The authors argued that death competence, defined as specialized skill in tolerating and managing clients’ problems related to dying, death, and bereavement, is a necessary prerequisite for ethical practice in grief counseling. A selected review of the literature tracing the underpinnings of this concept reveals how a robust construct of death competence evolved. Using the vehicle of a case study, the authors analyzed an example of empathic failure resulting from an apparent lack of death competence on the part of a mental health provider to illustrate the importance of this characteristic in delivering clinically effective and ethically sensitive grief counseling.

With the proliferation of thanatology literature, counseling manuals and sheer numbers of medical and mental health professionals purporting to practice grief counseling (cf. Neimeyer, 2000), it is increasingly important to have standards in the field ensuring the basic competence of practitioners who work with the dying and the bereaved (Doka, 2003). This ethical mandate calling for competence in dealing with loss-related problems is even more compelling given that practitioners from many different disciplines and licensing sources conduct “domain-specific” work in thanatology.

Recently, Gamino and Ritter (2009) coined the term death competence to describe specialized skill in tolerating and managing clients’ problems related to dying, death, and bereavement. Their model of death competence builds on the work of previous...
theorists and reflects many of the competency provisions in the Code of Ethics of the Association for Death Education and Counseling (ADEC; 2006). Death competence is a construct that not only describes an essential feature of the therapeutic repertoire of grief counselors but also constitutes an ethical imperative when working with the dying and the bereaved. Competence on the part of health care providers is integral to ensuring adherence to two classic ethical principles: beneficence (i.e., accomplishing something helpful for the client by knowing how to effectively address the problem) and nonmaleficence (i.e., avoiding harm to the client through incompetent, ineffective, or deleterious actions; Beauchamp & Childress, 2008).

The aim of this article is to explore and extend the concept of death competence. Following a historical review of the literature, including development of the ADEC Code of Ethics (2006), Gamino and Ritter’s (2009) hierarchical model of death competence is revisited, including notation of certain impediments that may preclude a grief counselor from demonstrating death competence. A detailed case example of one antithesis of death competence—empathic failure—has instructive value in elaborating what is meant by death competence and, by omission, showing “what it takes” to effectively and sensitively counsel the bereaved.

### Historical Literature Review

In Herman Feifel’s (1959) groundbreaking scholarly text, The Meaning of Death, he quoted the 17th-century French writer and moralist, La Rochefoucauld: “One can no more look steadily at death than at the sun” (p. xiii). Yet, grief counselors who work with the dying and the bereaved are required to do just that every day—face death steadily. In the same edited volume, Kasper (1959) admonished physicians and health care workers to manage their countertransference feelings of fear, disillusionment, and weakness when working with the dying so as to comfort, offer hope, and help patients live life to the end as productively as possible. Management of one’s countertransference in the face of imminent death is one of the building blocks of death competence.

Influenced in part by publication of Elisabeth Kübler-Ross’s (1969) landmark work, On Death and Dying, many medical schools began introducing formal curricula for student physicians to
encounter the reality of death and their personal feelings evoked by dying patients (cf. Barton, 1972; Liston, 1973; Noyes, 1971). A notable example was the work of Worden and Proctor (1976), who published a provocative text designed for teaching medical students how to understand and confront their own death-related feelings. The authors devised an ingenious series of exercises to bring students into fuller awareness of their attitudes and feelings related to death. Examples of these exercises include contemplating the “time-line” of one’s own life, encountering various death scenarios while recording one’s subjective responses, and depicting a graphic representation of how death is understood. Worden and Proctor sought to desensitize readers by increasing their personal death awareness and reducing their denial or avoidance of death. Such training is essential for health care professionals who must have the capacity to tolerate intense emotions triggered by the prospects of death and loss if, in fact, they expect to work effectively with the dying and the bereaved. These characteristics of self-awareness and tolerance for strong emotion are precursors of a contemporary concept of death competence.

