

**Exploring Wellness Behaviors following a Non-Death Loss Experience:
A Structural Equation Model**

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DEDICATION

This work is dedicated to my family.

To my sunshine, Silas, whose big hugs and need to explore and play provided the perfect counterbalance to life in a doctoral program. You arrived in the middle of this research and taught me that I am capable of being more than I ever thought. That I can be both a mother and a scholar. You are my endless wonder.

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ABSTRACT

Loss and grief are inevitable aspects of the lifespan. Although non-death loss (NDL) is not a new phenomenon, it has recently entered the public knowledge. Researchers have connected death loss experiences to sometimes dramatic changes in wellness and wellbeing; however, NDL experiences have yet to be empirically connected to wellness. Building resilience in clients is a common strategy for addressing death related loss and developing effective wellness behaviors. The first manuscript is a primer on NDL for counselors. I review the types of non-death loss experiences, grief responses, theories, and skills and processes utilized for clinical work related to NDL. The second manuscript is an empirical study ($N = 462$) using structural equation modeling (SEM) to examine relationships between non-death loss, wellness behaviors, and resilience. Improvable fit between proposed models and data led to additional analyses. Results included statistically significant covariances and regressions between resilience, reactions to loss, and wellness behaviors. Implications for counselors include greater attention to the impact of NDL and resulting grief, creating resilience interventions for NDL and grief presenting issues, and engaging in continuing education about counseling grief and loss presenting concerns.

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INTRODUCTION

Non-death loss (NDL) is a young field with primarily conceptual manuscripts. Many of the theories, processes, and interventions were created to explain and predict bereavement loss (Harris & Winokuer, 2016; Rothaupt & Becker, 2007). To work with clients who have presenting concerns related to NDL, counselors must possess a basic understanding of NDL, its theoretical history, and conceptual beliefs about interventions and counseling strategies. This background will create opportunities for deeper understanding and engagement with NDL.

Scholars suggest that interventions and strategies created for bereavement will be effective for NDL work (e.g., Kuit & Ryke, 2021; Smith & Delgado, 2020); however, there is little data to support this claim. The second chapter is an empirical study framed within the Dual Process Model (DPM) of grief which posits that individuals oscillate between restoration-oriented and loss-oriented behaviors in response to significant loss (Stroebe & Schut, 1999, 2001, 2016). Wellness is a defining aspect of counseling (Brubaker & Sweeney, 2022) and acts as a protective factor in times of stress and upheaval (Baskin et al., 2010; Briggs et al., 2011; Graybill & Esquivel, 2012; Linscott et al., 2016; McIvor et al., 2013). Resilience is linked to wellness behaviors (e.g., Gogo et al., 2019; Rink et al., 2022; Song et al., 2020) and counseling strategies and interventions for loss (e.g. Bonanno, 2004; Neimeyer et al., 2011; Neimeyer & Thompson, 2014; Peterson & Goldberg, 2016; Philpott, 2013). Based on the literature, these constructs likely have a meaningful relationship with NDL. The relationships will provide greater information to develop appropriate interventions. By examining these relationships, the study aims to contribute to the development of evidence-informed interventions and counseling strategies for individuals experiencing non-death losses.

CHAPTER I: Working with Non-Death Loss & Grief: A Brief Introduction for Counselors

ABSTRACT

Non-death loss has received little attention within clinical settings, despite being a common occurrence in counseling. In the past few years, awareness of non-death loss has increased dramatically. With increased awareness comes increased need for guidance in assessing and treating issues of non-death loss. Within this manuscript, I review types of non-death loss experiences and grief responses, theories, and skills and processes utilized for clinical work with non-death loss. I share future directions for counselors and researchers.

Keywords: non-death loss, nonfinite loss, ambiguous loss, non-death loss interventions

Working with Non-Death Loss & Grief: A Brief Introduction for Counselors

Loss and grief are inescapable aspects of the human experience. For decades most of the research in this field has focused on death related losses and grief. More broadly, loss is “any experience across the lifespan that demands the surrender of something personally significant and/or familiar” (Whiting, 1986, p. 37). Furthermore, loss is a permanent change to one’s assumptive world that prohibits a return to the person they were before the loss experience (Harris, 2020a). Within this definition, there is space for a multitude of losses to occur. Non-death loss describes loss experiences outside of bereavement that create an unwilling and permanent change of one’s assumptive world.

Parkes (1971) coined the concept of the assumptive world to represent the foundational understanding of individuals’ perspectives of the world, others, and themselves. The assumptive world integrates underlying “expectations, hopes, and wishes” (Bruce & Schultz, 2001, p. 34). Loss experiences violate these foundational understandings. Development also affects the construction and stability of the assumptive world. Children, adolescents, and those in different stages of adulthood will have varying responses to non-death loss based on both development

and individual characteristics (Browning, 2008; Bruce & Schultz, 2001; McCoyd et al., 2021). Due to greater breadth of experiences, cognitive abilities, and perspective-taking, adults may be better able to contextualize specific losses within their assumptive world. For example, the loss of a sentimental item, such as a prized stuffed animal, could be frustrating or saddening for an adult, but that loss is unlikely to engender the same response for a child whose item was a deeply prized treasure. Additionally, a loss of fertility through hysterectomy or illness would have drastically different impact on a younger person or one looking forward to being a parent than it would upon an individual past childbearing or one who is not interested in becoming a parent.

There are many overlapping qualities of non-death loss experiences and death loss-experiences, including the grief experiences accompanying non-death loss (Harris, 2020b). Chronic sorrow, disenfranchised grief, and suffocated grief are commonly linked with non-death losses in the research; however, these grief responses can also be present in cases of death-related losses (Harris, 2020a). Perception of loss is a mediating factor in both non-death loss and death-related loss (Brown, 2017; Wayment & Brookshire, 2018). The greater disruption to the assumptive world typically indicates a greater reaction to loss. Similarly, losses more central to individuals' identities carry the most significant impact and grief response (Harvey & Miller, 1998; Papa et al., 2014; Prigerson et al., 2009).

There is limited published empirical research regarding non-death loss and its impact on individuals, and systems (Germany, 2020; Gitterman & Knight, 2019; Smith & Delgado, 2020); however the topic is becoming increasingly popular. Over the past few years, many theses and dissertation studies have explored non-death loss, but often siloed their research, meaning that the focus may be more on ambiguous, nonfinite, or intangible losses (e.g. Adams, 2021; Germany, 2021; Leach, 2021; Leiva, 2018; Molla, 2020; Tikare, 2018; Williams, 2020), despite

there being overlaps among various types of non-death losses. The purpose of this manuscript is to review the current literature on non-death loss and interventions and provide implications for counselors.

Non-Death Loss

Non-death loss is commonly divided into nonfinite and ambiguous loss with attention to intangible losses (Harris, 2020a, 2020b). Brief definitions can be found in Table 1 located in Appendix A. Tangible and intangible losses do not have to be connected, but any type of loss experience could have both tangible and intangible aspects (Harris, 2020b). Tangible losses are visible and often recognized by others, whereas intangible losses are less defined and more hidden. For example, a divorce may involve the tangible loss of a house and intangible sense of belonging from losing a marriage and home. Intangible losses can also involve lost sense of security, autonomy over one's life, or perceived safety (Germany, 2020). Aspects of both tangible and intangible losses appear across subtypes of non-death loss.

Nonfinite Loss

Nonfinite loss refers to “losses that are contingent on development; the passage of time; and on a lack of synchrony with hopes, wishes, ideals, and expectations” (Bruce & Schultz, 2001, p. 7). Nonfinite loss includes loss of the ideal or imagined, such as parents learning of developmental or genetic differences in their children (Bruce & Schultz, 2001; Harris, 2020; Read, 2005). Nonfinite loss is also experienced as a result of prejudice and discrimination that affect how people are able to move around their world. Individuals with one or more marginalized identities are more likely to experience nonfinite loss due to a difference in treatment by others and systems (Bordere, 2016; Brown-Manning, 2013; Wood & Conley, 2014). Significant changes to personal identities can also trigger nonfinite loss. An example of an

identity change is a professional athlete who sustains a career-ending or pausing injury, illness, or concern. The shift from being a professional athlete who can rely on their body to someone who is no longer able to participate in their sport can lead individuals who have spent their entire lives training to feel the loss of their profession, imagined futures, and sense of self (Roos, 2020).

Because nonfinite loss is a continuous experience, individuals must adjust to that loss daily throughout their lives. These losses may create barriers to reaching full potential and meeting daily expectations due to compounding pervasive effects across physical, cognitive, social, emotional, or spiritual realms (Bruce & Schultz, 2001; Harris, 2020). Feelings of shame, doubt, dread, and anxiety often accompany nonfinite loss, and individuals often feel isolated and disconnected from others, especially when they experience little in terms of normalizing or appropriately recognizing the impact of the loss (Bruce & Schultz, 2001; Harris, 2020; Jones & Beck, 2007; Ray & Street, 2007).

Nonfinite loss has been explored in specific areas, including within the LGBTQIA+ community (Wood & Conley, 2014), parental nonfinite loss regarding permanent changes to their children (Collings, 2007; Ray & Street, 2007; Read, 2005), and the families of death row inmates (Beck & Jones, 2008; Jones & Beck, 2007). Despite having overlapping experiences, the concepts of nonfinite loss and ambiguous loss are often researched separately. However, nonfinite loss is often connected to both disenfranchised grief and chronic sorrow in research (Bruce & Schultz, 2001; Harris, 2020c; Jones & Beck, 2007). Nonfinite loss researchers must be able to account for ongoing grief cycles while paying close attention to the context of the losses (Bruce & Schultz, 2001; Germany, 2020). Research into nonfinite loss has demonstrated a connection with the grief response chronic sorrow due to ongoing, repeated violations of the assumptive world (Germany, 2020).

Ambiguous Loss

Ambiguous loss is characterized by uncertainty and lack of resolution (Boss, 2007, 2016). Boss, the leading expert in ambiguous loss, identified two types of ambiguous loss, “physical absence with psychological presence [or] psychological absence with physical presence” (2007, p. 105). This term refers to the loss experience of individuals who are impacted by the psychological or physical absence of others, not those individuals who are absent in some manner. An ambiguous loss in which the other is physically absent and psychologically present is family worried for a loved one stationed in a war zone. Ambiguous loss in which the other is physically present but psychologically absent could be experienced by an adult child who is acting as a caretaker for a parent with dementia. Ambiguous loss can be differentiated from a nonfinite loss by a lack of clarity about the loss and its inherent relational nature. Although uncertainty about moving forward is a hallmark of nonfinite loss, the nonfinite loss event is clear and defined (Bruce & Schultz, 2001; Harris, 2020c), unlike ambiguous loss.

Boss (2016) identified 10 underlying assumptions of ambiguous loss, beginning with the idea that “a phenomenon can exist even if it cannot be measured” and covers topics including the lack of an objective truth, the impact of cultural beliefs and values, the need to name experiences, the nature of family structures and supports, and resilience. Individuals experiencing ambiguous loss are at a higher risk for feelings of hopelessness, guilt, and ambivalence about life. Immobilization, freezing of part of themselves or their family experiences, including feelings of grief, can occur. Individuals experiencing ambiguous loss are more likely to experience trauma and complicated grief reactions. They are also more likely to develop depression and anxiety disorders (Boss, 2007, 2010, 2016).

