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The Influence of Personal Threat, Personal Loss, Age, Practice Characteristics, and Death Education on Counselors' Death Anxiety and Death Acceptance

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THE INFLUENCE OF PERSONAL THREAT, PERSONAL LOSS, AGE, PRACTICE CHARACTERISTICS, AND DEATH EDUCATION ON COUNSELORS’ DEATH ANXIETY AND DEATH ACCEPTANCE

BY

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DISSERTATION

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy
Counselor Education

The University of New Mexico
Albuquerque, New Mexico

December, 2017
DEDICATION
(with help from the works of Stephen Sondheim)

Look, I made a hat . . . where there never was a hat.
For Carol (1955-1987). I think you would have been proud of this.

Somebody crowd me with love . . .
For Lisa, my patient, supportive, and loving wife. I love sharing my life with you.

Children will look to you
For which way to turn,
To learn what to be . . .
For my sons, Aaron and Joshua. I can only hope what you see when you look to me is something worth learning.
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look at my dominant culture preconceptions, expanding my view to look beyond Western academic tradition. He also provided an essential turning point in my life by introducing me to the existential philosophers. More importantly, during the hours we spent running around Yellow Springs and through Glen Helen, Al modeled for me a philosophy of education (and of life) that has become the essence of what I strive to be as Counselor, Psychotherapist, and Counselor Educator. Those runs, combined with life and study at Antioch, inculcated in me something deeper and more important than I understood at the time: the amazing guilt trip Horace Mann laid on all Antiochians: *Be ashamed to die until you have won some victory for humanity.* Finally, although we have never met, I am eternally indebted to Dr. Irvin Yalom. Dr. Yalom’s existential wisdom has become the foundation of my theoretical approach to counseling and psychotherapy, and informs a large part of my approach to life.

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her bar exam, she nursed me through my numerous and varied life crises. In many ways she provided a stability for me as an adult I had never known as a child.

I must, at last, speak of how this work began. The mid-1980s were dark days as AIDS ravaged my community; each week someone in my life would disappear—simply disappear—with no explanation or comment. In this environment, a week before Christmas, I received a call telling me Carol Anders Mears, who had once been the center of my life, had died. The following weeks (and months and years) constituted a crash course in grief and societal silence about death. It was also, although I did not know it at the time, the week that gave birth to this project. I will always be grateful to those who disappeared during that time—and especially to Carol—for the lessons their lives and deaths taught me.

Synchronicity, or simply coincidence? This project ends almost 30 years to the day that I received that call about Carol. The lesson of that 30-year journey and, I hope, of this work, is the one Yalom teaches:

We psychotherapists simply cannot cluck with sympathy and exhort patients to struggle resolutely with their problems. We cannot say to them you, and your problems. Instead, we must speak of us and our problems, because our life, our existence, will always be riveted to death, love to loss, freedom to fear, and growth to separation. We are, all of us, in this together.
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Client Death

Death Acceptance

Death Anxiety

Death, Dying and Bereavement (DDB) Issues

Death Education

Life-Threatening Experience

Personal Grief Experience

Professional Work with DDB Issues

Conclusion

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ABSTRACT

The purpose of this study was to examine select factors that affect professional counselors’ levels of death anxiety and death acceptance. Identified factors included personal experiences of mortality (personal threat), experiences of bereavement (grief), hours working with clients presenting death, dying, and bereavement (DDB) issues (client hours), numbers of clients who have died (client death), age, and hours of formal death education (death education). The measures of death anxiety and death acceptance were participants’ scores on the Death Attitudes Profile—Revised.

The sample population consisted of 234 professional counselors recruited from two counseling-related listservs and five LinkedIn professional groups related to counseling. Participants completed the Death Experience Survey (DES), a demographic questionnaire and the Death Attitudes Profile—Revised (DAPR). Participants’ ages ranged from 24 to 74. Almost two-thirds reported experiences of personal threat, all reported experiences of grief, hours working with clients presenting DDB issues ranged from 10 to 800, slightly under half reported having worked with clients who died, and almost 85% reported having received some form of death education.

Multiple regression analyses did not support the study’s hypotheses regarding the effects of bereavement, client deaths, and death education, a further examination of the data revealed areas of possible future research. Most particularly, the relationship between participants’ bereavement and client death experiences and scores on the Neutral Acceptance and Approach Acceptance scales suggest future studies should consider exploring a construct of life reappraisal that may be independent of the death acceptance construct.
Additionally, the study’s sample was more heavily weighted toward those holding agnostic, and atheist beliefs. Given this reality, the sample’s responses to the DAPR’s Approach Acceptance scale, with its use of explicitly religious language, suggests it might be useful to conduct additional research into how religious attitudes affect counselors’ death attitudes.

Multiple regression analyses did, however, support several study hypotheses. Most particularly, the analyses revealed the most consistent predictor of death anxiety and death acceptance scores was number of hours working with clients presenting DDB issues. The more hours reported, the lower the participants’ death anxiety scores and the higher their death acceptance scores. The effect was found for both scales and all subscales (Fear of Death, Death Avoidance, Neutral Acceptance, Approach Acceptance, and Escape Acceptance). There were also significant correlations between the criterion variables and personal threat and age.

While the findings relating to personal threat and age contribute to understanding of factors affecting death attitudes, these are not factors that can be manipulated in counselor education curricula. The finding that number of hours working with clients presenting DDB issues, however, does provide an approach counselor education programs might use to improve their trainees’ ability to work with DDB issues. Whether effective approaches would include increased counseling scenarios involving DDB issues, or more active recruitment of clients presenting DDB issues for counselor training clinics is an important area for future investigation.
CHAPTER 1

INTRODUCTION

Professional counselors must be aware of the issues that touch their own lives in emotionally powerful ways (Corey, 2013; Norcross, 2005; Yalom, 1980, 2005). The failure to do so can affect their work with their clients and even lead to professional impairment (Corey, 2013; Norcross, 2005; Yalom, 1980, 2005). Almost any issue a client can raise has the potential to affect the client’s counselor. However, because all counselors must face the reality of their own mortality, the client who raises issues of death, dying and bereavement (DDB) poses a singular challenge to every counselor.

The inevitability of death and grief raises the question of how counselor education programs should prepare counselor trainees. However, before that question can be answered, we must know how counselors and counselor trainees react to issues of death, dying and bereavement (DDB), and what factors influence those reactions. This study was designed to address this fundamental question.

Theory of and Research Into Reactions to Death

Counseling theorists argue that the reality of personal mortality creates fear and anxiety within individuals (Frankl, 1984; Yalom, 1980, 2008). The most common reaction to this anxiety is to deny or avoid the reality of death. Counseling theorists argue such denial leads to any number of dysfunctional behaviors and to counselor inauthenticity and ineffectiveness (Corey, 2013; Yalom, 1980, 2002, 2005).

To a large extent, research supports the theoretical framework. Research into attitudes toward death support the theoretical proposition that individuals react to death with fear and anxiety (Abdel-Khalek, 2011; Templer et al., 2006; Wong, et al., 1994). A
small body of literature that finds this anxiety extends to professional counselors (Carney & Cobia, 2003; Kirchberg & Neimeyer, 1991; Kirchberg, Neimeyer, & James, 1998).

There is also evidence for the theoretical proposition that avoidance is a common reaction to the anxiety created by the reality of death. With the HIV/AIDS epidemic of the 1980s, the terror attacks of 9/11, and the aging of the baby boomer generation, DDB issues have gained some traction in academia and in counselor training programs. However, according to existential theorists (Barnett, 2009b; L. Hoffman, 2009; Yalom, 1980, 2002, 2008) and death education proponents (Feifel, 1990; Wass, 2004) the approach to DDB issues remains largely one of avoidance. As Wass (2004) points out, this avoidance can even be seen within areas of health care that directly deal with DDB issues as providers and academicians turn to euphemisms such as “end-of-life” for “death,” “palliative” for “terminal” and even “life-threateened” for “dying” (p. 303).

Few counseling programs devote much attention to death education (Wass, 2004). This can be seen through a search of course catalogs from the 12 universities in CACREP’s Intermountain Region that offer counseling Masters programs with a specialty of Clinical Counseling or Mental Health Counseling. These programs offer approximately 650 graduate level classes in Counseling. Of these classes, only seven have course titles that contain the words death, dying, grief, loss, or bereavement.

Research provides additional evidence that counseling programs usually ignore DDB issues. Humphrey’s (1993) survey of counseling programs found that most respondents reported they did not offer classes devoted to DDB issues. Instead, these respondents reported the most common approach was to infuse the topic into counseling courses though lecture and class discussion. A recent study (Ober, Granello, & Wheaton,
2012) of a sample of counselors in Ohio, found that less than half reported any training in grief during their academic programs.

**The Problem: Increased Likelihood of Working With Clients Presenting DDB Issues**

This lack of attention to DDB issues suggests current counselors and counseling trainees may not be adequately prepared to work with clients presenting DDB issues. This problem is made more important by several changes that will likely lead to an increase in clients presenting with DDB issues.

First, the U.S. population is aging, meaning a larger proportion of the U.S. population will be directly affected by DDB issues as friends and loved ones die and as individuals directly face their own mortality. The 2010 U.S. census showed that, while the overall U.S. population grew by 9.7 percent from 2000 to 2010, the part of the population that is 65 years old or older grew by 15.1 percent (Werner, 2011).

Second, counselors today and in the near future are more likely to see members of the aging population as clients. Historically, older individuals have been less likely than others to seek mental health services (Robb, Haley, Becker, Polivka, & Chwa, 2003). However, Robb and colleagues (2003) found that a larger part of today’s aging population has lived in times when mental health issues have become less stigmatizing. As a result, it is likely these older individuals will seek mental health services more often than did previous generations. Other studies provide additional evidence counselors will be working with a larger proportion of older adults. Mojtabai (2007) reports that, overall, Americans’ attitudes toward mental health treatment is becoming more positive. At the same time, Mackenzie, Scott, Mather, and Sareen (2008) report that, contrary to common expectations,
older adults hold more positive attitudes toward mental health services than do younger adults.

Finally, working with an increasing number of older adults means counselors are more likely to work with clients who are dying and are more likely to experience client death (Centers for Disease Control and Prevention, 2012). Once again, however, there is little available research into the effects of client death on counselors. McAdams and Foster (2000) investigated how often counselors have experienced client suicide and the effects of those suicides on counselors. They found almost 25% of counselors surveyed had experience a client suicide and the effect on these counselors was a clinical level of stress.

These realities mean that over the next two decades counselors are more likely to be working with older clients, with more clients who bring DDB issues to counseling, and with clients who die. These realities also mean that, given the lack of attention to DDB issues in training programs, and some evidence that DDB issues raise anxieties in counselors, counselors may not be adequately prepared to work well with these clients.

**Addressing the Problem: Moving from Death Anxiety to Death Acceptance**

To address these issues, theory proposes individuals work to directly confront mortality instead of avoiding the issue (Frankl, 1984; Yalom, 1980, 2002, 2005). The construct of death acceptance suggests support for the theoretical position that confronting mortality, rather than avoiding or denying it, is beneficial. This is seen in literature that finds evidence of a construct called post-traumatic growth. Studies show that various encounters with mortality, including one’s own possible death (Buxton, 2011; Greyson, 1992; Groth-Marnat & Summers, 1998; Hefferon, Grealy, & Mutrie, 2009; Martin & Kleiber, 2005; Noyes, 1980; Sawyer, Ayers, & Field, 2010; Tedeschi & Calhoun, 1996,
2004; Yalom, 1989, 2008; Yalom & Lieberman, 1991), aging (Reker, Peacock, & Wong, 1987; Sands, 2009; Sinnott, 2009; Weber, 2011; Wong, et al., 1994), the death of a loved one (Haas-Thompson, Alston, & Holbert, 2008; Hayes, Yeh, & Eisenberg, 2007; Kouriatis & Brown, 2011), the death of a client (Dwyer, Deshields, & Nanna, 2012; Hendin, Haas, Maltsberger, Szanto, & Rabinowicz, 2004; Knox, Burkard, Jackson, Schaack, & Hess, 2006; Veilleux, 2011), or work with clients who present DDB issues (Terry & Bivens, 1995), while challenging and stressful, can be important for counselors. The literature also supports the theoretical position that education specifically designed to encourage contemplation of personal mortality, often called death education, can have similar effects as direct confrontations with mortality (Barrere, Durkin, & LaCoursiere, 2008; Chan & Tin, 2012; Haas-Thompson, et al., 2008; Harrawood, Doughty, & Wilde, 2011; Hutchison & Scherman, 1992; Maglio & Robinson, 1994; Ober, et al., 2012; Schroder, Heyland, Jiang, Rocker, & Dodek, 2009; Wass, 2004).

**Theoretical Constructs: Death Anxiety and Death Acceptance**

In the current study, the researcher examined how DDB issues, as measured by the constructs of death anxiety and death acceptance, affect professional counselors. As described in the following sections, the researcher hypothesized that professional counselors’ increased exposure to DDB issues would be associated with the counselors showing lower levels of death anxiety and higher levels of death acceptance.

**Death Anxiety**

Wong, Reker and Gesser (1994) suggest that fear of death and death anxiety describe different experiences. Fear of death is specific and conscious while death anxiety is a more generalized experience that might not be accessible to an individual’s
awareness. Many have argued that fear of death is universal (Barnett, 2009a; Collett & Lester, 1969; Neimeyer, 2009; Wass, 2004; Yalom, 2008) and that many react to this fear by using denial and avoidance.

However, death is not an issue counselors can avoid. Inevitably, clients will bring death into the consulting room either in the form of grief for someone lost, or in the form of grappling with the existential reality of their own mortality. Unless counselors are in personal denial, these clients will bring home the reality that, at some point, they will face the death of their own loved ones. Even more challenging is that these clients will bring home to their counselors the reality that one day each one of us will face our own death. Because of this reality, because each counselor must one day face “my death” (Yalom, 1980, p. 159), working with a client who is bereaved or dying will inevitably touch the counselor’s deep beliefs and fears about that encounter. The first and most likely result of facing this reality is that counselors will be faced with their own death anxiety.

**Death Acceptance**

The question then becomes what does the counselor do with this anxiety? Wong et al. (1994) suggest the development of death acceptance which they and Klug and Sinha (1987) argue consists of a cognitive awareness of one’s own mortality and at least a neutral, if not a positive, emotional reaction to this awareness (Wong et al., 1994, p. 124). This work is echoed by Wittkowski (2001) who argued for a multidimensional approach to fear of death and acceptance of death and developed the Multidimensional Orientation toward Death and Dying Inventory (MODDI-F).

Most approaches to counselor education teach that counselors must be aware of issues that present personal emotional challenges (Corey, 2013; Yalom, 1980, 1989, 2002).
Certainly, death poses such challenges. This reality means it is crucial that counselors be prepared to work with issues surrounding death.

**Purpose of the Study and Research Question**

The purpose of this study was to test the theoretical proposition that personal encounters with mortality can help reduce death anxiety and increase death acceptance in professional counselors. More specifically, the researcher examined whether experience working with clients who present with DDB issues; a personal experience of loss; a personal experience of one's own mortality through illness, accident, or age; or participation in a death education course or program can predict professional counselors' levels of death anxiety and death acceptance.

Based on these theoretical constructs, the study’s research questions and hypotheses were:

**Research Question 1**

Does a personal experience of mortality through illness, accident, or disaster affect professional counselors’ levels of death anxiety and death acceptance?

**Hypothesis 1**

Professional counselors who have experienced a life-threatening illness, accident, or disaster will show lower levels of death anxiety and higher levels of death acceptance than professional counselors who have not had such an experience.

**Research Question 2**

Does a personal experience of grief affect professional counselors’ levels of death anxiety and death acceptance?
Hypothesis 2

Professional counselors who have experienced the loss of a loved one will show lower levels of death anxiety and higher levels of death acceptance than professional counselors who have not had such an experience.

Research Question 3

Does age affect professional counselors’ levels of death anxiety and death acceptance?

Hypothesis 3

Professional counselors who are older will show lower levels of death anxiety and higher levels of death acceptance than younger professional counselors.

Research Question 4

Does working with clients who present with DDB issues affect professional counselors’ levels of death anxiety and death acceptance?

Hypothesis 4

Professional counselors who have worked with clients who present with DDB issues will show lower levels of death anxiety and higher levels of death acceptance than professional counselors who have not worked with such clients.

Research Question 5

Does working with clients who die (either during or following treatment) affect professional counselors’ levels of death anxiety and death acceptance?
Hypothesis 5

Counselors who have worked with clients who have died (either during or following treatment) will show lower levels of death anxiety and higher levels of death acceptance than professional counselors who have not worked clients who have died.

Research Question 6

Does specific training in DDB issues affect professional counselors’ levels of death anxiety and death acceptance?

Hypothesis 6

Professional counselors who have received specific training in DDB issues will show lower levels of death anxiety and higher levels of death acceptance than professional counselors who have not received such training.