Later, Sanders (1984) warned how professional competence can be threatened when therapists fail to manage their own countertransference after a client dies by suicide. In addition to grief reactions of sadness, anger, and guilt, suicide can engender shame, helplessness, and a loss of “therapeutic omnipotence.” At the same time, experiencing the suicide death of a client can lead to deeper sensitivity and keener compassion. Sanders highlighted the necessity for professionals who work with dying, death, and bereavement to confront not only their existential powerlessness over death but also their human vulnerability to grieving the death of a client. By inference, an inability to manage such feelings and reactions precludes professional competence.

Similar admonitions came from Bertman (1991) based on her work using visual and literary art to train medical students, physicians, nurses, and counselors about death. Bertman emphasized that professional providers must first reflect on their own losses and understand how they coped with loss in order to truly empathize with other people’s grief. When countertransference reactions arise, competent grief counselors recognize the personal sources of their feelings, embrace that knowledge to enhance their
understanding of the griever’s anguish, and seek consultation when necessary.

The ability of grief counselors to manage their own death anxiety is one aspect of handling countertransference. Kirchberg, Neimeyer, and James (1998) replicated an earlier study (Kirchberg & Neimeyer, 1991) in finding that neophyte counselors ranked client situations involving death and loss significantly more uncomfortable to confront than other life crises, such as sexual assault, marital problems, or drug abuse. Conversely, practitioners with many years of experience counseling the dying and bereaved rated such situations as less distressing to address than other problem areas (Terry, Bivens, & Neimeyer, 1995). Accruing experience with grief counseling appears to reduce counselors’ apprehensions in confronting death-related situations and therefore potentially build death competence.

In a detailed treatise on grief and loss problems generating chronic sorrow, Roos (2002) identified therapist qualities necessary for effective intervention. She used the term *potency* to refer to therapists “knowing what [they are] doing and [doing] it with confidence” (p. 184). In addition to fundamental knowledge about the nature of loss, Roos described six specific qualities necessary for a therapist to be experienced as trustworthy and able to inspire hope. These qualities included (a) an ability to maintain focus, (b) consistency with regard to goal-directed work, (c) a spirit of rational confidence, (d) perceptive and empathic accuracy, (e) respectful acknowledgment of the client’s pain, and (f) competence in timely and parsimonious interventions. Although these attributes can be applied generally to the enterprise of psychotherapy and counseling, the qualities of perceptive and empathic accuracy and respectful acknowledgment of the griever’s pain have particular importance when treating those bereft by a major loss in their lives. In order to be effective, grief counselors must “tune in” to an individual’s subjective experience of loss by apprehending empathically that griever’s emotional and phenomenological reality and conveying an accurate understanding of the suffering and distress involved.

The perceptive and empathic accuracy described by Roos (2002) depends on listening. Graybar and Leonard (2005) referred to the willingness to listen and the ability to understand as the two greatest capacities of the psychotherapist. They view empathic...
listening as the “mortar” that binds and connects counselor and client in a successful helping relationship:

Listening and being listened to are the cornerstones of psychological development, psychological relatedness, and psychological treatment. It is hard to imagine an intimate, close or curative relationship where listening does not occur, or where one does not feel seen through the process of being heard. The need to be listened to is never outgrown. Being listened to allows us to be understood in all our complexity. It allows our experiences to count and ourselves to matter. Being listened to is not an optional experience. It sustains us throughout the life cycle. (Graybar & Leonard, 2005, p. 3)

When grief counselors listen empathically and understand accurately, clients perceive that they are “heard” and their story of loss is validated, thus setting the stage for the timely and parsimonious interventions (Roos, 2002) needed to help them assimilate their losses and accommodate more adaptively.

Katz (2006b) reiterated the countertransference challenges faced by professional caregivers who apply their skills specifically in grief counseling:

Our professional work with the dying and the bereaved is extremely personal in nature...we, as “experts,” cannot responsibly divorce ourselves from this whole—nor from the alchemical reaction that occurs when two individuals engage together at what is, perhaps, the most vulnerable time in a human being’s existence, the end of life. (p. 6)

Developing personal awareness (i.e., knowing oneself well enough to understand when and how personal issues influence one’s responses as a provider of grief counseling) is the key to detecting the presence of countertransference. Katz (2006a) suggested grief counselors identify what drew them into end-of-life work, what experiences with losses or endings they have had, and what motivates their ongoing interest in grief—all de rigueur elements of a contemporary construct of death competence.

