DEATH, DYING, AND BEREAVEMENT EDUCATION FOR MFT TRAINEES IN CALIFORNIA

By

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ABSTRACT

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Research shows that counseling students receive relatively little death, dying, and bereavement (DD&B) education from the graduate programs in which they are enrolled. This trend has been observed across many disciplines within the health care field, despite research findings that show DD&B education positively influences students' DD&B knowledge, attitudes and competency when working with individuals facing DD&B related challenges. In this study, masters level graduating marriage and family therapy trainees (MFTTs) were surveyed in order to examine their DD&B education and training experiences, as well as their knowledge of grief related phenomena, and interest in working with bereaved clients; their perceived competency in their ability to do so effectively was also investigated. In addition, accredited masters level marriage and family therapy (MFT) programs were surveyed in order to determine the amount of DD&B education currently offered to MFTTs within that graduate program. All data were collected in the state of California using three surveys created for this study, the Texas Revised Inventory of Grief (Faschingbauer, Zisook, & DeVaul, 1987), and the Grief Counseling Experience and Training Survey (Deffenbaugh, 2008). Results showed that masters level MFT programs offered relatively low amounts of DD&B education;

MFTTs reported similar deficits. Predictions that MFTTs possess little knowledge of grief-related phenomena and low perceived competency in working with bereaved clients were partially supported. The expectation that MFTTs would report low interest in counseling bereaved clients was not supported. The hypothesized positive relationships between MFTTs' interest in providing bereavement counseling, and their grief knowledge, DD&B education and training, and perceived competency in working with bereaved clients were not supported by study findings. Study strengths and limitations, implications of study findings, and directions for future research are also discussed.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

CHAPTER ONE

INTRODUCTION

Death, dying, and bereavement courses are not a standard part of curricula in the health care field (Christ & Sormanti, 1999; Dickinson, 2007; Humphrey, 1993), nor are they commonly offered by psychology departments at the undergraduate level (Eckerd, 2009). It is strongly suspected that graduate counseling programs provide negligible education in this area as well, despite the fact that grief is experienced by most people at some point. Furthermore, the profound grief experienced by approximately 10% of bereaved individuals can degrade their physical and mental health and may require psychotherapeutic intervention in order to be resolved (Boelen & Prigerson, 2007; Currier, Neimeyer, & Berman, 2008; Prigerson et al., 1997).

Considering how pervasive the experience of bereavement is, results of the limited research assessing MFT students' comfort levels and empathic responses to DD&B issues are unsettling (Kirchberg, Neimeyer, & James, 1998). Studies examining the readiness of therapists in training to work with bereaved or terminally ill individuals reveal a general lack of confidence in DD&B related skills and a pervasive desire for more DD&B training (APA Ad Hoc Committee on End of Life Issues [EOL Working Group], 2003; Hunt & Rosenthal, 1997). Similar results have been found among licensed counselors, social workers, psychiatric residents, and medical and nursing students (Buss, Marx, & Sulmasy, 1998; Christ & Sormanti, 1999; Deffenbaugh, 2008; Kovaks &

Bronstein, 1999; Tait & Hodges, 2009). Furthermore, the EOL Working Group found that while the majority of responding graduate psychology students desire comprehensive DD&B education and training, representatives of state and provincial psychological associations and APA divisions report few DD&B training opportunities (EOL Working Group, 2003).

Studies assessing the relationship between DD&B education and experience and DD&B related skills, attitudes, and knowledge among counselors, nursing students and medical students are promising (Degner & Gow, 1988; Kirchberg et al., 1998; Porter-Williamson et al., 2004). For example, DD&B experience was related to increased comfort and empathy among experienced death counselors in comparison to MFT students, who displayed lower levels of both comfort and empathy when responding to death related vignettes (Kirchberg et al., 1998; Terry, Bivens, & Neimeyer, 1995). Similarly, exposure to DD&B education was found to be related to increased DD&B knowledge and favorable attitudes towards the dying among both medical and nursing students (Degner & Gow, 1988; Porter-Williamson et al., 2004). In addition, the nursing students in Degner and Gow's (1988) study also became more competent in their work with dying individuals and their families.

Even though comprehensive death education is available through many sources outside of MFT programs via online and traditional continuing education courses, the necessary components of quality DD&B education outlined by the International Work Group on Death, Dying, and Bereavement (2006) could readily be provided by MFT

programs. Furthermore, being skilled in DD&B related matters will become increasingly important to the future of MFTs over the next few decades as the baby boomers join the ranks of the elderly, a group that, due to their phase of life, faces loss at higher rates than members of the general population. The growing number of military veterans and their loved ones constitute another group of individuals who are more likely to suffer loss; MFTs with ample DD&B education and training would be in a better position to help veterans and their families than MFTs without.

Considering the bulk of evidence pointing to the need for attention to DD&B education and training, there are several aims of this study. The first goal is to determine the amount and modality of DD&B education offered by MFT programs; modality for the purposes of this study is defined as either a full course, integration into a related course, or infusion into the entire curriculum. The amount of DD&B education MFTTs have obtained both within and outside of the MFT programs in which they are enrolled will be quantified as well. Additionally, MFTTs' interest and competence in providing counseling to bereaved clients will be assessed. MFTTs' knowledge of grief related phenomena will be evaluated as well. A final goal is to describe the relationship between MFTTs' interest in providing bereavement counseling and their understanding of grief related phenomena, amount of DD&B education and training obtained outside of their MFT program, and competence in working with the bereaved. Ultimately, data will provide a clearer picture about MFTT preparedness for serving individuals facing bereavement, and the contribution of higher education to this skill set.

CHAPTER TWO

LITERATURE REVIEW

The following literature review presents findings from previous surveys assessing the availability of graduate DD&B education, as well as the experiences and perceptions of graduate students and health care professionals regarding DD&B education and training. In addition, studies investigating the relationship between DD&B education and experience, and DD&B related attitudes, knowledge, and competency are reviewed. Results from studies examining complicated grief and grief therapy are also presented. Lastly, additional considerations are brought forth.

Graduate DD&B Education Availability

Research shows that DD&B education is generally considered important by many programs and educators within the counseling field. For example, in her survey of 135 general counseling programs, 40 of which were MFT programs, Humphrey (1993) found that 70% considered providing instruction on grief counseling as "important" or "very important" and 56% acknowledged having faculty with a special interest or training in grief counseling.

How do these attitudes translate in terms of DD&B course offerings? Studies assessing the prevalence and modality of DD&B education within the counseling, social work, medical and nursing professions have shown that DD&B material is often a standard part of the curriculum but is rarely offered as a standalone course. For example,

Humphrey (1993) found that while 81% addressed grief counseling, the majority of counseling programs (66%) did not offer a distinct grief counseling course; most counseling programs (73.3%) addressed grief counseling via other coursework; note these findings are dated as they were obtained nearly two decades ago. Similarly, when Christ and Sormanti (1999) surveyed 35 end-of-life educators from 30 MSW programs, DD&B material was reportedly infused into broader courses; participants also reported that when offered, an entire course dedicated solely to DD&B issues was an elective, and therefore not taken by all students. Likewise, Dickinson (2007) surveyed 410 nursing schools and 99 medical schools regarding end-of-life course offerings and found that while 93% of nursing students and 96% of medical students received some DD&B education, only 16-18% of medical and nursing schools offered an entire DD&B course.

While it is apparent that DD&B education is addressed in the majority of counseling, medical and nursing programs, the actual amount of DD&B education that these students receive seems to be relatively low. Specifically, Dickinson (2007) found while the majority of medical and nursing students were exposed to some DD&B education, nursing and medical schools offered an average of 14 and 12 hours, respectively, of material regarding end-of-life issues.

Even at the undergraduate level, at least in psychology, DD&B course offerings are minimal. According to a recent survey assessing the availability of DD&B courses offered through the psychology departments of 161 four-year colleges, only 20% had offered a DD&B course in the five years prior to completing the survey. More

commonly, DD&B courses were offered through other departments, with 31% of respondents indicating this was the case, and 16% of schools infused DD&B material into another psychology course (Eckerd, 2009).

Judging from the current available literature, DD&B education appears to receive relatively little attention in the curricula of many health related professions. However, changes in MFT education requirements put forth by the California Board of Behavioral Sciences (BBS) in California Senate Bill 33 (BBS, 2010) mandate end-of-life and grief instruction to be included in MFT program content; this step towards increased awareness of the importance of DD&B education and training is critical to the future of MFT participation in DD&B related work.

Experiences and Perceptions Concerning DD&B Education and Training among Graduate Students and Health Care Professionals

Research focusing on the perceptions and experiences of counseling students corresponds with information provided by graduate programs. For example, in their survey of state and provincial psychological associations and APA divisions, psychologists and psychology graduate students, the EOL Working Group (2003) found that between 55% and 75% of graduate students were interested in additional DD&B education. Specifically, counseling graduate students expressed interest in learning more about existential and spiritual aspects of DD&B, hospice, financing and reimbursement. Similarly, a survey of 160 rehabilitation counselors-in-training showed that while only

23% had received some type of DD&B training, 83% of respondents considered DD&B training to be "important" or "very important" (Hunt & Rosenthal, 1997).