Definitions of Important Terms

Client Death

The death of a client a counselor has worked with either during the counseling relationship or following the termination of that relationship.

Death Acceptance

The acknowledgement and “positive emotional assimilation” (Klug & Sinha, 1987, p. 230) of the prospect of one’s own death.

Death Anxiety

Feelings of uneasiness and apprehension when faced with thoughts or situations involving death.
Death, Dying and Bereavement (DDB) Issues

Topics of therapeutic concern clients may bring into counseling sessions that involve the prospect of the client’s personal mortality, the actuality of the client’s dying, or the client’s grief following the death of someone important to the client.

Death Education

Any formal educational program specifically devoted to exploring the physical and emotional realities of those who are dying and those who are bereaved. Death education programs can be strictly didactic and provide information about those who are dying or bereaved or experiential and encourage students to explore their own emotional reactions to death, including their own death.

Life-Threatening Experience

Any experience that causes an individual to believe he or she is in imminent peril of dying. Such an experience could include a life-threatening illness, an accident, a natural or man-made disaster, or a criminal act.

Personal Grief Experience

Any experience that causes an individual mental and emotional suffering or anguish because of the death of a person that is important to the individual.

Professional Work with DDB Issues

Any professional engagement by a professional counselor that involves DDB issues. This can include counseling relationships with clients who are dying or bereaved or clients who desire to explore the prospects of their own mortality.
Conclusion

As described in this chapter, DDB issues present powerful challenges for professional counselors. This is because these issues will unavoidably affect every counselor personally, as well as professionally. However, current research provides sparse information about how these issues affect counselors and how well counselors are equipped to work with them. What is clear, according to current literature, most counselors receive little formal preparation to work with these issues.

This has become a more important issue as the United States population changes. The percentage of the population that is over 60 will continue to increase over the next 10-20 years and that part of the population will face DDB issues more directly and more frequently. In addition, because these individuals are more open to seeking counseling than previous generations, they are likely to make up a greater part of professional counselors’ client load. The result is counselors must expect to face DDB issues as an important part of their practice.

These realities—the challenges presented by DDB issues, and the increased likelihood that counselors will need to work with these issues—makes it important for counselor educators to understand what factors affect professional counselors’ abilities to work with DDB issues, and what formal preparation might help counselors work with these issues. This importance of this study is that it was designed to provide information about factors affecting counselors’ attitudes toward DDB issues which could help suggest methods to prepare counselors to work with these issues.

In the following chapters, literature relevant to DDB issues and counseling is reviewed, the methodology of the study is explained, and the results of the study are
presented. Finally, the results’ implications for future research and counselor education are explored.
CHAPTER 2
REVIEW OF LITERATURE

Introduction

Counselor self-awareness is often cited as a core quality of effective counselors. In discussing training of counselors, Yalom (2005) argues the necessity for counselors to be self-aware and provides a detailed list of problems that might arise in counseling if the counselor has not developed the appropriate self-knowledge (p. 526). Norcross (2005), in reviewing research into effects of counselors receiving their own counseling, found an overwhelming majority of counselors surveyed reported the experience had improved their effectiveness with clients.

Because all counselors must eventually face the reality of their own deaths, it would appear this self-knowledge would be vitally important in dealing with DDB issues. In discussing the process of confronting DDB issues in counseling, Yalom (1980) argues counselors must have worked through their own DDB issues. Those who have not done so may avoid the issues and fail to challenge clients’ denial about problems they face.

Theory of Reactions to Death

Counseling Theory of DDB Issues

Frankl’s classic, Man’s Search for Meaning (1984), draws upon his own experience as a survivor of the Holocaust and as a psychotherapist to emphasize the importance of meaning-making in human life. His observations of life in the camps are that those who could somehow make meaning of their experience were more likely to survive. Frankl’s conclusion is that meaning exists for all, and that the counselor’s job is to help clients discover that meaning.
Echoing Frankl, Yalom (1980) argues for the central importance of meaning. In his textbook *Existential Psychotherapy*, he argues that human existence is bound to life’s unavoidable realities, its “four givens”: death, freedom, isolation, and meaninglessness. Anxiety arises from the individual’s confrontation with these givens and the attempt to avoid them creates dysfunction. The counselor’s goal, he argues, is to help clients confront the givens and manage the anxiety raised by this confrontation. According to Yalom, ultimately, the healthiest way of handling the anxiety is through full engagement in life which allows clients to tangentially create meaning from life. Yalom supports his argument with reference to classic psychoanalytic work as well as the history of human literature.

**Research into DDB Issues**

Research into how individuals react to DDB issues supports the theoretical suppositions. To investigate constructs such as fear of death and death anxiety, numerous researchers have designed and tested various instruments to measure the constructs. In each case, the researchers have found evidence to support the ability of their instruments to measure death-related anxiety.

Collett and Lester (1969) investigated individuals’ fear of death using a Fear of Death Scale (FDS). They found fear of death could be divided into four components: fear of death of self, fear of dying of self, fear of death of others, and fear of dying of others.

Abdel-Khalek (2011) studied 630 undergraduates in an attempt to construct a scale to measure death attitudes. They identified one over-riding attitude they labeled “death distress” that could be made up of three components: death obsession, death anxiety, and death depression. They defined death anxiety as “an unpleasant response centered around
death and dying of the self or significant others” (p. 172), death depression as “a sort of sadness or sober reflection associated with one’s own death, the death of others, and the concept of death in general” (p. 172), and death obsession as “repetitive thoughts or ruminations, persistent ideas or intrusive images that are centered around the death of the self or significant others” (p. 172).

Templer, Awadalla, Al-Fayez, Frazee, Bassman, Connelly, Arikawa, and Abdel-Khalek (2006) extended the Death Anxiety Scale (DAS) (Templer, 1970) in an attempt to improve its internal validity and diversity. They administered the instrument, the Death Anxiety Scale—Extended (DASE) to four groups of participants. The first group consisted of 236 undergraduate students from universities in Sudan, the second group consisted of 233 undergraduates from universities in Kuwait, the third group of 135 undergraduates from universities in the United States, and the final group consisted of 336 participants who completed the instrument on the Internet. The researchers found responses could be grouped into 10 factors: externally caused deaths, thought of death, excruciating pain, fear of surgery, image of death, death proximity, presence of death, death anxiety denial, dreams of death, and death thoughts.

Wong, Reker and Gesser (1994) suggest that fear of death and death anxiety describe different experiences. Fear of death is specific and conscious while death anxiety is a more generalized experience that might not be accessible to an individual’s awareness (p. 122).

Published literature on how DDB issues affect professional counselors is sparse. There are some empirical studies of effects on counselors-in-training, and one of effects on experienced counselors. There are also a few empirical studies of effects of client
suicide on counselors. Casting a wider net, there are empirical studies of other therapists: psychiatrists, psychologists, and “psychotherapists” who do not specifically identify their academic training. This wider net also collects numerous qualitative studies and personal narratives regarding the effect of DDB issues or client death on therapists. With few exceptions, the literature indicates DDB issues provide emotional challenges to professional counselors that few other counseling issues present.

**DDB Issues and Counselors-in-Training.** Two studies have found counselors-in-training are more uncomfortable with counseling scenarios involving DDB issues than they are with other counseling scenarios.

Kirchberg and Neimeyer (1991) administered a Counseling Situations Questionnaire (CSQ) to 81 students in graduate counseling programs at Memphis State University. The questionnaire presented the students with 15 counseling scenarios and asked them to rate their reactions to the scenarios. Of the 15 scenarios, 5 included DDB issues. The scenario receiving the highest discomfort scores was that involving a 35-year-old male who presents with a recent diagnosis of AIDS. The other death-related scenarios involved diagnosis of a terminal illness (3rd highest discomfort scores), suicide (5th), death of a child (6th), and death of a spouse (8th).

Kirchberg, Neimeyer and James (1998) expanded the previous study by using videotaped counseling vignettes and by exploring factors that affected counseling students’ comfort levels. The participants in this second study were 58 students enrolled in practicum immediately before completing their master’s degree in counseling at the University of Memphis. Before viewing the scenarios, the participants completed the Multidimensional Fear of Death Scale (MFOD) (Neimeyer & Moore, 1994) and the
Threat Index (TI) (Krieger, Epting, & Hays, 1979). The MFOD is designed to measure eight factors related to an individual’s death fears and philosophies of life and death. The TI measures three components of “death threat”: Threat to Well Being, Uncertainty, and Fatalism. After completing the instruments, participants watched four videotaped counseling vignettes involving death and four involving other counseling situations. After each scenario, the participants rated their comfort levels from 1, very uncomfortable, to 9, very comfortable.

The results confirmed the hypothesis that participants would feel more uncomfortable watching death-related vignettes ($M=5.65, SD=1.83$) than vignettes not involving death ($M=6.56, SD=1.45$). The difference was significant ($t(57)=-5.84, p<.001$). Comparing the reactions to the scenarios with scores from the MFOD revealed the overall MFOD score did predict discomfort with the death-related scenarios (multiple $R=.28, R^2=.08, \beta=.28, p<.05$), indicating that personal fear of death and discomfort from watching death-related counseling vignettes were positively correlated.

Carney and Cobia (2003) studied 97 school counseling students’ preparation for working with children with HIV disease. The students were recruited from counselor education programs in the U.S. Southeast. In addition to responding to HIV-specific instruments, students were given an open-ended question asking for their comments. In those comments, 43% of participants expressed concern about working with persons who had a potentially life-threatening disease, and about the person’s reactions to death, and their own reactions to death.
Problem: Counselor Training Programs and DDB Issues

Despite the research finding anxiety related to DDB issues does extend to professional counselors, particularly counseling trainees, few counselor training programs directly address these issues. Two studies have documented this lack of attention.

Humphrey (1993) surveyed 135 counselor preparation programs regarding their teaching of grief counseling. The survey asked participants to rate the importance of teaching grief counseling and the methods used to cover the topic. Grief counseling was considered very important or important by 70.4% (n=95) of the responding programs. However, 90 programs (66.7%) reported they did not offer specific courses on grief counseling. Instead, 89% reported the topic is infused throughout the curriculum with the most common courses listed being practicum/internship (39), introductory/foundations/theories (24) and techniques/methods (23).

A more recent survey of counselors provides similar results. Ober, Granello, and Wheaton (2012) surveyed 369 licensed counselors in Ohio to investigate their grief counseling preparation and competence. Most (54.8%, n=190) reported they had not completed a specific course on grief. However, many (73.2%, n=254) reported having attended at least one course that infused grief in a significant way. The researchers also administered the Grief Counseling and Experience and Training Survey (GCET) (Ober, 2007), a 12-item competency instrument adapted from the Sexual Orientation Counselor Competency Scale (SOCC) (Bidell, 2005). Mean scores on the GCETS could range from 1 to 5 with higher scores indicating higher levels of training and competence. The participants’ mean scores on the GCETS were 2.71. Thus, despite a large majority of participants’ reports of attending courses which “significantly” infused grief, their
training and competence as measured by the GCETS was only slightly above the mid-point of the scale.

These studies of programs and counselors suggest lack of specific attention to grief counseling may not be preparing counselors for the increase in DDB issues they will likely face soon. In addition, because grief is only one part of the larger area covered by DDB issues, there is little, if any, information available about how well-prepared counselors are to handle these issues.

The Problem: Increased Likelihood of Working with Clients Presenting DDB Issues

The reality of death anxiety and its effects on counselors, when combined with the lack of attention given to DDB issues by most counselor training programs is made more problematic by several demographic and policy developments.

Aging of the U.S. Population

The first is the aging of the U.S. population. Werner (2011) described data collected from the 2010 U.S. Census that shows that between 2000 and 2010 the part of the U.S. population aged 65 and older increased by 15.1% compared to the increase in the overall population of 9.7%. The percentage of the population made up of those 65 and older also increased from 12.4% in 2000 to 13.0%.

Changing Attitudes of Older Adults

The second is that current samples of older adults in the U.S. show increasingly more positive attitudes toward seeking treatment for behavioral health issues. Robb, Haley, Becker, Polivka, and Chwa (2003) examined the assumption that attitudes toward seeking mental health care differed between younger and older adults in the U.S. They surveyed 474 adults aged 65 and over and compared their data with data collected from a national
survey of 1001 adults aged 21-65. They found members of the younger group were significantly more likely to have actually seen a mental health professional than were those in the older group. However, they reported there was no statistically significant difference in the two groups’ attitudes toward mental health care. Instead, older adults reported, in significantly higher numbers, inadequate access to mental health care, and lack of insurance coverage for mental health care.

Mojtabai (2007) studied changes in attitudes toward mental health care have over time by comparing data from the 1990-1992 National Comorbidity Survey (NCS) with data from the 2001-2003 National Comorbidity Survey—Replication (NCS—R). The studies showed participants in the NCS—R were more willing to seek professional help for mental health problems than were participants in the NCS (41.4% for NCS—R and 35.6% for the NCS). In addition, NCS—R participants were more comfortable talking with a professional about personal problems (32.4% for NCS—R and 27.1% for NCS) and less likely to be embarrassed by others finding out about their problems (40.3% vs. 33.7%). The authors argue that seeking mental health treatment has become more acceptable in the U.S. and that less stigma is now associated with such treatment.

Mackenzie, Scott, Mather, and Sareen (2008) examined age differences in responses to the NCS—R’s questions regarding attitudes toward mental health care. They found more than 80% of adults 55 and older had positive attitudes toward seeking mental health treatment and more than 70% had positive beliefs about treatment. They also found that the first part of the baby boom generation, those aged 55 to 64 had the most positive help-seeking attitudes.
Client Death and Counselors

In addition to working with more clients presenting DDB issues, working with older adults increases the likelihood the counselor will experience the death of a client. The Centers for Disease Control and Prevention’s (CDC) Online WONDER Database (2012) reports that in 2010, the mortality rate of adults aged 60-64 was 1,015.8 per 100,000. This compares with the mortality rate of adults aged 55-59 of 711.7 per 100,000, a difference of 29.9%. Moving from age group 60-64 to 65-69 the mortality increases by 33.5%, to 70-74 the increase is 34.7%, to 75-79 the increase is 37.3% and from 80-84 the increase is 39.1%.

Despite this reality, the literature does not discuss the effect of client death on professional counselors. Numerous qualitative studies and personal narratives of therapists from other disciplines have been published (Rubel, 2004; Siegel, n.d.; Veilleux, 2011), but nothing speaks directly to the effects of client death with the singular exception of a study of client suicide.

McAdams and Foster (2000) investigated the frequency of client suicide for counselors and the effects client suicide have on counselors. The researchers surveyed 376 randomly-selected professional counselors who were either certified by the National Board for Certified Counselors (NBCC) or licensed by the Virginia Board of Licensed Professional Counselors and Marriage and Family Therapists (LPC). They asked the participants to complete a questionnaire asking about demographics, experience of client suicide, effect of client suicide on their professional performance, and effect of client suicide on their personal lives. They also asked the participants to complete the Impact of Events Scale (IES) (Horowitz, Wilner, & Alvarez, 1979), which contains scales
measuring intrusive thoughts and avoidance of such thoughts. They found 97 respondents (23.7%) had experienced the suicide of a client they were treating, and of those, 21 (23.6%) reported the suicide had occurred while they were students.

McAdams and Foster (2000) reported that combined IES scores (intrusion plus avoidance) greater than 19 indicated clinical levels of stress. For all respondents who had experienced a suicide, the average combined IES was 30.2. This score for professional counselors was higher than scores obtained in other studies for psychiatrists ($n=131$, intrusion $M=14.3$, $SD=9.1$, avoidance $M=10.3$, $SD=9.3$) (Chemtob, Hamada, Bauer, & Kinney, 1988), and psychologists ($n=81$, intrusion $M=13.3$, $SD=9.0$, avoidance $M=8.9$, $SD=6.6$) (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988).

The study provides evidence that death of a client through suicide provides serious stressors for professional counselors. This, combined with the qualitative and personal literature from other disciplines indicates death of a client may provide important challenges for professional counselors.

**Factors Affecting Death Acceptance**

**Personal Threat**

The literature supports the idea that personal encounters with death, both as bereaved and threatened, increase individuals’ acceptance of existential realities. Yalom and Lieberman (1991) studied 30 bereaved spouses (mean age 56.7) and a control group of 20 individuals. The participants were given a clinical interview and questionnaires regarding awareness of death, purpose in life, and regrets. The interviews and questionnaires were administered twice: on entry into the study (4 to 10 months after spousal death) and one year later. Interviews were reviewed by independent raters and
their evaluations were combined with the questionnaire scores to arrive at a determination of whether the participants were “existentially aware.” Of the 30 participants, 11 were judged to be existentially aware. The two groups were compared to determine whether existential awareness affected their bereavement and their personal growth over the year of the study. The results concluded that existential awareness had no significant effect on the course of participants’ bereavement. However, there was a significant correlation between existential awareness and personal growth. The researchers found that, as participants’ awareness of existential issues increased, they showed increased growth on the researchers’ measure of the construct.