**ADEC Code of Ethics**

The Code of Ethics published by ADEC (2006) contains several provisions pertaining to professional competence in the specific domain of thanatology-related work. Similar to the aspirational
principles included in other professional codes (cf. American Psychological Association, 2002), the ADEC Code of Ethics includes Basic Tenets that set the tone for how grief counselors should conduct themselves at all times. These Basic Tenets state first that professional work be “based upon a thorough knowledge of valid death-related data, methodology, and theory rather than stereotypes or untested hypotheses” (Basic Tenet 1). Simply put, grief counselors must “know their stuff” in order to practice ethically. Second, grief counselors are exhorted to “understand [their] death-related feelings and experiences and the ways in which these may impact [their] thinking and work in the field” (Basic Tenet 2). The self-awareness prescribed by Worden and Proctor (1976) and Bertman (1991) is so critical for the successful, and ethical, endeavor of grief counseling that its importance cannot be overemphasized.

The ADEC Code of Ethics (2006) also contains several specific provisions addressing competence (II. Competence, A–E). These provisions call for “continually [striving] to attain higher levels of competence” through continuing education and professional growth so that one’s knowledge and skills remain current. Practitioners should “accept only those positions and assignments for which they are professionally qualified,” and “provide only those services and utilize only those techniques for which their training and experience qualifies them.” Grief counselors respect themselves and others by adhering to “the limits and boundaries of their professional competence and in no way represent themselves as having qualifications beyond those which they possess.” Again, accurate self-awareness should lead to judicious decision-making about what one is capable of doing professionally so that grief counselors “do not engage in professional activities when it is likely that personal problems or impairment may prevent them from performing such activities in a competent manner.”

Although these latter provisions on competence from the ADEC Code of Ethics (2006) are more general in nature and parallel codes of other mental health associations (e.g., American Counseling Association, 2005; American Psychological Association, 2002), the former provisions cited from the Basic Tenets of the ADEC Code of Ethics are more specifically targeted to those working with the dying and the bereaved, and thus represent
maturation in the field of thanatology as grief counselors strive to practice with the highest ethical standards (see Worden, 2009a).

**Competencies in Psychotherapy**

In their textbook on ethics in psychotherapy and counseling, Pope and Vasquez (2007) drew a distinction between “intellectual competence” for therapy and “emotional competence.” Intellectual competence consists of knowing about the subject matter that governs one’s professional practice and knowing how to apply that knowledge in psychotherapy for the benefit of one’s clients. This definition is similar to Roos’s (2002) notion of potency—knowing what to do and doing it with confidence. It harmonizes well with the ADEC Code of Ethics (2006) in requiring that professional work be based on a sound, credible knowledge base.

For Pope and Vasquez (2007), emotional competence involves knowing oneself and accepting one’s limits as a fallible human being. Self-knowledge informs therapists of their emotional strengths and weaknesses as well as their capacities and limits for doing psychotherapy. Pope and Vasquez emphasized the therapist’s ability to withstand emotional stress and strain arising from the intensely interpersonal work of therapy. Emotional competence requires monitoring one’s own emotions experienced in therapy—particularly strong feelings such as anger, hate, fear, sadness, or sexual stirrings—and preventing any potential compromise in performance as a result of one’s affective responses, such as acting out these feelings rather than using them to understand affectively the client’s position and to intervene more effectively. For Pope and Vasquez, maintaining emotional competence requires constant application of self-care strategies to prevent becoming chronically distressed, drained, or demoralized (cf. Becvar, 2003; Gamble, 2002; Norcross & Barnett, 2008).