Surveys of medical students reveal the same trend. For example, Tait and Hodges (2009) surveyed 82 psychiatric residents and found that 91% considered end-of-life care education to be important. Even though the majority (74%) reported the quality of their end-of-life care education to be good, only one respondent reported the current amount of education as sufficient. Respondents felt least prepared to deal with DD&B issues that are spiritual and cultural in nature. Psychiatric residents are not the only medical students with concerns. In their assessment of graduating medical students' knowledge, attitudes, and experiences regarding end-of-life issues, Buss et al. (1998) found that most participants felt unprepared to address these concerns with patients. Of the 162 medical students surveyed, less than half (41%) considered their end-of-life education to be adequate and the majority (80%) endorsed increasing end-of-life education.

In addition to student reported dissatisfaction with the minimal amount of DD&B education and training, and low perceived competence, health care professionals report similar views. For example, the majority of 147 counselors surveyed by Charkow (2002) rated the DD&B education provided by their counseling program to be less than adequate. Similarly, in her dissertation concerning DD&B education and training among 369 Licensed Professional Counselors, Deffenbaugh (2008) found that while participants' mean scores indicated comfort with their overall counseling skills and knowledge, mean scores regarding grief counseling competencies reflected a belief that participants "still

have much to learn" in order to call themselves competent. However, these data should be interpreted with caution as participants in Deffenbaugh's survey reported elevated levels of DD&B professional development hours and education (46% completed at least one DD&B course in their graduate program), and participants in Charkow's (2002) dissertation endorsed moderate to high levels of DD&B counseling competence and personal death competence, indicating possible self-selection sample biases.

In a related vein, Hunt and Rosenthal (2000) conducted a study in which they assessed rehabilitation counselors' work-related DD&B experiences. While 76% of respondents thought DD&B training was "important" or "very important", only 62% had received this training. When asked what would increase their competence and comfort when working with terminally ill clients, 45% of respondents expressed a desire for more DD&B education. Note the large discrepancy in regards to acquisition of DD&B education between the rehabilitation counselors and their trainee counterparts in Hunt and Rosenthal's studies (1997, 2000), 62% and 23% respectively; apparently a substantial percentage of rehabilitation counselors pursue DD&B education after licensure. What are the implications for the quality of care provided by those who do not?

Similarly, Christ and Sormanti (1999) surveyed 48 oncology social workers and interviewed 38 social workers via five focus groups in order to assess the role of social work in the treatment of the terminally ill and bereaved. Participants rated the ability of their MSW program to adequately prepare them for eight of the 10 main end-of-life social worker functions poorly. Specifically, MSW program training regarding symptom

management, communication, bereavement, education, ethics, case management, decision making, and discharge planning were rated as unsatisfactory by 50% or more of the 62 responding clinical social workers.

Oncology social workers are not the only social workers dissatisfied with their DD&B education. Kovaks and Bronstein (1999) conducted a study of 188 hospice social workers' views regarding their training. When presented with an open ended question asking which area of knowledge was lacking in their education, 22% of participants answered DD&B, the most common answer. Because of the nature of these respondents' line of work, results need to be taken with caution; it is possible that professionals who chose to work exclusively with dying and bereaved individuals would be more likely to report dissatisfaction with their DD&B education than professionals who do not.

Students and health care professionals are not alone in their concern with the current state of DD&B education. In the survey described earlier, Christ and Sormanti (1999) found that only a quarter of participating educators believed students were prepared for entry level work with the dying after completing courses offered by their institution. Again, these data must be interpreted with caution as respondents were end-of-life specialists and may be more likely to endorse a need for ample DD&B education.

If MFTTs are similar to the counseling students surveyed by the EOL Working Group and students and practitioners of other health related professions, they may not feel prepared to work with bereaved clients. This would be problematic in the sense that ethical principles pertaining to scope of competence require MFTs to treat only

difficulties for which they have had sufficient education, training and supervision; low confidence in DD&B related skills may play a significant part in determining the appropriateness of treatment and referral of potential clients to specialized "grief therapists", thus narrowing MFT opportunities for personal and professional growth and limiting the choices of clients seeking treatment. In addition, when grief difficulties surface after the client-therapist relationship has been established, disruption in therapy may occur if the MFT lacks the DD&B education, training, and supervision to competently proceed with treatment.

Relationship between DD&B Education and Experience and DD&B Related Attitudes, Knowledge, and Competency

A solid body of evidence shows improvement in DD&B related attitudes, knowledge and competency after exposure to DD&B education and training among nursing and medical students. For example, Degner and Gow (1988) found that taking a required palliative care course was positively related to favorable attitudes toward caring for the dying one year after graduation. When compared to the 51 nursing students in the control group who had not been selected to receive the course, the 61 nursing students from the experimental group felt more able to care for the dying.

Not surprisingly, these nurses also thought their program better prepared them to care for dying patients. In another study, using a pre-post test design, completion of a 32 hour palliative care course was associated with increases in DD&B knowledge and decreased concern over working with the dying among a sample of 127 third year

medical students (Porter-Williamson et al., 2004). Qualitative data obtained from these medical students also showed that they viewed this information as important to their clinical practice and that the material had not been covered in other courses.

In addition to increased DD&B knowledge and favorable attitudes toward the dying, competency and approach behaviors increased among the nursing students in Degner and Gow's (1988) study as well. Specifically, compared to their control group equivalents, the nurses in Degner and Gow's (1988) experimental group reported having more discussions with dying patients about their emotional concerns and death preferences, making more referrals to mutual support groups and taking the responsibility for communicating with patient's family members about their condition.

Correlational studies using samples of counselors reveal similar trends. For example, Charkow (2002) found a positive relationship between DD&B training and experience, and counseling knowledge and skills based competencies among participants. Similarly, in her dissertation regarding 257 licensed counselors' understanding of their own DD&B values, and their ability to assist clients facing DD&B related issues, Smith (2002) found a positive relationship between these two variables and DD&B education.

A study by Terry et al. (1995) further supports these findings. Specifically, Terry et al. (1995) found that experienced grief counselors were more comfortable and empathic when confronted with death related vignettes than they were with non-death related vignettes. In a follow up study, Kirchberg et al. (1998) compared MFT students' levels of comfort and empathy regarding death related vignettes with their responses to

non-death related vignettes. They found that like the experienced grief counselors, levels of empathy were higher in response to the death related vignettes. However, unlike their more experienced counterparts, levels of comfort were lower among the MFT students. While the research design of these studies prevents drawing causal conclusions, the results highlight the positive correlation between DD&B experience and practitioner comfort, further supporting the general trend found among nursing and medical students. Based upon the available data, it is highly likely that DD&B education and experience result in increased knowledge and favorable attitudes, which may ultimately translate into higher quality care for dying and bereaved individuals and their families.

Complicated Grief and Grief Counseling

One example of a DD&B issue that an MFT may likely deal with is complicated grief. Clinicians have long recognized atypical and maladaptive grief responses among those they treat (Worden, 2009). Although terms such as unresolved grief, complicated mourning, complicated grief and traumatic grief have been used to describe this set of symptoms, prolonged grief disorder (PGD) is the current nomenclature used by many researchers (Boelen & Prigerson, 2007). Prigerson et al. (2009) identified yearning for the deceased or intense separation distress as a primary symptom of PGD. Emotional numbness, bitterness and a sense that life is meaningless are also common, as well as mistrust, difficulty in accepting the loss, identity confusion, and difficulty moving on with life (Prigerson et al., 2009). This set of symptoms is the hallmark of PGD, as they are not evident in other diagnoses such as major depressive disorder, post traumatic stress

disorder, and adjustment disorder (Lichtenthal, Cruess, & Prigerson, 2004). By comparing the pre-loss depression data with the post-loss depression and grief symptom data of 205 widows and widowers, Bonanno et al. (2002) found that approximately 10% to 15% of the participants met criteria for PGD.

PGD has been found to correlate with psychological and functional impairment. For example, Prigerson et al. (1995) studied 82 participants three to six months after the death of their spouses and found that disturbances in mood, sleep, self-esteem and global functioning were observed among the 56 participants who completed the follow-up interview 18 months after the first assessment. In their prospective study of 96 individuals who had lost a loved one within the previous 6-24 months, Boelen and Prigerson (2007) found that persons scoring higher on a measure of PGD had higher incidence of suicidal ideation 12-18 months post loss than those with lower scores. Bonanno et al. (2002) also found that the participants suffering from PGD were more likely to score higher on scales of global and interpersonal dependency and to report less instrumental support than their non-grieving counterparts.

The ramifications of PGD extend beyond mental health disturbances and functional impairment. Increased morbidity and mortality among those with PGD has also been demonstrated. In their study of 135 bereaved widows and widowers, Prigerson et al. (1997) found that participants suffering from PGD were more likely to develop cancer and heart disease. Although PGD shares symptoms of other diagnoses such as depression and anxiety (Prigerson et al., 1995; Prigerson et al., 1997), sufferers of PGD

face unique challenges. PGD is precipitated by the loss of a significant other, and as a consequence, persons with PGD have often lost an integral support person in the process (Lichtenthal et al., 2004). As a whole, these findings make more evident the necessity of receiving effective professional support when suffering from PGD.