In addition to his study of spousal bereavement, Yalom has published numerous case studies (1989, 2008) of his work with dying clients. With these studies Yalom documented how dying clients often re-examine their lives. He reported that these clients often find meaning and growth through their encounters with death.

Buxton (2011) provides a first-person account of a psychiatry intern’s first experience of patient death. He observes the institutional avoidance of the reality of patients’ death by its focus on paperwork and death protocols. He also observes that, despite the institutional avoidance, his cohort of interns was aware of an almost universal discomfort and apprehension about facing their patients’ deaths.

Martin and Kleiber (2005) reviewed literature on the construct of post-traumatic growth (PTG), particularly how a “close brush” with death affects individuals. Based on their reading of the literature, they propose that the major contributors to growth following an encounter with death are: 1) less reliance on “generic knowledge structures”; 2) increased reliance on personal experience; and 3) a more benign worldview (p. 228).
Sawyer, Ayers, and Field (2010) conducted a meta-analysis of 38 studies of PTG in individuals who had received diagnoses of cancer or HIV/AIDS. The studies involved 7,927 participants, 78% of whom had a cancer diagnosis while 21.1% had an HIV/AIDS diagnosis. They concluded that their analysis of the studies showed that, in the short-term, PTG reduced negative symptoms and in the long-term PTG was important in fostering well-being.

Hefferon, Grealy and Mutrie (2009) analyzed the qualitative literature on PTG by examining 57 journal articles published between 1976 and 2007. They found common themes among the studies regarding individuals’ reactions to traumatic events in their lives. All studies but two found participants faced with a diagnosis of a serious illness were prompted to re-evaluate their lives and their priorities. Participants reported they reappraised their relationships with family members and others close to them resulting in a closer relationship. They also reported a renewed appreciation of life, and a change in their life goals that included a desire to learn new skills and achieve new things.

Tedeschi and Calhoun (1996), in developing the Posttraumatic Growth Inventory (PTGI), administered the instrument to 117 participants (55 men and 62 women). Of these, 54 reported at least one major trauma in the past 12 months while 63 reported no trauma. The researchers found that subjects who had experienced a major trauma scored higher than those who had not experienced a trauma on the PTGI’s scales of Relating to Others, New Possibilities, Personal Strength, and Appreciation of Life.

Tedeschi and Calhoun (2004), in their theoretical overview of the PTG literature, reported individuals experiencing PTG demonstrated: increased appreciation for life; a changed sense of priorities; warmer, more intimate relationships with others; a greater
sense of personal strength; recognition of new possibilities for one’s life; and spiritual development.

Greyson (1992) administered the Threat Index (TI) to 390 subjects of whom 135 had experienced a near death experience (NDE), 43 had come close to death but had not had an NDE and 112 had not come close to death. Greyson found those who had an NDE scored significantly lower on the TI than those from the other two groups.

Groth-Marmat and Summers (1998) examined how NDEs affect individuals’ beliefs, attitudes, and values. They recruited 52 subjects who had reported an NDE, and 27 who had experienced a life-threatening event but not reported an NDE. They also surveyed 45 individuals who identified as significant others of those in the study. The researchers found that those who had reported an NDE also reported significantly more changes in beliefs, attitudes, and values than did those who did not report an NDE. The significant others supported these reports. Specific changes included increased concern for others, reduced death anxiety, strengthened belief in an afterlife, reduced interest in material possessions, increased sense of self-worth, increased appreciation for natural phenomena, and enhanced awareness of paranormal phenomena.

Noyes (1980) collected accounts of life-threatening experiences from 215 participants. Experiences included falls, drowning, motor vehicle accidents, and serious illnesses. Noyes’ participants variously reported reduced fear of death (41%), a sense of invulnerability (numbers not reported), a sense of destiny (21%), a sense that they had been rescued by a higher power (17%), a new or stronger belief in continued existence after death (10%), a new or renewed sense of the presence of death and a sense of its integration into their lives (25%), a greater appreciation for life (23%), and a feeling of urgency
leading to a reassessment of priorities (number not reported), and a freer approach to life characterized by increased willingness to take risks (2%). Noyes reported other participants responded with greater passivity toward life, but the descriptions presented seemed to describe more an increased ability to accept what could not be controlled and to increase their ability to live in the present (5%). Some participants reported negative reactions including an increased fear of death (2%), a greater sense of vulnerability (6%), extreme anxiety or phobic reactions (6%), and increased caution (4%).

**Bereavement**

Kouriatis and Brown (2011) reviewed the literature about therapists’ experiences of loss and found it “quite limited” (p. 211). In reviewing the limited literature, the authors looked at three areas of therapist loss: loss of a close relative, client death, and “other” losses. They found reactions to the loss of a close relative can be both negative and positive. Because of their helping role, therapists can often feel pressure that they should somehow react to loss “better” than others. However, on returning to work, the experience of loss can make therapists more sensitive in reacting to clients’ loss-related issues. However, the studies also showed therapists who have unresolved issues regarding loss often resort to avoidance, which can hurt the therapeutic process and disrupt the working alliance with the client.

Hayes, Yeh and Eisenberg (2007) explored the effects of counselors’ personal grief by surveying 69 therapists who had experienced the death of a loved one and 69 of these therapists’ clients. The researchers measured the therapists’ feelings about their loss using an analysis of the Texas Revised Inventory of Grief (TRIG) (Faschingbauer, Zisook, & DeVaul, 1987) that revealed two factors in the Present Feelings scale the researchers
labeled “Missing” and “Acceptance.” The Missing factor measured how much the subject still missed the lost loved one; the Acceptance factor measured the degree to which the subject had come to accept the loss. The researchers examined the relationship between scores on these two factors with scores on the Empathy scale of the Barrett-Lennard Relationship Inventory Form (BLRI) (Segal, Coolidge, Cahill, & O'Riley, 2008). The researchers found that higher Missing scores were significantly negatively correlated with clients’ ratings of therapists’ empathy. At the same time, higher Acceptance scores were significantly positively related to clients’ empathy ratings.

Age

Increasing professional experience is, naturally, accompanied by increasing age. In addition, as individuals age, they are more likely to be confronted with the reality of their personal mortality. Thus, it would not be surprising that as age increases, so does death acceptance. This relationship is supported by the literature.

Sands’ (2009) first-person account of being a therapist in the last third of life reveals that the sense of being closer to death can spark a “narcissistic crisis” (p. 159) that, if negotiated positively, can foster a greater acceptance of death, an expansion of the self through Erikson’s idea of generativity, a sharpening of the sense that time is limited and an increased focus on what can be done with the time left. The older therapist can be more aware of containing and experiencing all the ages she has lived making possible a greater ability to empathize with a wider range of clients of all ages. Sands reports that her age gives her a greater appreciation of the reality that “life is hard” and that such an appreciation also increases her empathy for her clients’ troubles, increases her sense of shared humanity, and reduces her sense of separation or pathologizing of her clients. She
also reports increased freedom to self-disclose authentically, and to be pragmatic and more concerned with what works than with the “rules” of technique or theory. She concludes by observing that age had made her more realistic about herself and her limitations, which allows her to be more realistic about the limitations of even the most functional relationships. More importantly, she notes this realism allows her to better use herself more fully as she is as opposed to who she might be.

Sinnott (2009) makes a theoretical argument that aging and confrontation with death requires individuals to reconstruct their sense of self to find a meaning that goes beyond the limitations of their aging and personal death.

Reker, Peacock, and Wong (1987) studied 300 adults from 5 developmental stages: 60 each from young adulthood (16-29 years old), early middle age (30-49), late middle age (50-64), young-old (65-74), and old-old (75 and older). They found that age was significantly related to measures of Life Purpose $F(4,286)=4.07, p<.01$ and Death Acceptance $F(4,287)=9.87, p<.01$.

Wong, Reeker, and Gesser (1994) also found significant age-related differences on their scales. Fear of Death was negatively-related with age ($F(2,294)=3.42, p<.05$), as was Neutral Acceptance ($F(2,294)=8.55, p<.001$), Approach Acceptance ($F(2,294)=2.86, p<.05$) and Escape Acceptance ($F(2,294)=14.76, p<.001$).

Weber (2011) presents a first-person account of how aging has sharpened his sense of empathy with his clients and made him realize how even organizations that focus on aging appear to have difficulty discussing the unpleasant aspects of aging. His own experience of aging has enabled him to confront those aspects and use them in a more effective way with his clients.
Work with Clients Presenting DDB Issues

**DDB Issues and Experienced Counselors.** Terry and Bivens (1995) replicated Kirchberg and Neimeyer’s (1991) study with experienced counselors. They administered the CSQ to 71 experienced death counselors (mean years of experience was 14). In contrast to the beginning counselors, these experienced counselors were more comfortable with death-related scenarios. In contrast to the beginning counselors whose levels of discomfort scores for the death-related scenarios were 1st (AIDS), 3rd (adult terminal illness), 5th (suicide), 6th (child leukemia), and 8th (deceased spouse), the experienced counselors’ discomfort with the death-related scenarios were 5th (suicide), 6th (AIDS), 9th (child leukemia), 13th (adult terminal illness), and 15th (deceased spouse).

Haas-Thompson, Alston, and Holbert (2008) studied death attitudes of 148 rehabilitation counselors in North Carolina. They surveyed the numbers of counselors’ experiences of death, including death of loved ones, friends, grandparents, and clients. They grouped respondents into three categories, those with 1-2 death experiences (n=42), those with 3-4 death experiences (n=73), and those with 5 or more death experiences (n=28). Using the Collett-Lester Fear of Death Scale (FDS) (Collett & Lester, 1969) they found those with more death experiences had significantly more positive attitudes toward death than did counselors with fewer death experiences.

The results of this study suggest that experience as a counselor, particularly experience as a counselor specializing in DDB issues, is an important variable that may affect counselors’ comfort working with clients who present with DDB issues.
Client Death

Dwyer, Deshields and Nanna (2012) presented case studies from their work as health psychologists in oncology wards to illustrate the challenges counselors face when their clients die. They note that the literature provides little information on therapist reaction to a client’s death but that their experience is that therapists may grieve, but that the professional culture encourages counselors to disavow personal feelings toward clients and, at worst, pathologize counselors who express sadness about the loss of a client. The result may be a feeling of isolation from colleagues and a feeling of being removed from the formal grieving process. Counselors may also feel a lack of closure toward the counseling process with the client, or a sense of guilt that they could not provide what the client needed before death. The client’s death may also raise the counselor’s own fears of death and those reactions may lead the counselor to reprocess previous losses.

Hendin, Pollinger, Maltsberger, Szanto and Rabinowicz (2004) conducted structured interviews with counselors of 34 clients who had died by suicide. Thirteen counselors were severely distressed. Factors contributing to the distress included the failure to hospitalize a suicidal patient who then committed suicide, treatment decisions the counselor believed contributed to the suicide, lack of institutional support, and concerns over possible legal actions by family members who blamed the counselor. The researchers used a scale of emotional intensity that ranged from 1 to 10, with severe distress identified as a 7. For all counselors, 33 reported severe levels of grief, 31 severe levels of guilt, 20 severe levels of anger and shock, and 9 severe levels of depression. Other severe emotions reported included inadequacy (7), anxiety (5), shame (7), and betrayal (3).
Knox, Burkard and Hess (2006) conducted interviews with 13 counselors who had experienced a client suicide while in training. Qualitative analysis of the interviews revealed the trainees’ beliefs about suicide primarily fell into two areas: the first was that suicide happens when clients are suffering, the second was that suicide was not a sin or a sign of weakness. The trainees also typically reported that their graduate programs provided minimal training about suicide. Typical responses to the suicide included questioning clinical abilities, anger, sadness, frustration, numbness, and guilt. They also reported a lack of support for their responses and continued sensitivity to therapeutic responsibilities to suicidal clients, and continued feelings and reactions related to the suicide.

Veilleux (2011) provides a first-person account of his reactions to the unexpected death of a client to unknown causes. Echoing the other literature, he reports feelings of disbelief, shock, and confusion. In addition, confusion about the details of what had happened to his client, he also reports confusion about the “appropriate” feelings a counselor should experience when a client dies.

**Death Education**

The literature suggests death education can reduce death anxiety and increase death acceptance. Barrere, Durkin and LaCoursiere (2008) studied the effects of the End-of-Life Nursing Consortium (EOLNC) project designed specifically to prepare nursing students to work with dying patients. They conducted a longitudinal, repeated measures research study of 73 baccalaureate nursing students participating in the EOLNC project. The student nurses completed the Frommelt Attitudes toward Care of the Dying Scale (FATCOD) (Frommelt, 1991) at the beginning and at the end of their nursing programs. The students
also completed a demographic questionnaire that gathered information on age, sex, previous death education and whether they had any experience, either before or during the program, with death care. The data collected were analyzed using multiple regression. The researchers found younger students (18-22) showed significantly greater positive change in their attitudes toward caring for dying patients than did other students. The other factor that was significantly related to a change in attitude was experience caring for dying patients. Students with no previous experience showed significantly greater positive change in their attitudes than did students with previous experience. Finally, those who cared for a dying patient following their program also showed a significant positive increase in their scores on the FATCOD, indicating a more positive attitude toward working with dying patients.

Chan and Tin (2012) conducted a qualitative study of 176 helping professionals, including social workers, nurses, pastors, pastoral care workers, and chaplains, about their attitudes toward competencies needed for working with DDB issues. The participants identified four areas: knowledge competence, practice competence, self-competence, and work-environment confidence. Self-competence was mentioned most frequently and responses could be broken into three additional categories: personal resources, existential coping, and emotional coping. The authors argue their findings indicate preparing professionals to work with DDB issues cannot be limited to imparting knowledge and skills. Instead, training should help professionals develop their self-competence by helping them examine how they construct meaning and how they emotionally react to DDB issues.

In the Haas-Thompson et al. (2008) study described in the previous section, the researchers also studied the effects of death education programs. They compared the counselors who had completed a death education program during their training (n =91)
with those who had not completed such a program \((n=52)\). They found counselors with death education had significantly more positive attitudes on the Dying of Others subscale of the Collett-Lester Fear of Death Scale (FDS) (Collett & Lester, 1969) than did counselors who had not completed a death education program.

Hutchison and Scherman (1992) studied the effects of death education on 74 student nurses using the Death Anxiety Scale (DAS) (Templer, 1970). The scale was administered to the students before beginning either a didactic or an experiential death education program. The scale was administered again following the end of the programs and once more eight weeks following the end of the programs. The authors reported that, although there was no differential effect of didactic as opposed to experiential death education, there was a significant overall reduction in students’ levels of death anxiety following the programs. The reduction was maintained in the final administration of the DAS eight months after the programs ended.

Harrawood, Doughty, and Wilde (2011) conducted a qualitative study of 11 graduate counseling students who completed a course on death education. The qualitative analysis identified three themes: openness to examining death, an increased understanding of beliefs about death in general and one’s own death, and a reduction in negative emotions about death. The results suggest death education can have an important effect on individuals’ attitudes toward death.

In the most recently published study, Ober, Granello, and Wheaton (2012) administered several death-related instruments to 364 professional counselors in Ohio. In regression analyses, training in grief counseling was significantly related to improvements
in measures of personal grief counseling competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills.

**Death Anxiety and Death Acceptance**

Wong, Reker, and Gesser (1994) argued that most investigations of death attitudes had exclusively focused on negative attitudes. Their Death Attitude Profile—Revised (DAPR) attempted to provide a more balanced instrument. They proposed a five-component model that consisted of two negative attitudes—fear of death and death avoidance—and three positive attitudes—neutral acceptance, approach acceptance, and escape acceptance. The researchers administered the DAPR to three groups: 100 young adults (ages 18-29), 100 middle-aged adults (ages 30-59), and 100 older adults (ages 60-90). The researchers’ factor analysis found support for their five independent factors.

Wittkowski (2001) also attempted to measure positive as well as negative attitudes toward death. He noted the conceptual limitations of instruments focusing solely on fear of death or death anxiety and designed the Multidimensional Orientation Toward Dying and Death Inventory (MODDI-F). The instrument was developed by administration to 944 participants recruited from undergraduate students and their extended families. Ages of participants ranged from 18 to 93 with a mean of 51.6. Factor analysis of responses indicated four factors making up the fear of death dimension and three making up the acceptance of death dimension. The four fear of death factors were fear of another person’s dying and of corpses, fear of one’s own death, fear of one’s own dying, and fear of another person’s death. The three death acceptance factors were acceptance of one’s own dying and death, acceptance of another person’s death, and rejection of one’s own death.
Neimeyer, Wittkowski, and Moser (2004) examined the existing literature on death anxiety and its correlates. They found the literature showed no clear correlations between age or health status. In general, studies appeared to challenge the conventional wisdom that age and life-threatening illness would be associated with increased death anxiety.