**Death Competence**

Incorporating many of the historical antecedents discussed so far, Gamino and Ritter (2009) introduced the term death competence and proposed the hierarchical model shown in Figure 1 as an illustration of this construct. They defined death competence as specialized skill in tolerating and managing clients’ problems related to dying,
death, and bereavement. They believe cognitive competence and emotional competence are essential components necessary to support a more developed and refined level of death competence.

Gamino and Ritter’s (2009) definition of cognitive competence (i.e., “what the counselor knows”) is conceptually similar to Pope and Vasquez’s (2007) description of intellectual competence and to Roos’s (2002) notion of potency. Cognitive competence refers to consolidation of sound academic training and supervised field experience culminating in proven proficiencies that constitute the counselor’s expert knowledge and skill set that is the basis for professional licensure in one’s respective discipline. ADEC has published a Handbook of Thanatology in an effort “to develop a comprehensive resource covering the fundamental and foundational knowledge in thanatology” (Balk, Wogrin, Thornton, & Meagher, 2007, p. v) and as a preparation manual for practitioners seeking ADEC’s Certification in Thanatology to prepare themselves for work in the field of dying, death, and bereavement. Cognitive competence also includes discriminating who needs grief counseling (cf. Currier, Neimeyer, & Berman, 2008; Gamino, Sewell, Hogan, & Mason, 2009–2010; Schut, Stroebe, van den Bout, & Terheggen, 2001) and using empirically supported treatment methods (see Shear, Frank, Houck, & Reynolds, 2005).
Emotional competence, as defined by Gamino and Ritter (2009), refers to the grief counselor’s capacity “to endure the emotional rigors of the therapy process, with its attendant graphic discussions of conflict, trauma, loss, anguish and suffering” (p. 35). This capacity requires psychological resilience, adequate strategies for ongoing self-care, and timely support from other colleagues.

Whereas Pope and Vasquez (2007) emphasized a therapist’s ability to manage intense feelings arising during the course of treatment as their definition of emotional competence, Gamino and Ritter (2009) proposed the additional concept of death competence to incorporate managing one’s own death-related feelings when working with problems of dying and bereavement. Particularly when death is tragic, traumatic, horrific, gruesome, or violent, grief counselors must be certain of their ability to tolerate such descriptions, monitor their internal responses, and maintain therapeutic objectivity and perspective. Additionally, grief counselors must understand and accept their own loss history and emotionally integrate those experiences in order to accomplish effective use of self when counseling the dying and the bereaved. In this sense, Gamino and Ritter’s concept of death competence builds on the work of earlier theorists who addressed the rigors of working specifically with death-related problems. Certainly, attempting to provide grief counseling without a demonstrated level of death competence fails to meet the basic standards for the profession outlined in the ADEC Code of Ethics (2006).

Gamino and Ritter (2009) identified four common impediments to the development of death competence among counselors. First, if unfinished business regarding the death of a loved one propels an individual to enter the field of grief counseling, the drive to heal oneself can impose on the therapy encounter and result in the discussion serving the counselor’s unmet need rather than addressing the client’s agenda. Second, if the practitioner is hampered by inordinate levels of death anxiety, this can lead to an avoidant or overly circumspect interaction style that serves to “protect” the provider from overwhelming anxiety rather than meeting the genuine needs of the client. Third, if zealous or underinformed counselors overgeneralize from their own loss experience to compensate for an insufficient knowledge base, they can fall prey to “counselor-centric” or formulaic thinking that does not honor individual differences or adequately reflect the client’s unique experience, thus violating the
ethical principle of autonomy and the right to self-determination (cf. Beauchamp & Childress, 2008). Fourth, if aspiring grief counselors lack a personal history of loss, care must be taken to ensure that they understand their own emotional responses to the prospect of death and can use that self-awareness in working with the dying and the bereaved. Gamino and Ritter also provided a self-assessment tool for practitioners to gauge their level of death competence, including honestly facing one’s own mortality as evidenced by having a Professional Will stipulating how to care for one’s clients and one’s practice in the event of untimely death or disability.