Researchers have explored ambiguous loss within multiple populations (e.g., LGBTQ persons, disappearing or missing persons, chronically ill children, individuals with autism spectrum disorder, and refugees). Research in ambiguous loss often focuses on the lack of closure and the lack of a clearly defined loss (Germany, 2020). Many of the empirical studies are based on smaller participant sizes, with in-depth analysis of experiences. Overall, there is limited empirical research regarding broader-scale impacts of ambiguous loss in general.

Responses To Non-Death Loss

Chronic sorrow, disenfranchised grief, and suffocated grief are types of grief responses common to non-death losses and deserving of attention in the conceptualization. Chronic sorrow is “an ongoing response to losses that are continual and unending in nature” (Roos, 2020, p. 202). In research, chronic sorrow was often tied to nonfinite loss due to ongoing violations of the assumptive world caused by nonfinite loss (Ahlström, 2007; Coughlin & Sethares, 2017; Roos, 2020). Disenfranchised grief is experienced when “the grief [loss event, or griever] is not openly acknowledged, socially validated, or publicly mourned” (Doka, 2020, p. 26). Bordere (2016) coined the term “suffocated grief” to build on disenfranchised grief that is actively dismissed or punished, an experience often seen in marginalized communities. These loss responses are important to keep in mind as the type of grief and response to grief impact which skills and processes a counselor will utilize.

<<insert Table 1>>

Theoretical Perspectives, Models, and Processes

Grief and loss are universal experiences with extremely individualistic bereavement responses; however, a number of scholars have created overarching theories of loss and grief, primarily in regards to death losses (Harris & Winokuer, 2016; Rothaupt & Becker, 2007). To

begin understanding counseling skills and techniques that can be useful in working with clients who have experienced non-death loss, I outline several of the most influential models and theories represented in teaching and research guiding understanding of loss and grief. Specifically, Bowlby and Parkes (1970) and five stages of grief (Kübler-Ross, 1969) represent stage and phase models; Freud (1959) and Worden (2018) represent task models; and the dual process model, two track model, continuing bonds, and meaning making represent postmodern theories regarding loss and grief. These theories were created to conceptualize grief responses and integration following bereavement, but they can be applied to non-death loss as well (Smith & Delgado, 2020). Most models and theories remain conceptual and lack empirical validation, especially for application to non-death losses. Despite needing additional research for application to NDL, knowing the process of how scholars have described and explained grief and loss is vital to understanding how to conceptualize NDL and grief.

Stage/Phase Theories

Stage/phase theories are the most well-known theories and models of loss and grief (Rothaupt & Becker, 2007). Bowlby and Parkes (1970) and Kübler-Ross (1969) created two of the most influential stage/phase theories. In these bereavement-focused theories, the goal is to reach acceptance and divestment of energy in the deceased. Stage models are somewhat linear, and each stage must be completed before proceeding to the next (Davies, 2004; Harris & Winokuer, 2016; Rothaupt & Becker, 2007). Although considered together in this manuscript, stage and phase theories are not the same. Stage theories were often interpreted to need to be moved through linearly, which inspired theorists to create phase theories that allowed for more overlap between each phase when creating phase theories. For example, Bowlby and Parkes (1970) built upon Bowlby's attachment theory to create a phase theory that framed loss as

separation anxiety (Davies, 2004; Rothaupt & Becker, 2007), which means that it could be interpreted as one of the earliest theories of non-death loss and grief. The phases of grieving in this model were identified as “[1] numbness, shock, and denial with a sense of unreality; [2] yearning and protest... [3] despair, disorganization, hopelessness, low mood; [and 4] reorganization, [which] involved letting go of attachment and investing in the future” (Bowlby & Parkes, 1970). Although many of the postmodern theories of grief and loss utilize attachment theory, it is important to note that they are not founded upon Bowlby and Parkes’ model (Harris & Winokuer, 2016; Rothaupt & Becker, 2007; Worden, 2018).

The most well-known theory of grief and loss is the five stages of grief developed by Kübler-Ross (1969). In this model, grieving individuals process their loss through denial, bargaining, anger, despair, and finally, acceptance. This model is often conceptualized as a linear progression, but Kübler-Ross did not intend for the model to be interpreted so strictly. It is also important to acknowledge that Kübler-Ross created the theory based on interviews with individuals coming to terms with their own death (Rothaupt & Becker, 2007); therefore, this model is more appropriately considered as one to explain how people come to terms with their own deaths. Modern adaptations of this theory are more consistent with Kübler-Ross’ intention and allow flexibility for grieving individuals to move between, and sometimes repeat, stages (Harris & Winokuer, 2016).

Task Models

Task models are more flexible than stage/phase models. The tasks are often not accomplished in any order, and grieving individuals are often working on more than one task at a given time. Freud (1959) created one of the first task models, conceptualizing individual movement between hypercathexis, a hyperfocus on the loss, and decathexis, or the retrieving of

the energy invested in the mental model of the deceased. Though Freud is known for psychoanalysis, the structure of this model includes a list of tasks that must be completed before being able to fully integrate a loss. Freud expected grieving individuals to break their emotional bonds so they could reinvest that energy into other relationships (McCoyd et al., 2021; Rothaupt & Becker, 2007; Worden, 2018). After Freud's daughter died, he turned towards an early conceptualization of continuing bonds (Harris & Winokuer, 2016; McCoyd et al., 2021; Rothaupt & Becker, 2007), which I address further below.

Worden (2018) developed a task-based model that depathologized grief with a focus on healing from the loss experience. Worden and Winokuer (2011) defined the tasks necessary to heal as “[1] to acknowledge the reality of the loss” (p. 58), “[2] to process the pain of grief” (p. 60), “[3] to adjust to a world without the deceased” (p. 62), “[4] to find an enduring connection with the deceased in the midst of embarking on a new life” (p.65). This model, which embraced a more flexible approach to grieving, served as a stepping stone to postmodern loss and grief theories.

Postmodern Theories

Postmodern theories of loss and grief are marked by a change of theoretical orientation from loss in which the ideal outcome is severing ties with the focus of the loss experience. Meaning-making and continuing bonds theories are minimally structured, focused on processes in loss integration, and have been integrated into other models. Worden (2018) highlighted how meaning making is an expectation in both his task theory and the two-track bereavement model. Over the last twenty years, researchers have emphasized meaning making as an integral process of grief integration (Neimeyer, 2000; Worden, 2018). Sense-making, benefit-finding, and identity change are different aspects of meaning making or meaning reconstruction in grief

(Gillies & Neimeyer, 2006; Neimeyer, 2000; Neimeyer & Krawchuk, 2020). Gitterman & Knight (2019) integrated meaning-making strategies into non-death loss by addressing the loss of times, places, and opportunities as a way of validating the loss and grief clients experience.

Continuing bonds focuses on redefining and maintaining a connection to the target of the loss. Both Worden (2018) and Neimeyer et al. (2006) identified continuing bonds as a theoretical perspective that fits along with and within their frameworks of loss and grief. Continuing bonds is a strategy often utilized on internet platforms, including social media (Bell et al., 2015; Cavanaugh & Smith, 2014; Goldschmidt, 2013; Sofka, 1997). For example, Facebook legacy pages, funeral signature books, and digital memorial pages are common methods of maintaining connections with deceased loved ones. Additionally, continuing bonds can be seen in physical creations, such as teddy bears, children's clothes, and quilts made of a loved one's shirts or clothes. This loss integration process has been researched to determine its effectiveness with suicide-related loss (Wood et al., 2012), bereavement in connection with hospice (Epstein et al., 2006), and long-term bereavement rituals (Mathijssen, 2018). However, some researchers have observed that an over-investment in continuing bonds can lead to extended and potentially pathological grief (e.g. Root & Exline, 2014; Stroebe & Schut, 2005).

Two theories, the Dual Process Model and the Two-Track Model of Bereavement provide new frameworks for conceptualizing the grieving process. The Dual Process Model is not a true postmodern theory, but it is not a discrete fit into any of the theories due to its roots in attachment and attention to contextual features. Within the Dual Process Model (Stroebe, 2002; Stroebe & Schut, 1999), grieving clients move between loss-oriented and restoration-oriented coping and processing behaviors. Loss-oriented behaviors and coping are rooted in the past and painful present; whereas, restoration-oriented behaviors look towards the future. Restoration-

oriented behaviors may initially be distractors from the loss experience so that grief is experienced in bursts, but they develop into more complex behaviors as the individual rebuilds their assumptive world. When individuals are loss-oriented, they can create meaning and connect with their loss. In restoration oriented, they rebuild and plan. The oscillation between these mindsets is the process to loss integration (Stroebe & Schut, 1999, 2010). The two track model of bereavement (Rubin, 1999; Rubin et al., 2011) features two multidimensional axes in which the first is a reflection of how the individual is functioning and the second is focused on the relationship to the deceased. Both tracks include biopsychosocial aspects such as emotional factors, cognitions, relationships with family, self-perception, and somatic concerns (Rubin, 1999). This model provides context for the positive and negative changes that occur in the cognitive, behavioral, biological, and interpersonal aspects of a grieving individual (Harris & Winokuer, 2016; Rubin et al., 2011; Worden, 2018).

Skills and Processes for Working with Non-Death Loss

There is a dearth of non-death loss interventions and skills, and many scholars suggest that bereavement interventions are applicable and relevant to non-death loss (Germany, 2020; Neimeyer & Krawchuk, 2020). Additionally, loss and grief are not spread evenly throughout the population, with some individuals and communities bearing more of the weight (Bordere, 2016). Counselors must be prepared to address that inequity, beginning with an awareness of cultural and social norms and differences (Harris, 2020b; Sabucedo et al., 2021). To appropriately address loss experiences and grief, counselors must understand more about how non-death loss impacts the general population. Their ability to recognize and address these experiences would be greatly improved with increased education during graduate programs and beyond (Blueford et al., 2022; Doughty Horn et al., 2013; Eckerd, 2009; Gitterman & Knight, 2019; Harrawood et al.,

2011; Servaty-Seib, 2004; Smith & Delgado, 2020; Wheat et al., 2022) Along with greater training, utilizing a loss-focused lens will help counselors create effective and appropriate interventions with their clients (Harris, 2020d; Smith & Delgado, 2020).

Integration of Non-Death Loss and Grief Lens into Practice

Counselors can use psychoeducation to create a framework for client understanding of non-death loss (Harris & Winokuer, 2016; Humphrey, 2009; Worden, 2018). Clients need language to be able to talk about their loss experiences (Gitterman & Knight, 2019; Harris & Winokuer, 2016; Smith & Delgado, 2020), and this is especially true for non-death losses which often are overlooked or dismissed (Harris, 2020b). Counselors can model using loss-focused vocabulary. Using loss and grief language indicates recognition of the loss experience and acknowledgment of the ongoing nature of non-death loss, thereby validating clients' experiences. When counselors can openly discuss loss and grief related concerns, the stigma and shame often associated with loss lessen as well (Smith & Delgado, 2020; Doughty Horn et al., 2016). Although naming is an important intervention across presenting issues, it is especially important when working with individuals who are experiencing ambiguous loss. Due to the amount of uncertainty, clients often need counselors to introduce language to address this phenomenon (Boss, 2007). In some instances, clients will not have identified an experience as a loss until the counselor provides identification and language.