Neimeyer et al. (2004), reviewed studies suggesting medical providers tended to avoid talking of death with their patients because of their own anxieties about death. They found initial studies suggesting caregiver anxiety were not supported by subsequent studies. In fact, they found most studies found that caregivers actively involved in work with patients with life-threatening illness showed lower levels of death anxiety than the general population. The researchers found studies do support the proposition that caregivers with higher levels of death anxiety have more difficulty providing care to older or dying patients than do caregivers with lower levels of death anxiety.

Templer, Awadalla, Al-Fayez, Frazee, Bassman, Connelly, Arikawa, and Abdel-Khalek (2006) extended the Death Anxiety Scaled (DAS) (Templer, 1970) in an attempt to improve its internal validity and diversity. They administered the instrument, the Death Anxiety Scale—Extended (DASE) to four groups of participants. The first group consisted of 236 undergraduate students from universities in Sudan, the second group consisted of 233 undergraduates from universities in Kuwait, the third group of 135 undergraduates from universities in the United States, and the final group consisted of 336 participants who completed the instrument on the Internet. The researchers found responses could be grouped into 10 factors: externally caused deaths, thought of death, excruciating pain, fear of surgery, image of death, death proximity, presence of death, death anxiety denial, dreams of death, and death thoughts.
Summary

Existing research supports the theoretical proposition that individuals react to DDB issues with anxiety and that such anxiety can extend to professional counselors. This can present challenges to counselors who may react to such anxiety with avoidance of DDB issues. Despite this reality, counselor training programs appear to give little attention to DDB Issues. This presents a problem because Census Bureau statistics show the challenge of working with DDB issues is likely to increase over the next several years as counselors’ client loads are likely to include larger numbers of older individuals who bring more DDB issues with them to counseling. In addition, the increase in clients who are older also increases the likelihood counselors will face the death of clients.

However, research also supports the theoretical proposition that confronting DDB issues can be more productive than avoiding them. Research into the construct of death acceptance supports this proposition and suggests several forms of confrontation can reduce death anxiety and increase death acceptance. Research indicates individuals’ encounter with their own mortality (through illness or accident), their own experiences of bereavement, and the inherent losses of aging can all reduce death anxiety and increase death acceptance. Finally, in the case of professional counselors and therapists, work with clients who present with DDB issues, or with clients who die, can also reduce death anxiety and increase death acceptance.

Because of these elements, the present study, investigating factors contributing to counselors’ reactions to DDB issues, has the potential to make an important contribution to the existing literature. The information gained from this study could document the
need for counselor training programs to address DDB issues more regularly and, perhaps, inform that direction such training should take.
CHAPTER 3

METHODOLOGY

Introduction

The theory of this study was that confrontation with death affects counselors’ death anxiety and death acceptance. More specifically, the theory argued that increased experience confronting death and DDB issues can predict lower levels of death anxiety and higher levels of death acceptance. Existing literature has suggested that confrontations with an individual’s personal mortality, grieving the loss of a friend or loved one, working with clients presenting DDB issues, working with clients who die, and death education can all affect levels of death anxiety and death acceptance. The theory of this study is that such experiences can predict levels of death anxiety and death acceptance.

The researcher used regression analyses to examine the relationships between professional counselors’ experiences of death, dying, and bereavement (DDB) issues and their levels of Death Anxiety and Death Acceptance as measured by the Death Attitude Profile—Revised (DAPR) (Wong, et al., 1994). To date little work has been done exploring how professional counselors are affected by DDB issues. A few recent studies have explored professional counselors and their grief competencies (Ober, et al., 2012; Servaty-Seib, 2004), but there has been no investigation to date of the variables influencing counselors’ reactions to DDB issues. This study investigated variables of death education, personal loss, characteristics of professional practice, personal experiences of life-threatening incidents, and age and their effects on professional counselors’ death anxiety and death acceptance.
Research Design and Methodology

In this study, the researcher examined the relationship between professional counselors’ experience with DDB issues and their levels of death anxiety and death acceptance. The study examined how six variables—professional training specifically related to issues of death; work with clients presenting with dying, and bereavement (DDB) issues; work with clients who have died; personal experiences of bereavement; personal experiences of a life-threatening accident, disaster, or illness; and age—predict counselors’ reactions to death as measured by the Death Attitude Profile—Revised (Wong, et al., 1994). The study used regression analyses of data gathered from a representative sample, randomly gathered from a database of professional counselors in the U.S. as well as data gathered from a sample of professional counselors actively participating in a listserv devoted to counseling issues.

This study used an Internet-based survey of practicing professional counselors. While such a methodology has its limitations, it is also an efficient and effective way of gathering data (Dillman, Smyth, & Christian, 2009). The instrument used to collect the data was a researcher-developed questionnaire to measure the independent variables and the Death Attitude Profile—Revised (DAP-R) (Wong, et al., 1994) to measure the dependent variables.

Participants

Population

This was a study of professional counselors in the United States of America. Participants were recruited by posting an invitation on the Counselor Education and Supervision Network Listserv (CESNET), the American Counseling Association
Network Listserv (ACANET), and several groups on the LinkedIn professional networking site. The LinkedIn groups included the American Counseling Association group; the Grief and Loss group; the International Bereavement Specialists group; the Psychologists, Coaches, Psychotherapists, and Counselors group; and the Psychology Network group. There was no information available for the numbers of participants on ACANET. Approximate numbers of participants from the other sources were: CESNET, 2,400; the American Counseling Association group on LinkedIn, 24,336; the Grief and Loss group on LinkedIn, 110,898; and the Psychologists, Coaches, Psychotherapists, and Counselors group, 76,537. While active participation on these listservs and groups is undoubtedly lower, total active members of these groups is approximately 214,171.

**Subject Description**

This was a study of licensed, professional counselors in the United States of America. Information for this population was unavailable. However, the researcher obtained information from the ACA describing the ACA membership (V. Cooper, personal communication, February 5, 2013). According to this information, approximately 77% of all ACA members hold a Master’s degree while 23% hold a Ph.D. Members are 74% female and 26% male; and ethnic identity is 82% Caucasian, 8% African American, 3% Latino, 2% Asian, and 4% other ethnicities.

**Sample Size**

Researchers have proposed numerous methods for estimating sample size needed for studies of human behavior (Bonett & Wright, 2011; Dillman, Smyth, & Christian, 2009; Maxwell, 2000). Maxwell (2000) proposes that researchers use multiple methods to triangulate an estimate. To that end, two sample size calculators were used to identify
the estimate of the sample size needed for this study. For both calculators an estimated effect size of .15, an $\alpha$ of .05, power of .8, and number of predictors of 6 were used. The effect size selected derives from Cohen’s categorization of effect sizes (Cohen, 1988) and from results from a pilot study. In the pilot study, correlations between counselors’ evaluations of their own comfort working with DDB issues and their experiences of death, age, and death education were examined. Analysis of the data gathered from 24 subjects found a statistically significant correlation between comfort with DDB issues and each of the three predictor variables and the effect size of these correlations was large. Because the sampling from the pilot was limited and the pilot examined only three predictor variables, it was not possible to be confident that a more expanded sample with twice as many predictor variables would discover a result with such a large effect size. Therefore, a medium effect size was selected for purposes of estimating the needed sample size. For $\alpha$ and power, values were selected that have been identified within the behavioral science literature as conventional values that identify an appropriate balance between the power of the study and the probability of spuriously finding a significant difference (Cohen, 2003; Lipsey & Hurley, 2009).

Using these values with the online software provided by Soper (2013) provided an estimated sample size of 97. The same values input into the G*Power software (Faul, 2012) provided an estimated sample size of 98. Some survey research (Dillman, et al., 2009) suggests a that even without response incentives a response rate of at least 20% is likely. However, there is little data on response rates to listserv and online group-based surveys. However, given the total numbers of members on the listservs and groups recruited from, even a .1% response would have resulted in a sample size of over 200.
**Sampling Procedure**

Participants were recruited by adapting the four-contact method for the listserv and online group environment. An initial posting described the project, noted the start date for data collection, and provided an e-mail address for requesting additional information. On the date when the survey was available for data collection, a second posting invited participation, provided a web link to the survey, and the e-mail address for requesting additional information. Two weeks later another posting notified listserv and group members that the survey would close in two weeks, invited participation, provided a web link to the survey, and the e-mail address for requesting additional information. Ten days later, a final posting notified listserv and group members the survey would close in four days, invited participation, provided a web link to the survey, and the e-mail address for requesting additional information.

**Predictor Variables**

**Experience of Having One’s Life Threatened (Personal Threat)**

This was a continuous ratio variable. Participants were asked how many times they have experienced a life-threatening accident, disaster, or illness. The response was analyzed for its ability to predict counselors’ levels of death anxiety and death acceptance. The theoretical predication was that the number of these experiences would be inversely correlated to death anxiety scores and positively correlated with death acceptance scores.

**Experiences of Grief (Grief)**

This was a continuous ratio variable. Participants were asked how many times they have experienced the death of a loved one. The response was analyzed for its ability
to predict counselors’ levels of death anxiety and death acceptance. The theoretical prediction was that the number of these experiences would be inversely correlated to death anxiety scores and positively correlated with death acceptance scores.

**Age**

This was a continuous ratio variable. Participants were asked to report their age in years. The response was analyzed for its ability to predict counselors’ levels of death anxiety and death acceptance. The theoretical predication was that as age increases, levels of death anxiety will decrease while levels of death acceptance will increase.

**Work With Clients Presenting with DDB Issues (Client Hours)**

This was a continuous ratio variable. Participants were asked to report the number of treatment hours they have spent working with clients who have raised DDB issues. This number was analyzed for its ability to predict counselors’ levels of death anxiety and death acceptance. The theoretical prediction was that as numbers of hours of working with clients who have raised DDB issues increase, levels of death anxiety will decrease while levels of death acceptance will increase.

**Work With Clients Who Have Died**

This was a continuous ratio variable. Participants were asked how many of their clients have died, either during or following treatment. The response was analyzed for its ability to predict counselors’ levels of death anxiety and death acceptance. The theoretical prediction was that as numbers of client deaths increase, levels of death anxiety will decrease while levels of death acceptance will increase.
**Death Education**

Death education was a continuous ratio variable that was derived from participants’ responses to four questions. The first question asked participants how many credit hours they took that were dedicated solely to DDB issues (they will be reminded that a standard graduate course is 3 semester credit hours or 5 quarter credit hours). Participants were then asked whether their program was on a semester-hour or quarter-hour system. They were also asked to enter the number of classroom hours they spent in other courses, seminars, or workshops that were devoted to discussion of DDB issues. Finally, they were asked how many continuing education hours dedicated to DDB issues they have attended.

From responses to the first two questions, a total number of classroom hours were calculated. If participants reported their system was semester hour, the number they entered in the first question was multiplied by 15 (for the number of weeks in a standard academic calendar made up of semesters). If participants reported their system was quarter hour, the number entered in the first question was multiplied by 10 (for the number of weeks in a standard academic calendar made up of quarters). This number was added to the numbers entered in the final two questions to calculate the total hours of death education participants have received.

This number was analyzed for its ability to predict counselors’ levels of death anxiety and death acceptance. The theoretical prediction was that as numbers of hours of death education increase, levels of death anxiety will decrease while levels of death acceptance will increase.
Criterion Variables

Death Anxiety

Death anxiety was a criterion variable calculated from items on the Death Anxiety scale of the Death Attitude Profile—Revised (DAP-R) (Wong, et al., 1994). The psychometrics of the instrument are described in the Instruments section that follows. This was an interval level variable derived by calculating the mean scores to specific items on the DAP-R’s Fear of Death and Death Avoidance scales. These scales comprise 12 items asking participants to report their level of agreement with statements about fear of death and death anxiety. The responses were entered on a 7-point Likert-type scale with values being 1 for “strongly agree,” 2 for “agree”, 3 for “mostly agree,” 4 for “undecided,” 5 for “mostly disagree,” 6 for “disagree,” and 7 for “strongly disagree.”

Death Acceptance

Death acceptance was a criterion variable calculated from items on the Death Anxiety scale of the Death Attitude Profile—Revised (DAP-R) (Wong, et al., 1994). This was an interval level variable derived by calculating the mean scores to specific items on the DAP-R’s Neutral Acceptance, Approach Acceptance, and Escape Acceptance scales. These scales comprise 20 items asking participants to report their level of agreement with statements about their acceptance of death. The responses were entered on a 7-point Likert-type scale with values being 1 for “strongly agree,” 2 for “agree”, 3 for “mostly agree,” 4 for “undecided,” 5 for “mostly disagree,” 6 for “disagree,” and 7 for “strongly disagree.”
Instruments

Death Attitude Profile—Revised

The Death Attitude Profile—Revised (DAP-R) (Wong, et al., 1994) is a 32-item survey that was adapted from the Death Attitude Profile (Gesser, Wong, & Reker, 1987) to include the construct of death avoidance. The profile was developed as one reaction to the academic focus, in death studies, on death anxiety. The goal was to explore the reality that individuals’ attitudes toward death extend beyond negative attitudes, such as fear and anxiety, to include acceptance of death’s reality. The theoretical bases of the instrument were the existential proposition that meaning and meaning making are powerful influences on how individuals face the reality of their own morality (Wong, et al., 1994).

Psychometric Properties of the Death Attitude Profile—Revised. Wong et al. (1994) conducted a test-retest analysis of the DAP-R with 300 adults and found reliability coefficients for the five scales were .65 for Neutral Acceptance, .84 for Escape Acceptance, .86 for Fear of Death, .88 for Death Avoidance, and .97 for Approach Acceptance. In a later study, Clements and Rooda (1999) achieved similar results. Their study of 403 hospital and hospice nurses found Cronbach’s alpha coefficients of .60 for Neutral Acceptance, .81 for Escape Acceptance, .82 for Fear of Death, .87 for Death Avoidance, and .91 for Approach Acceptance.

In the Wong et al. (1994) study, construct validity was supported by a convergent-discriminant analysis comparing results on the DAP-R with the Death Anxiety Scale (DAS) (Templer, 1970), the Death Perspective Scale (DPS) (Hooper & Spilka, 1970), and a Semantic Differential scale. Results supported the theoretically-based predictions that Fear of Death would be positively related to the DAS (.61) and negatively related to SD.
ratings for life (-.25) and death (-.61). Death Avoidance was negatively related to SD ratings of death (-.32). Neutral Acceptance was positively related to the Indifference Toward Death scale of the DPS (.27) and to SD ratings of life (.20).

Clements and Rooda (1999) tested the concurrent validity of the DAP-R by comparing scores on its scales with scores on the Frommelt Attitude Toward Care of the Dying Scale (Frommelt, 1991). The Frommelt scale measures nurses’ comfort working with the dying so it was theorized that scores on the “negative” scales of the DAP-R (Fear of Death, Avoidance of Death) would be negatively correlated with scores on the Frommelt scale. At the same time, it was theorized scores on the “positive” scales of the DAP-R (Neutral Acceptance, Approach Acceptance, and Escape Acceptance) would be positively correlated with scores on the Frommelt scale. Except for the Escape Acceptance subscale, the results from the study supported the predictions. Scores on the Frommelt scale were significantly negatively correlated with the Fear of Death subscale ($r(357)=-.34, p<.001$) and with the Death Avoidance subscale ($r(356)=-.37, p<.001$), and significantly positively correlated with scores on the Neutral Acceptance subscale ($r(357)=.22, p<.001$) and the Approach Acceptance subscale ($r(346)=.21, p<.001$).

Clements and Rooda (1999) found that the Escape Acceptance subscale was not significantly correlated with the Frommelt scale. The authors suggested this could be due to the possibility that the Escape Acceptance subscale reflects two constructs: Death Is Natural and Neutral Attitude. Analyzing concurrent validity using this assumption, the authors found that scores on the Frommelt scale were significantly positively correlated with scores on the Death Is Natural subscale ($r(362)=.37, p<.001$) but there was no significant correlation with the Neutral Attitude subscale ($r(361)=.03, p=.57$).
Death Experiences and Death Education Questionnaire.

A questionnaire (see Appendix A) of participants’ experiences with death and with death education was created based on research suggesting factors that might influence counselors’ death anxiety or death acceptance: personal experience of a life-threatening illness, accident, or disaster (I. Z. Hoffman, 2000; Stratton, Kellaway, & Rottini, 2007; Weber, 2011; Yalom & Lieberman, 1991); personal experiences of grief (Osband, 2006; Rappaport, 2000; Siegel, n.d.); age (Weber, 2011; Yalom, 1980, 2008); work with clients presenting DDB issues (Hunt, 2007; Kiemle, 1994; 1991; Ringel, 2001; Werth Jr. & Carney, 1996); work with clients who die either during or after treatment (Dwyer, et al., 2012; Gabriel, 1991; Knox, et al., 2006; Munson, 2010; Veilleux, 2011); and death education (Dickinson, 2007; Dickinson, Sumner, & Frederick, 1992; Field & Wee, 2002; Frommelt, 1991; Harrwood, et al., 2011; Hegedus, Zana, & Szabó, 2008; Hunt, 2007; Maglio & Robinson, 1994; Manis & Bodenhorn, 2006; Muela, 2011).

