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THE PREPARATION OF GRADUATE HEALTH PROFESSIONALS FOR WORKING WITH BEREAVED CLIENTS: AN AUSTRALIAN PERSPECTIVE*

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ABSTRACT

Students enrolled in health profession courses require grief education so that, upon graduation, they are able to meet the needs of clients living with loss and grief. We investigated grief and loss education in six Australian university programs—medicine, nursing, counseling, psychology, social work, and occupational therapy—drawing from course documents and face-to-face interviews with key staff and final-year students. Only the counseling course included a dedicated grief and loss unit. The nursing, medicine, and occupational therapy courses emphasized end-of-life issues rather than a breadth of bereavement experiences. The social work course taught grief as a socially-constructed practice and the psychology course focused on grief and loss in addiction. Several factors influenced the delivery of grief education, including staffing, time, placement opportunities, student feedback, and needs of each profession. The study provides an indication as to how future health professionals are prepared for grief and loss issues in their practice.

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Most bereaved people will not seek professional help (Bonanno, Boerner, & Wortman, 2008); however, a significant minority of bereaved people seek and require professional support. A recent systematic review of the literature estimated that 10 to 20% of bereaved individuals develop complicated manifestations of grief (Lobb, Kristjanson, Aoun, Monterosso, Halkett, & Davies, 2010), which includes Prolonged Grief Disorder (Prigerson, Vanderwerker, & Maciejewski, 2008). Research has demonstrated that the presence of such complicated grief symptoms predicts negative physical and psychological outcomes including serious illness, suicidal ideation, and impairments in quality of life (Latham & Prigerson, 2004; Ott, 2003; Prigerson, Horowitz, Jacobs, Parkes, Aslan, Goodkin, et al., 2009). The interest in disordered bereavement is growing rapidly; Bereavement Related Disorder appears as an adjustment disorder in the draft Diagnostic and Statistical Manual of Mental Disorders (DSM), due for publication in 2013, and Prolonged Grief Disorder (formerly known as traumatic grief and Complicated Grief Disorder) is under review for inclusion (www.dsm5.org).

Despite this increasing interest in the provision of grief interventions, which are predominantly underpinned by psychological and psychiatric disciplines, a misalignment between contemporary grief research and current grief supports has been identified (Breen & O'Connor, 2007; Bridging Work Group [BWG], 2005; Center for the Advancement of Health [CAH], 2004; Neimeyer, Harris, Winkouer, & Thornton, 2011). For instance, research in the United Kingdom demonstrated that health professionals (counselors and general practitioners) had little to no awareness of contemporary models and understandings of grief, which emphasize grief as a complex, multidimensional, contextually-bound, and unique experience (Payne, Jarrett, Wiles, & Field, 2002; Wiles, Jarrett, Payne, & Field, 2002). This gap in knowledge was also demonstrated in a survey of 116 homicide bereavement counselors in the United States, which showed significant endorsement of the need to "work through" grief via intense emotional expression (Hatton, 2003). In Australia, interviews with six grief counselors indicated that, although their grief counseling practices were predominantly theory-driven, none of the counselors reported using empirical knowledge to guide their work (Coyne & Ryan, 2007). Similarly, interviews with 19 grief counselors in Australia revealed that most reported a lack of grief education in their formal studies and limited access to professional development opportunities related to grief and loss (Breen, 2011).

A potential barrier to effective grief interventions is the general lack of grief education offered to health professionals. Surveys of American, British, and Australian medical, nursing, pharmacy, and social work departments and schools demonstrated that most presented at least some information on grief but the information was limited and lacking depth or detail (e.g., Dickinson, 2007, 2012; Dickinson & Field, 2002; Dickinson, Sumner, & Frederick, 1992; Johnson, Chang, & O'Brien, 2009). A recent Australian study of nurses and care aides working in palliative care settings, where you would expect ongoing grief

education and professional development, demonstrated that fewer than half report receiving any such education (Lobb, Oldham, Vojkovic, Kristjanson, Smith, Brown, et al., 2010). Similarly, a survey of 320 general practice registrars receiving palliative care education in the United Kingdom revealed that 67 (20%) reported receiving no bereavement care training, and another 114 (36%) rated their bereavement care training as poor or very poor (Low, Cloherty, Wilkinson, Barclay, & Hibble, 2006). These studies and reviews highlight that the grief education of health professionals is underdeveloped. Further, the education that does exist tends to emphasize end-of-life issues and palliative care (e.g., Barclay, Wyatt, Shore, Finlay, Grande, & Todd, 2003; Dickinson & Field, 2002; Wass, 2004), rather than reflecting the full diversity of bereavement experiences.

It is important to note that while most grief counselors believe that their interventions are efficacious (Jordan & Neimeyer, 2003), research has demonstrated that grief interventions for those with "normal" grief demonstrate little to no beneficial effect (e.g., Currier, Holland, & Neimeyer, 2007; Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007; Schut, Stroebe, van den Bout, & Terheggen, 2001). Rather, interventions aimed at people with greater need are the ones that are most effective. Recent research demonstrates greater efficacy for interventions that are targeted to grievers with higher levels of distress (e.g., clinical symptomatology) and for bereaved people who meet the criteria for Prolonged Grief Disorder (Boelen, de Keijser, van den Hout, & van den Bout, 2007; Currier, Neimeyer, & Berman, 2008; Shear, Frank, Houck, & Reynolds, 2005). It could be that improved grief education to health professionals would enable them to differentiate between people with high and low bereavement need and intervene and refer appropriately (i.e., to specialist therapeutic services for the minority of bereaved people with high need and to community-based services and mutual-help groups for the majority with lower need).