Naming and validating individuals experiencing non-death loss and grief, especially disenfranchised, suffocated, and chronic grief, is critical to creating a healing environment (Gitterman & Knight, 2019; Roos, 2020). When working with ambiguous loss, validation of the loss and resulting grief responses is critical to addressing concerns of complicated and traumatic grief responses (Boss, 2007, 2010; Tubbs & Boss, 2000). In a review of multiple articles, Kuit

and Ryke (2021) found a significant subtheme was “listening to the voice of the child,” (p.5) which further stressed the importance of contextualizing counseling within the individualized experience of each client. Assisting clients to identify their individual contexts and experiences of loss and grief may lead to a greater ability to express and process the related emotional content (Kuit & Ryke, 2021).

In addition to naming, validation, and psychoeducation, clients will benefit from more traditional counseling interventions. Practicing presence, intention, and compassion are basic components of counseling, and these practices are especially important when working with grieving clients. Researchers have suggested motivational interviewing (Fineran, 2012), CBT (Beaumont, 2013; Edgar-Bailey & Kress, 2010) compassion-focused therapy (Harris, 2021), and group work (Brown & Coker, 2019; Larsen et al., 2021; Neimeyer et al., 2021; Newton & Ohrt, 2018; Supiano et al., 2021) as consistent with integration of loss experiences and grief. Suggested interventions include validating the nature of the loss, including or creating rituals, and allowing for the client’s growth and resilience (Harris, 2020d, 2022).

Developing and encouraging individual growth and resilience is another important aspect to consider when integrating a non-death loss experience. Several researchers have documented post traumatic growth (PTG) following traumatic loss and/or complicated grief. Calhoun and Tedeschi (1998) posited that grief-focused treatments for loss events result in greater PTG, a claim that has been since supported in multiple studies (Bellet et al., 2018; Wagner et al., 2007; Yilmaz & Zara, 2016). Although Eisma et al. (2019) found that there seems to be no positive or negative impact of PTG on client mental health, qualitative researchers suggest that there are positive impacts of PTG, such as forgiveness and discovering a new path forward (Martinčėková

& Klatt, 2017). These data support the concept that counseling following a non-death loss experience may have a similar impact on PTG.

Rituals are a key aspect of approaching both bereavement and non-death losses. Adapting and creating rituals to attend to the specific needs of the individual and loss experience provide comfort and support to bereaved individuals (Castle & Phillips, 2003; Mitima-Verloop et al., 2021; Romanoff, 1998). Rituals can provide structure, create opportunities for managing and expressing emotions, regulate behaviors, and acknowledge the relationship that existed prior to the loss experience (Castle & Phillips, 2003; Hobson et al., 2018; Lewis & Hoy, 2011; Mitima-Verloop et al., 2021; Norton & Gino, 2014; Romanoff, 1998). Rituals for non-death losses are often non-existent or minimalized, such as the stereotyped ritual of American women eating ice cream and crying after ending a romantic relationship, despite that ritual leading to increased social and emotional regulation. Sas and Coman (2016) explored how individuals created rituals for bereavement experiences, highlighting the rituals' structure, symbolism, sociality, and uniqueness. They found that individuals were able to utilize linking objects in more ways than previously identified to create new rituals. Similarly, linking or symbolic objects can be used to honor and process emotions for non-death loss and grief experiences as well (Edgar-Bailey & Kress, 2010).

Mindfulness

Mindfulness is a two-component model consisting of self-regulation of attention to stay in the present and a curious, open attitude towards the present moment and experiences (Bishop et al., 2004). The use of mindfulness techniques and interventions seems a natural fit for both bereavement and non-death loss. Neimeyer and Young-Eisendrath (2015) found that a meditation weekend focused on secular Buddhist practice of meditation about change, loss, and

acceptance was effective for addressing loss and grief experiences. Researchers have also explored mindfulness-based cognitive behavioral therapy (MBCT) as a potentially effective intervention for complicated grief with older adults (O'Connor et al., 2014). Less structured mindfulness programs can significantly affect the severity of grief symptoms. In one study, participants were taught four types of mindfulness interventions, of which the majority of participants were still practicing at six months post intervention (Tacón, 2011). These mindfulness interventions can be utilized for any type of loss, including non-death loss events. They may be especially useful in addressing nonfinite loss events that have triggered chronic, disenfranchised, or suffocated grief.

Expressive Arts

Expressive arts interventions are the most common bereavement intervention in the conceptual literature. Even when loss and grief are not the presenting concerns, counselors are often guided to seek out creative/expressive art interventions (Fineran, 2012). Although much of this literature is conceptual, there are a plethora of ideas regarding specific interventions, encapsulated in both journal articles (e.g., Buser et al., 2005; Philpott, 2013; Rafaely & Goldberg, 2020) and books, such as *New Techniques of Grief Therapy: Bereavement and Beyond* (Neimeyer, 2022) and *Grief and the Expressive Arts: Practices for Creating Meaning* (Thompson & Neimeyer, 2014). Specific expressive arts interventions fall within a variety of categories including music, creative writing, theater and performance, dance and movement, metaphor and visualization, and multimodal approaches (Crenshaw, 2005; Edgar-Bailey & Kress, 2010; Neimeyer, 2022; Thompson & Neimeyer, 2014).

In addition to engaging in art, drama, and other specific expressive arts, researchers have explored the use of narrative and narrative reconstruction in bereavement loss experiences

(Bertrand, 2021; Kuit & Ryke, 2021; Neimeyer & Young-Eisendrath, 2015; Whiting & Lee III, 2003). Kuit and Ryke (2021) found that social work researchers utilized narrative stories, which encouraged children in the foster care system to share their experiences and aided adult understanding of those individualized experiences. Both reading and writing stories and poetry assisted individuals in processing grief and loss experiences (Neimeyer and Young-Eisendrath, 2015). Additionally, the narrative writing experiences fostered meaning making even if counselors did not attend directly to the autobiographical aspects of the stories and poetry. Scholars have also utilized autoethnographies (Bertrand, 2021) and photography (Jiménez-Alonso & Brescó de Luna, 2022; Jiménez-Alonso & Luna, 2021) to explore using narrative approach to storytelling to address issues of grief and loss experience.

Future Directions

Due largely to the nascence of this field, counselors and researchers have many opportunities for continued research and development. Counselors have a significant role in advocacy to further education, destigmatization, and treatment of non-death loss and grief. Marginalized populations unfairly bear heavier burdens of non-death loss and grief (Bordere, 2016), including whether or not they are even allowed to express their grief (Bordere, 2017, 2020). Individuals, counselors, and others often overlook and undermine non-death loss experiences, especially in these populations. Counselors are mandated to advocate for systemic change. Engagement in community advocacy to create recognition of losses will align the counselor's goals to the needs of the given populations. Advocacy activities may include engaging with policymakers in person or via email, participating in legislative advocacy days, funding lobbyists, and voting to bring about systemic change. Counselors must also work to destigmatize and increase understanding of non-death loss and grief through opinion pieces in

local or national news, papers, websites, or guest appearances. Counselors can provide educational events for local schools and organizations serving communities disproportionately impacted by non-death loss. If no one is talking about it, nothing can be changed. Through advocacy, counselors can work to minimize stigma and shame, which may minimize disenfranchisement of loss and grief experiences, including suffocated grief. Greater advocacy will also result in greater resources for both clients and counselors.

Researchers have plentiful opportunities for engagement with non-death loss experiences. Currently, there are no best practices to guide research, education, and clinical work. Scholars can gather professional consensus to develop best practices for non-death loss that can then be validated through additional research. Utilizing the professional consensus can guide future research, such as evaluating the theories and models of loss and grief to determine if they are appropriate outside of their original context of death loss (Holland & Neimeyer, 2010; Rothaupt & Becker, 2007; Worden, 2018; Worden & Winokuer, 2011). Scholars must also assist counselors in developing a greater understanding of non-death loss and reactions to those experiences. Currently, there is a dearth of research exploring overall reactions to non-death loss and its impact on individuals' ability to maintain wellness.

Research into techniques and interventions from theoretical perspectives, such as cognitive therapy (e.g., Meichsner et al., 2019), would provide insight into how to integrate grief-aware practices into existing theoretical frameworks. Additionally, empirical testing of techniques for addressing non-death loss and grief will lead to a greater ability to validate a system of best practices. For example, greater insight into whether and how an intervention functions can provide the foundation for standards needed to measure the effectiveness of interventions. Researchers may also focus on their specific application in framing appropriate

interventions for non-death loss experiences (Smith & Delgado, 2020). Additionally, researchers should pursue coping, resilience, and reactions to non-death loss. Perhaps these factors will demonstrate unity across types of non-death loss experiences.

Researchers may also explore whether current grief trainings are effective in preparing counselors to address non-death loss experiences (Doughty Horn et al., 2013; Eckerd, 2009; Gitterman & Knight, 2019; Harrawood et al., 2011; Servaty-Seib, 2004; Smith & Delgado, 2020). Again, well-researched best practices could guide education through providing a professional consensus on how to best prepare training and educational opportunities. Although there are few programs and courses that have a specific focus on loss experiences and grief, understanding how the instructors utilize course design and what information they consider most significant will provide a greater ability to create evidence-based courses in the future.

Researchers have begun to pursue this area of focus, but more research needs to be done in this area (Doughty Horn et al., 2013; Harrawood et al., 2011; Wheat et al., 2019, 2022). Many of the interventions for loss experiences and grief, especially the creative/expressive art interventions, are conceptual rather than empirical. Researchers need to engage in both qualitative and quantitative studies on interventions and techniques for working with non-death loss (Kuit & Ryke, 2021; Smith & Delgado, 2020). Additionally, researchers can work to develop best practices for working with non-death loss and grief experiences.

A trend in loss and grief research is to explore siloed aspects, such as type of loss or grief, with specific populations. Researchers must take on more holistic views to consider the specific effects across the loss and grief experiences. In the review of counseling literature, there was a lack of resources for developing cultural competence in loss and grief experiences. Culture is a

key structure in a client's worldview and researchers must assist counselors in understanding its impact (Neimeyer & Krawchuk, 2020; Sabucedo et al., 2021).

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Appendix A

Table 1.1

Important Definitions in Non-Death Loss

Non-Death Loss	The experiences of surrendering something personally significant, causing a permanent change in one's worldview or identity, without involving the death of a valued being.
Nonfinite Loss	Losses related to changes in development, time, or a divergence from one's hopes and expectations, including unfulfilled ideals, impacts of discrimination, or alterations to personal identities.
Ambiguous Loss	Losses that are unclear, relational losses marked by uncertainty and lack of resolution and involving a psychological or physical absence of a loved one.
Chronic Sorrow	An ongoing response to non-death losses that is “continuous and unending in nature” (Roos, 2020, p.202)
Disenfranchised Grief	A response to grief in which the loss is not validated, socially acceptable, or acknowledged (Doka, 2020)
Suffocated Grief	A response to grief that is not only disenfranchised, but also publicly dismissed or punished by society – created to represent some grief experiences in marginalized communities

**CHAPTER II: Exploring Wellness Behaviors following a Non-Death Loss Experience:
A Structural Equation Model**

ABSTRACT

Non-death loss (NDL) is not the topic of many quantitative studies, however public recognition of the experience and its potential impacts have increased in recent years. The purpose of this study was to clarify the relationship between the reactions to loss and wellness behaviors as moderated by resilience through structural equation modeling (SEM). A nationally representative sample ($N = 462$) completed an online survey on wellness behaviors, reactions to loss, and resilience. Initial analyses of measurement model led to modification of scales based on results of factor analyses. Results demonstrated that resilience only moderated one predictive relationship. A SEM analysis revealed that resilience and reactions to NDLs had statistically significant predictive relationships with wellness behaviors. Implications for counselors include empirical support for developing interventions that build resilience, validating and supporting all NDLs and resulting grief, and engaging in continuing education about loss and grief counseling.