While Currier et al. (2008) found that most people are able to adjust to loss without professional help, their meta-analysis of 61 studies also found that grief counseling is effective in treating persons suffering from complicated grief. Specifically, Currier et al. compared the effect sizes of studies that used participants who had recently lost a loved one (but were not necessarily experiencing severe grief) with studies that used participants who had recently lost a loved one and were exhibiting severe grief symptoms; meaningful effect sizes post treatment (d = .53) and at follow up (d = .58) were observed in the latter studies. It is precisely these self and clinically referred individuals that MFTs would likely assist. Additionally, even persons without complicated grief seem to benefit from bereavement counseling via an accelerated healing process (Currier et al., 2008; but see Bonanno, 2004).

The Centers for Disease Control reported 2,426,264 deaths in the United States for the year 2006 (Heron et al., 2009); if 10% of their surviving loved ones develop complicated grief, tens of thousands of Americans will develop complicated grief each year. At the very least MFTs must be able to recognize this symptomatology as problematic and be prepared to make an appropriate referral. However, a well trained MFT can play an integral role in the treatment of these individuals.

Additional Considerations

Compared to the general population, older adults are more likely to face bereavement. According to current estimates provided by the Administration on Aging, persons 65 years of age or older comprise approximately 13% of the U.S. population but by the year 2050, that figure is expected to rise above 20% (United States Department of Health and Human Services, 2008). Considering the changing demographic trends, it is imperative that MFTs are fully prepared to assist the growing elderly population with DD&B related difficulties.

Military personnel and their loved ones are another group of people who are more likely than members of the general population to suffer loss, and their numbers are increasing as well. A recent publication by the Iraq and Afghanistan Veterans of America (IAVA; 2011) reported over 2.2 million Americans have served in Iraq and Afghanistan since September 11, 2001. In addition, the IAVA (2011) states over one million families have been affected by the deployment of a loved one. Properly trained MFTs can better help these people deal with DD&B related issues.

The International Work Group on Death, Dying, and Bereavement (2006) made several important points in their article regarding the traits, needs and responsibilities of persons who provide services for the dying or bereaved. Mutual support, team, organizational and environmental culture, and access to human and material resources are all integral factors in sustaining these professionals' interest in working with these populations. Furthermore, attaining adequate DD&B education, supervision and

guidance, self-care, correct self-assessment, and appropriate referrals are responsibilities that professionals working with dying and bereaved clients have to themselves, their clients, and their colleagues.

Currently, comprehensive death education is available to MFTs after licensure in the form of continuing education (e.g., APA, psychceu.com, Association for Death Education and Counseling, National Center for Death Education at Mount Ida College in Newton, Massachusetts). However, MFT programs are in an excellent position to provide the support and resources outlined by The International Work Group on Death, Dying, and Bereavement to MFT students as well; in-depth DD&B education, supervision, and self-care instruction can all be tailored to meet the DD&B training needs of future generations of MFTs. Offering all MFT students ample DD&B material within their MFT programs will help to ensure a well rounded education as well as increase the effective assessment and treatment of grief related issues.

The benefits of DD&B education may extend beyond those who seek treatment for DD&B issues. A qualitative study by Paris, Linville and Rosen (2006) examined the relationship between the personal and professional growth experiences of 13 participating MFT interns. A reciprocal relationship between these two variables was identified, with clinical practicum being the top cited professional experience that influenced personal growth. Although the sample size was small, it is reasonable to suspect that MFTTs can be positively influenced by their professional experiences. This may partially explain Charkow's (2002) finding that MFTs who report adequate DD&B training also appear to

have stronger personal death coping skills. Working with clients who are facing DD&B issues may help prepare MFTTs to deal with their own past or future loss experiences.

CHAPTER THREE

STATEMENT OF PURPOSE AND STUDY GOALS AND HYPOTHESIS

If the trends observed in general counseling, medical, nursing and social work programs are characteristic of MFT programs, graduating MFTTs may not be adequately prepared to work with dying and bereaved clients. They may also believe that they are not able to competently provide services to these individuals. Despite the fact that grief counseling has been shown to be effective for individuals with complicated grief (Currier et al., 2008), possible gaps in DD&B experience and limited knowledge base of clinicians who do not pursue targeted DD&B continuing education may hinder the effective assessment and treatment of grief related difficulties.

The elderly and military personnel face DD&B related issues more frequently than do members of the general population, and their numbers are increasing rapidly (United States Department of Health and Human Services, 2008; IAVA, 2011); because of the aging baby boomers and military personnel, there will be an increase in demand for DD&B related services. As a whole, deficits in thorough DD&B education, the reality of complicated grief, and the burgeoning elderly and veteran populations call for an increase in knowledge about this topic among MFTTs.

Goals and Hypothesis

One goal of this study is to determine how much DD&B education is currently offered by accredited masters level MFT programs in California. An examination of the

modality in which DD&B issues are addressed by these programs will also be undertaken. Taking into account the overall lack of DD&B education provided within the health care field, it is thought that MFT programs will present relatively little DD&B instruction in comparison to the hours of instruction regarding child development. Child development education is comparative to DD&B education in the sense that they both present material regarding human developmental processes, albeit during different life phases; because of this, child development was the logical choice.

Another goal of this study is to collect information regarding the amount of DD&B education and training MFTTs have received both within and outside of their MFT programs. MFTTs' knowledge of grief related phenomena and their perceived competency and interest in treating bereaved clients will also be quantified. Minimal amounts of DD&B education and training, and grief knowledge, as well as low perceived competency and interest in working with bereaved clients among MFTTs are expected.

The relationship between MFTTs' interest in treating bereaved clients, and their knowledge of grief related phenomena, amount of DD&B education and training obtained outside of their MFT program, and perceived competency in providing bereavement counseling will be examined. MFTTs reporting high interest in working with bereaved clients are predicted to have more grief knowledge, a greater number of outside DD&B education and training hours, and higher bereavement counseling competence than those with less interest. If confirmed, this finding will support the position that discrepancies in knowledge base and skill may exist between those

interested in DD&B and those who are not. MFTTs without interest in DD&B matters may not possess the education and training to effectively assess for, let alone treat, difficulties with grief and loss among clients facing these unique challenges.

CHAPTER FOUR

METHODS

Participants

There were two distinct groups of participants. The first group of participants was comprised of 45 responding MFTTs; to be eligible, responding MFTTs had to currently be enrolled in an accredited, masters level MFT program located within the state of California, and be completing their final year of the MFT program. First year MFT students were not eligible because they might not have had exposure to much of the education they are scheduled to receive. MFTTs ranged in age from 22 to 48 with a mean of 32.44 years (*SD* = 7.91), and 84.44 % of participants reported their gender as female (*n* = 38). The ethnicity of participants was as follows: 77.77 % were Caucasian, 6.66% were Asian American, 6.66 % were Latino, 4.44 % were Multiracial, 2.22 % were African American, and 2.22 % were West Indian. A little over half of the participants (55.55 %) reported attending a CSU, with the remainder indicating they attend a private university. The second group of participants was comprised of 29 MFT program coordinators; to be eligible, MFT programs had to be located in California, accredited and be masters level programs. The majority of respondents (72.41 %) indicated the MFT program they represented was embedded in a private university, with the remainder selecting CSU.

Measures

Five questionnaires were used in this study, four of which were administered to MFTTs in the form of a 63-item MFTT survey (see Appendix A). The MFTTs first responded to four demographic questions. Next, MFTTs answered questions that assess personal experience(s) with death using the Texas Revised Inventory of Grief (TRIG; Faschingbauer et al., 1987). The TRIG is a 21-item scale designed to assess respondents' grief over the death of a loved one by quantifying their past and present responses to the death. The first subscale measures the extent to which the death affected respondents' emotions, activities and relationships at the time it occurred. The second subscale measures respondents' present feelings regarding the death of their loved one by assessing current levels of rumination, ongoing emotional distress, lack of acceptance and painful memories. Hansson, Carpenter and Fairchild (1993) found internal consistency estimates of the two subscales to be $\alpha = 0.77$ and $\alpha = 0.86$, respectively. Also, evidence for the construct validity of the TRIG using criterion group analysis has been reported (Hansson et al., 1993). Permission to use the TRIG was obtained by Dr. Zisook prior to use in the current study. Reliability coefficients for the TRIG portion of the MFTT survey were examined using Cronbach's alpha; high internal consistency reliability coefficients were found for the two TRIG scales (past behavior $\alpha = .90$, present feelings $\alpha = .91$) in the present study.

Then, MFTTs answered questions that assess perceived grief competency using a modified version of the Grief Counseling Experience and Training Survey (GCETS;

Deffenbaugh, 2008). The GCETS is a 12-item measure that assesses the respondents' grief counseling training, consultation and supervision; also assessed are respondents' perceptions of their ability to effectively treat grief as a result of these experiences. Due to the lack of an appropriate measure, Deffenbaugh (2008) developed the GCETS by modifying the Sexual Orientation Counselor Competency Scale (SOCCS); the SOCCS assesses the counseling competencies of therapists working with gay, lesbian and bisexual clients (Bidell, 2005, as cited in Deffenbaugh, 2008). Strong internal consistency of the GCETS ($\alpha = .93$) had been established by Deffenbaugh (2008). For comparison purposes, this investigator added to the GCETS questions assessing MFTTs' perceived general counseling competency and perceived competency in regard to the treatment of grief, depression and anxiety. Permission to use and modify the GCETS was obtained by Dr. Deffenbaugh prior to use in the current study. The reliability coefficient for the GCETS portion of the MFTT survey was examined using Cronbach's alpha; an adequate internal consistency reliability coefficient was found for the GCETS ($\alpha = .83$) in the present study.