Breen and O'Connor (2007) highlighted the need for a research agenda to embed the contemporary grief literature into the policies and practices of health professionals, in order to improve the supports offered to bereaved clients. The current study investigates where and how grief, loss, bereavement, death, and dying are embedded in health professional courses. The research question guiding the study was, "To what extent does current education and training of health professionals prepare them to work with bereaved clients/patients?"

METHOD

Multiple case study methodology (Yin, 1994) was used to document the presence and scope of grief education in undergraduate and graduate tertiary training programs for key health professionals likely to come across grief and loss issues in their practice—medicine, nursing, counseling, psychology, social work, and occupational therapy. Data consisted of course documents and interviews with key teaching staff and final year students.

Sample and Context

In Australia, grief interventions may be provided by a range of service providers, from not-for-profit organizations to private organizations and individuals, and by health professionals of various discipline backgrounds. Of the six health profession courses examined across five universities (four public, one private), five were undergraduate degrees while the psychology course was at Masters level with a clinical specialization. All courses met their respective professional accreditation and registration requirements. Twenty-nine people were interviewed—20 final year students and 9 teaching staff (Table 1). Australia has 39 universities and not all courses are offered at all universities. Further information would render the courses, and perhaps the staff and students, identifiable, and is not provided at the request of some course coordinators.

In Australia, a course (e.g., Bachelor of Arts, Bachelor of Occupational Therapy) comprises many units (e.g., Introductory Psychology, Anatomy). We examined six courses in their entirety, rather than individual units. Therefore, all the students commenting on the discipline were all in the same course, and all were final year students reflecting on their course. For each unit, the instructors typically comprise a unit coordinator, one or more lecturers (academic staff), and one or more tutors (often graduate students). The person in charge of the course is typically called the course coordinator.

Materials and Procedure

Edith Cowan University's Human Research Ethics Committee approved the research. We examined online information about each course (e.g., course structure, unit names and descriptions, student prospectuses) for the extent to which each course included attitudes toward death and dying, psychosocial experiences of grief and loss, and supports and interventions for the bereaved.

Table 1. Summary of Participants

	Students		Staff	
Course	Women	Men	Women	Men
Medicine	3			1
Nursing	4			1
Social work	2		2	
Psychology	3			1
Counseling	5		1	
Occupational therapy	2	1	3	

Online search functions were used to search for keywords, sentences, and phrases regarding the inclusion of grief, loss, and bereavement in the courses.

Each course coordinator (or equivalent) was contacted by letter and then a follow-up telephone call was made inviting them to participate in an interview and asking them to disseminate information about the study to their colleagues and final year students. Those who were interested were interviewed either face-to-face or via telephone, depending on participant preference. Topics covered included: whether grief and loss featured in the course; the content, including grief theories and theorists; methods of delivery (e.g., lectures, guest speakers, practicum placements, assessments, readings, clinical case discussions, videos); how the content had changed over the life of the course; and the background and experience of teaching staff (see Appendix). Mean length of interviews was 17.14 minutes (SD = 11.17). Each participant received a $50 book voucher.

Data Analysis

A matrix table was constructed with each university course in a row and information on each course in columns (e.g., the length of the course, mode(s) of study available, the extent to which the courses included content on attitudes toward death and dying, psychosocial experiences of grief and loss, and supports and interventions available for the bereaved). The matrix aided data reduction and provided a simplified way of presenting the information (Miles & Huberman, 1994). In order to maintain course confidentiality, neither unit names nor direct quotes from course materials appear in this article.

Each interview was transcribed verbatim. The analysis was informed by the strategy of constant comparison (Lincoln & Guba, 1985). The data analysis began as soon as possible after each interview with reading and re-reading of the interview transcripts. A summary of each interview was generated to aid further sampling and exploration of ideas in subsequent interviews. The coding process involved underlining and circling aspects of the transcripts and rewriting each idea as an abstract concept in the transcript margin. These codes were subsequently developed, refined, and integrated into themes. The emerging thematic scheme was continually refined throughout the analysis process and write-up of the findings. The process was aided by the comparison between the data and the existing literature, enabling a data-driven approach to interpretation. Finally, quotes from the participants illustrate the themes. The fourth author performed the document analysis and the second author conducted and transcribed the interviews, both under the supervision of the first and third authors. The first and second authors analyzed the interview data. The data and emerging interpretations were discussed among the team, which promoted rigor in the development of data themes.

FINDINGS AND INTERPRETATIONS

A case study of each course appears below.

Example One: Medicine

Elements of grief education feature throughout the 6-year medicine course. One unit delivered over the first 3 years focuses on health issues and aims to develop the communication skills of students. The fifth year of the course features a 2-week cancer module consisting of practical learning in hospital oncology wards complemented by lectures and tutorials. The module covers medical oncology, surgical oncology, radiation oncology, and palliative care, wherein students gain skills in cancer diagnosis and management. Student performance is assessed via a written case report and a ward assessment. A sixth-year unit focuses on emergency medicine and students learn about breaking bad news to patients. The lecturer stated:

> We sort of give a model of what environment you are going to break the news. So it has to be a private environment, make sure you are presentable and that you've got the right people that you are talking to, introduce yourself, and then explain that the patient has died, and then wait for the grief reaction after that.