Having traced the historical evolution of the concept of death competence, we now turn to a case example. Exploring the operation of death competence in everyday clinical practice illustrates its pivotal importance for therapeutically effective and ethically conscientious delivery of grief counseling.

Case Example

The following case example was drawn from a research interview (Gamino et al., 2009–2010) with a bereaved participant describing her attempt to get grief counseling.

“Corrie” (a pseudonym) was a widow in her early 30s who sought grief counseling after the sudden death of her second husband. She had been married previously and had a 10-year-old daughter from her first marriage that she and her second husband were raising. They also had a son together, age 2, making theirs a household of four. Corrie worked as a kindergarten teacher, and her husband worked the evening shift in maintenance for a local municipality. Her parents lived in the same community and provided back-up care for the children when needed.

Corrie’s husband, also in his early 30s, was thought to be in good health. He was bothered frequently by complaints of “acid reflux,” but had no known symptoms of heart disease. However, he telephoned her from work one evening asking her to pick him up because he did not feel well. On the way home, he complained that his chest hurt. He was short of breath and felt numb on his left side. They stopped only briefly for him to change out of his muddy work clothes before going on to the local emergency room. Their son was with them, but the daughter was visiting her natural father.
At the emergency department, Corrie put her husband in a wheelchair, and they were registered by a clerk. Corrie expressed concern that maybe he was having a heart attack, but the clerk dismissed that possibility because of the husband’s young age and proceeded with the paperwork. While answering insurance questions, the husband made a guttural sound and “passed out.” Staff immediately mobilized to take him into the treatment area and tried unsuccessfully to resuscitate him for about 30 min before pronouncing him dead from a heart attack. She was “in shock” at the turn of events and only remembered being ushered back into the treatment area where she spoke briefly to the physician and then viewed her husband’s body. Her parents came and picked up Corrie and her son. Corrie’s sister stayed with her.

Because Corrie’s in-laws had to travel from out-of-state, the funeral did not take place until 5 days later. Corrie spent most of that time either sleeping from exhaustion or holding vigil at the funeral home. She found selecting a casket to be very hard because that physical object made his death so “permanent.” Corrie greeted many sympathizers and cried a lot. The funeral and burial services brought her no comfort. Seeing her husband’s body in the open casket and watching it close were particularly “hard.”

To make matters worse, Corrie’s young son had laryngitis during the few days preceding the funeral so she took him to their primary care physician. She asked the medical doctor to refer her for grief counseling and an initial session with a licensed professional counselor was scheduled for later that week, the day after the funeral and burial. Corrie had never had any prior mental health treatment. Yet, she knew she was not coping well and thought this might help. As it turned out, her experience was that the counselor did not help at all.

In Corrie’s recollection, the counselor’s opening inquiry was worded as follows, “What is it that you think is wrong with you?” She was immediately taken aback and felt that was a “stupid” question. In her mind, surely the counselor already knew that her husband had died so this approach seemed like “a waste of time.” From there, the experience got no better. Because Corrie felt so put off at the beginning, “I didn’t have much to say.” The subsequent questions were judged to be simplistic and elemental, as if “anyone could have asked them.” There was no apparent attempt to provide concrete suggestions for coping.
Corrie described herself as a shy person who takes a while to “warm up” to people. She did not perceive that the counselor really cared so she never developed a sense of “connection” with the counselor. Her own words express it best:

For someone who is in my position, the last thing you want is for someone to act like they have no vested interest in what you have to say. And that’s kind of what I felt like. She was just there. She got paid to be there. She’d give me the hour, but don’t ask anything beyond that... I think if it was me in her position, I would have said, “I don’t know what you feel. I really don’t. I can’t know how [you feel], but I’m here if I can help.”

Not surprisingly, Corrie attended only that first session and never went back.