Keywords: non-death loss, wellness, resilience, structural equation modeling, exploratory factor analysis

Exploring Wellness Behaviors following a Non-Death Loss Experience:

A Structural Equation Model

Non-death loss (NDL) has become a greater topic of conversation as lifestyles, relationships, and planned experiences were forever changed during the coronavirus pandemic. Interest in therapeutic services appears to have doubled over the past three years (American Psychological Association [APA], 2021), and engagement in mental health services for adults increased across all population areas (Terlizzi & Schiller, 2022) with many individuals seeking loss-related care (Goveas & Shear, 2021; Kumar & Nayar, 2021; Sanderson et al., 2020). Despite increased attention and an increasing number of conceptual publications, there is limited

empirical research exploring NDL (Germany, 2020; Gitterman & Knight, 2019; Smith & Delgado, 2020), especially in regard to wellness. Scholars have long observed the behavioral impact of bereavement, including increased suicide mortality risk, overactivity, restlessness, and social withdrawal (Stroebe et al., 2007). Additionally, building resilience is a frequent strategy to address these symptoms and buffer against future death losses (Abrams, 2001; Bonanno et al., 2002; Bonanno et al., 2002; Bonanno et al., 2004; Kirk & Wall, 2010; Mancini & Bonanno, 2009). Resilience is also related to increased wellness (Gogo et al., 2019; Meier & Kim, 2022; Saeed et al., 2017; Song et al., 2020) and wellness behaviors (Rink et al., 2022). Considering these aspects together, resilience likely plays a factor in moderating the relationship between wellness and NDL experiences. If counselors and scholars can build an understanding of the relationship between how individuals respond to NDLs and their current wellness behaviors, not only will they be able to gain insight into the impact of NDLs, but also develop and modify appropriate interventions and counseling strategies for addressing individuals experiencing NDLs.

Literature Review

Non-Death Loss

Loss is “any experience across the lifespan that demands the surrender of something personally significant and/or familiar” (Whiting, 1986, p. 37). A NDL means that the loss experience is not directly related to the death of an individual or being (such as a beloved pet). NDLs may be further categorized as either nonfinite or ambiguous, with attention to tangible and intangible features.

Nonfinite losses are continuous experiences that are tied to individuals’ sense of identity and belonging (Bruce & Schultz, 2001). Black, Indigenous, and people of color (BIPOC)

experience nonfinite loss due to facing prejudice and discrimination on a daily basis as well as the history of intergenerational trauma (Bordere, 2016; Brown-Manning, 2013). Individuals with injuries that derail their dreams (Roos, 2020) or parents of children who experience injury or disability, thereby losing dreams and hopes for the kind of futures their children will have (Collings, 2007; Coughlin & Sethares, 2017) also experience nonfinite loss.

There are two distinct types of ambiguous loss, “physical absence with psychological presence [or] psychological absence with physical presence” (Boss, 2007, p. 105). These losses are marked by continued uncertainty, and individuals may never receive a satisfactory resolution (Boss, 2016). A family with an incarcerated parent would experience ambiguous loss in that the person is psychologically present but physically absent. An individual experiencing the second type of ambiguous loss may be a caretaker for a loved one with a brain injury or dementia.

Additionally, NDL can be tangible (e.g., loss of one’s home), intangible (e.g., loss of feelings of safety or trust following an assault) or have features of both. Grief responses to NDL can include chronic sorrow (Coughlin & Sethares, 2017; Roos, 2020), disenfranchised grief (Doka, 2020), and suffocated grief (Bordere, 2017). Researchers agree that responses to NDLs can range due to factors including individual characteristics, aspects of the loss, and developmental stage (Browning, 2008; Bruce & Schultz, 2001; McCoyd et al., 2021). It is important to note that some individuals may not have strong grief responses or loss reactions regardless of the significance of the loss, which early researchers connected with preexisting resilience (Bonanno, 2004).

Factors about the COVID-19 pandemic, such as unpredictability, difficulty trusting sources of information, increased anxiety, and increased difficulty for everyone, but especially for those with marginalized identities (Xiong et al., 2020), made fertile ground for NDL. During

2020, college students experienced an average of six NDLs (Sirrione et al., 2021). Although there is no published research regarding an average number of NDLs for adults, NDLs for adults during the course of the pandemic ranged widely, including “loss of agency, canceled plans and missed milestones, losing social contact and physical touch, health struggles, loss of normalcy and daily routines, and societal and economic woes” (Statz et al., 2022, p. 1).

At the same time, wellbeing, one’s sense of their overall wellness, also decreased. Stress, depression, and anxiety increased in many areas of the population (Brown et al., 2020; Gallagher et al., 2021; Hoyt et al., 2021; Xiong et al., 2020). Adults perceived their wellbeing was significantly affected by physical concerns, psychological concerns, financial concerns, and concerns about the social gaze (Yu et al., 2021). Wellness behaviors decreased as well, with many adults reporting trouble sleeping, focusing at work, coping, being present with their loved ones, and maintaining hope during the pandemic (Brown et al., 2020; Como et al., 2021; Gallagher et al., 2021; Grover et al., 2020; Litam et al., 2021; Prime et al., 2020; Yu et al., 2021).

Theoretical Framework

Most loss and grief models were designed to explain, describe, and predict experiences of and reactions to death losses, or bereavement. Although the dual process model (DPM) (Stroebe & Schut, 1999) was also designed for bereavement, its framework of oscillation between a restoration-orientation and loss-orientation, as modified by their attachment to the focus of their loss, allows for a conceptualization of NDL experiences. The target of the loss can be more nebulous than a death loss, but still clear, such as the loss of one’s career, independence, or expectations for the future. The DPM can even allow for ambiguous loss, in which the loss isn’t as clear, the dosing of loss and grief is still representative of their experience. To be able to truly integrate a loss experience, individuals must allow themselves to be present in their grief in

bursts, while also finding meaning and hope for the future despite a permanently changed assumptive world. In DPM, it is this oscillation that integrates a loss event (Stroebe & Schut, 1999, 2010). Wellness is achieved through balancing restoration and loss orientations; resilience may be a factor in how and when individuals are able to make positive reappraisals of their loss experiences (Stroebe & Schut, 2010).

Wellness

Wellness is “a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community” (Myers et al., 2000, p. 252). In this way, wellness is both an active, intentional process as well as an outcome (Brubaker & Sweeney, 2022). Wellness is a defining feature of the counseling profession (Brubaker & Sweeney, 2022; Kaplan et al., 2014; Myers & Sweeney, 2007); a holistic conception of wellness, including an awareness of contextual factors and social justice principles impacting wellness, should infuse all aspects of counseling work (Brubaker & Sweeney, 2022).

Wellness theory in the Western world is rooted in elementalism, the body, mind, and spirit (Gamby et al., 2021; Westgate, 1996). Wellness gained scholarly attention, attributed to Dunn’s “higher levels of wellness” (1959) in the late sixties, and entered the public consciousness in approximately the late 1970s and 1980s (Gamby et al., 2021). Despite the concept of holistic wellness existing for thousands of years (Brubaker & Sweeney, 2022; Gamby et al., 2021), it is a more recent addition to the United States. Since that time, wellness has remained a frequent topic of research and practice. Even now, wellness is often examined through subtypes, such as physical or spiritual wellness. The rise of attention to holistic wellness in Western scholarship has led to greater acknowledgement of how aspects of wellness are

intertwined and act on one another (Shannonhouse et al., 2020). The artificial separation of wellness subtypes is linked to the ability to consider and address smaller areas to allow for greater autonomy and feelings of self-efficacy (Myers & Sweeney, 2004). Scholars have identified wellness as a protective factor for adults and adolescents (Baskin et al., 2010; Briggs et al., 2011; Dolbier et al., 2007; Greybill & Esquivel, 2012; Nansook, 2003), especially when wellness practices are rooted in cultural contextual factors (Baskin et al., 2010; Grey et al., 2009; Linscott et al., 2016; McIvor et al., 2009). Relating loss experiences to wellness behaviors may allow for a greater understanding of the impact of NDLs.

Resilience

Resilience has been difficult to define, largely because it possesses aspects of both dynamic change and long-term endurance (Stainton, 2019). It is generally accepted as a characteristic that affects how individuals may respond to stressors with flexibility and return to previous or better functioning (Bonanno, 2004; Boss, 2013; Stainton et al., 2019). Resilience appears to be the most common reaction to bereavement loss (Bonanno, Papa, et al., 2002; Bonanno, Wortman, et al., 2002). Many scholars believe that resilience plays an important role in successful integration of loss events, thereby proposing interventions that assist clients in drawing upon inner strength (Bonanno, 2004; Neimeyer et al., 2011; Neimeyer & Thompson, 2014; Peterson & Goldberg, 2016; Philpott, 2013). Resilience is also featured in the wellness literature, often related to the medical field (e.g., Gogo et al., 2019; Rink et al., 2022; Song et al., 2020). Counseling researchers have used resilience to predict older adult self-perception of their aging experiences (Fullen et al., 2018). Together, this suggests resilience may be a moderating factor in relationships between reactions to NDL and wellness behaviors.

Recent years have brought a high volume of NDL (Sirrine et al., 2021; Statz et al., 2022; Zhai & Du, 2020), evidence of significant challenges to wellness (Hoyt et al., 2021; Xiong et al., 2020), and drastically increased rates of mental health help seeking, especially for loss related issues (APA, 2021; Goveas & Shear, 2021; Kumar & Nayar, 2021; Sanderson et al., 2020; Terlizzi & Schiller, 2022). Resilience may be a key factor in understanding relationships among these experiences (Bonanno, 2012; Mancini & Bonanno, 2009). Professional counselors are called to support clients as they work to help clients integrate NDL, foster resilience, and enhance wellness.

Purpose of the Study

In this study, I sought to test statistical models of the relationships between NDL and wellness behavior as suggested by the current literature. To date, there is limited understanding regarding relationships among these constructs (e.g., Bonanno, 2012; Kirk & Wall, 2010; Mancini & Bonanno, 2009; Zhai & Du, 2020), and current counseling intervention recommendations are largely conceptual or anecdotal (e.g., Fineran, 2012; Kuit & Ryke, 2021). A deeper understanding of these relationships may be a first step to developing evidence-informed interventions to address NDL.