The lecturer suspected that grief and loss was present in the psychiatry unit where students might get "exposure to posttraumatic stress disorder" and the "dying process in palliative care." Additionally, in this (their final) year, students undertake an 8-week medicine pre-internship consisting of a clinical placement and tutorial classes. Palliative care is one of several specialty areas included in the tutorials and students must complete a palliative care written case report assessment.

In reflecting on their course, one student felt that grief education was "sort of covered" and another felt that it was mentioned "a couple of times." A third student stated, "I can't specifically think of a time it was done." The first two students recalled learning about the "different ways grief can present," "shock" experiences after a terminal diagnosis, and "grief responses in different cultural backgrounds." One recalled, "We are not allowed to say 'I know what you are going through'—because you don't—or 'I understand.' It's more just about letting them react and giving them time."

The presence of grief education required time, opportunity, and negotiation of resources. The lecturer stated that some students gain first-hand grief and loss experiences in their clinical placements but the experience is "opportunistic." The lecturer explained that clinical placements are distributed among health disciplines offered at the university, restricting availability for medicine students. He stated, "Palliative care has a one week clinical placement. . . . We could try for longer but the problem is the availability of supervision and how

many students can you put in a hospice before it gets too crowded?" The lecturer thought that grief education could be coordinated throughout the course to avoid gaps and duplication among the different units:

> If I had to design a curriculum and have some grief education . . . I would prioritize . . . understanding what the grief process is, how to break bad news, how to deal with the acute grief reaction, and then recognizing pathological grief and knowing what to do about it or at least who to refer them on to. I think for a junior doctor they are more of the essential things that they need to know.

Two students felt that a "refresher" course in the sixth year would enhance their clinical skills. One student commented, "All the teaching is dealing with unwell patients; we haven't had anything on dealing with family members, for example, telling a family member that someone has just passed away. . . . That is something that you have to figure out." Another student reported that the course should include aspects of physician self-care. She said, "Students are very scared to tell a family member that someone has died. . . . Maybe just a bit more information and education about our personal response [and] not so much [focus on] getting the information across to other people."

Example Two: Nursing

Grief education appeared in a quarter of the course's units across the 3 years. The lecturer felt that the content on grief and loss was "reasonably well covered." However, the students had trouble recalling this content. For example, one stated, "Very little actually. . . . It was covered in only one unit that I can recall." Another student added, "We did about two weeks on grief and loss so it wasn't as much content as I would have liked personally but it was briefly covered." Despite the students' responses, the lecturer reported that "grief, loss and mourning" featured in two lectures in a counseling unit taught in third year. Grief education also appeared briefly in other units pertaining to community nursing, palliative care, ethical practice, and mental health. Additionally, students have the opportunity to complete a major (a specialist stream of study) in palliative care, which includes a palliative care placement and palliative care content throughout the course from its second semester.

The students and lecturer reported that the course content drew from Elisabeth Kübler-Ross's five stages of grief. In addition, the lecturer stated that Colin Murray Parkes's theory on grief and loss also featured in the course. These theories were used to "look at the process of grief and loss, anticipated grief and to help students define it and manage it" (lecturer). The students recalled learning about the "different types of grief," "loss of relationships," "loss of functions," "Indigenous loss," "grief and how it affects the family," how "nurses handle grief," and how to become "aware of your own grief" when working with dying patients. Lecture content on these topics was augmented with assigned readings. For instance, one student reported that one of the principal readings

for a counseling unit was a book that covered "the main components of interventions for grief counseling."

Two main issues appeared to affect the presence of grief education and these were the clinical experience of lecturers and the staff members' ability to keep up-to-date with the literature. One student reported she would have liked "a guest speaker . . . who has worked with grief and loss" to deliver the content. The lecturer described:

> To a great degree it's guided by our clinical experience. I mean because certainly when I teach I use real examples of issues for people. I think the other thing is that always make sure you are up-to-date with whatever the current trends are but also using topical issues. I think personal experience and sometimes telling them things that went wrong, you know? The patient rushed off and killed themselves and how do you deal with that because there is grief and anger all mixed up.

Two students reported being satisfied with the grief content and felt that the information had equipped them for their practicum placements. Two other students would have liked more integration of the units to emphasize skills for working with people dealing with grief and loss. To illustrate this point, one student stated, "rather than just wait for the counseling units, [grief education] could be introduced or integrated with other units on developmental psychology and mental health" while the other added, "Sometimes you can miss it [grief] because you don't have understanding of what to look for to help grieving families."

Example Three: Social Work

Grief education appears in one third year unit of this 4-year course. The unit focuses on social theory, social policy, and practice skills, and comprises three topics—aged care, working with children, and grief and loss—each of these is the focus for 3 weeks. One student described, "Grief and loss was given a couple of weeks of fleshing out and ruminating over so it was really well done." The content provides a historical account of grief and loss literature, which is taught from a critical theory perspective, and students are encouraged to reflect upon the different grief theories and to critique the concept of "grief work" (see Bonanno & Kaltman, 2000). According to the lecturer, the unit emphasizes that grief is a "socially constructed practice" and students are encouraged to appreciate "the uniqueness," "cultural differences," and "religious differences" of grief. For example, she stated she taught:

> . . . the history of the various models that have been used in the past and I critique those and end up with William Worden. . . . I point out that it is a very modernist view [referring to Worden] and it does suggest people have to get over the grief . . . and work through it. . . . It also suggests we all do it the same way.