The first question asked participants to enter the number of personal experiences of mortality (in the form of a life-threatening accident, disaster, or illness) they have experienced. The second question asked how many times participants have experienced the death of a loved one. The third question measured work with clients presenting DDB issues by asking participants to estimate total hours spent working with clients on such issues. The fourth question asked participants how many clients they have worked with have died. The final four questions measured death education by using total hours discussing DDB issues in participants’ academic programs and in workshops following their programs. Finally, the questionnaire asked for the participant’s age.
Data Collection

Procedures for Data Collection

Potential subjects from the listservs and online groups were contacted through a posting on the listservs and groups. The posting described the study, its purpose, the researcher and the importance of the participants’ participation. The posting explained that full details and confidentiality information and informed consent approval could be found at the study’s website. The posting then included the address to the website.

The study website was an internet survey prepared in the online survey software Opinio. The survey consisted of 47 questions divided into four major sections:

1. Study information, confidentiality information, and informed consent agreement.
2. 10 questions designed to gather participants’ data regarding the predictor variables (see Appendix A).
3. 32 questions that make up The Death Attitude Profile—Revised (DAP-R) (Wong, et al., 1994) (see Appendix B).
4. 5 demographic questions (see Appendix C).

The online survey was designed to encourage completion by simplifying participants’ response to the questions. The design included an easily readable font, a straightforward screen design with clear instructions, a limited amount of text per screen to minimize the need to scroll down the screen, and a response layout designed to minimize the need for repeated mouse movements (Dillman, et al., 2009). Dr. Wong granted permission to use the DAP-R and, because the original instrument was designed for
administration with paper and pencil, gave approval for changes that simplify its electronic administration (see Appendix C).

Advantages and Disadvantages of Data Collection Procedure

An internet-based survey makes it feasible to collect data from a representative and diverse sample of professional counselors in the United States (Dillman, et al., 2009; Fowler, 2009). Such a survey encourages participation because participants can complete the survey at a time they choose, and in a location that meets their needs for privacy and confidentiality. Disadvantages of the method include possible low response rates, possible misunderstanding of questions, and the inability of the researcher to follow up with specific participants (Dillman, et al., 2009; Fowler, 2009). To address these disadvantages, contact information included multiple ways for the participant to contact me and multiple contacts to encourage participation.

Data Preparation

In this study data on multiple variables was collected and analyzed to determine how the variables predict participants’ levels of death anxiety and death acceptance. The predictor variables may operate independently or in concert making a multiple regression analysis the appropriate method for analyzing the relationships among the variables (Heppner, Wampold, & Kivlighan, 2008; Wampold & Freund, 1987).

As mentioned previously, responses were collected using the Opinio survey software. After data collection ended, results were exported to an Excel spreadsheet which allowed data to be aggregated and prepared for analysis within SPSS. Specific steps taken were:
1. Personal experience of having one’s life threatened was measured by participants’ responses to question 1 of the Death Experiences and Death Education Survey (DES) (Appendix A).

2. Personal experience of grief were measured by participants’ responses to question 2 of the DES.

3. Age was measured by participants’ responses to question 3 of the Demographic Questionnaire (Appendix C).

4. Work with clients presenting with DDB issues was measured by participants’ responses to question 3 of the DES.

5. Work with clients who have died was measured by participants’ responses to question 4 of the DES.

6. Death education was measured by calculating total number of hours participants have spent in classes, seminars, and workshops dedicated to DDB issues. Those hours were calculated by the following two steps:
   - The responses were converted to the single quantitative measure of classroom contact hours because responses to question 5 of the DES could include semester hours, quarter hours, or direct classroom hours. The calculation was performed based on the definitions of credit hour published by the United States Federal Government (Definitions, 2010). One semester hour is one hour of classroom contact every week of a 15-week semester. Therefore, to calculate total classroom hours each semester hour was multiplied by 15. One quarter hour is one hour of classroom contact every week of a 10-week quarter.
Therefore, to calculate total classroom hours each quarter hour was multiplied by 10.

- Responses to questions 7 and 8 of the DES (number of hours in seminars, continuing education, and workshops) were added to the transformed number from the previous calculation to arrive at the total number of hours of death education.

7. After the data transformation described, the Excel spreadsheet was imported into SPSS to perform the regression analyses.

**Data Analysis**

The data were analyzed using seven multiple regression analyses. The first three analyzed how well each predictive variable (experiences of personal threat, experiences of bereavement, work with clients presenting with DDB issues, work with clients who die, age, and death education) predicted measures of counselors’ death anxiety as measured by the Fear of Death and Death Avoidance scales of the DAP—R and as measured by the overall Death Anxiety score calculated from the DAP—R. The final four analyzed how well each predictive variable (experiences of personal threat, experiences of bereavement, work with clients presenting with DDB issues, work with clients who die, age, and death education) predicted measures of counselors’ death acceptance as measured by the Neutral Acceptance, Approach Acceptance, and Escape Acceptance scales of the DAP—R and as measured by the overall Death Acceptance score calculated from the DAP—R.
Validity

Threats to Internal Validity

Threats to the study’s internal validity included the possibility that instructions were not clear, questions were confusing, or participants might interpret questions incorrectly, or respond in a way they believe might be socially acceptable. Attempts were made to address these threats by seeking criticism of the survey’s instructions and questions and by taking steps to ensure participants know their participation is anonymous. There is also the threat that external events could affect participants’ responses. Such events cannot be fully controlled, but by making it possible to easily complete the survey within a short period, the influence of external events changing responses during the survey administration are reduced.

Threats to External Validity

The study design presented several possible limitations on generalizability. Participants self-selected making it possible actual participants in the survey differ significantly from the full population of professional counselors or even from the full ACA membership. To test for differences, the survey collected demographic information and that information was compared with information about the full ACA membership to see how well the demographics of the sample match the demographics of the full membership.

Summary

This study examined the effects various encounters with DDB issues has on counselors’ Death Anxiety and Death Acceptance. The motivation for conducting the study was driven by several factors:
First is the lack of attention DDB issues have received in the literature and in counselor training programs. Second is the strong likelihood that counselors will be working with increasing numbers of clients presenting DDB issues over the next several years. Third is my desire to document counselors’ reactions to DDB issues and to test the theory that direct confrontation with DDB issues increases counselors’ Death Acceptance while reducing their Death Anxiety.

Participants in the study were recruited from the American Counseling Association Network (ACANET) listserv, and the CESNET listserv. Participants were also recruited from three groups on the LinkedIn website: The Psychology Network group; The American Counseling Association group; and The Psychologists, Coaches, Psychotherapists, and Counselors group. Participants were asked to complete the Death Education and Death Experiences Survey detailing their experiences confronting DDB issues. Participants’ levels of Death Anxiety and Death Acceptance were determined by scoring their responses on the DAPR. Responses were analyzed using multiple regression analysis to determine the relative predictive values of six death encounters: personal threat, bereavement, age, work with clients presenting DDB issues, work with clients who have died, and death education.
CHAPTER 4

RESULTS

In this chapter, the results of the data analysis are presented. In the first section, the participants’ demographic characteristics are described. In the following section, the participants’ responses to the Death Experience and Death Education Survey (Appendix A), which provide the data for the predictor variables, are summarized. Responses to the Death Attitudes Profile—Revised (Appendix B), which provide data for the criterion variables, are presented. The statistical analyses conducted and their results are then described and how those results address the research questions is discussed.

Participants’ Demographics

Degrees and Licenses

Participants were 234 respondents to the recruitment message posted on two listservs and four professional groups on the LinkedIn professional networking site. Most participants (166, 70.94%) hold masters level degrees while the rest (68, 29.06%) hold doctorate level degrees. Of all participants, 156 (62.5%) hold an independent license, 66 (28.21%) hold a license to practice under supervision, and 12 (5.13%) do not hold a license. The following describes the demographic characteristics of the sample.

Of all participants 183 (78.2%) identified as female, 48 (20.5%) identified as male, and 3 (1.3%) identified as transgendered male. Participants’ identified sexual orientations were: 171 (73.1%) as straight, 24 (10.3%) as bisexual, 18 (7.7%) as gay, 12 (5.1%) as lesbian, and 9 (3.8%) as pansexual.
Ethnicity

Ethnicity distribution is shown in Table 1. Participants were predominantly White or Caucasian (191, 81.6%) and Latino or Hispanic (19, 8.1%).

Table 1

*Participants’ Ethnicity Distribution*

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<th>Ethnicity</th>
<th>Frequency (N = 234)</th>
<th>Percentage</th>
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<tr>
<td>White or Caucasian</td>
<td>191</td>
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<tr>
<td>Latino or Hispanic</td>
<td>19</td>
<td>8.1</td>
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<tr>
<td>Black or African American</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>Asian</td>
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<td>3.0</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>5</td>
<td>2.1</td>
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</table>

Comparison with ACA Population

The ACA provided information about ACA membership (V. Cooper, personal communication, February 5, 2013). Table 2 presents a comparison between the study sample and ACA membership. In many respects, the sample reflects the ACA membership, skewing slightly more female (78% for the sample versus 74% for ACA), more doctoral than master’s (29% versus 23%), more Hispanic or Latino (8% versus 2%), and more African-American (5% versus 3%).
Table 2

*Comparison of Demographics from the Sample and ACA Membership*

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Sample</th>
<th>ACA</th>
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<tbody>
<tr>
<td>Degree</td>
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<td></td>
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<tr>
<td>Master’s</td>
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<tr>
<td>Doctoral</td>
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<td>Ethnicity</td>
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<tr>
<td>Asian</td>
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<td>4%</td>
</tr>
</tbody>
</table>

*Religion, Spirituality, and Meaning*

A distribution of participants’ religious identification is presented in Table 3. Predominant identifications were Roman Catholic, mainline Protestant Christian, and agnostic each category with 30 participants (12.8%). The next highest identification was evangelical Protestant Christian with 24 participants (10.3%).
Table 3

Participants’ Religious Identification

<table>
<thead>
<tr>
<th>Religion</th>
<th>Frequency (N=234)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agnostic</td>
<td>30</td>
<td>12.8</td>
</tr>
<tr>
<td>Mainline Protestant Christian</td>
<td>30</td>
<td>12.8</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>30</td>
<td>12.8</td>
</tr>
<tr>
<td>Evangelical Protestant Christian</td>
<td>24</td>
<td>10.3</td>
</tr>
<tr>
<td>Buddhist</td>
<td>15</td>
<td>6.4</td>
</tr>
<tr>
<td>Atheist</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>None</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>Native American Spiritual Tradition</td>
<td>6</td>
<td>2.6</td>
</tr>
<tr>
<td>Jewish: Secular</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>Latter Day Saints</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>Other</td>
<td>69</td>
<td>29.5</td>
</tr>
</tbody>
</table>

Participants were also asked to identify the role religion, spirituality, and meaning play in their lives. The most frequent responses for Religion were: None (90, 38.5%), Important (84, 35.9%), and Very Important (30, 12.8%). The complete distribution is presented in Table 4. The most frequent responses for Spirituality were: Important (108, 46.2%) and Very Important (93, 39.7%). The complete distribution is presented in Table 5. The most frequent responses for Meaning were: Very Important (141, 60.3%) and Important (78, 33.3%). The complete distribution is presented in Table 6.

Table 4

Participants’ Description of the Role of Religion

<table>
<thead>
<tr>
<th>Role of Religion</th>
<th>Frequency (N=234)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>90</td>
<td>38.5</td>
</tr>
<tr>
<td>Important</td>
<td>84</td>
<td>35.9</td>
</tr>
<tr>
<td>Very Important</td>
<td>30</td>
<td>12.8</td>
</tr>
<tr>
<td>Negative</td>
<td>9</td>
<td>3.8</td>
</tr>
<tr>
<td>Highly Negative</td>
<td>6</td>
<td>2.6</td>
</tr>
<tr>
<td>N/A</td>
<td>15</td>
<td>6.4</td>
</tr>
</tbody>
</table>
Table 5

*Participants’ Description of the Role of Spirituality*

<table>
<thead>
<tr>
<th>Role of Spirituality</th>
<th>Frequency (N=234)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important</td>
<td>108</td>
<td>38.5</td>
</tr>
<tr>
<td>Very Important</td>
<td>93</td>
<td>35.9</td>
</tr>
<tr>
<td>None</td>
<td>18</td>
<td>12.8</td>
</tr>
<tr>
<td>N/A</td>
<td>6</td>
<td>6.4</td>
</tr>
<tr>
<td>Did not specify</td>
<td>9</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Table 6

*Participants’ Description of the Role of Meaning*

<table>
<thead>
<tr>
<th>Role of Meaning</th>
<th>Frequency (N=234)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Important</td>
<td>140</td>
<td>59.8</td>
</tr>
<tr>
<td>Important</td>
<td>80</td>
<td>34.2</td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>3.4</td>
</tr>
<tr>
<td>N/A</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Did not specify</td>
<td>4</td>
<td>1.7</td>
</tr>
</tbody>
</table>

**Measuring Predictor Variables**

**Correlations**

Correlations and descriptive statistics of predictor variables are presented in Table 7.

Table 7

*Predictor Variables: Correlations and Descriptive Statistics (N=234)*

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Threat</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Grief</td>
<td>.05</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Age</td>
<td>.07</td>
<td>.26***</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Client Hours</td>
<td>.24***</td>
<td>.10</td>
<td>.15*</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Client Deaths</td>
<td>.08</td>
<td>- .07</td>
<td>.27***</td>
<td>.10</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>6. Death Education</td>
<td>.07</td>
<td>- .01</td>
<td>- .09</td>
<td>.28***</td>
<td>.06</td>
<td>-</td>
</tr>
</tbody>
</table>

**M**

1.88 4.78 44.33 165.75 2.17 34.18

**SD**

2.68 2.84 13.09 159.94 4.70 72.01

**Range**

0-16 1-18 24-73 0-1,100 0-25 0-533
*p<.05. ****p<.001.

**Personal Experience of Having One’s Life Threatened (Threat)**

This was a continuous ratio variable. Participants were asked how many times they have experienced a life-threatening accident, disaster, or illness. Of all participants, 156 reported such an experience while 78 reported they had not had such an experience. Numbers of such experiences ranged from 0 to 17. The mean of the distribution was 1.885 and the standard deviation was 2.701. The distribution is presented in Table 8.

<table>
<thead>
<tr>
<th>Number of experiences</th>
<th>Frequency (N=234)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>78</td>
<td>33.3</td>
</tr>
<tr>
<td>1</td>
<td>50</td>
<td>21.4</td>
</tr>
<tr>
<td>2</td>
<td>56</td>
<td>23.9</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
<td>6.4</td>
</tr>
<tr>
<td>4</td>
<td>13</td>
<td>5.6</td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>5.6</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
<td>.9</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>16</td>
<td>2</td>
<td>.9</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>.4</td>
</tr>
</tbody>
</table>

**Personal Experience of Grief (Grief)**

This was a continuous ratio variable. Participants were how many times they have experienced the death of a loved one. All participants reported such an experience. The numbers of such experiences ranged from 1 to 19. The mean of the distribution was 4.782 with a standard deviation of 2.839. The distribution is presented in Table 9.
Table 9

*Participants’ Personal Experiences of Grief*

<table>
<thead>
<tr>
<th>Number of experiences</th>
<th>Frequency (N=234)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18</td>
<td>7.7</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>6.4</td>
</tr>
<tr>
<td>3</td>
<td>42</td>
<td>17.9</td>
</tr>
<tr>
<td>4</td>
<td>60</td>
<td>25.6</td>
</tr>
<tr>
<td>5</td>
<td>33</td>
<td>14.1</td>
</tr>
<tr>
<td>6</td>
<td>24</td>
<td>10.3</td>
</tr>
<tr>
<td>7</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>8</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>9</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>2.6</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>14</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>.4</td>
</tr>
</tbody>
</table>

**Age**

This was a continuous ratio variable. Participants were asked to report their age in years. Participants’ age distribution is presented in Table 10. Ages ranged from 24 to 74 with the mean age being 44.53.