MFTTs then answered eight items intended to assess their basic knowledge of grief. The grief knowledge questionnaire is reflective of current DD&B information as provided by Hospice of Humboldt and consultation feedback from two experts in the DD&B field. The grief knowledge questionnaire was created for this study because no such measure has been found to date in the current literature. It is suspected that a grief knowledge questionnaire has not yet been created because there exists no established

bereavement counseling standard of practice upon which to base such a measure. Because of the inherent biases in creating a grief knowledge questionnaire under such circumstances, test items were based off of popular, yet empirically unsupported, beliefs regarding grief related phenomena, with the assumption that MFTTs possessing basic grief knowledge would be able to correctly identify common myths.

Lastly, MFTTs answered seven questions designed to assess the amount of DD&B education and training they have acquired both within and outside of their MFT program. Questions regarding the amount of child development education offered to MFTTs by their MFT programs were asked as well for comparison purposes. The questions assessing grief knowledge and DD&B education and training experiences were placed after those examining perceived competency and interest, as it was strongly suspected that realizing one is uneducated in DD&B matters would influence responses to questions pertaining to interest and perceived competency. Both surveys were designed such that once a section had been completed, it was not possible for participants to go back to view or change their responses.

Coordinators of MFT programs completed the MFT program survey. The MFT program survey is a four item questionnaire designed to assess the current amount and modality of DD&B education being offered by the MFT program. For comparison purposes, information regarding the amount of child development education offered by the MFT program was also collected (see Appendix B).

Procedure

All data were collected in California because MFT licensure education requirements vary by state. An e-mail was sent to the administrative assistant of all eligible MFT programs with the request that it be forwarded to all MFTTs completing the last year of that MFT program. In order to determine the response rate, administrative assistants were also asked to reply with the number of MFTTs to which they forwarded the e-mail.

The e-mail that was forwarded by the administrative assistants to the MFTTs was an invitation to participate in the study and provided the internet link to the MFTT survey on the Survey Monkey website (see Appendix C). Survey Monkey is web-based software that was used to administer both the MFTT and MFT program surveys. In order to participate, respondents had to indicate they met the requirements for participation and provide informed consent by clicking on the "I agree" option before completing the survey.

A different e-mail was sent to the coordinator(s) of all eligible MFT programs inviting them to participate in the study and contained the internet link to the MFT program survey on the Survey Monkey website (see Appendix D). In order to participate, respondents had to indicate their program met the requirements for participation and provide informed consent by clicking on the "I agree" option before completing the MFT program survey.

The list of MFT programs was generated using current data from the California Association of Marriage and Family Therapists (CAMFT) website, which also includes contact information for MFT program coordinator(s). Phone calls to MFT program staff/faculty were made prior to e-mailing the invitations to participate in order to verify contact information derived from the CAMFT website with the hope that a larger and more representative sample would be secured. Of the 92 schools and universities listed on the CAMFT Website, 70 currently offered MFT education and had a valid email address. Fifty three (75.71%) of these 70 programs were embedded in private universities with the remainder hailing from CSUs. Follow-up e-mails were sent to the administrative assistants and MFT program coordinators two weeks after the first notice (see Appendices E and F).

The invitations to participate were e-mailed to 70 California based MFT programs. Coordinators from 29 programs completed the MFT program survey online, resulting in a 41.43% response rate; 72.41% of these MFT programs were embedded in private universities and the rest were from CSUs (this proportion closely resembles the MFT program population). MFT program administrative assistants from six out of the 70 programs contacted reported forwarding the invitation to a total of 143 MFTTs. Forty five MFTTs took the 63-item online survey, yielding a response rate of 31.47%. It is possible that the actual response rate is lower than reported, as it is suspected that some MFT program administrative assistants forwarded the survey to MFTTs but did not reply to the e-mail requesting that information.

MFTTs' personal experience(s) with death were evaluated using the TRIG to check for MFTT self-selection sample bias; in other words, whether participants had higher or lower TRIG scores than the norms. TRIG norms are reported for four respondent groups, based on the time passed since the loved one's death, so current participants were divided into four groups using the same criteria. Group 1 is comprised of people who lost a loved one during the past year; Group 2 consists of people who lost a loved one between 1-5 years ago; Group 3 is comprised of people whose loved one died between 5-10 years ago; and Group 4 includes people whose loved one died over 10 years ago.

For some groups of MFTTs, mean scores and standard deviations differed considerably from the norms provided in the TRIG manual (see Table 1), so one-sample *t*-tests were run.

Table 1: MFTT TRIG Means and Standard Deviations as Compared to TRIG Norm

Group, sample	TRIG Past			TRIG Present		
Group 1, MFTT sample	n = 4	*M* = 21.7	*SD* = 4.92	n = 4	*M* = 40.75	*SD* = 2.63
Group 1, TRIG sample	n = 62	*M* = 15.7	*SD* = .9	n = 53	*M* = 34.2	*SD* = 1.5
Group 2, MFTT sample	n = 10	*M* = 14.40	*SD* = 5.74	n = 10	*M* = 31.50	*SD* = 1.89
Group 2, TRIG sample	n = 152	*M* = 17.8	*SD* = .7	n = 143	*M* = 37.1	*SD* = 1.4
Group 3, MFTT sample	n = 11	*M* = 17.81	*SD* = 6.87	n = 11	*M* = 33.36	*SD* = 12.48
Group 3, TRIG sample	n = 83	*M* = 16.6	*SD* = .7	n = 72,	*M* = 34.3	*SD* = 1.3
Group 4, MFTT sample	n = 14	*M* = 22.93	*SD* = 8.85	n = 13	*M* = 32.15	*SD* = 10.68
Group 4, TRIG sample	n = 98	*M* = 16.3	*SD* = .8	n = 88	*M* = 29.6	*SD* = 1.2

One-sample *t*-tests were calculated for only MFTT scores on the present scale of the TRIG as it is believed that those scores are the most relevant for the purposes of the current study. Results showed that there was a significant difference only for MFTTs belonging to Group 1 (t (3) = 4.98, p = .016, d = 2.49). TRIG scores of MFTTs whose loss occurred more than one year ago did not significantly differ from TRIG norms.

To protect participant confidentiality several precautions were taken. All responses were anonymous but in order to enter the raffle and have a chance to win an incentive, MFTTs had to provide an e-mail address for contact purposes; the incentives were three $50 Amazon gift certificates that were raffled off and awarded upon completion of data collection. After navigating through the webpages of the survey, the final page had a place to enter an e-mail address if so desired. MFTTs were explicitly directed to withhold their name when entering an e-mail address and the e-mail addresses that came from this final page were exported to a separate data file from the survey responses, eliminating any connection between the responses and the e-mail addresses. The e-mail addresses were erased promptly after completion of the raffle. All data is stored on a password-protected computer belonging to the Principal Investigator's thesis advisor.

CHAPTER FIVE

RESULTS

MFT Program Results

All data were collected between the dates of April 19th, 2011 and June 19th, 2011. Because data for DD&B and child development hours reported by both MFT programs and MFTTs were positively skewed, *t*-tests involving these variables were all conducted using square-root transformations of these data. The means and standard deviations reported, however, were derived from the untransformed data, so represent the actual number of hours reported.

MFT program survey results showed that 86% of MFT programs offer some DD&B instructional hours. For comparison purposes, data regarding the number of child development instructional hours offered by MFT programs were also collected. Results of a paired-samples *t*-test showed child development instructional hours (M = 45.66, SD = 30.78, median = 40.00) were significantly higher than DD&B instructional hours (M = 7.07, SD = 7.92, median = 4.00), t (28) = -8.08, d = -1.49, p = < .000. Group differences between CSUs and private universities in regards to the amount of DD&B instructional hours offered to MFTTs were examined using an independent samples *t*-test; no statistically significant difference between private university based MFT programs (M = 8.14, SD = 8.75) and CSU based MFT programs (M = 4.25, SD = 4.43, t(27) = -0.80, p = .43, d = .56) was found.

When asked to choose which education modality best described that MFT program's approach to teaching DD&B material, the majority of respondents (55.17%) reported integrating DD&B material into another course, 10.34% indicated DD&B material is infused throughout the entire curriculum and five (17.24 %) chose "other". When asked to describe "other" DD&B education modalities, three respondents specified the number or names of courses that included DD&B material, one MFT program reported offering a four unit DD&B course as an elective, and another indicated providing a course on bereavement. A sizable minority of MFT programs (13.79%) reported teaching no DD&B material whatsoever. One program reported presenting DD&B material in a full course.

MFTT Results

MFTTs' knowledge of grief related phenomena was first explored. MFTTs had a high ability to refute common DD&B myths; out of a possible score of 8 on the grief knowledge questionnaire, the mean score was 7.67 (*SD* = .36, range = 7 to 8), which translates into 95.88%. However, when asked to rate their familiarity with specific grief counseling theories, MFTTs' most frequent response was none; stage theories were the lone exception (see Table 2).