The content is explored through readings, activities (e.g., discussing a personal loss with a classmate), watching DVDs (one on parenting children with a disability and the likelihood of ongoing and disenfranchised grief, and the other about a Rwandan project named "The Tree of Life," which examined grief experiences of orphans whose parents were massacred), self-reflection exercises, and two assignments, one of which required students to interview a person who has experienced grief and loss. The students were satisfied with this unit. One student described the unit as, "fantastic and it really made me understand death and dying and the process of grieving a lot better" and the other stated it was one of her "favorite units." However, the students would have preferred this content to be earlier in their course and connected with other content. One stated, "There wasn't like a previous unit that led onto that one and this didn't lead onto anything else . . . there was so much in there that they could have made a whole unit about it." The other student also commented that grief education:

> . . . wasn't really highlighted much at all until my first field practicum . . . [the unit with grief education] would have been quite relevant prior to placement, because I think a lot of placements were quite confronting and you didn't feel quite prepared for it [referring to grief].

The lecturers described four factors that drive course content including time constraints, a lecturer's theoretical background, the department's philosophy, and current theoretical trends. One stated, "I think there could be more of an idea of looking across the 4 years and perhaps seeing if grief and loss ought to be in there at a broader level." However, of great concern to both staff members is that the department is considering removing grief education from the unit, despite positive student evaluations of the unit. The other lecturer emphasized the importance of outside factors on the course and attempting to meet competing agendas:

> There are also some broader issues about what a social workers need to be able to practice. . . . You are trying to give students a tool kit and so there is quite a few areas to be covered and it competes with other things. . . . There are tensions in what employers are looking for and what we are aiming to do pedagogically and also what students are wanting to do.

Example Four: Psychology

The presence of grief education in this 2-year, graduate psychology course was limited and appeared in a second year unit on psychological aspects of addictions. The lecturer explained that grief is analogous to how clients may experience drug and alcohol addictions: "The analogy is that drug addiction is like falling in love and there is an emotional attachment there . . . stopping the drug is a bit like a grief process where someone has to adjust to life without it." Although the lecturer stated that the addictions unit incorporates Elisabeth Kübler-Ross's five stages of grief, he reported that the course does not "provide good enough coverage of grief."

One student recalled, "Some of the readings cover grief and loss but it wasn't mentioned in the lectures as such." Another student felt that grief education was not a component of her course. She stated, "I can't really recall throughout my study ever covering grief, loss, and bereavement." However, this student later added that a unit on social and behavioral health covered aspects of grief in postnatal depression and "the loss of a child or a miscarriage." The third student reported that a unit on health psychology covered "grief and loss in response to pain," "adjustment issues" following a disability, and "loss in functioning." Despite this, this student felt that grief was "mentioned but not really focused on at all."

Due to professional accreditation requirements, the course emphasizes, "getting trained with the DSM [text revision; American Psychiatric Association [APA], 2000] diagnosis and treatments rather than anything else" (lecturer). The lecturer also felt that it would be appropriate to introduce other "forms of grief" instead of "just limiting it to a Kübler-Ross model." The Better Access to Mental Health scheme (see Pirkis, Harris, Hall, & Ftanou, 2011) appears to affect course content:

> The whole Medicare system has brought in an increased focus on short-term therapy, so things like bereavement, which are considered a bit more complicated and a bit more experiential, have kind of dropped from the type of approach like CBT [cognitive-behavior therapy] for panic disorder that people have been trained up in. (Lecturer)

Students felt that practical strategies on how to work with a grieving client would be beneficial. For example, one student stated, "I would have definitely liked to cover more strategies, tools, or even just ways of wording and explaining things to make sense to a client." Another student reported she would like information on how grief may impede clinical practice and practical skills relating to working with a grieving client:

> They [referring to clients] may not be ready to take strategies to move forward in their associated depression if they are still in their early stages of grieving. So how does that interplay with intervention and how do you address and sit with the grief? What do you do with that, if that is going to be a factor that will prevent them to uptake normal manualized treatment?

Example Five: Counseling

This 3-year counseling course includes a dedicated bereavement and loss unit in its first year and includes an examination of attachment, grief, and loss as well as support strategies so that students are able to assist the bereaved. The lecturer reported that the goal of the unit was to cover "structured theories and frameworks" so that students can "feel secure to actually think about helping the person rather than being overwhelmed by the person's chaos or distress." The lecturer advised that the grief and loss unit covered a "range of models" including those of Elisabeth Kübler-Ross, John Bowlby, William Worden, Mal

McKissock, and Margaret Stroebe and Henk Schut. The students also recalled covering these theories; one student stated, "We covered a number of different theorists and it wasn't that there was only one way to do it or this is 'the' way to do it. It was broader-based." The lecturer reported that it was crucial to teach the breadth of grief experiences:

> I think what's important to cover in the course is a variety of responses that people have for loss and bereavement. . . . Whilst we don't specifically pay a lot of attention to that in the course it is highlighted for the students that they need to be aware of different cultural responses. So it's not sort of colonised mind that they go out with . . . but they have a broader mind particularly with integration into our population here of survivors from trauma, torture and war-torn countries.