Analysis and Conclusions

This unfortunate scenario provides a unique opportunity to examine the operation of death competence, or lack thereof, in an actual clinical encounter. However, before proceeding with a detailed analysis, some limitations of this case must be acknowledged. First, only the client’s side of the story is available so her recollections alone are the basis for any inferences made. We have no information about the provider’s perceptions of Corrie as a client or of the session itself. However, we are inclined to trust her perception of the events. Because this case was taken from a research interview focused on coping with bereavement, talking about Corrie’s abortive attempt at grief counseling was not the central focus, and it does not seem likely that she would have anticipated discussing it. Also, Corrie impressed us as an honest person with good common sense and no ulterior agenda or “axe to grind.” Therefore, we believe her report to be an unrehearsed, authentic rendition of her experience. Second, not as many facts about the counselor are available as would be preferred. We have no knowledge of the counselor’s training, licensure, level of experience, or practice specialties. The counselor’s age, family status, and personal experiences with death are unknown as well. Even without detailed information ordinarily crucial to the understanding of countertransference reactions (Bauer & Kobos, 1987), analysis of
this case example still can be instructive for exploring further the concept of death competence.

Although it is possible that the counselor did not know prior to the session that the client’s husband had just died, this seems unlikely. Most initial referrals contain at least some modicum of information as to why the consultation is sought. Even if the counselor was uninformed about the client’s status as recently widowed, upon learning this news from the client she could have shifted immediately her set of expectations about the session and adjusted her inquiry accordingly. Empathy for the pain and distress of another human being is such a fundamental part of psychotherapy (cf. Graybar & Leonard, 2005) that most mental health professionals either possess this characteristic naturally or cultivate it to the point that it becomes almost reflexive. So why did something so basic seem to be missing from the case example?

When bereaved persons present themselves for grief counseling, some are more eager to “tell their story,” and some are more hesitant to do so. In our thinking, this initial “position” correlates with the direction of the client’s oscillation between loss-oriented and restoration-oriented processes predicted by the dual-process model (Stroebe & Schut, 1999).

Extrapolating from Stroebe and Schut (1999), individuals more “into their grief work” seem focused on their subjective distress and more ready to communicate their anguish to the counselor. These clients often require little prompting from the professional in order to pour out their troubles. They want help. An opening as simple as, “I understand your husband died very recently, can you tell me what happened?” may be sufficient to start off the interview on the proper course. Receiving the client’s narrative with an interested, empathic openness is essential. “Following the story” of such an eager communicant to develop a thorough understanding of the loss dynamics equips the counselor with the historical information necessary for giving guidance, proposing alternatives, or making suggestions—some of the key therapeutic tasks in any form of psychotherapy, including grief counseling (Bruch, 1974; Frank & Frank, 1991).

Conversely, Stroebe and Schut (1999) also described individuals more involved in restoration-oriented processes following a significant loss. Focused more toward “going on with life” and less inclined to dwell on the pain of their loss, these clients may be more
hesitant to “tell their story.” Nonetheless, some basic understanding of the death circumstances and awareness of risk factors for complications in grieving (cf. Rando, 1993; Worden, 2009b) require taking pertinent history. Sometimes these clients hesitate because the consultation was more someone else’s idea rather than their own—perhaps a physician, minister, or family member recommended counseling. With these clients, counselors can take deliberate steps to reiterate their clients’ control over the counseling process. For example, the counselor may explain patiently that, once the client sees what is involved in counseling and how it is designed to help, the client retains the autonomy to decide whether to participate.

Some clients may hesitate to relate their story of loss not because they are ambivalent about seeking help but because they do not want to relive the pain of loss or re-experience excruciating emotions generated by describing events to the counselor. Avoidance and suppression are part of their defenses. They may fear losing control or crying in front of a stranger. Corrie appeared to personify individuals hesitant for these reasons—it hurt too much to talk about it.

With clients like Corrie, counselors can consciously work to convey empathy and build rapport so that clients can relate more details of their loss experience once they are ready. For example, the counselor might say something similar to the following explanation:

I understand your husband died very recently and that’s why you’re here. I’m hoping you can tell me something about what happened to him and how his death has affected you. I’m also interested in getting to know you better as a person during today’s visit, like your upbringing and background. So, we can start with whichever area would be easier for you to talk about first. My goal is to try to identify some things that will help you cope better with what’s happened.