NDL is still a newly recognized phenomenon in research without quantitative support of its impact. Unlike wellness with many potential measurement scales, the Reactions to Loss Scale (RTL) is the only quantitative assessment to measure the impact of losses that is inclusive to NDLs. DPM states that in response to a significant loss, an individual will vacillate between restoration oriented and loss oriented behaviors, eventually stabilizing on more restoration oriented behaviors (Stroebe & Schut, 1999). Connecting immediate reactions to significant NDLs with current wellness behaviors can provide insight into the impact of NDL on

individuals. Just as a NDL experience will likely affect wellness behaviors, resilience may help to buffer or otherwise provide resources to address the impact of the NDL. Researchers frequently suggest building resilience as a loss and grief counseling strategy, but there have been no quantitative explorations of resilience and loss integration. In this study, I aimed to clarify the relationships in hopes of providing more insight into the interconnections among NDLs, reactions to loss, resilience, and wellness.

Because I sought to understand relationships among reactions to NDL and wellness behaviors, structural equation modeling (SEM) provided the opportunity to visualize relationship structures among measured variables in an iterative process that builds upon itself to determine the best fit measurement for the structural model (Kline, 2015; Thakkar, 2020). To gain a deeper understanding of the impact of NDL on wellness, I chose to run two models. The first model is a true SEM measuring the impact on wellness behaviors overall; whereas the second model is a regression model that tests the relationships between the measured constructs of wellness. Research questions for this investigation included: (1) Do either of these models provide a good fit for the relationship among resilience, reactions to NDL, and wellness, and (2) Does resilience moderate the relationship between reactions to NDL and wellness?

The first hypothesized model, Model A, for this study focused on resilience and reactions to loss (loss of control, avoidance, positive reappraisal) as exogenous variables and wellness behaviors as an endogenous variable. I hypothesized that resilience would emerge as a moderating factor for all relationships. I expected that all RTL domains will have relationships with wellness, with the loss of control and avoidance subscales being negatively associated.

The second model, Model B, is the regression model in which all variables, resilience, loss of control, avoidance, positive reappraisal, mind, body, and spirit are measured. I again

hypothesized that all relationships would be moderated by resilience. I anticipated positive relationships between positive reappraisal and body, mind, and spirit wellness. Mirroring that hypothesis, I expected loss of control to have a negative relationship with the three wellness dimensions. Finally, I hypothesized that avoidance would have a negative relationship with the mind and spirit dimensions. Figure 2.1 provides a visual representation of all hypotheses.

Methods

Participants

The study included 462 participants aged 18 and 87 years old ($M = 38.96$, $SD = 13.95$) recruited through a Qualtrics Panel to represent a diverse participant sample representative of the population of the United States, an increasingly common method of digital participant collection services (Boas et al., 2020; Hunt, 2015). Inclusion criteria included being over the age of 18, living in the United States or US Territories, and experiencing at least one NDL in the past 12 months. The only exclusion criterion was to not have a significant death loss in the past 24 months. Participants received equivalent reimbursement for completion of the survey based on their preferences directly through Qualtrics. Further demographic information for participants is in Table 2.1 located in Appendix B.

Procedures

After receiving institutional review board approval, participants were collected through a Qualtrics Panel, which also served as the digital management platform for the survey. This method allowed for a nationally representative survey utilizing the most recent census data. Screening was the initial method of verifying that participants were aged 18 years or older, lived in the United States, and had not experienced a death loss in the last 24 months. If participants identified a significant death loss in the past 24 months, they were directed to the termination

page and provided additional resources. Potentially eligible individuals were then directed to a modified version of Sofka's Loss History Checklist Revised (LHCR) to record the number and type of NDLs experienced in the last 12 months. If participants choose, "I have not experienced a non-death loss," they were directed to the termination page. There were no exclusions for other demographic filters.

Eligible participants then provided informed consent and proceeded to complete a demographic questionnaire, the Body-Mind-Spirit Wellness Behavior and Characteristic Inventory (BMS-WBCI; Hey et al., 2006), the Reactions to Loss Scale (RTL; Cooley et al., 2010), and the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003) with embedded validity checks assessing attention. Instructions prompted participants to consider their current wellness behaviors when completing the BMS-WBCI. Next, participants were directed to consider their NDL experience(s) before sharing the approximate time of the loss and completing the RTL. Finally, participants addressed their overall resilience by completing the CD-RISC.

I embedded three data protection methods within the survey. The initial check was a reCAPTCHA that immediately followed the informed consent agreement page. I also utilized a commitment to honesty and thoughtfulness immediately prior to the BMS-WBCI. This method was suggested and supported by Qualtrics researchers (Geisen, 2022). Finally, I used a textual attention check in which the participants had to answer a basic math question.

Assessments and Measures

Loss History Checklist Revised (LHCR)

To screen for eligibility, I modified the LHCR, an adaptation of Sofka's (1999) Loss History checklist. Sofka (1999) created this tool to assist in assessing for loss and grief with

clients who experienced childhood sexual abuse. Research and interventions were focused on death losses and the Loss History Checklist allowed a greater perspective of the types of losses (Harris, 2020). Additionally, this tool allowed clinicians to either share it with clients or keep tally as clients shared their experiences; thereby increasing clinicians' understanding of the impact of loss events (Sofka, 1999).

The LHCR features four categories of potential losses, covering “(a) death losses, (b) relationship losses that did not involve death, (c) other losses (non-death/abstract losses), and (d) significant impact of historical events (impact on self or significant others)” (Harris, 2020, p. 4). The list was designed outside of the current understanding of types of loss, but many of the losses can be framed within the currently understood types of ambiguous, nonfinite, tangible, intangible, or mixed. For this study, I did not include section A, instead opting for a yes/no question to determine if a potential participant had experienced a death loss in the previous 24 months. In section B, an example of non-death relationship losses include: “loss of contact with child(ren),” “temporary separation due to employment, military deployment, or other reason,” and “separation of parents.” Section C, other losses (non-death/abstract losses), featured topics such as “loss of independence,” “loss of life as it was,” and “loss of career.” From the final section, I only used acts of war and terrorism due to the 12-month time limit. I further modified the LHCR by collapsing similar losses. I combined individual items such as “my own divorce” with similar items to produce the item “my own divorce, separation, or loss of romantic partner.” The resulting checklist was 26 items, with the last item inviting participants to identify any NDL not mentioned. At the end of the modified LCHR, there was a space to describe losses a participant did not see listed but wanted to include.

Body-Mind-Spirit Wellness Behaviors and Characteristics Inventory (BMS-WBCI)

The BMS-WBCI was designed to bring wellness measurements to a wider population via a holistic, cost-effective manner. This model is unique in its ability to assess both wellness behaviors and personal wellness characteristics from a multidimensional perspective. Despite only having three named divisions in the model and corresponding assessment, the assessment measures physical, emotional, intellectual, occupational, social, and spiritual dimensions of wellness (Bart et al., 2018).

The BMS-WBCI is a 44-item assessment with three subscales: body, mind, and spirit. Participants rated their current wellness behaviors on a scale of one to three in which one signified “rarely/seldom,” two signified “occasionally/sometimes,” and three signified “often/always.” The body subscale contains 9 items addressing overall physical wellness behaviors, such as “I eat a variety of foods and get the recommended number of servings from each food group,” and “I participate in recreational sports or activities that help maintain my fitness.” One item refers to a choice and a characteristic, “I have a reasonable amount of flexibility and do exercises that help maintain my range of motion.”

The mind subscale contains 29 items measuring mental health through chosen behaviors and self-identified characteristics. Concepts nestled into the mental health construct include social/relational wellness, intellectual wellness, and emotional wellness. Examples of these items include, “I learn from my mistakes and try to behave differently next time,” “I feel loved by family and friends,” and “I analyze my thoughts (I think, question, and evaluate) before I act.”

The spirit subscale has 15 items that more often prompt reflection of personal characteristics than chosen behaviors. Examples of the characteristic-based items include, “I experience peace of mind,” and “My spirituality helps me remain calm and strong and helps me to better deal with difficult times.” Four of the fifteen items are chosen behaviors, including “I

routinely undertake new experiences to enhance my spiritual health,” and “I express my spirituality appropriately and in healthy ways.”

In a two-study publication, Hey et al. (2006) found that the BMS-WBCI had high internal consistency ($\alpha = .81 - .91$) and good overall reliability ($r = .73 - .86$). The BMS-WBCI subscales demonstrated strong criterion validity as evidenced through subscale correlations with TestWell Physical Fitness ($r = .73$) and Emotional Awareness and Sexuality ($r = .31$). Hey et al. (2006) described the instrument as stable due to additional tests revealing a split-half reliability alpha range of 0.73 - 0.92. Marenco and James (2010) provided additional support of the BMS-WBCI in a cross-sectional study. The researchers found a high internal consistency for the overall instrument ($\alpha = 0.91$), and acceptable scores for the subscales (body = 0.69, mind = 0.87, and spirit = 0.88). In this sample, reliability scores for the unmodified instrument were also acceptable to good (body $\alpha = 0.78$; mind $\alpha = 0.89$; and spirit $\alpha = 0.93$).

Reactions to Loss Scale (RTL)

The RTL is a 70-item, self-report scale designed to assess reactions to a significant loss event (Cooley et al., 2010). Participants rate the frequency of their reaction on a scale from 1 (never reacted this way) to 6 (always reacted this way). Three subscales comprise the RTL: positive reappraisal, avoidance, and loss of control. The positive reappraisal subscale includes 21 items and assesses for growth-oriented thoughts and behaviors (“Changed or grew as a person in a good way,” “I was inspired to do something creative”). The avoidance subscale includes 20 items regarding thoughts and behaviors that attempt to separate the individual from or ignore the loss event (“I tried to keep my feelings from interfering too much with what I had to do,” “I tried hard not to think about the loss”). The loss of control subscale includes 29 items and measures the degree to which an individual feels as though they were not able to manage (“This loss has

caused me to question my beliefs,” “I could not stop thinking about the loss”). Because the RTL was normed on college students, I made minor adaptations for this assessment to be used with adults of all ages. For example, “Missed classes because of the loss” became “Missed work or classes because of the loss.” All changes were minor and only added to the phrasing of original items.

Cooley et al. (2010) reported strong correlations between each subscale with one or more outcome measurements from Beck Depression, Trait Anxiety, Satisfaction with Life, Positive and Negative Affect Scale (PANAS), Eating symptoms, and Self-control assessments among others across four total studies. Correlations between the positive reappraisal scale and the PANAS Positive Affect subscale ($R^2 = .24$) and Satisfaction with Life ($R^2 = .29$) indicated content validity. Additionally, the RTL was able to predict depression ($R^2 = .44$) and anxiety ($R^2 = .39$). Cooley et al. (2010) reported strong internal consistency reliability in the positive reappraisal, avoidance, and loss of control subscales with alphas of .89, .89, and .93, respectively. The avoidance scale and the loss of control scale were moderately correlated, but neither was correlated with the positive reappraisal scale. In a second study, researchers found additional support for the validity of this scale when the RTL results were correlated with Feelings about Loss and Preoccupation scales (Cooley et al., 2014). The RTL was determined to predict how individuals may integrate their loss based on their predominant reaction style.

The length of the assessment provided a potential difficulty to the study. The length, when combined with the other assessments and demographic questions could lead to participant fatigue and thereby less reliable results. To address these concerns and test an abbreviated version, I selected ten items that best represented each subscale to represent the RTL scale in this study. See the full list in Appendix F. To address potential effects from bias or beliefs, I

collaborated with my dissertation chair [second author] to ensure appropriate item representation of each subscale. Reliability scores for the initial subscales in this sample were good (positive reappraisal $\alpha = 0.88$; avoidance $\alpha = 0.82$; and loss of control $\alpha = 0.88$).