The lecturer also reported a focus on loss responses to issues other than bereavement, including "loss of employment," "loss of a body part," and "loss of functioning through illness." One student supported this notion stating, "We did cover things about other losses, not just loss from death." Students also recalled learning about loss of relationships, "loss of identity," "anticipatory grief," and "complicated and uncomplicated grief." Another student added that the unit also focused on "how different groups, such as children, might deal with bereavement." Two students also added that the unit included specific counseling skills for grief and loss issues.

This unit comprised a 2-hour lecture and a 1-hour tutorial, with content delivered through lectures, guest speakers (e.g., a hospice counselor working with terminally-ill clients), videos and film extracts, group activities (e.g., role plays and case studies to develop grief counseling skills), and self-reflection exercises, all of which are specific to grief and loss. Three students described a group assignment requiring them to interview a grief counselor about working with grief and loss issues. This unit had William Worden's book, *Grief Counseling and Grief Therapy* as the main reading, which was supplemented with additional readings.

In addition to this dedicated unit, the lecturer reported that grief and loss issues also arose in other units of the course. Students added that grief and loss arose in other areas of the course including in their practicum placements and in course content relating to sexual abuse and mental health. They emphasized another unit focused on personal growth, which provided the opportunity to reflect on and share their experiences of grief and loss. One student stated:

> It's not counseling; the idea is that we share our personal experience. . . . So we talk about it and it's brought back to us individually, and it's learning of how to work through your own emotions. There is quite a lot of grief that comes up for people; we have lots of crying.

A student also stressed the importance of this unit in preventing transference and counter-transference in therapy, "So you get to know yourself more deeply so

that you are not going to sit there and be triggered by someone's grief because you haven't dealt with your own. So that's worthwhile."

The lecturer felt that the course material was influenced by two factors—staffing and student evaluations. She stated, "I think it's just a case of passing the baton to another runner. I think that when that happens it's a timely point for review. But . . . it is a lot of work to change." The lecturer also stated that the staff attend to student feedback and "adjust the direction of the course accordingly." An additional concern is the effect of the unit on students. The lecturer stated that other teaching staff in the course report that some students become "distressed and upset" by the grief and loss unit. She stated that they are aware that the unit may bring forth past grief and loss issues for some students, and that they try their best "to keep watch" and "support them through it."

Overall, the students appeared satisfied with the unit that incorporated grief and loss issues. For example, some comments included, "that unit that we did was excellent" and "I actually think it's covered pretty well." However, the students also made some suggestions for improving the unit, especially a greater focus on skill development. For instance, one stated, "Now I'm on placement and it would be good to have had more practice. So to put some of those things we've learned into practice before we go out into the workplace." Other students made suggestions concerning content, wanting more information on "different areas of loss," "suicide," "guest lecturers" working with grief and loss, and the "psychology of grief." Two students felt that an additional unit would better equip for grief and loss presentations. The lecturer also felt that an additional unit would be useful for students. She stated:

> I think there is a bigger space [for grief issues] that should be made in our course. I know that we don't have a lot of time to explore secondary losses, non-observable losses. . . . Often counselors are looking at what they can *do*[participant's emphasis]. . . . Perhaps I think it could be better integrated where a space in the course could have a practice-oriented unit to just give them tools and things they can do.

Example Six: Occupational Therapy

The lecturers acknowledged that there is no specific unit on grief and instead grief and loss issues appear in a quarter of this 4-year course's units. All six participants reported that Elisabeth Kübler-Ross's five stages of grief underpinned the grief and loss content covered throughout the course. One lecturer stated, "The main theory is the Kübler-Ross theory when we are talking about preparation for their own death and anticipated grief." One lecturer stated that she taught other concepts of grief such as "pathological grief where people get stuck" and "the process of avoidance, confrontation, and restoration" and "developing bonds and meaningful ways of remembering the deceased."

Throughout the course, issues of loss and grief are discussed primarily within the context of palliative care and included spirituality, meaning-making, and achieving a "good death" in older age. This information was delivered through guest speakers working in palliative care, palliative care workbooks, and a palliative care CD-ROM. In addition to the palliative care focus, the lecturers also felt confident that the students are exposed to a variety of loss-related issues relevant to disability and rehabilitation, including loss of functions and roles, and adjustment to disabilities, injuries, amputations, burns, arthritis, and fibromyalgia.

Two students felt that the course's grief and loss content was at the appropriate depth and relevant to their work. For example, one stated, "The units covering grief have taught me to be quite sympathetic toward certain situations. . . . It's very helpful for my prac[ticum] now." On the other hand, two students felt that the content on grief and loss issues was too brief, and one suggested "The grief content could be better incorporated. It could actually be given a unit on its own." All three students stated that the course should include content that is more practical. One suggested this information should be delivered in "a workshop" format consisting of "information for us to take with us. . . . Maybe like a communication module on how to communicate with patients and families in that phase." One student felt that the content was somewhat brief and lacking in its obvious relevance to occupational therapy practice:

> We did a unit on palliative care and I guess obviously that touches on grief and stuff like that but not particularly in relation to the role of an OT [occupational therapist]; it was more the role of the patient and their grief. With regards to dealing with grief from a therapist's perspective, no we haven't really dealt with that.

