Grief and Bereavement Beliefs Among U. S. Mental Health Professionals and the General Public

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Keywords: Bereavement, assessment, beliefs, death education

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Abstract

The present study examined beliefs about grief and bereavement in a sample of mental health professionals and the general public in the United States. In part 1 of this study, we developed a 12-item questionnaire based on extant thanatology literature and expert review. In part 2, 210 participants rated their beliefs about grief and bereavement using this questionnaire. Participants rated most items accurately, and mental health professionals were more likely to answer items accurately compared to the general public. These findings provide support for increasing grief literacy in professional and public domains.

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Grief is an experience that all will encounter at some point in their life. Reactions to grief are unique to each individual, and specific reactions vary widely. Most people cope successfully with grief with the assistance of family and friends and do not require clinical attention by mental health professionals (Aoun et al., 2018; Jordan & Neimeyer, 2003; Stroebe et al., 2007). In one recent study, about 90% of respondents described family and friends as very or quite helpful in providing emotional support, practical assistance (e.g., food and transportation), and sense of belonging (Aoun et al., 2018).

Others seek out professional support during bereavement. Researchers noted that approximately 2 to 3% of people develop chronic and debilitating grief reactions after the death of a loved one (Shear, 2015). This type of response is termed *complicated grief* and is defined as "intense grief that lasts longer than would be expected according to social norms and that causes impairment in daily functioning" (Shear, 2015, p. 154). Research assessing the effectiveness of clinical interventions for complicated grief suggested that targeted treatment methods can be effective in reducing symptoms of complicated grief and improving psychological well-being (Shear, 2010; Simon, 2013; Wittouck et al., 2011).

For uncomplicated, or "normal" grief, the effectiveness of clinical interventions is less clear. Meta-analyses on the effectiveness of interventions for psychological and physical symptoms during uncomplicated bereavement report small effect sizes for treatment outcomes (Kato & Mann, 1999; Neimeyer, 2000). Additionally, Neimeyer (2000) concluded that 38% of individuals receiving counseling for grief had worse outcomes than those receiving no treatment. One explanation for these findings is that bereavement care interventions for uncomplicated grief

are not often informed by evidence-based practices (Kent et al., 2020). Others have noted an evidence-practice gap (Breen & Moullin, 2020), with calls for systemic approaches to improve bereavement care informed by research findings.

Myths and inaccuracies related to beliefs about grief and bereavement may play a role in the limited effectiveness of interventions during bereavement. Researchers have suggested that mental health professionals and the general public likely hold a number of myths about the process of grief and bereavement. In a widely cited article, Wortman and Silver (1989) described several common myths that persist despite an absence of empirical evidence: distress or depression is inevitable and failure to experience distress indicates pathology, bereaved individuals must work though a loss, there is a final stage of grief related to recovery, and one will reach a state of resolution or acceptance after working through a loss. Though some researchers have questioned the pervasiveness of these specific myths (e.g., Stroebe et al., 1994), Wortman and Silver (2001) concluded that "these myths are still prevalent among clinicians and the general public" (p. 424) in a follow-up article.

These common myths may be widespread. For instance, recent findings suggest that people are generally much more resilient to loss and trauma than is frequently assumed (Bonanno, 2004) and stage theories of grief (e.g., Kübler-Ross, 1969) lack empirical evidence and may even be harmful for those who believe they should grieve through discrete, set stages (Stroebe et al., 2017). Bonanno and Kaltman (1999) suggested Freud's concept of grief work (1957), which incorrectly assumed that severing the attachment bond to the deceased is a necessary part of bereavement, significantly influences many of the misconceptions found today.

Indeed, recent research findings suggest that a number of mental health professionals may be ill-equipped to respond effectively to bereaved clients. Among one sample of licensed

professional counselors, training and experience significantly predicted self-perceived grief counseling competencies, though over half of the sample lacked any course preparation related to grief (Ober et al., 2012). Additionally, participants were most familiar with Kübler-Ross' stage theory of grief compared to other theories with empirical support, such as task (Worden, 2009), meaning making (Neimeyer, 2001), continuing bonds (Klass, 2001), and the dual-process model (Stroebe & Schut, 1999). A recent study on the training experiences of therapists in university counseling centers found that few had received formal training in grief counseling, though a majority were either very interested or generally interested in learning more (Jankauskaite et al., 2021). Given these gaps in knowledge and training for mental health professionals, an empirical examination of grief and bereavement beliefs in this group is necessary.