Connor-Davidson Resilience Scale (CD-RISC)

The CD-RISC is a 10-item, self-report scale designed to assess resilience (Connor & Davidson, 2003). Participants rate items on a 5-point scale ranging from 0 (not true at all) to 4 (true nearly all the time). Examples of items include, “Able to adapt to change” and “Thinks of myself as a strong person.” Scores for the CD-RISC can range from 0-40 in which greater resilience is denoted by a higher score.

Initial studies for the CD-RISC supported high internal consistency ($\alpha = 0.89$) and reliability (Connor & Davidson, 2003). Researchers found convergent validity by demonstrating negative relationships with the Perceived Stress Scale and the Sheehan Stress Vulnerability Scales; meaning that resilience was negatively correlated with high levels of perceived stress (Connor & Davidson, 2003). When the scale was refined in 2007, Campbell-Sills and Stein (2007) completed a psychometric analysis for the 25-item scale and refined the scale to an abridged 10-item assessment. The abridged version was highly correlated with the 25-item instrument, but demonstrated greater stability, reliability, and validity (Campbell-Sills & Stein, 2007). Internal validity for the ten-item assessment ($\alpha = 0.85$) was good. Additionally they found that there was a high moderation effect of personal resilience on impact of trauma, meaning that despite the intensity of trauma, individuals with higher resilience reported fewer or less severe symptoms (Campbell-Sills & Stein, 2007). The reliability score for the CD-RISC in this sample was good ($\alpha = 0.87$).

Data Analysis

Researchers utilizing survey methodology need to attend to potential cheating, carelessness, and/or insufficient effort from participants (Kim & Oh, 2022). Quality control questions, which direct participants to select a specific answer, are a simple way to build in checks on participant engagement (Cobanoglu et al., 2021; Kim & Oh, 2022; Miller et al., 2020). Another way to check for quality data is to measure response time to determine if participants are speeding through the survey (Meade & Craig, 2012; Wood et al., 2017). To minimize potential for bots, researchers suggest utilizing a captcha (Cobanoglu et al., 2021). Qualtrics Panels also has measures in place to minimize, if not eliminate, the use of bots in survey collection (Miller et al., 2020).

In this study, I recorded timing scores for all participants, comparing them to the mean and median times from the overall participant engagement to assess for speeding responses. Finally, I analyzed demographic data and IP addresses to address duplicate surveys. Due to the length of this survey, I utilized three attention check items, including a commitment, a textual check, and a reCAPTCHA; reviewed demographic data; and analyzed completion times to flag extreme outliers from the median time. The survey was accessed 867 times, with 294 individuals not meeting eligibility criteria, two choosing not to provide informed consent, and 85 not meeting Qualtrics quality controls. I accepted 462 (98.72%) of the remaining 486 responses; three failed the reCAPTCHA, one failed the commitment check, and 20 were multiple submissions.

I screened data for completion and whether it meets SEM needs: sample size within parameters, missing data and outliers managed, limited multicollinearity, and multivariate

normality (Kline, 2015; Schreiber, 2017). Due to the large sample size and the non-normal data, I am reporting the standardized results as well as the robust test results from the SEM analyses.

To address missing data, three responses with greater than 15% missing data were excluded. For responses with 15% or less missing data (Kline, 2015; Osborne, 2013), I used multiple methods of addressing missing data so they best fit the analysis and purpose of the data. All statistical analyses were run in R Studio using the lavaan package. To run some of the analyses, I needed a total score for each subscale. Within each subscale, individual participants that were missing less than three scores in each subscale received an averaged value from their other answers in their missing values. If the individual participant was missing more than three items, the method used diverged based on the type of analysis. As part of the model reiteration stage of the SEM process (Kline, 2015), I had to run confirmatory factor analyses (CFAs) on the measurement models. Prior to the CFAs, I ran an exploratory factor analysis (EFA) on a random sample from both the RTL and BMS-WBCI to address the changes in population for both scales and the modifications to the RTL. For the EFAs and CFAs, I used multivariate imputation by chained equations using maximum likelihood and an oblimin rotation to fill in any missing scores. In the SEM and regression analyses, I used maximum likelihood (Kline, 2015) to address the missing data while running the SEM models.

I used cutoff values suggested by Kline (2015) in testing for global adequacy of the models with the following analyses: chi square test (cutoff value $> .05$), Tucker-Lewis Index (TLI, cutoff value $\geq .95$), Bentler Comparative Fit Index (CFI, cutoff value $\geq .95$), Steiger–Lind Root Mean Square Error of Approximation (RMSEA, cutoff value $\leq .05$), and Standardized Root Mean Square Residual (SRMR, cutoff value $\leq .08$). To assess correlation strength, I used the structure provided by Akoglu (2007) in which 0.00-0.19 is a negligible correlation, 0.20 to 0.39

is a weak correlation, 0.40 to 0.59 is a moderate correlation, 0.60 to 0.79 is a strong or moderately strong correlation, and 0.80 to 1.00 is a very strong or near-perfect correlation.

Results

Measurement Models

Testing the measurement model is a feature of all SEM analyses (Kline, 2015). The BMS-WBCI and RTL were created for and normed on undergraduate populations. Additionally, the RTL was originally constructed to address the impact of death loss while being inclusive of NDL. I changed the population, focused the assessment on NDL, and abbreviated the RTL. Thus, CFAs were necessary to evaluate the assessment prior to further analyses. The CD-RISC demonstrated a strong fit ($\chi^2(35) = 38.81, p < 0.30$; CFI = 1.00; TLI = 1.00; RMSEA = 0.02, SRMR = 0.02). The CFA showed high loading items and no concerning results on the modification indices.

The measurement model for Wellness as defined by Body, Mind, and Spirit (BMS-WBCI) demonstrated an improvable fit ($\chi^2(899) = 1524.65, p < 0.001$; CFI = 0.90; TLI = 0.90; RMSEA = 0.04, SRMR = 0.06). It's important to note that the Chi squared test was significant, which often happens with larger sample sizes and will continue to happen through these analyses. CFI and TLI analyses were under the ideal cutoff, but could be argued to be borderline acceptable, especially when considered alongside the RMSEA and SRMR could be considered an acceptable fit. However, the modification indices revealed a lot of potential interaction between items of different constructs, suggesting cross loading items.

The measurement model for the modified RTL demonstrated a borderline acceptable fit ($\chi^2(402) = 1067.03, p < 0.001$; CFI = 0.85; TLI = 0.84; RMSEA = 0.07, SRMR = 0.09). Analyses of covariance among the constructs demonstrated significant covariance. The strength

of Avoidance and Loss of Control covariance coefficients (standardized, $r = 0.85$, $p < 0.001$) suggested potential cross-loading factors. The first factor for Avoidance demonstrated a lower loading factor (0.33) than typically accepted, even when relevant to theory (Hinkin, 1998). The modification indices revealed a lot of potential interaction between items of different constructs, suggesting cross loading items.

The CFA modification indices results for the BMS-WBCI and RTL demonstrated that many items had low factor loadings or loaded more strongly for other factors, which indicated a need to better understand the instruments. Based on the low factor loadings and improvable fit analyses for the BMS-WBCI and RT, I chose to explore these instruments using an EFA with follow-up CFA. All CD-RISC items were highly loaded onto its factor, so I did not explore this instrument.

Instrument Factor Analyses

For each EFA, I created a dataset specific to that assessment, then randomly split the sample to have a test sample for the initial EFA and a confirmation sample for the CFA. I ran a version of each EFA with oblimin rotation in which I removed potential outliers with the Mahalanobis distance score, but there was only a minimal difference whether these items were cut in both the BMS-WBCI and RTL. I chose not to remove potential outliers through the Mahalanobis distance in the final EFAs. For both EFAs, I ran a parallel analysis and a Kaiser criterion analysis with the old measure (eigenvalues at 1.0) and new measure (eigenvalues at 0.7) to determine how many factors to extract. I ran models until I achieved simple structure. I looked for low and cross loaded items across factors. Appropriate loading was measured at 0.45 or higher (Tabachnick & Fidell, 2007). If an item was important to theory and its loading was above 0.40 (Hinkin, 1998), I retained the item.

Typically items are not removed based on statistical tests alone. These decisions are also rooted in theory, which is consulted when determining whether items should be removed (Kline, 2015). For these assessments, I was entrenched in the grief theories supporting the RTL to remove items and let theory keep two items when the statistical analysis identified low loading. The BMS-WBCI was a slightly more difficult decision, but the only theoretical foundation for the BMS-WBCI was in the belief that wellness is holistic and covers the body, mind, and spirit. I was supported in removing the data because there was not a theoretical basis and a clear statistical suggestion for removal. Before I removed any items, I reviewed each item, its contribution to the overall assessment, its fit in the theoretical structure, and the statistical findings.

BMS-WBCI

The initial EFA for the BMS-WBCI ($n = 225$) indicated that Bartlett's test of sphericity was statistically significant ($\chi^2 = 4514.70$, $df = 946$, $p < 0.001$), and the Kaiser-Meyer-Olkin value was 0.93, which meant that the sample from which these data was collected was adequate for factor analysis. All three methods of determining factors, the parallel analysis and both old and new Kaiser criterion rules (eigenvalues at 1.0 and 0.7), suggested a three-factor structure. In the first round of analysis, I found several no to minimally loading items. I eliminated two items from the Body subscale and two items from the Mind subscale for negligible loading. Additionally, I removed eight other items for loading values under 0.45. In the second round, two more items were cut for low loading, communality, and permissible via theory. The results from the third round suggested a good fit based off diagonal values (0.98), which was supported by RMSEA (0.04) and TLI (0.93). All three factors demonstrated reliability via a Cronbach alpha analysis. Factor one, Spirit, was highly reliable ($\alpha = 0.93$) and did not have items with low

or cross loading to other factors. Factor two (New Mind, $\alpha = 0.88$) and factor three (New Body, $\alpha = 0.81$) were both highly reliable after items were removed for minimal factor loading scores. All results are located in Table 2.2 in Appendix C. The CFA ($n = 234$) on the other randomized sample demonstrated an acceptable fit ($\chi^2(492) = 698.31, p < 0.001$; CFI = 0.90; TLI = 0.89; RMSEA = 0.04, SRMR = 0.06). Items loaded significantly and with approximate expectations of loading values.

RTL

In the initial EFA for the RTL ($n = 225$), the Bartlett's test of sphericity was statistically significant ($\chi^2(435) = 5805.188, p < 0.001$), and the Kaiser-Meyer-Olkin value was 0.89, which meant that the sample from which these data were collected was adequate for factor analysis. The parallel analysis and Kaiser criterion rule (eigenvalues at 0.7) reported three factors. The Kaiser criterion rule (eigenvalues at 1.0) reported two factors. In the first round analyzing a three-factor model, I found significant cross loading. In round two, I analyzed a two-factor model and found minimal cross loadings. I eliminated three items that did not have a high factor loading and two more items from the Avoidance subscale that had low loading values on factor two. I ran a two-factor analysis with those items removed, but it showed an item that still needed to be considered.