Table 2: MFTT Familiarity with Grief Counseling Theories

Grief Counseling Theory	None	Very Little	Some	A lot
Stage Theories	23.68%	7.89%	44.74%	23.68%
Task Theories	57.89%	23.68%	13.16%	5.26%
Dual-Process theory	60.53%	31.58%	7.89%	0
Meaning Making Theory	50%	26.32%	15.79%	7.89%
Continuing Bonds	65.79%	18.42%	15.79%	0
Posttraumatic Growth	76.32%	13.16%	10.53%	0

Next, MFTT perceived grief counseling competency was quantified. Results showed similar levels of MFTT perceived grief counseling competency (M = 2.8, SD = .8) as measured by the GCETS compared to Deffenbaugh's (2008) sample (M = 2.7, SD = .9). MFTTs' perceptions regarding their ability to competently provide various types of counseling were examined as well. Results indicated that compared to depression, anxiety, and counseling overall, MFTTs were considerably more likely to endorse needing to learn a great deal more about grief counseling and notably less likely to report feeling comfortable with their grief counseling knowledge and skill (see Table 3).

Table 3: MFTT Counseling Competencies by Percentage

Perceived Counseling Competency	Overall	Grief	Depression	Anxiety
I feel I need to learn a great deal more before I would call myself competent.	7.90%	25.64%	5.13%	5.13%
I still have much to learn in order to call myself competent.	56.41%	61.54%	53.85%	38.46%
I feel comfortable with my knowledge and skill level.	33.33%	10.26%	38.46%	51.28%
I am highly competent, I could teach others.	2.56%	2.56%	2.56%	5.13%

When asked about their interest in counseling clients for bereavement issues, results showed the majority of MFTTs (58.97%) were moderately interested, a substantial number (28.49%) were very interested, and the remaining 12.82% endorsed minimal interest; no MFTTs indicated they were not at all interested in counseling bereaved clients.

MFTTs were asked to quantify the number of DD&B instructional hours offered to them by their MFT program. For comparison purposes, information regarding the number of child development instructional hours received by MFTTs via their MFT program was also solicited. Results showed that the number of DD&B instructional hours obtained by MFTTs within their MFT programs, as reported by MFTTs, (M = 4.84, SD = 5.88, median = 3) was significantly lower than the number of child development hours obtained (M = 29.71, SD = 28.04, median = 28, t (32) = -7.17, d = -2.65); 29.73% reported receiving zero DD&B instruction within their MFT program. While the majority of MFTTs (73%) reported completing zero DD&B units within their graduate

program, only 10.81% of respondents said the same about child development units. When asked how many courses within their graduate program did/will they complete in which death and/or grief material accounts for at least 25% of course content, the majority of MFTTs (67.57%) indicated zero; only 2.70% of MFTTs reported the same in regards to child development material. In addition, GCETS question #1 asks respondents to rate the adequacy of their grief counseling training and supervision on a scale of one (representing the lowest rating) to five (representing the highest rating); 84.21% of responses fell between one and three.

MFTTs were also asked to quantify the number of hours they have completed on the subject of death and or grief via volunteerism, work experience, undergraduate education, and other training outside of their MFT program. A little over 65% of MFTTs had obtained some amount of DD&B experience outside of their MFT program. Descriptive statistics were used to quantify and compare the number of hours of DD&B education, training and experience MFTTs had obtained within their MFT program to those obtained outside of their MFT program. The median number of DD&B education and training hours obtained by MFTTs outside of their MFT programs (M = 12.00, SD = 20.91, median = 4) was marginally higher than those obtained from within (M = 4.84, SD = 5.88, median = 3).

To test study hypotheses, a series of analyses of variance (ANOVA) was conducted. The first ANOVA examined group differences between three different levels of MFTT interest in treating bereaved clients (minimal, moderate, very) and MFTT

scores on the grief knowledge questionnaire. The results demonstrated that scores on the grief knowledge questionnaire do not vary as a function of how interested MFTTs are in treating bereaved clients $F(2,35) = .81$, $p = .45$, $\eta^2 = .044$. A second ANOVA examined group differences between the same three different levels of MFTT interest in treating bereaved clients and the number of DD&B education and training hours that MFTTs had obtained outside of their MFT program. The results demonstrated that the number of DD&B education and training hours obtained outside of MFT programs do not vary as a function of how interested MFTTs are in treating bereaved clients $F(2,32) = .81$, $p = .45$, $\eta^2 = .048$. A third ANOVA examined group differences between the three different levels of MFTT interest in treating bereaved clients (minimal, moderate, very) and MFTT scores on the GCETS. The results demonstrated that MFTT scores on the GCETS (which measures perceived competency) do not vary as a function of how interested MFTTs are in treating bereaved clients $F(2,35) = 2.86$, $p = .071$, $\eta^2 = .14$, although there was a trend in this direction.

CHAPTER SIX

DISCUSSION

One goal of this study was to examine the amount and modality of DD&B education provided by MFT programs. Other objectives included quantifying the amount of DD&B education obtained by MFTTs and assessing MFTTs' knowledge of grief related phenomena. MFTTs' interest and perceived competency in treating bereaved clients were also explored. The relationship between MFTT interest in providing grief counseling, and their grief knowledge, perceived grief counseling competency, and DD&B education and training was also investigated. However, sample characteristics must first be discussed.

While it is unknown what percentage of masters level California MFTTs are female or Caucasian, a comparison of demographic information from studies using similar populations (LPCs and LPCCs) revealed some differences. For example, 95.7% of Smith's (2002) sample, 90.5% of Charkow's (2002) sample, and 92.7% of Deffenbaugh's (2008) sample were Caucasian; the present sample was comprised of comparatively fewer (77.77%) Caucasians. It is possible that these discrepancies indicate sample biases in the current study. However, a more likely explanation involves the present study's location, as California is home to a relatively high percentage of ethnic minorities as compared to Ohio, the location of Smith's (2002) and Deffenbaugh's (2008) samples, and the United States as a whole, the location of Charkow's (2002) sample.

In a similar vein, 67.3% of Smith's (2002) sample and 66% of Charkow's (2002) sample were female, as compared to 84.44% in the present study. While Smith (2002) and Charkow (2002) sampled licensed professionals, the current study surveyed trainees; this may be a factor in the observed demographic differences. Specifically, it is possible that females comprise a greater proportion of the student population than they do the professional population; demographic information provided by Hunt and Rosenthal's (1997, 2000) surveys of rehabilitation counselors and rehabilitation counselors-in-training support this view. While females only comprised 67% of the sample among licensed rehabilitation counselors, they accounted for 82% of the sample of rehabilitation counselors-in-training; a difference that closely parallels those between the present study and the studies by Charkow (2002) and Smith (2002). Since the findings of this study are meant to be generalized only to MFTTs in California, the ethnic and gender differences between the current study and similar studies would not likely limit the external validity of conclusions drawn from the data.

However, one MFTT characteristic that must be addressed is the elevated scores on the TRIG present scale among MFTTs who had lost a loved one in the prior year (see Table 1). It is likely that the small sample size of the current study accounts for the anomaly. For example, looking again at Group 1, the sample size was much smaller (n = 4) in this study than the sample size used to derive the normative data (n = 62). In addition, the percentage that Group 1 MFTTs comprised of the total MFTT sample (8.89%) is much lower than the percentage of undergraduate college students bereaved in

the past year (30%) found by Balk, Walker, and Baker (2010) in their study using stratified random sampling procedures. While it is possible that MFTTs with uncharacteristically high DD&D education, training, interest and competency may have self-selected to participate in the current study, based on the available data, it does not appear as if elevated rates of MFTTs experiencing severe bereavement symptoms did so.

Several predictions were formulated based upon analyses of relevant literature and were supported by study findings. Specifically, MFT programs reported offering a low number of DD&B instructional hours in comparison to the number of child development instructional hours. In addition, MFT program DD&B instructional hours were considerably lower than the number of end-of-life hours offered to nursing and medical students (14 and 12, respectively) by their programs (Dickinson, 2007). However, the percentage of MFT programs that reported teaching no DD&B material (13.79%) was somewhat smaller than the percentage (19%) found by Humphrey (1993) in her survey of general counseling programs. While the relatively low number of DD&B instructional hours offered by MFT programs is disconcerting, the comparatively low likelihood that an MFT program would be completely void of DD&B education is promising.

Study findings also provided support for the prediction that MFTTs would obtain relatively fewer DD&B instructional hours, in comparison to the hours of child development instruction, from their MFT programs. This proved to be the case; MFTTs reported significantly fewer DD&B instructional hours than child development

instructional hours. In addition, nearly 30% of MFTTs reported receiving zero DD&B instructional hours within their MFT program. This is similar to Hunt and Rosenthal's (2000) findings concerning rehabilitation counselors' DD&B training; 38% received no DD&B training while in their program. Considering the prevalence of complicated grief and current demographic trends in the U.S., this finding is especially alarming.

Results regarding DD&B education modality obtained in the current study are similar to those of earlier studies. For example, the majority of MFT programs (75.86%) either integrated DD&B material into another course or infused it throughout the entire curriculum; this resembles the figure (73.3%) found by Humphrey (1993) and follows the general trend noted by the 35 end-of-life educators interviewed by Christ and Sormanti (1999). Another similarity between the present findings and previous findings is the paucity of DD&B courses; only two MFT programs reported offering a full DD&B course (including the MFT program that selected "other" and filled in "bereavement course"). The percentage of MFT programs that offer a full DD&B course (6.90%) is much lower than the percentage of counseling programs (33.3%) found by Humphrey (1993), as well as the medical schools (16.16%) from the more recent survey by Dickinson (2007). However, a higher percentage of MFT programs than nursing programs (4.41%) offer a DD&B course (Dickinson, 2007). While the last comprehensive survey of counseling programs occurred nearly two decades ago (Humphrey, 1993), these results may signal a decline in DD&B course offerings among counseling programs over time and may ultimately translate into less availability of

comprehensive DD&B education at a time when demand for these types of services is expected to increase.