Table 10

*Participants’ Age Distribution*

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency (N=234)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;26</td>
<td>6</td>
<td>2.56</td>
</tr>
<tr>
<td>26-30</td>
<td>42</td>
<td>17.94</td>
</tr>
<tr>
<td>31-35</td>
<td>33</td>
<td>14.10</td>
</tr>
<tr>
<td>36-40</td>
<td>15</td>
<td>6.41</td>
</tr>
<tr>
<td>41-45</td>
<td>33</td>
<td>14.10</td>
</tr>
<tr>
<td>46-50</td>
<td>28</td>
<td>11.97</td>
</tr>
<tr>
<td>51-55</td>
<td>28</td>
<td>11.97</td>
</tr>
<tr>
<td>56-60</td>
<td>14</td>
<td>5.98</td>
</tr>
<tr>
<td>61-65</td>
<td>16</td>
<td>6.83</td>
</tr>
<tr>
<td>66-70</td>
<td>9</td>
<td>3.84</td>
</tr>
<tr>
<td>71-75</td>
<td>10</td>
<td>4.27</td>
</tr>
</tbody>
</table>
Work with Clients Presenting with DDB Issues (Client Hours)

This was a continuous ratio variable. Participants were asked to report the number of treatment hours they have spent working with clients who have raised DDB issues. Responses ranged from 10 to 800, with a mean of 158.11 and a standard deviation of 120.85. The distribution is presented in Table 11.

Table 11

Participants’ Reported Hours Working with Clients Presenting with DDB Issues

<table>
<thead>
<tr>
<th>Hours</th>
<th>Frequency (N =234)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-100</td>
<td>70</td>
<td>29.91</td>
</tr>
<tr>
<td>101-200</td>
<td>131</td>
<td>55.98</td>
</tr>
<tr>
<td>201-300</td>
<td>14</td>
<td>5.98</td>
</tr>
<tr>
<td>301-400</td>
<td>6</td>
<td>2.56</td>
</tr>
<tr>
<td>401-500</td>
<td>7</td>
<td>2.99</td>
</tr>
<tr>
<td>501-600</td>
<td>1</td>
<td>4.27</td>
</tr>
<tr>
<td>601-700</td>
<td>4</td>
<td>1.71</td>
</tr>
<tr>
<td>701-800</td>
<td>1</td>
<td>4.27</td>
</tr>
</tbody>
</table>

Work with Clients Who Have Died (Clients Died)

This was a continuous ratio variable. Participants were asked how many clients they have worked with who have died, either during or following treatment. Responses ranged from 0 to 25, with a mean of 2.175 and a standard deviation of 4.70. The distribution is presented in Table 12.

Table 12

Reported Number of Clients Who Have Died
<table>
<thead>
<tr>
<th>Number of clients</th>
<th>Frequency (N=234)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>126</td>
<td>53.85</td>
</tr>
<tr>
<td>1</td>
<td>35</td>
<td>14.96</td>
</tr>
<tr>
<td>2</td>
<td>21</td>
<td>8.97</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>5.98</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
<td>2.56</td>
</tr>
<tr>
<td>5</td>
<td>12</td>
<td>5.13</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>.85</td>
</tr>
<tr>
<td>7</td>
<td>4</td>
<td>1.71</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>.85</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>.43</td>
</tr>
<tr>
<td>18</td>
<td>2</td>
<td>.85</td>
</tr>
<tr>
<td>20</td>
<td>6</td>
<td>2.56</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>1.28</td>
</tr>
</tbody>
</table>

**Death Education**

Death education was a continuous ratio variable that was derived from participants’ responses to four questions. The first question asked participants how many credit hours they took that were dedicated solely to DDB issues (they were reminded that a standard graduate course is 3 semester credit hours or 5 quarter credit hours). Participants were then asked whether their program was on a semester-hour or quarter-hour system. They were then asked to enter the number of classroom hours they spent in other courses, seminars, or workshops that were devoted to discussion of DDB issues. Finally, they were asked how many continuing education hours dedicated to DDB issues they have attended.

From responses to the first two questions, a total number of classroom hours was calculated. If participants reported their system was semester hour, the number they entered in the first question was multiplied by 15 (for the number of weeks in a standard academic calendar made up of semesters). If participants reported their system was quarter hour, the number entered in the first question was multiplied by 10 (for the number of weeks in a...
standard academic calendar made up of quarters). This number was added to the numbers entered in the final two questions to calculate the total hours of death education participants have received.

Participants’ reported death education hours ranged from 0 to 533, with a mean of 34.21 and a standard deviation of 71.96. The distribution is presented in Table 13.

Table 13

*Participants’ Reported Number of Death Education Hours*

<table>
<thead>
<tr>
<th>Number of Hours</th>
<th>Frequency (N = 234)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0</td>
<td>36</td>
<td>15.4</td>
</tr>
<tr>
<td>1.0</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>2.0</td>
<td>9</td>
<td>3.8</td>
</tr>
<tr>
<td>3.0</td>
<td>15</td>
<td>6.4</td>
</tr>
<tr>
<td>5.0</td>
<td>6</td>
<td>2.6</td>
</tr>
<tr>
<td>6.0</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>7.0</td>
<td>2</td>
<td>.9</td>
</tr>
<tr>
<td>8.0</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>10.0</td>
<td>15</td>
<td>6.4</td>
</tr>
<tr>
<td>11.0</td>
<td>6</td>
<td>2.6</td>
</tr>
<tr>
<td>15.0</td>
<td>6</td>
<td>2.6</td>
</tr>
<tr>
<td>16.0</td>
<td>2</td>
<td>.9</td>
</tr>
<tr>
<td>17.0</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>18.0</td>
<td>7</td>
<td>3.0</td>
</tr>
<tr>
<td>20.0</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>21.0</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>25.0</td>
<td>6</td>
<td>2.6</td>
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<tr>
<td>26.0</td>
<td>6</td>
<td>2.6</td>
</tr>
<tr>
<td>27.0</td>
<td>9</td>
<td>3.8</td>
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<tr>
<td>28.0</td>
<td>3</td>
<td>1.3</td>
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<tr>
<td>30.0</td>
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<td>2.6</td>
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<tr>
<td>31.0</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>33.0</td>
<td>2</td>
<td>.9</td>
</tr>
<tr>
<td>38.0</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>39.0</td>
<td>2</td>
<td>.9</td>
</tr>
<tr>
<td>45.0</td>
<td>6</td>
<td>2.6</td>
</tr>
</tbody>
</table>
Measuring Criterion Variables

Participants completed the Death Attitudes Profile—Revised (DAPR) (Wong, et al., 1994). The DAPR provides two Death Anxiety scales (Fear of Death and Death Avoidance) and three Death Acceptance scales (Neutral Acceptance, Approach Acceptance, Escape Acceptance). Summarized results from these scales are presented in Table 14.

<table>
<thead>
<tr>
<th>Score</th>
<th>Frequency</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>48.0</td>
<td>2</td>
<td>.9</td>
</tr>
<tr>
<td>49.0</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>51.0</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>60.0</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>63.0</td>
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<td>65.0</td>
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<td>75.0</td>
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<td>78.0</td>
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<td>80.0</td>
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<td>81.0</td>
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<td>.4</td>
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<td>82.0</td>
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<td>.9</td>
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<td>85.0</td>
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<td>.9</td>
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<td>87.0</td>
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<td>.4</td>
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<td>162.0</td>
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<td>.4</td>
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<td>167.0</td>
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<td>.4</td>
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<td>170.0</td>
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<td>206.0</td>
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<td>215.0</td>
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<td>.9</td>
</tr>
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<td>530.0</td>
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<td>531.0</td>
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<td>.4</td>
</tr>
<tr>
<td>533.0</td>
<td>1</td>
<td>.4</td>
</tr>
</tbody>
</table>

*Descriptive Statistics for Participants’ Scores on the Scales of the DAPR*
### Analysis of Data

To address the research questions, two sets of multiple regression analyses were conducted. The first set analyzed the relationship between the predictor variables and the Fear of Death, Death Avoidance, and Death Anxiety scales. The second set analyzed the relationship between the predictor variables and the Neutral Acceptance, Approach Acceptance, Escape Acceptance, and Death Acceptance scales.

### Death Anxiety Scales

In the first set of analyses, multiple linear regressions were calculated to predict Fear of Death, Death Avoidance, and Death Anxiety based on subjects’ personal experiences of a life-threatening nature (threat), personal experiences of grief (grief), age, hours working with clients presenting with DDB issues (hours), number of clients who died (died), and hours of death education (education).

For the Fear of Death analysis, a significant regression was found ($F(233)=5.793$, $p<.000$), with an $R^2$ of .133. The model is presented in Table 15. Of the six predictor variables examined, four proved to have a significant relationship to the criterion variable: Threat ($t = -2.974$, $p < .003$), Age ($t = -3.103$, $p < .002$), Hours ($t = -2.815$, $p < .005$), and Died ($t = 2.008$, $p < .046$). The model coefficients are shown in Table 16.
Table 15

*Regression Model for Fear of Death*

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>36.399</td>
<td>6</td>
<td>6.066</td>
<td>5.793</td>
<td>.000</td>
</tr>
<tr>
<td>Residual</td>
<td>237.731</td>
<td>227</td>
<td>1.047</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>274.130</td>
<td>233</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 16

*Coefficients for Fear of Death*

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>Std. Error</td>
</tr>
<tr>
<td>1 (Constant)</td>
<td>4.109</td>
<td>.258</td>
</tr>
<tr>
<td>Threat</td>
<td>-.076</td>
<td>.026</td>
</tr>
<tr>
<td>Grief</td>
<td>.014</td>
<td>.025</td>
</tr>
<tr>
<td>Age</td>
<td>-.017</td>
<td>.006</td>
</tr>
<tr>
<td>Hours</td>
<td>-.002</td>
<td>.001</td>
</tr>
<tr>
<td>Died</td>
<td>.030</td>
<td>.015</td>
</tr>
<tr>
<td>Education</td>
<td>.001</td>
<td>.001</td>
</tr>
</tbody>
</table>

For the Death Avoidance analysis, a significant regression was found (*F*(233) = 4.737, *p*<.000), with an *R*² of .111. The model is presented in Table 17. Of the six predictor variables examined, two proved to have a significant relationship to the criterion variable: Age (*t* = -3.018, *p* < .003), and Hours (*t* = -3.012, *p* < .003). The model coefficients are shown in Table 18.

Table 17

*Regression Model for Death Avoidance*

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>35.085</td>
<td>6</td>
<td>5.848</td>
<td>4.737</td>
<td>.000</td>
</tr>
<tr>
<td>Residual</td>
<td>280.212</td>
<td>227</td>
<td>1.234</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>315.298</td>
<td>233</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 18

*Coefficients for Death Avoidance*

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>Std. Error</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>3.954</td>
<td>.281</td>
</tr>
<tr>
<td>Threat</td>
<td>-.051</td>
<td>.028</td>
</tr>
<tr>
<td>Grief</td>
<td>.020</td>
<td>.027</td>
</tr>
<tr>
<td>Age</td>
<td>-.018</td>
<td>.006</td>
</tr>
<tr>
<td>Hours</td>
<td>-.002</td>
<td>.001</td>
</tr>
<tr>
<td>Died</td>
<td>.024</td>
<td>.016</td>
</tr>
<tr>
<td>Education</td>
<td>.002</td>
<td>.001</td>
</tr>
</tbody>
</table>

For the Death Anxiety analysis, a significant regression was found ($F(233)=5.862, p<.000$), with an $R^2$ of .134. The model is presented in Table 19. Of the six predictor variables examined, three proved to have a significant relationship to the criterion variable: Threat ($t=-2.52, p<.01$), Age ($t=-3.332, p<.001$), and Hours ($t=-3.061, p<.002$).

The model coefficients are shown in Table 20.

Table 19

*Regression Model for Death Anxiety*

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>36.003</td>
<td>6</td>
<td>6.000</td>
<td>5.862</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>232.378</td>
<td>227</td>
<td>1.024</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>268.380</td>
<td>233</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 20

*Coefficients for Death Anxiety*
Death Acceptance Scales

In the second set of analyses, multiple linear regressions were calculated to predict Neutral Acceptance, Approach Acceptance, Escape Acceptance, and Death Acceptance based on subjects’ personal experiences of a life-threatening nature (threat), personal experiences of grief (grief), age, hours working with clients presenting with DDB issues (hours), number of clients who died (died), and hours of death education (education).

For the Neutral Acceptance analysis, a significant regression was found ($F(233)=2.642, p<.017$), with an $R^2$ of .065. The model is presented in Table 21. Of the six predictor variables examined, two proved to have a significant relationship to the criterion variable: Age ($t = 1.230, p < .049$), and Education ($t = -1.990, p < .048$). The model coefficients are shown in Table 22.

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\beta$</td>
<td>Std. Error</td>
</tr>
<tr>
<td>1 (Constant)</td>
<td>4.065</td>
<td>.256</td>
</tr>
<tr>
<td>Threat</td>
<td>-.064</td>
<td>.025</td>
</tr>
<tr>
<td>Grief</td>
<td>.017</td>
<td>.024</td>
</tr>
<tr>
<td>Age</td>
<td>-.018</td>
<td>.005</td>
</tr>
<tr>
<td>Hours</td>
<td>-.002</td>
<td>.001</td>
</tr>
<tr>
<td>Died</td>
<td>.027</td>
<td>.015</td>
</tr>
<tr>
<td>Education</td>
<td>.001</td>
<td>.001</td>
</tr>
</tbody>
</table>
Table 21

Regression Model for Neutral Acceptance

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>10.312</td>
<td>6</td>
<td>1.719</td>
<td>2.642</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>147.654</td>
<td>227</td>
<td>.650</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>157.966</td>
<td>233</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 22

Regression Coefficients for Neutral Acceptance

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>Std. Error</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>5.369</td>
<td>.204</td>
<td>26.362</td>
</tr>
<tr>
<td></td>
<td>Threat</td>
<td>-.027</td>
<td>.020</td>
<td>-.119</td>
</tr>
<tr>
<td></td>
<td>Grief</td>
<td>-.029</td>
<td>.020</td>
<td>-.088</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>.005</td>
<td>.004</td>
<td>.081</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
<td>.001</td>
<td>.000</td>
<td>.187</td>
</tr>
<tr>
<td></td>
<td>Died</td>
<td>-.020</td>
<td>.012</td>
<td>-.116</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>-.002</td>
<td>.001</td>
<td>-.131</td>
</tr>
</tbody>
</table>

For the Approach Acceptance analysis, a significant regression was found 

\(F(233)=5.416, p<.000\), with an \(R^2\) of .125. The model is presented in Table 23. Of the six predictor variables examined, two proved to have a significant relationship to the criterion variable: Threat \((t = 4.076, p < .000)\), and Hours \((t = 2.924, p < .004)\). The model coefficients are shown in Table 24.

Table 23

Regression Model for Approach Acceptance

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>37.664</td>
<td>6</td>
<td>6.277</td>
<td>5.416</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>263.126</td>
<td>227</td>
<td>1.159</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>300.790</td>
<td>233</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 24

Regression Coefficients for Approach Acceptance

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>4.170</td>
<td>.272</td>
<td>15.335</td>
</tr>
<tr>
<td></td>
<td>Threat</td>
<td>.109</td>
<td>.027</td>
<td>-0.029</td>
</tr>
<tr>
<td></td>
<td>Grief</td>
<td>-.010</td>
<td>.026</td>
<td>-.024</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>-.003</td>
<td>.006</td>
<td>-.033</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
<td>.002</td>
<td>.001</td>
<td>.191</td>
</tr>
<tr>
<td></td>
<td>Died</td>
<td>-.022</td>
<td>.016</td>
<td>-.093</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>-.000</td>
<td>.001</td>
<td>-.029</td>
</tr>
</tbody>
</table>

For the Escape Acceptance analysis, a significant regression was found 

\(F(233)=5.125, p<.000\), with an \(R^2\) of .119. The model is presented in Table 25. Of the six predictor variables examined, four proved to have a significant relationship to the criterion variable: Threat \((t = 2.576, p < .011)\), Grief \((t = -2.112, p < .036)\), Age \((t = 3.066, p < .002)\),and Hours \((t = 2.826, p < .005)\). The model coefficients are shown in Table 26.

Table 25

Regression Model for Escape Acceptance

<table>
<thead>
<tr>
<th>ANOVA</th>
<th>Model</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regression</td>
<td>52.495</td>
<td>6</td>
<td>8.749</td>
<td>5.125</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>387.491</td>
<td>227</td>
<td>1.707</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>439.986</td>
<td>233</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

71
Table 26

*Regression Coefficients for Escape Acceptance*

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>Std. Error</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>2.812</td>
<td>.330</td>
</tr>
<tr>
<td>Threat</td>
<td>.084</td>
<td>.033</td>
</tr>
<tr>
<td>Grief</td>
<td>-.067</td>
<td>.032</td>
</tr>
<tr>
<td>Age</td>
<td>.022</td>
<td>.007</td>
</tr>
<tr>
<td>Hours</td>
<td>.002</td>
<td>.001</td>
</tr>
<tr>
<td>Died</td>
<td>-.012</td>
<td>.019</td>
</tr>
<tr>
<td>Education</td>
<td>-.001</td>
<td>.001</td>
</tr>
</tbody>
</table>

For the Death Acceptance analysis, a significant regression was found

\((F(233)=6.729, p<.000)\), with an R\(^2\) of .151. The model is presented in Table 27. Of the six predictor variables examined, four proved to have a significant relationship to the criterion variable: Threat \((t = 3.064, p < .002)\), Grief \((t = -2.004, p < .046)\), Age \((t = 2.051, p < .041)\), and Hours \((t = 4.162, p < .000)\). The model coefficients are shown in Table 28.