The staff members also expressed a desire for improved integration of grief education in the course. For example, one stated that she would like to dedicate more time to "burns, oncology and amputations and possibly also vision loss, [and to] actually dedicate a certain amount of time during those lab[oratorie]s to simply discuss grief." These comments were echoed by another lecturer who also wanted to incorporate strategies for working with grief and loss into the course. She stated:

> We might need to start implementing different strategies. . . . I think our students need to get a bit more information and a bit more of how to address somebody who has maybe lost a limb. . . . We need to understand what the person is going through mentally as well not just the fact that they can't dress themselves anymore.

Two issues affected the delivery of grief education and these were the difficulty in finding time within the course to explore grief and loss issues and the personal experiences and comfort of each lecturer in delivering grief and loss content. In terms of time, one lecturer felt that it was difficult enough to cover the various fields of occupational therapy in the course, therefore limiting the

time allocated for grief education. She stated, "I do 1 week on palliative care and we could have done weeks on it. . . . We had 5 hours [in] total and it was quite rushed." Two lecturers felt that the experience and comfort of teaching staff played a huge role in the delivery of grief education. One stated, "If you are not quite sure or don't feel comfortable talking about grief you might not be as open and sort of go into details as such and may be more inclined to gloss over things a bit." The other lecturer stated:

> One of the limitations I've had is that I am teaching this information but I've not worked in a palliative care setting so my understanding is primarily theoretical from what I have read and researched along with some limited personal experiences with losing grandparents and that type of thing.

DISCUSSION

The findings suggest that there are disciplinary differences in the presence, emphasis, and delivery of grief education in tertiary programs for health professionals. Of the six courses, only counseling included a dedicated grief and loss unit. The social work course taught grief as a socially-constructed practice and the psychology course focused on grief and loss in addiction. The nursing, medicine, and occupational therapy courses emphasized end-of-life issues rather than a breadth of bereavement experiences. This positioning of grief education within palliative care and/or end-of-life issues has been identified previously (Barclay et al., 2003; Dickinson, 2012; Dickinson & Field, 2002; Wass, 2004). While (in industrialized countries at least) the vast majority of deaths follow lengthy illness, the absence of information about sudden deaths, violent, and stigmatizing deaths, and/or deaths of children is a clear oversight in the courses we investigated.

Another oversight is the lack of attention to sociological contributions to grief education, with the courses tending to emphasize psychological and psychiatric aspects of grief and loss with little attention to the social contents of these phenomena. This is especially important as health professionals should ideally be able to differentiate between the majority of bereaved people with low to moderate need and the minority with high need and to intervene and refer appropriately (Aoun, Breen, O'Connor, Nordstrom, & Rumbold, 2012). Additionally, there is a need for more information on cultural differences in relation to grief and loss in order to reflect the full diversity of bereavement experiences. This is particularly important given that, with the exception of social work, the courses emphasized stage-based theories of grief. It is perhaps unsurprising that grief counselors tend to be influenced greatly by stage- and task-based notions in their practice (see Breen, 2011; Hatton, 2003; Payne et al., 2002; Wiles et al., 2002) to the detriment of more recent and empirically-based alternatives (Breen & O'Connor, 2007).

Implications for Policy, Practice, and Research

Although based within Australia, this small, exploratory study provides a snapshot of the presence and scope of grief education within Australian health professional curricula. Implications include enhancing our understandings of the ways in which contemporary grief literature could be incorporated into undergraduate and graduate health professional courses, and ways that health professionals might access education and training that allows them to work effectively with the diversity of grief experiences. The limited grief education in the courses examined is concerning given that health professionals will undoubtedly work with people who have been, or are, affected by grief and loss issues. Indeed, without appropriate training, their interventions are likely to be of little positive benefit and might even be deleterious (Currier et al., 2008). Given that disordered bereavement is likely to appear in DSM nosology, it is imperative that grief education be included in health professional curricula and in continued professional education opportunities for practicing health professionals so that professionals are competent in assessing bereavement need, offering treatment, and/or providing referrals. This point was emphasized recently in the context of palliative care service delivery (Aoun, Breen, O'Connor, Rumbold, & Nordstrom, 2012) but needs to occur beyond palliative care settings.

The courses used a range of teaching strategies to deliver grief education, including lectures, tutorials, guest speakers (e.g., hospice counselor), group activities (e.g., role plays, self-reflection, exploring personal losses), practical activities (e.g., case reports, ward assessments, interviewing either a grief counselor or a bereaved person), work placements and internships, texts and readings, and additional materials (e.g., films, workbooks, CD-ROM). Participants from five courses (psychology, counseling, occupational therapy, nursing, and medicine) acknowledged a desire for the inclusion of more applied knowledge and skills to help graduates meet the needs of clients and patients living with grief and loss, whereas the social work course appeared to be struggling with maintaining its existing grief education content, due to external pressures.

Balk (2005) provides excellent examples of classroom strategies and assessments to facilitate scholarship among human service practitioners who work with death and dying issues. Prigerson and Jacobs (2001) also provide a practitioner-friendly differentiation between "typical" and complicated grief as well as practical strategies for communicating with and caring for bereaved clients/patients. These strategies must be examined for their "fit" with each existing course and the varied factors that influence the delivery of grief education such as staffing (e.g., clinical experience and theoretical backgrounds, departmental philosophy), time, placement opportunities, student feedback, and current needs of each profession (e.g., professional accreditation requirements, employers). Furthermore, extending the limited grief education in health curricula could provide a foundation on which post-training professional development could be built. These

opportunities are important given that grief counselors express the desire for up-to-date, easily-accessible, quality continuing professional development opportunities that are relevant to their practice (Breen, 2011) and palliative care team members articulate a clear desire to provide psychosocial support to patients and families (O'Connor & Fisher, 2011).