Although there is little information about public beliefs about grief and bereavement, recent studies have highlighted discrepancies between research findings and commonly held beliefs. For example, one qualitative study examining community beliefs about grief in Australian adults found that most endorsed stage models of grief (Costa et al., 2007), and many considered the emotional expression of grief to be important during bereavement. This assumption is at odds with research findings suggesting coping and emotional flexibility, rather than emotional expression, may be more important factors in adjusting to distressing or traumatic events (Bonanno et al., 1995; Bonanno, Pat-Horenczyk, & Noll, 2011; Gupta & Bonanno, 2011).

Given the possibility of ineffective or even negative outcomes for clients seeking mental health care for grief (Kato & Mann, 1999; Neimeyer, 2000), additional examination of the accuracy of beliefs about grief and bereavement in mental health professionals is essential. Additionally, scholars have recently called for increased grief literacy and dialogue among the public (Breen et al., 2020), as family and friends are often the most common sources of support

for bereaved individuals (Aoun et al., 2018). As a result, we assessed the gap between research and practice (Breen & Moullin, 2020) in mental health professionals (e.g., psychologists, counselors, and others providing mental health care services) and the presence of inaccurate beliefs in the general public in the United States (U.S.).

Method

Participants

We analyzed data from 210 participants (61 mental health professionals) living in the U.S. for part 2 of this study. Among mental health professionals, 58 (95%) were licensed, and primarily employment included private practice 38 (62%), community agency 7 (12%), corrections facility 5 (8%), and 10 (17%) in another setting. Also, graduate training included clinical psychology 32 (53%), counseling psychology 10 (16%), mental health 7 (12%), social work 5 (8%), and other related fields 6 (9%). Their average length of work experience as a mental health professional was 24.43 years (*Mdn* = 22.00, *SD* = 12.32). In terms of perceived competency in issues related to grief and bereavement from a scale of 1 (*Not competent at all*) to 10 (*Extremely competent*), the average rating was 7.42 (*Mdn* = 8.00, *SD* = 1.84).

An error in the survey prevented 42% of participants from entering their current state of residence. Among those who could answer, mental health professionals listed 18 states, and the general public listed 13 states. See Table 1 for additional demographic items. In general, mental health professionals were on average 25 years older and much more highly educated than the general public.

Procedure

In part 1, we created an initial set of 20 statements based on a review of recent thanatology research. We identified the statements as either true or false based on how closely each statement corresponded to findings from recent research. For example, *The process of grief*

can be expected to progress through a predictable series of stages, starting with denial and ending with acceptance, was false based on a lack of empirical support for linear stage theories of grief (e.g., Stroebe et al., 2017; Wortman & Silver, 1989, 2001).

We identified 10 experts based on their research and/or membership on editorial boards of peer-reviewed thanatology journals. We sent an email to each expert asking them to access a link to rate 20 statements in their area of expertise. We used Qualtrics.com, an online survey platform that includes anonymous responding. A total of three experts completed the review. These experts rated their level of agreement with our assertions of a statement being true or false by selecting one of three responses for each statement (i.e., *I agree this statement is false, I do not agree that this statement is false, or Not enough information to determine if this is true or false*). We included a text box after each statement where expert reviewers could include any additional comments. We retained statements that received unanimous agreement as true or false for the final list. When experts disagreed, all members of the study team discussed the statement further to reach a consensus on the retention or exclusion of the statement for the final list. The final list was 12 items. The Institutional Review Board of the first author approved this project.

In part 2, a sample of mental health professionals and the general public completed the 12-item survey. In order to participate, participants had to affirm that they were 18 years of age or older and lived in the U.S. We used convenience and snowball sampling methods, including posting the survey link to social media websites (e.g., Facebook and Twitter) and listservs utilized by mental health professionals (e.g., state psychological association listservs) for recruitment. Prior to continuing past the informed consent page, participants indicated whether they were (a) a mental health professional, (b) a graduate student in a program that would allow them to engage in individual, group, or couples and family therapy with clients, or (c) neither.