When asked if they have had adequate clinical training and supervision to counsel clients who present with grief, MFTTs' responses mirrored those of others in health care related fields; only 15.79% of MFTTs rated it favorably. In a similar vein, Buss et al. (1998) found that out of the graduating medical students surveyed, less than half (41%) considered their end-of-life education to be adequate in preparing them to provide palliative care to dying patients. In addition, the majority of licensed counselors surveyed by Charkow (2002) rated the DD&B education provided by their counseling program to also be less than adequate. Similarly, when Christ and Sormanti (1999) surveyed social workers, the majority of participants rated the ability of their MSW program to adequately prepare them to provide services to dying or bereaved clients poorly. If accurate, this finding adds to the literature documenting widespread dissatisfaction among various professions with the current state of DD&B education.

Study findings provided only partial support for predictions that MFTTs possess little knowledge of grief related phenomena and low perceived competency in working with bereaved clients. Specifically, while MFTTs evidenced high scores (95.88%) on the grief knowledge questionnaire, they indicated limited familiarity with grief counseling theories. One potential explanation for these findings is that the grief knowledge questionnaire, being based on popular misconceptions, was too easy; the minimal range in scores provide support for this view. Another possibility is that MFTTs previously

learned about grief counseling theories, but did not recall the material at the time of study participation.

Partial support for the prediction that MFTTs would possess low perceived competence in providing grief counseling was obtained. Specifically, while MFTTs' GCETS scores were similar to those of licensed professionals who reported substantial DD&B education, training and experience (Deffenbaugh, 2008), they expressed low perceived competency when asked to evaluate their ability to provide grief counseling as compared to their abilities in providing other types of counseling. It is possible that MFTTs perceive themselves as competent in regards to grief counseling, but measurement issues with the comparison questions could be contributing to the contradictory results, as four questions are not usually sufficient to accurately assess most phenomena. Another potential reason for the divergent findings may be that the GCETS and comparative competency questions are measuring different constructs. It is also possible that there is no discrepancy between MFTT scores on the GCETS and comparative competency questions if both samples actually evidence low grief counseling competency; it is conceivable that competence in one's ability to provide grief counseling may remain low despite ample DD&B education, training and supervision. Additional GCETS normative data is needed.

Predictions regarding low MFTT interest in counseling bereaved clients were not supported by study findings. Specifically, 87.18% of MFTTs indicated they were moderately or very interested in providing grief counseling. It is unclear as to whether

this level of interest is typical of MFTTs or if it is an indicator that MFTTs possessing elevated levels of grief counseling interest self selected to participate in the present study. However, the small difference between the number of DD&B instructional hours MFTTs obtained within and outside of their MFT programs provides some evidence for the position that self selection sample bias was not responsible for the finding that most MFTTs are interested in grief counseling.

Study findings did not support the hypothesized positive relationship between MFTT interest in treating grieving clients and their grief knowledge or MFTT interest in treating grieving clients and the amount of DD&B education and training they obtained outside of their MFT program. A possible explanation for these non-significant findings may have to do with the likelihood that these MFTTs, like most graduate students, are busy completing their advanced degree, and despite their interest in grief counseling, have not had the time or resources to pursue outside DD&B education and experiences. Furthermore, it is logical to suspect MFTTs' lack of knowledge of grief related phenomena may stem from the paucity of DD&B education they have received both within and outside of their MFT program. Still possible, yet less likely, is the chance that one's interest in DD&B is not a good indicator of their efforts to learn more about it, or have adequate knowledge of it.

While statistical significance was not achieved when testing the relationship between MFTTs' interest in treating grieving clients and their perceived competency in providing grief counseling, the moderately large effect size of $\eta^2 = .14$ instead leads to

the belief that with a sufficient sample size, a positive relationship between MFTT interest in treating bereaved clients and their perceived competency in doing so would have been found. If true, it is possible that MFTTs who are interested in grief counseling perceive themselves to be more competent that those who are not interested, even though they have not obtained significantly more DD&B education and training, nor evidence more knowledge of grief related phenomena.

Strengths and Limitations

While results did not support some of the core predictions, the current study exhibits noteworthy strengths. For example, the data gathered from MFT programs regarding the amount and modality of DD&B education currently offered significantly updates the body of literature on this topic, as the last study completed on DD&B education in MFT programs was conducted nearly two decades ago (Humphrey, 1993). Another strength of the study was the attention to the high potential for self-selection bias among MFTTs; specifically, inclusion of the TRIG helped to rule out the possibility that elevated numbers of MFTTs experiencing current and/or difficult grief self selected to participate. One final study strength is the multifaceted approach taken; by asking MFTTs questions about their grief counseling interest and perceived competence, their grief knowledge, and their DD&B education and training experiences both within and outside of their MFT programs, more meaningful conclusions and questions were formulated.

Substantial limitations exist in the present study as well. One limitation concerns the sampling procedure. Surveys utilizing this sampling method are particularly vulnerable to insufficient sample size; the incentives and convenient internet data submission were designed to mitigate this limitation, but ultimately proved unsuccessful in garnering a sufficiently large MFTT sample. In addition, increased attention should have been placed on assessing for self selection sample biases. For example, had specific questions inquiring as to the importance of DD&B education, training and research been added to both surveys, it may have increased the researcher's ability to determine if an unusually high number of MFTTs and MFT program coordinators who value those things chose to participate in the current study. However, if self selection sample bias did occur and participants did indeed place a greater than average value on DD&B education, training and research, the results of the present study may be overestimating DD&B education, interest, perceived competency and grief knowledge.

Another limitation is the method of data collection as it is possible that non-qualifying MFTTs or MFT programs participated in the study and skewed the results. In addition, even if statistical significance had been achieved when examining the relationship between MFTT interest in grief counseling and their grief knowledge, perceived grief counseling competency, and DD&B education and training outside of their MFT program, the research design itself prevented any causal conclusions from being drawn.

Clinical Implications

These data may be used by staff and faculty members of masters level, California based MFT programs to make comparisons between their own and other MFT programs in regards to the number of DD&B and child development instructional hours offered. Larger questions regarding the sensibility of under educating and training future MFTs in DD&B related matters, given the changing U.S. demographics, may also be pondered.

Several clinical implications for the field of Marriage and Family Therapy emerge from the present study's findings. First, the trend towards high interest in counseling bereaved clients among MFTTs is noteworthy. Second, a substantial minority of MFT programs are not providing MFTTs with basic DD&B education. Last, and most importantly, taken together, these data suggest possible deficits in quality of care for grieving clients; specifically, findings concerning MFTT unfamiliarity with grief counseling theories, general interest in providing grief counseling, and MFTT overconfidence in their ability to competently provide these services, relative to their much more educated and experienced counterparts, is concerning. Ethical safeguards against working outside of one's scope of competence may not be as effective if trainees do not possess enough education to realize how undereducated and undertrained they actually are.

Directions for Future Research

As the demand for DD&B services increases, more researchers will likely turn their attention to DD&B related phenomena. Future studies investigating the preparedness of health care professionals to meet the needs of an aging society that contains a substantial number of war veterans must address DD&B issues. While death attitudes have been amply researched, more information concerning the translation of internal processes into concrete behaviors and general indicators of actual competence needs to be collected; the present study is a precursor to this type of research within the counseling field.

While this study attempted to emulate a multifaceted approach by attending to participant perceptions, experiences, attitudes, and skill set, the scope of the task proved too large for a masters thesis with limited resources. Sampling procedures that could ensure a sizable, representative sample would greatly enhance the external validity of similar studies. In addition, future studies collecting similar information from MFTTs and MFT programs may want to match the samples when obtaining data from these separate but related populations; this would increase the ability to check the reliability of the data. Also, more research investigating the difference in DD&B education offered by private and CSU based MFT programs might be useful for MFT student candidates who are interested in obtaining comprehensive death education and are in the process of choosing an MFT program. Furthermore, data exploring MFT, MFTT, and MFT program faculty and staff beliefs regarding death education in general may yield valuable

information. Also, the ability to draw causal conclusions would be of great benefit when assessing the relationships between perceptions, attitudes, experiences and skill set; in order to do this a different research design needs to be employed. Ultimately, replication will become critical as conceptually based, procedurally sound studies produce more complex results.

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APPENDIX A

MFTT CONSENT AND SURVEY

HUMBOLDT STATE UNIVERSITY
CONSENT TO ACT AS A RESEARCH SUBJECT

Are you an MFT trainee finishing your last year of coursework at an accredited California based masters level MFT program? If not, please do not participate in this study.

I hereby agree to participate in this study. I understand that this study will take place online using data collection software through surveymonkey.com from April 2011 to July 2011. I understand that questions regarding my MFT graduate education, my personal experience(s) with death, and my knowledge of death-related phenomena will be asked. I also understand that there is a risk that I will experience negative affect after answering these questions and that referrals to websites will be provided to me after I participate in this study. I understand that this study will take approximately 20 minutes to complete, and that my participation is voluntary and I may decline to enter this study or may withdraw from it at any time without penalty.