Table 27

*Regression Model for Death Acceptance*

<table>
<thead>
<tr>
<th>ANOVA</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td></td>
<td>Sum of Squares</td>
<td>Df</td>
<td>Mean Square</td>
<td>F</td>
</tr>
<tr>
<td>1</td>
<td>Regression</td>
<td>21.339</td>
<td>6</td>
<td>3.557</td>
<td>6.729</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>119.971</td>
<td>227</td>
<td>.529</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>141.310</td>
<td>233</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 28

*Regression Coefficients for Escape Acceptance*

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>4.117</td>
<td>.184</td>
<td>22.425</td>
</tr>
<tr>
<td></td>
<td>Threat</td>
<td>.056</td>
<td>.018</td>
<td>.193</td>
</tr>
<tr>
<td></td>
<td>Grief</td>
<td>-.035</td>
<td>.018</td>
<td>-.129</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>.008</td>
<td>.004</td>
<td>.136</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
<td>.002</td>
<td>.000</td>
<td>.267</td>
</tr>
<tr>
<td></td>
<td>Died</td>
<td>-.018</td>
<td>.011</td>
<td>-.110</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>-.001</td>
<td>.001</td>
<td>-.095</td>
</tr>
</tbody>
</table>

The Research Questions and the Analysis

**Research Question 1**

Does a personal experience of mortality through illness, accident, or disaster affect professional counselors’ levels of death anxiety and death acceptance? The hypothesis is that professional counselors who have experienced a life-threatening illness, accident, or disaster will show lower levels of death anxiety and higher levels of death acceptance than professional counselors who have not had such an experience.

The analyses showed a negative and significant relationship ($t = -2.525, p < .012$) between participants’ personal experiences of mortality and their Death Anxiety scores. This supports rejection of the null hypothesis. The analyses also showed a positive and significant relationship ($t = 3.064, p < .002$) between participants’ personal experiences of mortality and their Death Acceptance scores. This also supports rejection of the null hypothesis.
Research Question 2

Does a personal experience of grief affect professional counselors’ levels of death anxiety and death acceptance? The hypothesis is that professional counselors who have experienced the loss of a loved one will show lower levels of death anxiety and higher levels of death acceptance than professional counselors who have not had such an experience.

The analyses showed the relationship between participants’ experiences of grief and their Death Anxiety scores was not significant ($t = .679, p < .498$). The results do not allow rejection of the null hypothesis. The analyses also showed a negative and significant relationship ($t = -2.004 p < .046$) between participants’ experiences of grief and their Death Acceptance scores. While the relationship was significant, it was in the opposite direction that hypothesized, thus not allowing rejection of the null hypothesis.

Research Question 3

Does age affect professional counselors’ levels of death anxiety and death acceptance? The hypothesis is that professional counselors who are older will show lower levels of death anxiety and higher levels of death acceptance than younger professional counselors.

The analyses showed a negative and significant relationship ($t = -3.332, p < .001$) between participants’ age and their Death Anxiety scores. This supports rejection of the null hypothesis. The analyses also showed a positive and significant relationship ($t = 2.051, p < .041$) between participants’ age and their Death Acceptance scores. This also supports rejection of the null hypothesis.
Research Question 4

Does working with clients who present with DDB issues affect professional counselors’ levels of death anxiety and death acceptance? The hypothesis is that professional counselors who have worked with clients who present with DDB issues will show lower levels of death anxiety and higher levels of death acceptance than professional counselors who have not worked with such clients.

The analyses showed a negative and significant relationship ($t = -3.061, p < .002$) between the number of hours counselors worked with clients presenting DDB issues and their Death Anxiety scores. This supports rejection of the null hypothesis. The analyses also showed a positive and significant relationship ($t = 4.162, p < .000$) between the number of hours counselors worked with clients presenting DDB issues and their Death Acceptance scores. This also supports rejection of the null hypothesis.

Research Question 5

Does working with clients who die (either during or following treatment) affect professional counselors’ levels of death anxiety and death acceptance? The hypothesis is that counselors who have worked with clients who have died (either during or following treatment) will show lower levels of death anxiety and higher levels of death acceptance than professional counselors who have not worked clients who have died.

The analyses showed the relationship between the number of participants’ clients who have died and their Death Anxiety scores was not significant ($t = 1.812, p < .071$). The results do not allow rejection of the null hypothesis. The analyses also showed no significant relationship between the number of participants’ clients who have died and their
Death Acceptance scores ($t = -1.708, p < .089$). The results do not allow rejection of the null hypothesis.

**Research Question 6**

Does specific training in DDB issues affect professional counselors’ levels of death anxiety and death acceptance? The hypothesis is that professional counselors who have received specific training in DDB issues will show lower levels of death anxiety and higher levels of death acceptance than professional counselors who have not received such training.

The analyses showed the relationship between the number of participants’ death education hours and their Death Anxiety scores was not significant ($t = 1.582, p < .115$). The results do not allow rejection of the null hypothesis. The analyses also showed no significant relationship between the number of participants’ death education hours and their Death Acceptance scores ($t = -1.505, p < .134$). The results do not allow rejection of the null hypothesis.

**Summary**

In this chapter, the results of data collection and the analyses of the data were described. Also included were the study participants’ demographics and a summary of the participants’ responses on the predictor variables and their scores on the instrument used to analyze the criterion variables. The multiple regression calculations used to analyze the relationships between the predictor variables and the two criterion variables were explained. The results of those analyses provided evidence supporting three of the research hypotheses. The hypotheses of a negative relationship between participants’ experiences of mortality, age, and hours working with clients presenting with DDB issues and their Death
Anxiety scores were supported by the analyses. The hypotheses of a relationship between participants’ experiences of mortality, age, and hours working with clients presenting with DDB issues and their Death Acceptance scores were also supported by the analyses. The analyses failed to support the hypotheses of a negative relationship between participants’ experiences of personal bereavement, work with clients who died, or hours of death education and their Death Anxiety scores. The analyses also failed to support the hypotheses of a relationship between participants’ experiences of personal bereavement, work with clients who died, or hours of death education and their Death Acceptance scores.
CHAPTER 5
DISCUSSION

Purpose of the Study

The purpose of this study was to test the theoretical proposition that personal
encounters with mortality can help reduce death anxiety and increase death acceptance in
professional counselors. More specifically, the researcher examined whether experience
working with clients who present with DDB issues; a personal experience of loss; a
personal experience of one’s own mortality through illness, accident, or age; or
participation in a death education course or program can predict professional counselors’
levels of death anxiety and death acceptance. This data had not previously been collected
for professional counselors.

Findings

The results of the data analysis supported the first, third, and fourth hypotheses.
There was a significant relationship, in the direction hypothesized, between counselors’
experiences of personal mortality, numbers of hours working with clients presenting with
DDB issues, and age and their Death Anxiety and Death Acceptance scores. The analysis
did not support the other hypotheses. For client deaths and death education, no significant
relationship was found. For personal bereavement, there was no significant relationship
between number of experiences of personal bereavement and Death Anxiety. There was a
significant relationship between bereavement experience and Death Acceptance. However,
that relationship was in the opposite direction from that hypothesized. The analysis
indicated that as experiences of personal bereavement increased, Death Acceptance
decreased.
**Personal Threat**

The literature contains numerous studies of the effects an experience of personal mortality can have on individuals. Studied changes include personal and psychological growth (Martin & Kleiber, 2005; Yalom & Lieberman, 1991), post-traumatic growth (PTG) (Heffron, et al., 2009; Sawyer, et al., 2010; Tedeschi & Calhoun, 1996, 2004), a reduced sense of personal threat (Greyson, 1992), reduced death anxiety (Groth-Marnat & Summers, 1998), and reduced fear of death (Noyes, 1980). This study contributes to this body of literature in its finding that experiences of personal mortality can reduce death anxiety and increase death acceptance. However, this study provides new information with its focus on professional counselors and with its finding that counselors’ reactions to these experiences are similar to those outside the counseling profession.

Although the focus was on the Death Anxiety and Death Acceptance scales, the results were the same across all scales measured (Fear of Death, Death Avoidance, Death Anxiety, Neutral Acceptance, Approach Acceptance, Escape Acceptance, Death Acceptance) with two exceptions. The first is that the relationship between personal experiences of mortality and Death Avoidance was not significant. While there was a correlation consistent with the hypothesis, the lack of significance raises questions about whether this exception is the result of measurement error or a substantive difference in the relationship between experiences of mortality and Death Avoidance.

The more interesting exception is that experiences of mortality not only were not significantly related to Neutral Acceptance, but also that the relationship discovered was in the opposite direction to the hypothesis. Instead of these experiences correlating to increased Neutral Acceptance, they appear correlated to reduced Neutral Acceptance.
While it is possible that the findings could be the result of error, a re-examination of the literature on experiences of personal mortality and post-traumatic growth revealed interesting possibilities. The language used in such studies almost exclusively focuses on attitudes toward *life* following an experience of personal mortality. For example, Yalom (1989, 2008) speaks of *meaning and growth*. Sawyer and colleagues (2010) write of *reduced negative symptoms* and *well-being*. Hefferon and colleagues (2009) report re-evaluation of life and priorities, reappraised relationships, changes in life goals, and renewed appreciation of life. Finally, Tedeschi and Calhoun (2004) also speak of changes in priorities and relationships and increased appreciation for life.

However, the items on the DAPR (Wong, et al., 1994) Neutral Acceptance scale are clearly focused on attitudes toward *death* not *life*. In addition, the DAPR did not directly address how those who have an experience of personal mortality might score on a scale focused on death.

This difference of focus raises the possibility that, while those who have an experience of personal mortality might have a renewed appreciation of life, that experience might not have left them with an entirely neutral attitude toward the reality of death. This raises an interesting area for future research.

**Age**

The literature supports the idea that increased age has effects on individuals’ attitudes toward death. Those effects can include greater acceptance of death (Sands, 2009), reconstructing the sense of self and finding meaning (Sinnott, 2009), and increased life purpose and death acceptance (Reker, et al., 1987). This study was consistent with this previous work. This was particularly true with the significant inverse
correlations between age and scores on all three Death Anxiety scales and on the Escape Acceptance and Death Acceptance scales. In addition, although not significant, the relationship between age and the scores on the Neutral Acceptance scale were in the direction hypothesized.

The one unexpected result was the correlation between age and the scores on the Approach Acceptance scale. In this study, not only was that correlation not significant, it was in the opposite direction from that hypothesized. Thus, as age increased, Approach Acceptance decreased.

The analysis of the Approach Acceptance scores in the current study provided an interesting contrast to the hypothesis and to previous studies.

This study’s differing results could be the result of error. However, there is also the possibility that the characteristics of the subjects in the current study could have significant differences from those of the previous study. In the Wong and colleagues (Wong, et al., 1994) study, participants were a cross-section of residents of a middle-sized city. This means it is likely the participants’ religious identification reflected that of the U.S. population. In this study, subjects were licensed professional counselors and their religious identification included much higher percentage of atheists and agnostics than the U.S. population. As discussed previously, the wording of the questions on the Approach Acceptance questions could have resulted in differing responses based on religious identification.

These differing subject characteristics could also have contributed to the current study’s differing results on the Approach Acceptance scale. Again, in this study there was no significant correlation between age and scores on the scale. While this could be the
result of error, an examination of the items on the Approach Acceptance scale and the participant demographics of this study raise other possibilities.

Of the 10 questions on the Approach Acceptance scale, 9 refer to the concept of an afterlife and the other speaks of the “release of the soul” (Wong, et al., 1994, p. 134). However, in the current study, 30 participants (12.8%) labeled their religious identification as agnostic, 12 (5%) as atheist, and 12 (5%) as none. This contrasts with the U.S. population where less than 1% identify as agnostic, less than 1% identify as atheist, and 13.3% identify as no religion (U.S. Census Bureau, 2012). The specifically religious content of the Approach Acceptance scale, combined with the religious identification composition of the current study’s participants may help explain the findings.

Hours Working with DDB Issues

The literature does not speak directly to how the number of hours working with clients presenting with DDB issues affects counselors’ death attitudes. Terry and Bivens (1995) studied experienced death counselors’ (mean years of experience was 14) comfort with death-related counseling scenarios and found the experienced counselors were more comfortable with such scenarios than counseling students. A study by Haas-Thompson and colleagues (2008) also studied counselors’ death attitudes and found increased experiences of death were correlated with more positive attitudes toward death. However, neither of these studies specifically examined hours working with DDB issues.

In this study, this variable was the one most consistently correlated with the criterion variables on all the scales. Hours working with DDB issues was negatively and significantly correlated with scores on the Fear of Death, the Death Avoidance, and the Death Anxiety scales. This variable was also significantly correlated with scores on the
Neutral Acceptance, Approach Acceptance, Escape Acceptance, and Death Acceptance scales.

The predictive consistency of hours working with DDB issues in this study suggests a contrast between earlier studies that could be useful for counselor education. Terry and Bivens (Terry & Bivens, 1995) examined years of practice while Haas-Thomson and colleagues examined experiences of death. These are not variables that can be manipulated. However, this study’s finding that numbers of hours working with DDB issues is consistently predictive of useful changes in attitudes toward death opens the possibility that adding DDB scenarios to clinical training components could better prepare counseling trainees for working with these issues.

**Personal Bereavement**

The literature on how experiences of personal bereavement affects counselors’ death attitudes is mixed. Kouriatis and Brown (2011) found that personal bereavement can have positive and negative effects. The negative can include feeling personal pressure to react to loss “better” than others and, if their losses are unresolved, avoiding DDB issues with their clients. In the same way Hayes, et al. (2007) used the Texas Revised Inventory of Grief (TRIG) to categorize counselors’ reactions to personal bereavement as either Missing or Acceptance. They then surveyed the counselors’ clients asking them to rate the counselors’ levels of empathy. They found that higher Missing scores were significantly negatively correlated with clients’ ratings of therapists’ empathy. At the same time, higher Acceptance scores were significantly positively related to clients’ empathy ratings.
This study adds to this mixed view of the effect of personal bereavement on counselors as it found a significant relationship between the variable on only two of the seven scales. Interestingly, even on those two scales, the relationship was in the opposite direction than hypothesized. The study found that an increase in experiences of personal bereavement lowered counselors’ scores on the Escape and the Death Acceptance scales.

As discussed previously when examining the relationship between personal experience of mortality and the Neutral Acceptance scale, the literature on post-traumatic growth appears to emphasize changed attitudes toward life while the Neutral Acceptance scale focuses on attitudes toward death. This is even more the case for the wording on the Approach Acceptance scale. The scale speaks of “the burden of life,” “earthly suffering,” and “this terrible world” (Wong, et al., 1994, p. 134). If personal bereavement increases participants’ appreciation of life, it seems consistent that those participants might disagree with statements that indicate life is more something to be avoided than appreciated. In this study, it is also possible that the strength of that negative correlation also affected the overall Death Acceptance correlation as well.

**Client Deaths**

Several studies of client death describe a complex and difficult counselor reaction. Dwyer, et al. (2012) report isolation, removal from the formal grieving process, guilt, and reprocessing previous losses can follow the death of a client. Hendin et al. (2004) report the loss of a client to suicide can result in severe emotions including grief, guilt, shock, anger, and depression.

This literature makes it no surprise that this study shows the only significant correlation of client death is with Fear of Death and that correlation is in the opposite
direction than hypothesized. This result stands in contrast to this study’s other significant correlations on the Fear of Death scale. Client hours, personal threat, and age were all negatively correlated with Fear of Death. This indicates the experience of a client’s death has different effects on a counselor than do other encounters with mortality.

**Death Education**

There is evidence that death education programs can affect death attitudes. Barriere and colleagues (2008) studied a death education program for student nurses and found significant changes in attitudes following the program and particularly following work with dying patients. Haas-Thompson et al. (2008) found counselors who had completed a death education program had more positive attitudes toward death than did other counselors. Hutchison and Scherman (1992) studied the effects of a death education program on student nurses and found a significant overall reduction in students’ level of death anxiety following the program. Harrawood and colleagues (2011) conducted a qualitative study of counseling students who had completed a course on death education. The researchers found the program reduced negative emotions about death. Finally, Ober and colleagues (2012) found training in grief counseling was significantly related to personal competencies, conceptual skills and knowledge, assessment skills, treatment skills, and professional skills in grief counseling.

Given these studies it is surprising that this study found only a single significant relationship between death education and the criterion variables: Neutral Acceptance. In addition, that relationship was in the opposite direction than hypothesized. It is possible that relying on using hours as the sole measurement could have contributed to this result. It is
also possible that a few outliers who reported large numbers of death education hours might have affected the analysis.

**Limitations of the Study**

Study limitations included expected and unexpected limitations. Expected limitations included those of recruitment and the methodology of data selection. Unexpected challenges involved sample characteristics and the limits of the instrument employed.