Once participants confirmed they met eligibility requirements, they were able to continue with the survey, also hosted by Qualtrics.com, where they assessed the 12 statements on a scale from *Definitely True, Probably True, Probably False,* or *Definitely False.* We asked participants to select their best guess when they were unsure. A total of 270 individuals proceeded beyond the informed consent page. Data cleaning procedures resulted in a final sample of 210 after removing 49 because they did not complete any items on the survey, and 11 because they indicated they were currently a student in a mental health training program.

We determined response accuracy by assessing the percentage of participants who endorsed each statement in a way that corresponds with recent research findings. For example, we considered probably or definitely false as accurate for *The process of grief can be expected to progress through a predictable series of stages, starting with denial and ending with acceptance*.

Results

A majority of mental health professionals responded to the statements accurately except *About 20-30% of people who have experienced the death of a loved one will experience intense yearning, longing, or emotional pain, frequent preoccupying thoughts and memories of the deceased person, a feeling of disbelief or an inability to accept the loss, and difficulty imagining a meaningful future without the deceased person*. The average number of statements mental health professionals answered accurately was 9.21 (*Mdn* = 9.00, *SD* = 1.52). A majority of the general public sample responded to the same statement inaccurately, plus *The process of grief can be expected to progress through a predictable series of stages, starting with denial and ending with acceptance,* and *Responses to grief are typically consistent even when considering cultural differences*. The average number of statements the general public sample answered accurately was 6.88 (*Mdn* = 7.00, *SD* = 2.14). See Table 2 for a full summary of these ratings

along with the full text for each statement. Results of a Welch t-test indicated there was a statistically significant difference between the average number of accurately answered statements between the groups, $t(156.058) = 8.899$, $p < .001$.

We assessed bivariate correlations for total number of years in clinical practice, perceived competency in issues related to grief and bereavement, and total number of responses answered accurately for the mental health professional sample. Total number of accurate responses was not significantly related to years in clinical practice ($r = .04$, $p = .765$) or perceived competency ($r = .22$, $p = .096$). However, years in clinical practice was significantly correlated to perceived competency in issues related to grief and bereavement ($r = .26$, $p = .044$).

Discussion

Generally, these mental health professionals responded to most statements accurately, although there was some room for improvement. Specifically, there was wide recognition that most people do not develop a mental disorder after loss or need professional help to cope with grief, and that children grieve just as deeply as adults and should not be protected from pain that death creates. Room for improvement would be in understanding that grief does not necessarily progress through predictable stages, and in recognizing that only about 2 to 3% of people experience complicated grief (Shear, 2015). Accordingly, we recommend that mental health training programs highlight the symptomology and prevalence of concepts such as complicated grief.

The general public sample, in contrast, endorsed a little over half of the statements accurately. For instance, a majority of the general public sample mistakenly believed that stage theories of grief are accurate, overestimated how many people develop complicated grief reactions after the loss of a loved one, and mistakenly believed that responses to grief are

consistent across cultures. This corresponds to recent findings that suggest stage models continue to permeate public beliefs about bereavement (Costa et al., 2007). There has been a growing call by thanatology researchers to increase grief literacy in clinical, institutional, and public contexts (e.g., Breen et al., 2020; Noonan et al., 2016). We agree that these initiatives are necessary and warranted given the persistence of beliefs that are inconsistent with research findings about processes of grief and bereavement held by both mental health professionals and the general public.

Compared to the general public sample, mental health professionals were more likely to respond to all statements accurately except for statement 4, where there was no difference, and statement 6, where the general public sample responded in a more accurate manner. The general public may have slightly outperformed mental health professional on statement 6 due to the small number of university counseling center therapists in this sample. The difference, while statistically significant, was quite small (i.e., 75% compared to 67%). Though a larger sample of university counseling center therapists may have improved the rate of accurate responding for this statement, we recommend increased grief literacy related to college student bereavement for all mental health professionals.