I also understand that my responses to the study questions are anonymous, no identifying information will be collected, and surveymonkey.com will save study responses in a confidential manner; they will also be saved on Francis Muela's hard drive on a password-protected computer, and in a locked file cabinet belonging to Dr. Beth Eckerd, Francis Muela's thesis advisor. I also understand that at the end of the survey, a place to enter an e-mail address for contact purposes will be provided, should I chose to enter the $50 Amazon gift card raffle and win; my e-mail address will be exported to a separate

data file than my survey responses, thereby eliminating any connection between the two. For more information on how surveymonkey.com protects study responses from unauthorized use please visit: http://www.surveymonkey.com/Monkey_Privacy.aspx. I understand that Francis Muela will answer any questions I may have concerning this study or my participation at any time; I can contact Francis Muela at 707-443-2023 or frm4@humboldt.edu or Dr. Beth Eckerd at (707) 826-3757 or beth.eckerd@humboldt.edu. Please click on "I Agree" below to indicate your consent to participate in the study. If you choose not to participate, please click on "I Disagree".

[ ] I agree [ ] I disagree

1) What is your gender? _____female _____male _____transgender _____other

2) What is your age?_____

3) What is your ethnicity?

_____Black/African American _____Asian-American

_____White/Caucasian _____Hispanic/Latino

_____Native American _____Pacific Islander

_____Multiracial _____Other (please explain)_____

4) Which **type** of university do you currently attend? _____UC _____CSU _____Private

5) How many family members or close acquaintances have died in your lifetime? _____(If none, please skip to question #33)

6) How many family members/close acquaintances did you have who died? (Indicate the number in the space provided; if none put a "0")

Spouse/Partner____ Parent____ Child____ Sibling____ Grandparent____ Nieces/Nephews____ Aunt/Uncle____ Cousin____ Friend____ Other (Please explain)_____

Questions #7 through 33 ask you to reflect upon your personal experience with death. Please select the death of a loved one to which you had the most significant response (i.e. the death that most affected you).

7. The person who died was my (choose only one):

Mother____ Sister____ Friend____ Father____ Spouse/Partner____

Brother____ Child____ Other (Please

explain)_____

8. Looking back, I would guess that my relationship with this person was (choose only one):

_____ Closer than any relationship I've ever had before or since.

_____ Closer than most relationships I've had with other people.

_____ About as close as most of my relationships with others.

_____ Not as close as most of my relationships.

_____ Not very close at all.

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

10. How long ago did this person die? Years_____, months_____

11. This person's death was (check all that apply):

_____ Expected _____ Unexpected _____ Slow _____ Sudden

Part I: Past Behavior

Think back to when this person died and describe your feelings and actions at that time by choosing the best answer from the following options:

Completely true Mostly true Both true & false Mostly false Completely false

12. After this person died, I found it hard to get along with certain people.

_____

13. I found it hard to work well after this person died. _____

14. After this person's death, I lost interest in my family, friends, and outside activities.

_____

15. I felt a need to do things that the deceased had wanted to do.

_____

16. I was unusually irritable after this person died. _____

17. I couldn't keep up with my normal activities for the first 3 months after this person died. _____

18. I was angry that the person who died left me. _____

19. I found it hard to sleep after this person died. _____

Part II: Present Feelings

Now, answer all of the following items by indicating how you **presently** feel about this person's death by choosing from the following options: (Please do not look back at Part I)

Completely true Mostly true Both true & false Mostly false Completely false

20. I still cry when I think of the person who died. _____

21. I still get upset when I think about the person who died. _____

22. I cannot accept this person's death._____

23. Sometimes I very much miss the person who died._____

24. Even now it's painful to recall memories of the person who died.

_____

25. I am preoccupied with thoughts (often think) about the person who died.

_____

26. I hide my tears when I think about the person who

died._____

27. No one will ever take the place in my life of the person who died.

_____

28. I can't avoid thinking about the person who died._____

29. I feel it is unfair that this person died._____

30. Things and people around me still remind me of the person who died.

_____

31. I am unable to accept the death of the person who died. _____

32. At times I still feel the need to cry for the person who died. _____

33. This person's death was traumatic._____

Now we would like to ask you about your perceptions regarding your counseling competence.

34) Please rate your **overall** counseling competence by choosing the appropriate answer below

_____A) I feel I need to learn a great deal more before I would call myself competent

_____B) I still have much to learn in order to call myself competent

_____C) I feel comfortable with my knowledge and skill level

_____D) I am highly competent, I could teach others

35) Please rate your **grief** counseling competence by choosing the appropriate answer below

_____A) I feel I need to learn a great deal more before I would call myself competent

_____B) I still have much to learn in order to call myself competent

_____C) I feel comfortable with my knowledge and skill level

_____D) I am highly competent, I could teach others

36) Please rate your **depression** counseling competence by choosing the appropriate answer below

_____A) I feel I need to learn a great deal more before I would call myself competent

_____B) I still have much to learn in order to call myself competent

_____C) I feel comfortable with my knowledge and skill level

_____D) I am highly competent, I could teach others

37) Please rate your **anxiety** counseling competence by choosing the appropriate answer below

_____A) I feel I need to learn a great deal more before I would call myself competent

_____B) I still have much to learn in order to call myself competent

_____C) I feel comfortable with my knowledge and skill level

_____D) I am highly competent, I could teach others

38) Please rate your **interest** in counseling clients for bereavement issues

_____A) I am very interested

_____B) I am moderately interested

_____C) I am minimally interested

_____D) I am not at all interested

Using the five point scale (with the number one representing not at all true and the number five representing totally true), rate the truth of each item as it applies to you by choosing the appropriate number.

39) I have received adequate clinical training and supervision to counsel clients who present with grief. 1 2 3 4 5

40) I have experience counseling clients who present with grief. 1 2 3 4 5

41) At this point in my professional development, I feel competent, skilled and qualified to counsel clients who present with grief. 1 2 3 4 5

42) I have experience counseling persons who have experienced the loss of a loved one to suicide. 1 2 3 4 5

43) I have experience counseling children who present with grief. 1 2 3 4 5

44) I feel competent to assess the mental health needs of a person who presents with grief in a therapeutic setting. 1 2 3 4 5

45) I have experience with facilitating group counseling focused on grief concerns. 1 2 3 4 5

46) Currently, I do **not** have sufficient skills or training to work with a client who presents with grief. 1 2 3 4 5

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

Now we would like to ask you some questions about your graduate education.

48) How many units within your graduate program did/will you complete which focus specifically on death and/or grief? _____ (Quarter or semester- choose one)

49) How many hours of instruction within your graduate program did/will you complete which focus specifically on death and/or grief? _____

50) How many units within your graduate program did/will you complete which focus specifically on child development? _____ (Quarter or semester- choose one)

51) How many hours of instruction within your graduate program did/will you complete which focus specifically on child development? _____ (Quarter or semester- choose one)

52) How many courses within your graduate program did/will you complete in which death and/or grief material accounts for at least 25% of course content?_____ (Quarter or semester- choose one)

53) How many courses within your graduate program did/will you complete in which child development material accounts for at least 25% of course content?_____ (Quarter or semester- choose one)

54) Approximately how many hours have you completed on the subject of death and/or grief via volunteerism, work experience, undergraduate education, and other education/training **outside** of the graduate program in which you are currently enrolled?

_____

Now we would like to ask you some questions about your understanding of grief.

55) Please indicate your level of familiarity with the following Grief Counseling Theories by choosing the appropriate answer below (The authors of the models are included for your reference).

A) Stage Theories (e.g., Kubler-Ross)

None Very Little Some A Lot

B) Task Theories (e.g., Worden, Rando)

None Very Little Some A Lot

C) Dual-Process Theory (Stroebe & Schut)

None Very Little Some A Lot

D) Meaning Making Theory (Neimeyer)

None Very Little Some A Lot

E) Continuing Bonds (e.g., Hogan; Klass & Silverman)

None Very Little Some A Lot

F) Posttraumatic Growth (Tedeschi & Calhoun)

None Very Little Some A Lot

Please indicate to the best of your knowledge, whether the following statements are true or false.

56) People who do not experience grief after the death of a loved one are usually repressing negative symptoms. _____ True _____ False

57) Anticipatory grief is when a person feels grief even before a loved one has died. _____ True _____ False

58) Children and adults grieve the same way. _____ True _____ False

59) When a widow/widower does not experience grief after the death of their spouse, it usually means that the marriage was problematic. _____ True _____ False

60) “Resolved” grief may come up again in the future. _____ True _____ False

61) Grief does not decline in a steady fashion. _____ True _____ False

62) People who do not experience grief after the death of a loved one usually have dismissive attachment styles. _____ True _____ False

63) It is possible for people to grieve for years, even decades, the death of a loved one. _____ True _____ False

Please print this page for future reference

We wish to thank you for participating in our study. We recognize that parts of the survey touch upon several questions that are of an existential nature. As such we also recognize that some of the questions asked may be potential areas of concern for you. People may, while completing this survey, become aware of behaviors and thoughts that may suggest the need to talk to a professional or seek out further information.

If, after completing this survey, you recognize that there may be some issues or feelings that are a potential problem for you, we strongly urge you to contact a professional to talk to about your concerns or to answer questions that you may have.

