the proper tools to identify and counsel clients suffering from grief. Furthermore, because the education that does exist usually emphasizes “end-of-life” issues relevant to hospice settings and palliative care, according to Wass (2004), studies reinforce the need for comprehensive grief education for service providers that encapsulate the entire process of grief and not only grief issues pertaining to death.

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