Results of the bivariate correlation analysis suggest that total number of years in practice for mental health professionals is significantly and positively associated with perceived competence in issues related to grief and bereavement. Interestingly, total number of years in clinical practice and perceived competence were not significantly related to the total number of statements answered accurately by mental health professionals. As mental health professionals outperformed the general public on most statements, there could be other factors related to accurate grief and bereavement beliefs that we did not assess in this study. For instance, general

clinical knowledge gained in graduate mental health programs may increase one's ability to identify accurate responses to the statements posed in this study independently from number of years in practice. As most mental health trainees are interested in learning more about grief counseling (Jankauskaite et al., 2021), we recommend an increased focus on aspects related to grief and bereavement in graduate mental health training programs.

These findings must be interpreted in light of several limitations. One primary limitation is the relatively small sample size of both groups. Future research with larger sample sizes can allow for increased generalizability. We also recruited the sample exclusively online using convenience sampling methods. This sampling method limits participation from individuals without internet access and increases the risk for generalizability issues. Additionally, we do not account for additional factors beyond number of years in clinical practice and perceived competency in issues related to grief and bereavement that may be associated with actual competencies in mental health professionals. Future research should examine other factors that might predict competencies in working with bereaved clients (e.g., degree type, courses with a focus on grief and bereavement, continuing education, etc.). Another limitation is that, due to convenience sampling methods, our sample only covers a part of the U.S. population. It is unclear how these findings may apply to cultures and countries outside of the U.S. Finally, there may be a degree of ambiguity in some statements, making this method of rating difficult. For instance, though statement 4 includes a comprehensive definition of complicated grief, it is quite long. Participants might have had a difficult time identifying which part, if any, of this lengthy statement may be inaccurate. We recommend concise statements for future research in this area. Despite the aforementioned limitations, we hope that these findings provide a starting point for a more detailed quantitative assessment of bereavement beliefs and how these beliefs compare to

extant literature, particularly among mental health professionals, with a larger and more diverse sample.

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Table 1
Demographic Information for Mental Health Professionals and the General Public in the U.S.

Variable	Mental Health Professionals		General Public	
Age	*M* = 54.93 *SD* = 13.58 *Mdn* = 60.00		*M* = 29.87 *SD* = 15.00 *Mdn* = 21.00	
	n	%	*n*	%
Race				
African American/Black	0	0%	15	10%
Asian American/Pacific Islander	0	0%	1	1%
Hispanic/Latina/o	2	3%	5	3%
Multiracial	2	3%	3	2%
Native American/Indigenous American	0	0%	1	1%
White/Caucasian	52	85%	113	76%
Another race not listed	0	0%	6	4%
Not reported	5	8%	5	3%
Gender				
Man	11	18%	33	22%
Woman	45	74%	109	73%
Another gender not listed (e.g., “genderqueer, non-binary”)	0	0%	2	1%
Not reported	5	8%	5	3%
Highest Level of Education				
High school graduate	0	0%	16	11%
Some college	0	0%	79	53%
2-year college degree	0	0%	10	7%
4-year college degree	1	2%	20	13%
Master’s degree	19	31%	16	11%
Doctorate	36	59%	3	2%
Not reported	5	8%	5	3%

Table 2
Bereavement Beliefs

Statement	Mental Health Professionals	General Public	Empirical Support
1. The process of grief can be expected to progress through a predictable series of stages, starting with denial and ending with acceptance.	Definitely True: 8% Probably True: 38% **Probably False: 15%** **Definitely False: 39%**	Definitely True: 30% Probably True: 38% **Probably False: 13%** **Definitely False: 18%**	Neimeyer, 2000; Stroebe et al., 2017
2. People are more likely to show signs of resilience rather than long-term grief responses after experiencing the death of a loved one.	**Definitely True: 15%** **Probably True: 59%** Probably False: 20% Definitely False: 7%	**Definitely True: 10%** **Probably True: 46%** Probably False: 34% Definitely False: 10%	Bonanno, 2004
3. Older people are usually more anxious about death than younger people.	Definitely True: 3% Probably True: 26% **Probably False: 51%** **Definitely False: 20%**	Definitely True: 14% Probably True: 32% **Probably False: 42%** **Definitely False: 12%**	Fortner & Neimeyer, 1999; Russac et al., 2007
4. About 20-30% of people who have experienced the death of a loved one will experience intense yearning, longing, or emotional pain, frequent preoccupying thoughts and memories of the deceased person, a feeling of disbelief or an inability to accept the loss, and difficulty imagining a meaningful future without the deceased person.	Definitely True: 13% Probably True: 72% **Probably False: 13%** **Definitely False: 2%**	Definitely True: 37% Probably True: 56% **Probably False: 7%** **Definitely False: 0%**	Shear, 2015
5. People who do not become depressed after the death of a loved one are probably denying their true feelings.	Definitely True: 0% Probably True: 8% **Probably False: 41%** **Definitely False: 51%**	Definitely True: 4% Probably True: 27% **Probably False: 44%** **Definitely False: 26%**	Bonanno, 2004; Wortman & Silver, 1989; 2001
6. Approximately 25-30% of college students have experienced the death of someone within the past year.	**Definitely True: 3%** **Probably True: 64%**	**Definitely True: 15%** **Probably True: 70%**	Servaty-Seib & Taub, 2010