The results from the third round suggested a good fit based off diagonal values (0.97), which was supported by RMSEA (0.06) and TLI (0.90). Positive Reappraisal remained clearly represented by factor two, thereby retaining its name, ($\alpha = .88$); however, factor one, named Loss Impact Behaviors ($\alpha = .90$), embodied both Avoidance and Loss of Control subscales. All results are in Table 2.3 in Appendix D. The CFA ($n = 234$) on the other randomized sample demonstrated a borderline acceptable fit ($\chi^2(274) = 524.03, p < 0.001$; CFI = 0.88; TLI = 0.86;

RMSEA = 0.07, SRMR = 0.08). Items loaded significantly and with approximate expectations of loading values.

Structural Models

Model A ($n = 462$) demonstrated an improvable fit ($\chi^2(10) = 95.93, p < 0.001$; CFI = 0.87; TLI = 0.77; RMSEA = 0.14, SRMR = 0.04), with the SRMR indicating a good fit, while the CFI indicated a borderline fit, and the TLI and RMSEA indicated a poor fit. There were limited ways to change this model. Due to the poor fit, I did not assess for interaction effects. In Model B, I could not truly test for fit because it is a regression model with limited degrees of freedom. Only one interaction effect was significant. Resilience interacted with Loss Impact Behaviors ($\beta = -0.80, SE = 0.001, p < 0.001$).

To analyze main effects, I ran two models. I first ran Model A without the interaction effects (Model A1, Figure 2.2, Appendix E). This adjusted model demonstrated borderline acceptable fit ($\chi^2(6) = 68.42, p < 0.001$; CFI = 0.90; TLI = 0.80; RMSEA = 0.16, SRMR = 0.04). The non-significant RMSEA value suggested a poor fit, however, the CFI and SRMR both indicated a good fit and the TLI indicated an acceptable fit. All three regressions were significant. Loss Impact Behaviors was a weak, negative predictor for overall wellness ($\beta = -0.22, SE = 0.06, p < 0.001$). New PR ($\beta = 0.55, SE = 0.01, p < 0.001$) and Resilience ($\beta = 0.40, SE = 0.02, p < 0.001$) were both positive, moderate predictors for overall wellness. Descriptive statistics for all variables are in Table 2.4, located in Appendix F.

To measure fit, I altered Model B (now Model C, Appendix G, $n = 462$) to determine main effects as a true SEM analysis. By integrating the measurement models into the design, the subscales acted as endogenous variables, which allowed for a better estimate of overall model fit. Model C demonstrated an acceptable fit ($\chi^2(2195) = 3959.34, p < 0.001$; CFI = 0.88; TLI = 0.88;

RMSEA = 0.04, SRMR = 0.06). Although the CFI and TLI indicated a borderline fit, the RMSEA and SRMR indicated a good fit. Resilience weakly predicted physical wellness ($\beta = 0.23$, $SE = 0.06$, $p < 0.001$) and spiritual wellness ($\beta = 0.28$, $SE = 0.04$, $p < 0.001$). Resilience was a moderately strong predictor for psychological wellness ($\beta = 0.75$, $SE = 0.06$, $p < 0.001$). New PR moderately predicted physical wellness ($\beta = 0.43$, $SE = 0.04$, $p < 0.001$) and spiritual wellness ($\beta = 0.59$, $SE = 0.04$, $p < 0.001$). PR was a negligible, negative predictor for psychological wellness ($\beta = -0.19$, $SE = 0.06$, $p < 0.001$). Resilience and New PR had a moderately strong positive relationship ($r = 0.62$, $p < 0.001$). New PR also had a positive, but weak, relationship with Loss Impact Behaviors ($r = 0.23$, $p = 0.001$). Spiritual wellness had weak, positive relationships with physical wellness ($r = 0.37$, $p < 0.001$) and psychological wellness ($r = 0.29$, $p < 0.001$). Physical and psychological wellness also had a positive relationship, but it was negligible ($r = 0.16$, $p < 0.05$). The correlations for all variables can be found in Table 2.5 located in Appendix H.

Discussion

The research questions asked whether these models were the best model fit for the relationships between resilience, reactions to NDL, and wellness and whether resilience moderated those relationships. The answer to the second research question is that one relationship demonstrated that the impact of NDL on wellness varied as a function of resilience. The main effects analysis demonstrated that individuals with greater resilience had higher overall wellness. Results also demonstrated that individuals with greater loss impact behaviors had lower overall wellness. The interaction analysis demonstrated that the effect of loss impact behaviors on overall wellness varied depending on the level of resilience. This finding indicates that if individuals develop higher levels of resilience, they will experience less impactful

consequences of loss impact behaviors. Scholars have often suggested developing resilience as a strategy for coping with both bereavement and NDL (Bonanno, 2004; Neimeyer et al., 2011; Neimeyer & Thompson, 2014; Peterson & Goldberg, 2016; Philpott, 2013), but this study is the first to provide empirical support regarding the relationships among these constructs .

The answer to the first research question is more nuanced. Considering the modifications I made to the assessments, this study should be completed again with more precise tools.

However, due to the chosen instruments, there were minimal changes I could make to create a new iteration other than exploring the instruments themselves. It is important to note that these instruments were normed on college students, which may explain some variances in loading and reliability. Despite the identified models demonstrating room for improvement, there were still significant effects.

This study demonstrated that greater resilience leads to greater overall wellness during or after the loss integration process. Resilience contributed somewhat to physical and spiritual wellness and made a greater contribution to psychological wellness. This finding implies that overall resilience positively impacted wellness and buffered experiences that affected wellness. These findings are in line with other studies regarding resilience and wellness (Aluandez et al., 2021; Gogo et al., 2019; Rink et al., 2022; Saeed et al., 2017; Song et al., 2020). Edara et al. (2021) connected resilience with wellness and spirituality, which is in line with findings of the moderately strong relationship between resilience and spiritual wellness. Although Rink et al. (2022) explored a subtype of resilience, they found that it had a statistically significant relationship with wellness behaviors, consistent with findings in this study.

Spiritual wellness also had a meaningful presence in the findings. Spiritual wellness is more than religiosity. Spirituality is “a personal search for meaning and purpose in life, which

may or may not be related to religion” (Tanyi, 2002, p. 506), and spiritual wellness involves the ability to engage in that pursuit in a valuable manner. Individuals need their lives and worlds to have meaning and purpose (Routledge & FioRito, 2021), which is supported by findings that spiritual wellness was significantly correlated with many of the other variables. Greater spiritual wellness was also predicted resilience and positive reappraisal, suggesting that meaning making plays a role in these processes. Additionally, the relationship between spiritual and physical wellness is supported by studies demonstrating the connection between spirituality and physical health (e.g., Czekierda et al., 2017) and the Indivisible Self model of wellness in which the essential self is comprised of spirituality, identity, and self-care (Myers & Sweeney, 2004). Spirituality and spiritual wellness have been connected to mental health outcomes in a variety of studies (e.g., Disabato et al., 2017; Rippentrop et al., 2005; Steger et al., 2006). Rippentrop et al. (2005) found that greater participation in spiritual and religious activities was related to an increased severity of pain but interpreted that finding to explain that more severe chronic pain may lead to greater involvement in spiritual and religious practices. Findings in this study support that interpretation, indicating that more loss impact behaviors following a NDL was associated with greater spiritual wellness during or after the integration process. Loss and grief share commonalities with chronic pain, in that it is an emotional pain that never truly goes away but is integrated into the individuals’ new identity and worldview (Bowlby & Parkes, 1970; Harris, 2020; Neimeyer, 2000), providing further theoretical support for the empirical relationship between spiritual, physical, and psychological wellness.

Engagement in positive reappraisal led to greater overall wellness, particularly spiritual wellness, and resilience during or after the loss integration process. These findings are in line with studies exploring positive reappraisal as a coping method for climate change, a NDL

in which one is losing hope for the future (Ojala, 2012, 2013). Positive reappraisal had a positive relationship with loss impact behaviors, which likely supports the DPM's thesis that individuals must experience both restoration and loss-oriented behaviors to successfully integrate losses, although this study cannot speak to the balance of oscillation theorized within the DPM (Stroebe & Schut, 2010). This study appears to be the first to find empirical support for using the DPM to assess coping with NDL experiences.

The factor analyses on the abridged RTL revealed a significant change in the instrument from three factors initially reported by Cooley et al. (2010) to two factors. This change reflects and builds on the theoretical framework of this study. Importantly, the DPM was created to describe and predict coping and adaptation to death-related losses, with attention to individuality, the reframing of experiences as life affirming (Stroebe & Schut, 2010), and becoming overloaded with too many losses or the inability to balance oscillations between loss and restoration orientation (Stroebe & Schut 2016). Although this study cannot measure oscillation, there was a consistent covariance between positive reappraisal and loss impact behaviors, suggesting that these events are happening in connection with one another, supporting DPM theory.

Strengths and Limitations

This study has multiple strengths. It is rooted deeply in the literature, yet is the first study to explore NDL, wellness behaviors, and resilience empirically. The findings may assist in developing a deeper understanding of the impact of NDLs. SEM is an increasingly popular methodology in the social sciences (Wang & Rhemtulla, 2021). The *Journal of Counseling & Development* has published approximately 8 SEM studies in the last five years. This study is a robust, in-depth statistical investigation using a large, nationally representative sample.

Sampling is both a strength and limitation. Qualtrics was responsible for recruitment, which allowed for quota sampling rather than snowball or convenience sampling methods. However, Qualtrics does not typically provide transparency in recruitment procedures (Miller et al., 2020), making it difficult to know more about participant behaviors. Multiple researchers have raised concerns about utilizing online recruitment and panels and data quality from participants (Boas et al., 2020; Miller et al., 2020; Peer et al., 2021); however, ultimately these methods of recruitment had an advantage over many traditional methods (Miller et al., 2020). To further mitigate these concerns, I used a reCaptcha following consent to the study and three attention checks embedded in the survey. The Qualtrics project manager analyzed completion times to address speedy participants and monitored for duplicate IP addresses.

One limitation is that the RTL scale and the BMS-WBCI were normed on college students rather than adults in general. This study expanded their original purpose. These constructs also have a potential for bidirectionality. Personal wellness will likely impact an individual's response to a NDL because an individual with greater levels of wellness will likely have more cushion to assist in successful integration of the loss. A decrease in physical wellness, such as lack of sleep, could lead to individuals reporting greater feelings of loss of control or avoidance. To manage the potential bidirectionality, I incorporated resilience as a mitigating factor. Another limitation in using the RTL scale, the participants were asked to think of a time in the past rather than a current experience; therefore, the memory may have differing levels of clarity, dependent on timing, intensity of feelings in the moment, or reflective of current perceptions.

A final limitation is data management. As a researcher, I had to make choices about how to best manage missing and outlying data which could have an impact on study results.

Addressing missing data may lead to underestimation, minimization of variance, and other inaccuracies (Kline, 2015; Osborne, 2013).

Implications and Future Directions

This study illustrated empirical support between resilience, the ability to create meaning from NDL experiences, and wellness. In other words, positive reappraisal and resilience appear to play meaningful roles in the loss integration process. Counselors now have an empirical foundation supporting the idea that strategies and interventions that assist clients in meaning making and developing resilience may be essential in addressing presenting problems involving NDL. Counselors should continue to develop and investigate impact of interventions and strategies that assist clients in developing resilience and perspective.