*The following resources are available for you to contact should you wish to obtain bereavement counseling or referrals to a bereavement counselor in your local area:

Hospice- http://www.hospicenet.org/html/find.html

Association for Death Education and Counseling- http://www.adec.org

*If you would like more information regarding death and grief, the following resources are available:

Association for Death Education and Counseling- http://www.adec.org

National Center for Death Education at Mount Ida College in Newton, Massachusetts- http://www.mountida.edu/sp.cfm?pageid=307

Thank you for your participation. If you would like to be entered into the raffle for a chance to win a $50 Amazon gift card, please provide an e-mail address with which we can contact you, should you be chosen. Please, do not include your name._____

Should you want to see the results of this study, or have any questions, you may contact Francis Muela at 707-443-2023 or frm4@humboldt.edu or Dr. Beth Eckerd at (707) 826-3757 or beth.eckerd@humboldt.edu

APPENDIX B

MFT PROGRAM CONSENT AND SURVEY

HUMBOLDT STATE UNIVERSITY

CONSENT TO ACT AS A RESEARCH SUBJECT

Are you a representative of an accredited, California based masters level MFT program? If not, please do not participate in this study.

I hereby agree to participate in the following study. I understand that this study will take place online using data collection software through surveymonkey.com from April 2011 to July 2011 and that questions regarding the MFT graduate education offered by this program will be asked. I also understand that this study will take approximately 5 minutes to complete and that my participation is voluntary and I may decline to enter this study or may withdraw from it at any time without jeopardy. I also understand that my responses to the study questions are anonymous, no identifying information will be collected, and surveymonkey.com will save study responses in a confidential manner; they will also be saved on Francis Muela's hard drive on a password-protected computer, and in a locked file cabinet belonging to Dr. Beth Eckerd, Francis Muela's thesis advisor. For more information on how surveymonkey.com protects study responses from unauthorized use please visit: http://www.surveymonkey.com/Monkey_Privacy.aspx.

I understand that Francis Muela will answer any questions I may have concerning this study or my participation at any time; I can contact Francis Muela at 707-443-2023 or frm4@humboldt.edu or Dr. Beth Eckerd at (707) 826-3757 or beth.eckerd@humboldt.edu. Please click on "I Agree" below to indicate your consent to participate in the study. If you choose not to participate, please click on "I Disagree".

[ ] I agree [ ] I disagree

Please fill in the blanks with the correct answer. Thank you in advance for your participation.

1) How many instructional hours (not units) regarding death, dying and bereavement (DD&B) are currently offered by this MFT program? _____
2) How many instructional hours (not units) regarding child development are currently offered by this MFT program? ____
3) Please choose the option that best represents this program's approach to teaching DD&B material: _____Present DD&B material in a full DD&B course _____Integrate DD&B material into another course _____ Infuse DD&B material throughout entire curriculum _____We do not teach DD&B material _____Other (please specify)_____
4) In which **type** of university is this MFT Program embedded? _____UC _____CSU _____Private

APPENDIX C

MFTT INVITATION TO PARTICIPATE

To the MFT program Administrative Assistant,

Hello, my name is Francis Muela and I am a graduate student in the MFT program at Humboldt State University. I am recruiting participants for my thesis and would greatly appreciate it if you could please forward this e-mail to all MFT trainees completing their last year in your university's masters level MFT program. After you do so, please reply to this e-mail with the number of MFT trainees to whom you forwarded this e-mail. Should you have any questions, feel free to contact me at 707-443-2023 or frm4@humboldt.edu. The HSU IRB committee has reviewed this study and found it to be exempt; IRB#: 10-196, IRB date: 4-11-11. Thank you for your help.

Sincerely,

Francis Muela, Masters Candidate at Humboldt State University

Hello fellow MFT Trainees,

My name is Francis Muela and I am a graduate student in the MFT program at Humboldt State University. For my thesis, I am conducting a quantitative research study that examines the graduate education of masters level MFT trainees (MFTTs). In order to obtain a large survey sample of MFTTs, I have contacted MFT program administrative assistants and asked that this e-mail be forwarded to all MFTTs completing their last year of that MFT program. The only requirements for participation are that you are a MFTT completing your last year of coursework at an accredited, masters level, California based

MFT program. Your participation in this study would help contribute to ongoing efforts to improve clinician efficacy in treating clients and to express our sincere appreciation to participants, we will be raffling off three $50 Amazon gift cards upon completion of data collection. If you would like further information about this survey or have any questions, please feel free to contact me at frm4@humboldt.edu or my thesis supervisor, Dr. Beth Eckerd, at beth.eckerd@humboldt.edu. The HSU IRB committee has reviewed this study and found it to be exempt; IRB#: 10-196, IRB date: 4-11-11. If you choose to participate, please click on the URL https://www.surveymonkey.com/s/MFTtraineesurvey . If this does not work, the URL can also be cut and pasted into the URL bar at the top of the webpage. Your time and participation in this study are appreciated!

Sincerely,

Francis Muela, Masters Candidate at Humboldt State University

APPENDIX D

MFT PROGRAM INVITATION TO PARTICIPATE

To the MFT Program Director,

Hello! My name is Francis Muela and I am a graduate student in the MFT masters program at Humboldt State University. For my thesis, I am conducting a research study that examines the graduate education of masters level MFT trainees. This survey should take approximately five minutes to complete. The only requirements for participation are that you represent an accredited, masters level, California based MFT program. Your participation in this study would help contribute to ongoing efforts to improve clinician efficacy in treating clients. If you would like further information about this survey or have any questions, please feel free to contact me at frm4@humboldt.edu or my thesis supervisor, Dr. Beth Eckerd, at beth.eckerd@humboldt.edu. The HSU IRB committee has reviewed this study and found it to be exempt; IRB#: 10-196, IRB date: 4-11-11. If you choose to participate, please click on the URL https://www.surveymonkey.com/s/MFTprogramsurvey . If this does not work, the URL can also be cut and pasted into the URL bar at the top of the webpage. Your time and participation in this study are appreciated!

Sincerely,

Francis Muela, Masters Candidate at Humboldt State University

APPENDIX E

MFTT FOLLOW UP INVITATION TO PARTICIPATE

Hello,

My name is Francis Muela and I am a graduate student at Humboldt State University. I sent out an email on 4-19-11 requesting it be forwarded to all MFTTs who are completing their last year of coursework at this MFT program. I am resending this email to provide another opportunity for participation and to thank all of those who have already chosen to participate. I have pasted a copy of the original letter below for your reference. If you have not done so already, I ask that you please forward this e-mail to all MFT trainees completing their last year of coursework in that MFT program and reply with the number of MFT trainees to whom you forwarded this e-mail, I would greatly appreciate your help. Should you have any questions, feel free to contact me at 707-443-2023 or frm4@humboldt.edu. The HSU IRB committee has reviewed this study and found it to be exempt; IRB#: 10-196, IRB date: 4-11-11. Thank you for your help

Sincerely,

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of that MFT program. The only requirements for participation are that you are a MFTT completing your last year of coursework at an accredited, masters level, California based MFT program. Your participation in this study would help contribute to ongoing efforts to improve clinician efficacy in treating clients and to express our sincere appreciation to participants, we will be raffling off three $50 Amazon gift cards upon completion of data collection. If you would like further information about this survey or have any questions, please feel free to contact me at frm4@humboldt.edu or my thesis supervisor, Dr. Beth Eckerd, at beth.eckerd@humboldt.edu. The HSU IRB committee has reviewed this study and found it to be exempt; IRB#: 10-196, IRB date: 4-11-11. If you choose to participate, please click on the URL https://www.surveymonkey.com/s/MFTtraineesurvey . If this does not work, the URL can also be cut and pasted into the URL bar at the top of the webpage. Your time and participation in this study are appreciated!

Sincerely,

Francis Muela, Masters Candidate at Humboldt State University

APPENDIX F

MFT PROGRAM FOLLOW UP INVITATION TO PARTICIPATE

Hello,

My name is Francis Muela and I am a graduate student from Humboldt State University. I sent out an email on 4-19-11 inviting representatives of accredited, masters level, California based MFT programs to fill out a brief survey for my thesis. I am resending this email to provide another opportunity for participation and to thank all of those who have already chosen to participate. I have pasted a copy of the original letter below for your reference. Should you have any questions, feel free to contact me at 707-443-2023 or frm4@humboldt.edu. The link to my survey is https://www.surveymonkey.com/s/MFTprogramsurvey

To the MFT Program Director,

Hello! My name is Francis Muela and I am a graduate student in the MFT masters program at Humboldt State University. For my thesis, I am conducting a research study that examines the graduate education of masters level MFT trainees. This survey should take approximately five minutes to complete. The only requirements for participation are that you represent an accredited, masters level, California based MFT program. Your participation in this study would help contribute to ongoing efforts to improve clinician efficacy in treating clients. If you would like further information about this survey or have any questions, please feel free to contact me at frm4@humboldt.edu or my thesis supervisor, Dr. Beth Eckerd, at beth.eckerd@humboldt.edu. The HSU IRB committee has reviewed this study and found it to be exempt; IRB#: 10-196, IRB date: 4-

11-11. If you choose to participate, please click on the URL https://www.surveymonkey.com/s/MFTprogramsurvey . If this does not work, the URL can also be cut and pasted into the URL bar at the top of the webpage. Your time and participation in this study are appreciated!

Sincerely,

Francis Muela, Masters Candidate at Humboldt State University