Enhancing grief education offered to future health professionals has the potential to improve the delivery, efficacy, and relevance of grief supports and services provided by them, thereby benefitting bereaved client and patients. This move toward evidence-based practice in bereavement services is essential, given the current misalignment between bereavement research and practice (Breen & O'Connor, 2007; BWG, 2005; CAH, 2004; Neimeyer et al., 2011). Our preliminary findings provide the basis for a more structured national study, whereby the factors that facilitate and impede the incorporation of the latest grief literature into practice could be explicated on a nationwide basis. Thus, the study is a fundamental step toward evidence-based service provision that more readily reflects the latest grief literature and the diversity of grief experiences.

CONCLUSION

Grief education is of ongoing importance in health professions. Health professionals have a responsibility to be up-to-date in their knowledge and skills in order to meet the range of needs, not just psychiatric and psychological, of bereaved people. This study explored the presence and scope of grief education within undergraduate and graduate courses of six key health professions—medicine, nursing, counseling, psychology, social work, and occupational therapy. Although it is a small study, to our knowledge it is the first systematic investigation of the presence and scope of grief education within Australian health professional curricula. Investigating the extent to which health professionals are trained in grief and loss provides an indication as to how well future health professionals are prepared for dealing with grief and loss issues in their practice, an issue they will inevitably face.

APPENDIX
Interview Schedule

The purpose of this interview is to find out about where and how issues of grief and loss are embedded in the course here. I just want to remind you that the things you say will be treated in the strictest confidence and you won't be identifiable in the final report. I am particularly interested in your thoughts and opinions so please answer each question in your own words.

- Do you have any questions before we start?

First, I'd like to find out a bit more about the course you teach in/are enrolled in:

- Full name of course _____
- Year course began (if known) _____
- Length of course _____
- Approximate numbers of students currently enrolled_____
- Mode(s) of study
  - □ Full-time
  - □ Part-time
  - □ Internal
  - □ External

Now I'd like to find out a bit more about you:

- What is your discipline background/employment background?
- Experience in the field of practice?
- For students only—what brought you to this course?

What do you see as the most important issues that need to be covered in the course?

Does information on grief or loss or bereavement feature in this course?

- Where? (year of course, particular units, etc)

What content is covered?

- Any theories or theorists in particular?
- Why these theories or theorists?
- Has the grief and loss content changed over time? If yes, how so? If not, why not?
- What do you think are the most important things about grief and loss that should be included in the course?

How is it covered?

- (Course readings/texts; lectures; guest lecturers/guest speakers; practica; videos, clinical case discussions, etc.)
- Background of the lecturers?
- Core units or optional units?

Do you think the issues of grief and loss could be incorporate better in the course? Why? How so?

How important is grief education for [the profession]?

Thank you for participating in this interview today. Your answers have been really helpful to the understanding of where and how issues of grief and loss are embedded in the course here.

- Are there other questions you wished I had asked you or anything else you wish to talk about?

We've come to the end of my questions. Thank you for your time.

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REFERENCES

American Psychological Association (APA). (2000). *Diagnostic and statistical manual of manual disorders text revision* (4th ed.). Washington, DC: Author.

Aoun, S. M., Breen, L. J., O'Connor, M., Nordstrom, C., & Rumbold, B. (2012). A public health approach to bereavement support services in palliative care. *Australian and New Zealand Journal of Public Health, 36*, 14-16.

Balk, D. E. (2005). Scholarship, students, and practitioners: Bringing scholarship into the expectations of practitioners. *Death Studies, 29*, 123-144.

Barclay, S., Wyatt, P., Shore, S., Finlay, I., Grande, G., & Todd, C. (2003). Caring for the dying: How well prepared are general practitioners? A questionnaire study in Wales. *Palliative Medicine, 17*, 27-39.

Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of complicated grief: A comparison between cognitive-behavioural therapy and supportive counselling. *Journal of Consulting and Clinical Psychology, 75*, 277-284.

Bonanno, G. A., Boerner, K., & Wortman, C. B. (2008). Trajectories of grieving. In M. S. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of bereavement research and practice: Advances in theory and intervention* (pp. 287-307). Washington, DC: American Psychological Association.

Bonanno, G. A., & Kaltman, S. (2000). The assumed necessity of working through memories of traumatic experiences. In P. R. Duberstein & J. M. Masling (Eds.), *Psychodynamic perspectives on sickness and health* (pp. 165-200). Washington, DC: American Psychological Association.

Breen, L. J. (2011). Professionals' experiences of grief counselling: Implications for bridging the gap between research and practice. *Omega: Journal of Death and Dying, 62*, 285-303.

Breen, L. J., & O'Connor, M. (2007). The fundamental paradox in the grief literature: A critical reflection. *Omega: Journal of Death and Dying, 55,* 199-218.

Bridging Work Group (BWG). (2005). Bridging the gap between research and practice in bereavement: Report from the Center for the Advancement of Health. *Death Studies, 29*, 93-122.

Center for the Advancement of Health (CAH). (2004). Report on bereavement and grief research. *Death Studies, 28*, 491-575.