	Probably False: 33% Definitely False: 0%	Probably False: 14% Definitely False: 1%	
7. Most people develop a mental disorder after the death of a loved one.	Definitely True: 2% Probably True: 0% **Probably False: 20%** **Definitely False: 79%**	Definitely True: 3% Probably True: 21% **Probably False: 50%** **Definitely False: 25%**	Bonanno, 2004; Wortman & Silver, 1989; 2001
8. Responses to grief are typically consistent even when considering cultural differences.	Definitely True: 3% Probably True: 21% **Probably False: 43%** **Definitely False: 33%**	Definitely True: 4% Probably True: 50% **Probably False: 30%** **Definitely False: 15%**	Clements et al., 2003
9. It is typically more helpful for people to "move on" with their lives rather than think about memories of the deceased.	Definitely True: 2% Probably True: 12% **Probably False: 41%** **Definitely False: 45%**	Definitely True: 5% Probably True: 32% **Probably False: 41%** **Definitely False: 21%**	Boerner & Heckhausen, 2003
10. Most people need professional help to cope with grief.	Definitely True: 0% Probably True: 8% **Probably False: 38%** **Definitely False: 54%**	Definitely True: 5% Probably True: 34% **Probably False: 48%** **Definitely False: 11%**	Bonanno, 2004; Wortman & Silver, 1989; 2001
11. Bereaved children and adolescents do not grieve as deeply as adults.	Definitely True: 0% Probably True: 0% **Probably False: 18%** **Definitely False: 82%**	Definitely True: 3% Probably True: 20% **Probably False: 35%** **Definitely False: 40%**	Adams et al., 1999
12. Experts typically recommend that children should be protected from the pain and suffering that death creates.	Definitely True: 0% Probably True: 3% **Probably False: 43%** **Definitely False: 54%**	Definitely True: 7% Probably True: 29% **Probably False: 40%** **Definitely False: 23%**	Adams et al., 1999

Note. Bold ratings in the mental health professional and general public response sections are considered to have support from prior research.

Table 3

Frequencies and Chi-Square Results for Beliefs Reported by Mental Health Professionals and the General Public in the U.S.

	Mental Health Professional Response				General Public Response				
	Definitely or Probably True		Definitely or Probably False		Definitely or Probably True		Definitely or Probably False		
Statement Number	*n*	%	*n*	%	*n*	%	*n*	%	χ^2
1	28	45.90	33	54.10	102	68.46	47	31.54	9.33**
2	45	73.77	16	26.23	83	55.70	66	44.30	5.94*
3	18	29.51	43	70.49	69	46.31	80	53.69	5.04*
4	52	85.25	9	14.75	139	93.29	10	6.71	3.40
5	5	8.20	56	91.80	46	30.87	103	69.13	12.10***
6	41	67.21	20	32.79	127	85.23	22	14.77	8.79***
7	1	1.64	60	98.36	35	23.81	112	76.19	14.81***
8	15	24.59	46	75.41	80	54.42	67	45.58	15.46***
9	8	13.11	53	86.89	55	37.41	92	62.58	12.06***
10	5	8.20	56	91.80	58	39.46	89	60.54	19.95***
11	0	0	61	100	35	23.81	112	76.19	17.46***
12	2	3.28	59	96.72	53	36.05	94	63.95	23.81***

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

Note. The mental health professional sample had a response rate of 100% for all questions. The general public sample has a response rate of 100% for questions 1-6 and a 99% response rate for questions 7-12.