The sample for the study was drawn from a recruitment through two counseling listservs and several online groups of counseling professionals. While the listservs and online groups may draw from a diverse population of counselors, the fact these counselors are actively involved in online professional activities may indicate a level of involvement in the profession that is not representative of the entire population of professional counselors. In addition, the recruitment method relied on participants’ self-selecting into the study and research indicates individuals who self-select in this way may not be representative of the larger population (Dillman, Smyth, & Christian, 2009).

Another important limitation is that the study’s data collection relied on self-report data. Self-report data presents two major challenges. First, it relies upon subjects’ memory, which may not be accurate. Second, it relies upon subjects’ reports of attitudes, reports which may be affected by various social considerations including acceptability or desires to please the researcher or influence the research results.

The first unexpected limitation occurred during the recruiting process. To ensure a large enough sample size, the sources selected for recruitment included online groups devoted to DDB issues. The result may have been a sample weighted toward those already
involved in working with DDB issues. While this increased the number of participants, it may have had the paradoxical effect of not adequately sampling precisely those counselors who might benefit most from this study; those not involved or actively avoiding DDB issues.

The other unexpected limitation was the instrument selected for measuring the study’s criterion variables. While the DAPR (Wong, et al., 1994) has research supporting its reliability and the validity of its constructs, the instrument may have limitations in exploring the attitudes of professional counselors. The first limitation is that the instrument was developed and tested with a sample of the general population and professional counselors differ in important ways with that population. The second limitation is that the instrument did not examine how attitudes might be shaped by specific experiences with DDB issues. Finally, the instrument was developed before much of the research into the construct known as post-traumatic growth (Hefferon, et al., 2009; Pieters, De Gucht, Joos, & De Heyn, 2003; Sawyer, et al., 2010; Tedeschi & Calhoun, 1996, 2004). That research generally reports encounters with mortality often have life-affirming consequences. However, that research does not specifically address attitudes toward death. The results of the current study suggest that reactions to encounters with mortality may include changes in attitudes toward life and attitudes toward death that are not necessarily correlated. In this area, this limitation suggests possible avenues for future research.

**Implications for Practice**

DDB issues present particular difficulties for professional counselors, particularly student counselors (Kirchberg & Neimeyer, 1991; Kirchberg, et al., 1998; McAdams & Foster, 2000; McAdams III & Foster, 2002). However, few counselor education programs
address DDB issues (Humphrey, 1993; Ober, et al., 2012). At the same time, current demographics in the United States (Robb, et al., 2003; Werner, 2011) and changing attitudes toward mental health treatment (Mojtabai, 2007) indicate counselors will be facing these issues more frequently in the immediate future. Given these realities, this study attempted to identify what factors contribute to counselors’ anxiety about death and their acceptance of death.

The three predictor variables that most consistently predicted outcomes were experiences of personal mortality, age, and work with clients presenting with DDB issues. Age and personal experiences of mortality are factors that cannot be manipulated. The implication is that the one action counselors and counselor training programs can take to help counselors develop helpful attitudes toward death is seeking out direct experience with clients who bring DDB issues to counseling.

The results of this study, combined with results from other studies into death education, suggest counselor education programs approach this topic in an experiential way. This means programs should help student counselors explore the ways they construct meaning and emotionally react to DDB issues (Chan & Tin, 2012). Perhaps more important, programs should find ways to expose students to working with clients who present DDB issues (Barrere, et al., 2008). This study’s finding that work with clients presenting with DDB issues was the most consistent predictor of reduced death anxiety and increased death acceptance supports this idea. Based on these findings, counselor education programs should find ways to encourage clinical-level students to work with such clients. And where programs use role-plays, those should be structured to ensure scenarios that involve DDB issues.
Future Research

This study suggests several areas for future investigation. Given the literature and this study’s results, one important area of study appears to be how counselors respond to the deaths of their clients. Several studies (Dwyer, et al., 2012; Hendin, et al., 2004; Knox, et al., 2006; Veilleux, 2011) describe the difficulties this experience raises for counselors. This study’s finding that client death is significantly related to increased levels of Fear of Death supports this idea.

This study’s unexpected finding that personal bereavement may reduce levels of Death Acceptance also suggests a future course of research. The limited literature (Hayes, et al., 2007; Kouriatis & Brown, 2011) investigating this topic provides mixed information about the effects of personal bereavement on counselors.

While the study found a significant relationship between personal experiences of mortality and all criterion variables, this area is one that is open to additional research. Research into this area has proposed varying constructs: fear of death, death anxiety, death acceptance. More recently, research has moved to the construct of post-traumatic growth (PTG). However, in the studies cited in this work, the definitions of these constructs, particularly PTG, vary considerably (Hefferon, et al., 2009; Martin & Kleiber, 2005; Sawyer, et al., 2010; Tedeschi & Calhoun, 1996, 2004). While all these constructs may reflect a different reality of the personal experience of mortality, further clarification could be helpful for student counselors, counselors, and counselor educators.

The study also suggests a possible area for research: Attitudes toward life and those toward death may be independent constructs. The study’s selected instrument, the DAPR, has solid research supporting its constructs. However, subsequent research into post-
traumatic growth (Hefferon, et al., 2009; Pieters, et al., 2003; Sawyer, et al., 2010; Tedeschi & Calhoun, 1996, 2004) more often speaks of attitudes toward life. This study’s results suggest these constructs may not be directly connected.

Finally, more research into effective death education in the counseling profession is needed. The difference between didactic and experiential death education has been a common theme in this area of research (Durlak, 1978; Hutchison & Scherman, 1992; Maglio & Robinson, 1994). Given that studies of death education programs for nursing students (Barrere, et al., 2008) and this study have found work with clients presenting DDB issues is significantly related to death attitudes, research into ways to provide these opportunities in counselor education programs could be important.

**Conclusion**

**Purpose of the Study**

This study was designed to study what factors affect professional counselors’ levels of death anxiety and death acceptance. This is an important concern because the U.S. population is aging, and professional counselors will be working with an increasing number of clients who bring DDB issues into counseling. DDB issues affect all counselors personally; the same cannot be said of other counseling issues. Given that most counseling programs do not directly address these issues, the goal was to discover whether there were factors affecting death attitudes that could be incorporated into counselor education training.

The study recruited 234 professional counselors who completed a survey of their experiences with 6 variables: personal experience of mortality, personal experience of bereavement, age, numbers of hours working with clients on DDB issues, number of clients
who have died, and number of hours of death education. The second part of the survey measured their self-reported levels of death anxiety (measured as levels of fear of death and avoidance of death) and death acceptance (measured as levels of neutral acceptance, approach acceptance, and escape acceptance).

Findings

Multiple regression analyses revealed several significant correlations. Counselors’ age was significantly and inversely correlated with all death anxiety scales and positively correlated with the Escape and overall Death Acceptance scales. Counselors’ experiences of a personal threat to their mortality was significantly and inversely correlated with Fear of Death and overall Death Anxiety and significantly and positively correlated with all Death Acceptance scales. The most robust relationship was the number of hours counselors spent working with clients presenting DDB issues. That variable was significantly and inversely related with all Death Anxiety scales and positively correlated with all Death Acceptance scales. These findings were consistent with the hypotheses underlying the study.

Implications

Of the results that supported the study hypotheses, the only factor that could be manipulated in counselor education is hours working with clients presenting DDB issues. The findings suggest that presenting counselor trainees with scenarios involving DDB issues could reduce trainees’ death anxiety and increase their death acceptance.

However, an examination of the results presented interesting avenues for future exploration. Most particularly, the unexpected positive correlation between client deaths and inverse correlation between personal bereavement and escape acceptance and overall
acceptance, combined with an examination of more recent literature on post-traumatic growth, suggests death acceptance may be a construct that is distinct from a possible construct that could be identified at life affirmation.

These results suggest counselor educators should consider finding ways to provide counseling trainees with increased exposure to DDB issues in training scenarios. The results also suggest that researchers consider exploring a possible construct of life affirmation and how that construct might be correlated with a death acceptance construct.
References


Definitions, 34 C.F.R. § 600.2 (2010).


Research Support, N.I.H., Extramural


Veilleux, J. C. (2011). Coping with client death: Using a case study to discuss the effects of accidental, undetermined, and suicidal deaths on therapists. Professional Psychology: Research and Practice, 42(3), 222-228. doi: 10.1037/a0023650


APPENDIX A

DEATH EXPERIENCES AND DEATH EDUCATION SURVEY

1. How many times have you experienced a life-threatening accident, disaster, or illness?
   Number of times: ____

2. If you have experienced a life-threatening accident, disaster, or illness, which of the following describes the experience’s immediate effects on your life?
   
   - Important harm
   - Some harm
   - No effect
   - Some growth
   - Important growth

3. If you have experienced a life-threatening accident, disaster, or illness, which of the following describes the experience’s long-term effects on your life?
   
   - Important harm
   - Some harm
   - No effect
   - Some growth
   - Important growth

4. How many times have you experienced the death of a loved one?
   Number of times: ____

5. If you have experienced the death of a loved one, which of the following describes how the loss immediately affected your life?
   
   - Important harm
   - Some harm
   - No effect
   - Some growth
   - Important growth

6. If you have experienced the death of a loved one, which of the following describes how the loss affected your life over the long term?
   
   - Important harm
   - Some harm
   - No effect
   - Some growth
   - Important growth
7. In your professional work, approximately how many hours have you spent with clients discussing DDB issues?
Number of hours: ____

8. In your professional work, how many clients have you worked with who have died during or after your work with the client?
Number of clients: ____

9. During your training program, how many classes were exclusively devoted to issues of death, dying, and bereavement (DDB)?
Number of classes: ____

10. Was your program on a semester-hour or a quarter-hour system?
Semester-hour □ Quarter-hour □

11. Of all your other classes, including your field work, approximately how many class or seminar hours were spent discussing issues of DDB?
Number of hours: ____

12. Following graduation, how many workshop, professional development, or continuing education hours have you spent discussing DDB issues?
Number of hours: ____
APPENDIX B

DEATH ATTITUDE PROFILE—REVISED

Wong, P.T.P., Reker, G.T., & Gesser, G.

This questionnaire contains a number of statements related to different attitudes toward death. Read each statement carefully, and then choose the extent to which you agree or disagree. For example, an item might read: “Death is a friend.” Indicate how well you agree or disagree by selecting one of the following: Strongly agree; Agree; Moderately Agree; Undecided; Moderately Disagree; Disagree; Strongly Disagree. Note that the scales run both from strongly agree to strongly disagree and from strongly disagree to strongly agree.

If you strongly agreed with the statement, you would choose Strongly Agree. If you strongly disagreed you would choose Strongly Disagree. If you are undecided, choose Undecided. However, try to use the undecided category sparingly.

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

1. Death is no doubt a grim experience.

2. The prospects of my own death arouses anxiety in me.

3. I avoid death thoughts at all costs.

4. I believe that I will be in heaven after I die.
5. Death will bring an end to all my troubles.

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6. Death should be viewed as a natural, undeniable, and unavoidable event.

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7. I am disturbed by the finality of death.

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8. Death is an entrance to a place of ultimate satisfaction.

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9. Death provides an escape from this terrible world.

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10. Whenever the thought of death enters my mind, I try to push it away.

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11. Death is deliverance from pain and suffering.

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12. I always try not to think about death.

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13. I believe that heaven will be a much better place than this world.

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14. Death is a natural aspect of life.

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15. Death is a union with God and eternal bliss.

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16. Death brings a promise of a new and glorious life.

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17. I would neither fear death nor welcome it.

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18. I have an intense fear of death.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Mostly Disagree</th>
<th>Undecided</th>
<th>Mostly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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19. I avoid thinking about death altogether.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Mostly Agree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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20. The subject of life after death troubles me greatly.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Mostly Agree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
<th>Disagree</th>
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21. The fact that death will mean the end of everything as I know it frightens me.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Mostly Agree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
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</table>

22. I look forward to a reunion with my loved ones after I die.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Mostly Agree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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23. I view death as a relief from earthly suffering.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Mostly Agree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
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24. Death is simply a part of the process of life.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Mostly Agree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
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25. I see death as a passage to an eternal and blessed place.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Mostly Agree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Mostly Disagree</th>
<th>Disagree</th>
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</table>
26. I try to have nothing to do with the subject of death.

27. Death offers a wonderful release of the soul.

28. One thing that gives me comfort in facing death is my belief in the afterlife.

29. I see death as a relief from the burden of this life.

30. Death is neither good nor bad.

31. I look forward to life after death.

32. The uncertainty of not knowing what happens after death worries me.
APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

1. What degrees do you have (check all that apply)?

- □ EdD
- □ EdS
- □ MA
- □ Med
- □ MPH
- □ MS
- □ MSW
- □ PhD
- □ PsyD
- □ Other ________

2. What kind of license do you have?

- □ No license
- □ First professional license (work under supervision)
- □ Independent license

3. What is your age?

Given that issues of bereavement and death and dying are approached differently by different cultures, faith traditions, and groups of people, your answers to the following questions could help gain further knowledge about how therapists and supervisors work with issues of bereavement and death and dying. All questions are optional.

4. How would you identify your primary cultural background?

- □ American Indian or Alaskan Native
- □ Asian
- □ Black or African American
- □ Latino or Hispanic
- □ Native Hawaiian or Pacific Islander
- □ White or Caucasian
- □ Prefer not to answer

5. If you identify with a second cultural background, what would that be?

- □ American Indian or Alaskan Native
- □ Asian
- □ Black or African American
- □ Latino or Hispanic
- □ Native Hawaiian or Pacific Islander
- □ White or Caucasian
- □ Prefer not to answer
6. What is your sex?
□ Female
□ Male
□ Transgendered
□ Intersexed
□ Prefer not to answer

7. How would you identify your sexual orientation?
□ Bisexual
□ Gay
□ Heterosexual
□ Lesbian
□ Prefer not to answer

8. What role does religion play in your life?
Highly negative          Negative          None         Important    Very important
□                        □                   □             □              □

9. What role does spirituality play in your life?
Highly negative          Negative          None         Important    Very important
□                        □                   □             □              □

10. What role does the idea of meaning play in your life?
Highly negative          Negative          None         Important    Very important
□                        □                   □             □              □

11. Which of the following best describes your spiritual or religious identification?
□ Agnostic
□ Atheist
□ Buddhist
□ Eastern Orthodox
□ Evangelical Protestant Christian
□ Hindu
□ Historically Black Protestant Christian
□ Jehovah’s Witness
□ Jewish Conservative
□ Jewish Orthodox
□ Jewish Reform
□ Jewish Secular
□ Latter-Day Saints
□ Mainline Protestant Christian
□ Muslim
□ Native American Spiritual Tradition
□ Roman Catholic
□ None
□ Other, please specify
____________________
APPENDIX D

PERMISSION TO USE THE DEATH ATTITUDE PROFILE—REVISED

Re: DrPaulWong.com: Permission to use DAP-R

to Michael

Dear Michael,

You have my permission to use the Death Attitude Profile—Revised for your research. I have attached a copy to this e-mail. I would be interested in a copy of your findings once your study is complete.

Kind regards,

Paul Wong
www.dpaulwong.com

On Tue, Feb 5, 2013 at 3:34 PM, Michael Mered-McCoy <katbob@umr.edu> wrote:

This is an enquiry e-mail via http://www.dpaulwong.com/perm.

Michael Mered-McCoy <katbob@umr.edu>

Dr. Wong,

I am a doctoral candidate at the University of New Mexico. I am interested in using the Death Attitude Profile—Revised for my dissertation, which is tentatively entitled "Influence of Death Education, Bereavement Loss, Practice Characteristics, and Age on Counselors' Death Anxiety and Death Acceptance." Can you please let me know what formal steps I should take to acquire permission to use this instrument in my research?

Many thanks,

Michael Mered-McCoy, MA, LPC

DAPR SCALE.pdf

Michael Mered-McCoy <katbob@umr.edu>

On Wed, Feb 6, 2013 at 11:14 AM, Michael Mered-McCoy <katbob@umr.edu> wrote:

I appreciate your quick response. I do have a couple of additional questions. With your permission, I will be administering the profile in the form of an online survey and so, instead of participants circling answers, they would see something like this:

If this is acceptable to you, I would also need to change the instructions for the profile to change “circle 50” (or 3A, etc.) to “Choose Strong Disagree.” I hope these changes would meet with your approval.

I also neglected to ask whether I have permission to include the actual instrument as an Appendix in my proposal and dissertation or if you would prefer I simply include a reference to the source.

Many thanks for your generous cooperation,

Michael

Paul TP Wong <urn.edu>

On Wed, Feb 6, 2013 at 11:47 AM, Paul TP Wong <urn.edu> wrote:

Dear Michael,

Those changes would be fine. Also, you may include a copy of the questionnaire in your Appendix.

Kind regards,

Paul Wong
www.dpaulwong.com