Coyne, E., & Ryan, M. (2007). Mapping the knowledge bereavement counsellors use in practice. *Grief Matters: The Australian Journal of Grief and Bereavement, 10*, 64-68.

Currier, J. M., Holland, J. M., & Neimeyer, R. A. (2007). The effectiveness of bereavement intervention with children: A meta-analytic review of controlled outcome research. *Journal of Clinical Child and Adolescent Psychology, 36*, 253-259.

Currier, J. M., Neimeyer, R. A., & Berman, J. S. (2008). The effectiveness of psychotherapeutic interventions of the bereaved: A comprehensive qualitative review. *Psychological Bulletin, 134,* 648-661.

Dickinson, G. E. (2007). End-of-life and palliative issues in medical and nursing schools in the United States. *Death Studies, 31*, 713-726.

Dickinson, G. E. (2012). Twenty-first century end-of-life issues in selected U.S. professional schools. *Illness, Crisis & Loss, 20*, 19-32.

Dickinson, G. E., & Field, D. (2002). Teaching end-of-life issues: Current status in United Kingdom and United States medical schools. *American Journal of Hospice and Palliative Care, 19*, 181-186.

Dickinson, G. E., Sumner, E. D., & Frederick, L. M. (1992). Death education in selected health professions. *Death Studies, 16*, 281-289.

Hatton, R. (2003). Homicide bereavement counseling: A survey of providers. *Death Studies, 27*, 427-448.

Johnson, A., Chang, E., & O'Brien, L. (2009). Nursing the dying: A descriptive survey of Australian undergraduate nursing curricula. *International Journal of Nursing Practice, 15*, 417-425.

Jordan, J. R., & Neimeyer, R. A. (2003). Does grief counseling work? *Death Studies, 27*, 765-786.

Latham, A. E., & Prigerson, H. G. (2004). Suicidality and bereavement: Complicated grief as psychiatric disorder presenting greater risk for suicidality. *Suicide and Life-Threatening Behavior, 34*, 350-362.

Lincoln, Y. S., & Guba. E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lobb, E. A., Kristjanson, L. J., Aoun, S. M., Monterosso, L., Halkett, G. K. B., & Davies, A. (2010). Predictors of complicated grief: A systematic review of empirical studies. *Death Studies, 34*, 673-698.

Lobb, E. A., Oldham, L., Vojkovic, S., Kristjanson, L. J., Smith, J., Brown, J. M., et al. (2010). Frontline grief: The workplace support needs of community palliative care nurses after the death of a patient. *Journal of Hospice and Palliative Nursing, 12*, 225-235.

Low, J., Cloherty, M., Wilkinson, S., Barclay, S., & Hibble, A. (2006). A UK-wide postal survey to evaluating palliative care education amongst General Practice Registrars. *Palliative Medicine, 20*, 463-469.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Neimeyer, R. A., Harris, D. L., Winkouer, H. R., & Thornton, G. F. (Eds.). (2011). *Grief and bereavement in contemporary society: Bridging research and practice*. New York, NY: Routledge.

O'Connor, M., & Fisher, C. (2011). Exploring the dynamics of interdisciplinary palliative care teams in providing psychosocial care: "Everybody thinks that everybody can do it and they can't." *Journal of Palliative Medicine, 14*, 191-197.

Ott, C. H. (2003). The impact of complicated grief on mental and physical health at various points in the bereavement process. *Death Studies, 27*, 249-272.

Payne, S., Jarrett, N., Wiles, R., & Field, D. (2002). Counselling strategies for bereaved people offered in primary care. *Counselling Psychology Quarterly, 15*, 161-177.

Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., Weideman, R., & Rosie, J. S. (2007). Group composition and group therapy for complicated grief. *Journal of Consulting and Clinical Psychology, 75*, 116-125.

Pirkis, J., Harris, M., Hall, W., & Ftanou, M. (2011). *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative evaluation*. Melbourne, Australia: Centre for Health Policy, Programs and Economics. Retrieved August 22, 2011 from http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-eval-sum

Prigerson, H. G., Horowitz, M. J., Jacobs, S. C., Parkes, C. M., Aslan, M., Goodkin, K., et al. (2009). Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS Medicine, 6*(8), e1000121.

Prigerson, H. G., & Jacobs, S. C. (2001). Caring for bereaved patients: "All the doctors just suddenly go." *Journal of the American Medical Association, 286*, 1369-1376.

Prigerson, H. G., Vanderwerker, L. C., & Maciejewski, P. K. (2008). A case for inclusion of prolonged grief disorder in DSM-IV. In M. S. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of bereavement research and practice: Advances in theory and intervention* (pp. 165-186). Washington, DC: American Psychological Association.

Schut, H., Stroebe, M. S., van den Bout, J., & Terheggen, M. (2001). The efficacy of bereavement interventions: Determining who benefits. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 705-727). Washington, DC: American Psychological Association.

Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F. (2005). Treatment of complicated grief: A randomized controlled trial. *Journal of the American Medical Association, 293*, 2601-2608.

Wass, H. (2004). A perspective on the current state of death education. *Death Studies, 28*, 289-308.

Wiles, R., Jarrett, N., Payne, S., & Field, D. (2002). Referrals for bereavement counselling in primary care: A qualitative study. *Patient Education and Counseling, 48*, 79-85.

Yin, R. K. (1994). *Case study research: Design and methods* (2nd ed.). Thousand Oaks, CA: Sage.

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