For clients who choose to start with biographical information, practitioners can honor that choice and still look for junctures where the narrative may naturally lead into the story of their loss. Should the client avoid any discussion whatsoever of the death, one can gently remind the client of the counselor’s interest in hearing about the loss and, after additional rapport is established, try to coax the client in that direction.

In the case example, one is left to wonder what kept the counselor from using a more sensitive opening designed to reassure
Corrie, convey empathy, and invite her to “tell her story.” Beginning the interview by issuing a challenge seemed to put off Corrie and create distance between counselor and client. This brings up the possibility that the counselor’s own death anxiety may have been activated by the circumstances of Corrie’s story—sudden, unexpected death by heart attack of a cherished husband who was only 34 years old. Gamino and Ritter (2009) described how a healthcare professional’s death anxiety can affect clinical care, such as awkwardly struggling to provide treatment or avoiding certain aspects of care altogether as a result of one’s own discomfort. For some practitioners, it may not be possible to “look directly” at death.

Wogrin (2007) commented on how easily professional caregivers can imagine themselves in the position of the bereaved patient. The counselor’s own feelings elicited by the patient’s story of loss can be the basis for empathy, or the reason for self-protective avoidance and aloofness (Bertman, 1991; Wogrin, 2007). Without more direct information about the interview itself, it is impossible to know for certain why Corrie felt a lack of empathy and caring from the counselor. Yet, several potential explanations come to mind for the counselor’s apparent lack of death competence. Confronting Corrie’s sudden widowhood may have been too anxiety-provoking or “too close” to the counselor’s own fears and fantasies about sudden death or spousal loss. Identifying with Corrie as a wife and mother could have made the prospects of widowhood and single-parenting overwhelming. Addressing the general topic of dying and death may have been too threatening for the counselor to conduct an appropriate inquiry or “hold” the emotional content of Corrie’s story, thus precluding the perceptive and empathic accuracy emphasized by Roos (2002). Encountering Corrie could have reminded the counselor of unsettled or unintegrated aspects of her own life experiences associated with death and loss. Whatever the reason, there is little doubt that the counselor’s efforts failed to achieve a therapeutic outcome for Corrie and so violated the ethical principle of beneficence.

One may contend that scheduling an initial session of grief counseling the day after a young widow had buried her husband was too soon. Corrie’s grief could have been too fresh and raw to allow her to articulate reflectively. This timing may account for why Corrie “didn’t have much to say.” However, this argument appears flawed for two reasons. First, many hospice-related
professionals and pastoral counselors work effectively with dying patients and their families just prior to the time of death, at death, and immediately after death (Byock, 1997; Meyer, 1997). Their approaches typically include a great deal of supportive listening as well as sensitive “companioning” and their compassionate presence often provides a great deal of solace and comfort. Second, it is not uncommon for consultations with bereaved individuals, including those mourning tragic and violent deaths, to occur shortly after the loss (e.g., within the first week or month after death). Accordingly, as long as the practitioner takes into account the often “shell-shocked” emotional state of the griever and proceeds gently, a meaningful therapeutic exchange is possible. Given these considerations, it seems clear that the onus of responsibility for communicating a receptive and empathic attitude with regard to death-related material rested clearly with the counselor and that Corrie should not be faulted for being unwilling or ill-equipped for the therapeutic encounter.

**Summary**

It is ethically imperative that grief counselors demonstrate adequate death competence when working with the dying and the bereaved. This construct includes elements of cognitive competence and emotional competence as well as specialized skill in tolerating and managing clients’ problems related to dying, death, and bereavement. Death competence demands awareness of personal feelings about death and thorough self-knowledge of one’s own loss history, integrated in such a way that one’s own experiences with death inform and enrich one’s clinical practice rather than detracting from or limiting it. Review and analysis of a case example of empathic failure during an initial session of grief counseling illustrates how the absence of death competence can undermine foundational therapeutic tasks of understanding bereaved clients, empathizing accurately, and intervening effectively.

**References**