This study also provided support for the DPM as a model inclusive of NDLs and grief responses as conceptualized by NDL scholars (e.g., Smith & Delgado, 2020). The RTL EFA and confirmatory CFA demonstrated that out of control behaviors are likely more extreme forms of loss impact behaviors and grief responses. Although they may seem different at face value, they are related to and perhaps driven by the same needs as avoidance behaviors. With this empirical support, counselors may have greater faith in utilizing the DPM to conceptualize and address NDL presenting problems. This endorsement may also allow for greater comfort in conceptualizing restoration and loss-oriented behaviors within the NDL grief process.

Counselors should engage in continuing education in loss and grief. Because resilience and positive reappraisal are indicators for overall wellness, having a better understanding of NDL and grief allows for earlier intervention and a method of checking loss integration progress. Dosing and oscillation between loss and restoration orientations means that there may be weeks in which clients appear to have a flight to health and others in which they are convinced that they

will never be okay again. Additionally, investment in education about loss and grief models, processes, and empirically supported interventions in bereavement may increase counselor comfort in addressing issues of NDL, including providing psychoeducation that normalizes oscillation and encourages both counselors and clients to be patient in the process.

Future Directions

Further studies can explore the usefulness of the DPM with NDL presenting concerns with more precise assessments. Given the paucity of strong assessments related to NDL, this may require instrument development and validation. New assessment tools could assist researchers and counselors in understanding NDL. For example, a longitudinal study on the presence of oscillation between restoration and loss orientation may help researchers better understand NDL patterns. Likewise, longitudinal studies of individuals navigating NDL would create the opportunity to deeply explore the relationships among resilience, spiritual wellness, and positive reappraisal. More needs to be understood about the types of NDL in relation to each other as well as their impact. Investigating the impact of counseling on the oscillation process and development of positive reappraisal would provide additional insight on counseling interventions.

Explorations of different populations, including those who experience NDLs related to their social locations and identities, could provide additional insight into the impact of NDL with cultural context. A further study could investigate whether the types of loss affect the perception and impact of the NDL. The timing of the NDL must also be explored to provide greater insight into change over time.

The foundations above may facilitate development of evidence-informed counseling interventions specific to NDL. Current conceptual literature encourages the use of counseling

strategies, such as expressive arts (e.g., Buser et al., 2005; Neimeyer, 2022; Philpott, 2013; Rafaely & Goldberg, 2020; Thompson & Neimeyer, 2014) and mindfulness interventions (e.g., Neimeyer & Young-Eisendrath, 2015; O'Connor et al., 2014), to address bereavement. Further studies should explore the applicability of these strategies in relation to NDL. Additional studies should explore the impact of counseling interventions and support systems and meaning making strategies, both of which are believed to contribute to positive reappraisal (Stroebe & Schut, 2001).

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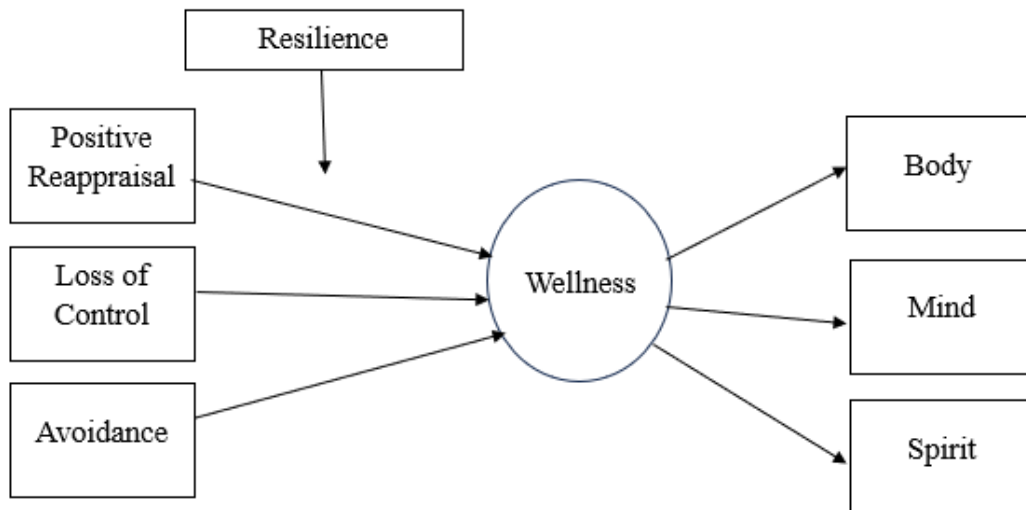
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Appendix A: Figure 2.1 Proposed SEM Map

Model A



Model B

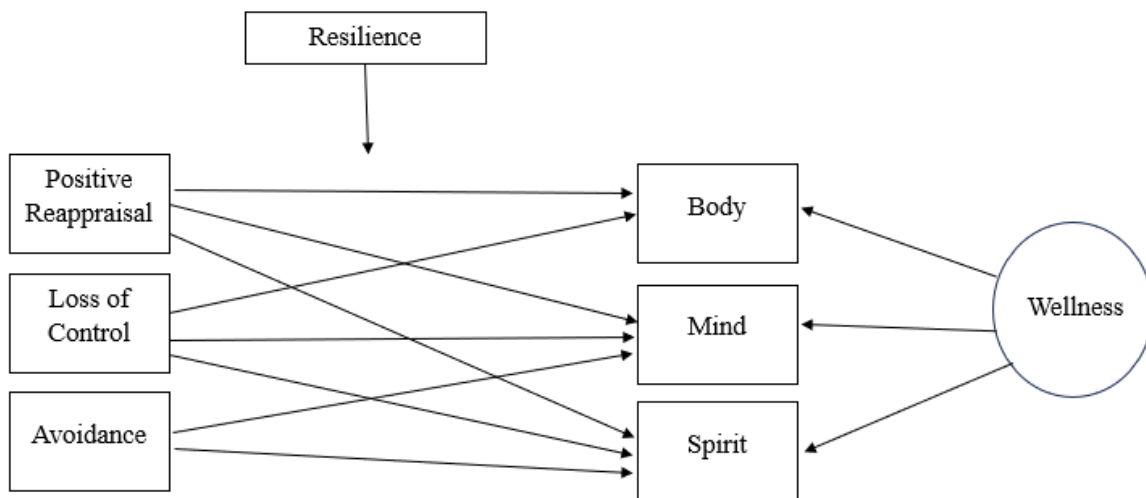


Figure 2.1

Proposed SEM Map

Appendix B: Participant Demographics

Table 2.1

Frequency Table of Demographics

Variable	<i>N</i>	%
Gender		
<i>Agender</i>	7	1.52
<i>Genderqueer or Genderfluid</i>	12	2.60
<i>Indigenous conception of gender (e.g. māhū, muxe, or two spirit)</i>	10	2.16
<i>Man</i>	204	44.16
<i>Non-Binary</i>	6	1.30
<i>Questioning or Unsure</i>	4	0.87
<i>Woman</i>	239	51.73
<i>Another Gender Identity</i>	1	0.22
<i>Transgender</i>	18	3.90
<i>Questioning Transgender</i>	7	1.52
Age of Participant		
<i>18-24</i>	67	14.50
<i>25-30</i>	61	13.20
<i>31-35</i>	67	14.50
<i>36-40</i>	86	18.61
<i>41-45</i>	53	11.47
<i>46-50</i>	16	3.46
<i>51-60</i>	38	8.23
<i>60+</i>	45	9.74
Racial and Ethnic Identity		
<i>Asian/Asian American</i>	32	6.93
<i>Biracial or Multiracial</i>	22	4.76
<i>Black/African American</i>	70	15.15

Table 2.1 Continued

Variable	<i>N</i>	%
<i>Indigenous (American) or Alaska Native</i>	7	1.52
<i>Latinx, Hispanic, or Spanish Origin</i>	57	12.34
<i>Native Hawaiian or Pacific Islander</i>	7	1.52
<i>White/Caucasian</i>	309	66.88
<i>Another race or ethnicity</i>	3	0.65
Sexual Orientation		
<i>Aromantic/Asexual</i>	8	1.73
<i>Bisexual/Pansexual/Fluid</i>	62	13.42
<i>Gay</i>	19	4.11
<i>Lesbian</i>	20	4.33
<i>Queer</i>	2	0.43
<i>Questioning/Unsure</i>	8	1.73
<i>Straight (heterosexual)</i>	346	74.90
<i>Other – Demisexual</i>	1	0.22
<i>Prefer Not to Say</i>	6	1.30
Date of NDL		
<i>1-2 Months ago</i>	68	14.72
<i>3-4 Months ago</i>	86	18.61
<i>5-6 Months ago</i>	97	21.00
<i>7-8 Months ago</i>	59	12.77
<i>9-10 Months ago</i>	44	9.52
<i>11-12 Months ago</i>	94	20.35

Note. N = 462.

Appendix C: Table 2.2 BMS-WBCI EFA Results

Table 2.2

Results from an Exploratory Factor Analysis on the Body-Mind-Spirit: Wellness Behavioral and Characteristics Inventory (BMS-WBCI)

BMS-WBCI Item	Factor Loading		
	1	2	3
Factor 1: Spirit			
Spirit1: I experience harmony within.	0.60	0.16	0.05
Spirit2: I experience peace of mind.	0.75	-0.11	0.04
Spirit3: I am in touch with the soul within.	0.61	0.08	0.07
Spirit4: I experience happiness within.	0.75	-0.02	-0.06
Spirit5: I experience joy within.	0.78	0.02	0.02
Spirit6: I experience self-satisfaction.	0.58	0.02	0.20
Spirit7: I express my spirituality appropriately and in healthy ways.	0.61	0.16	-0.01
Spirit8: My spirituality helps me remain calm and strong and helps me to better deal with difficult times.	0.62	0.14	-0.06
Spirit9: I recognize the positive contribution faith can make to the quality of my life.	0.71	0.03	-0.15
Spirit10: I routinely undertake new experiences to enhance my spiritual health.	0.62	-0.15	0.12

Table 2.2 continued

BMS-WBCI Item	Factor Loading		
Spirit11: I have a positive outlook on life.	0.56	0.12	0.01
Spirit12: I am content with who I am.	0.56	0.09	-0.01
Spirit13: I know my purpose in life.	0.73	-0.07	0.05
Spirit14: I read some form of spiritual literature on a regular basis.	0.63	-0.10	0.09
Spirit15: I experience love of others and myself.	0.61	0.09	0.09
Factor 2: New Mind			
Mind1: I learn from my past life experiences.	0.10	0.63	0.05
Mind2: I am open to new ideas.	0.00	0.64	0.02
Mind3: I learn from my mistakes and try to behave differently the next time.	0.03	0.62	-0.04
Mind4: I talk with people rather than talk at people.	-0.09	0.56	0.17
Mind5: I accept responsibility for my actions.	0.06	0.64	-0.13
Mind6: I understand and accept the existence of cultural diversity and its contribution to the quality of living.	-0.12	0.74	-0.01
Mind7: I make good ethical decisions.	0.07	0.67	0.05
Mind8: I consider alternatives before making decisions.	0.00	0.54	0.14

Table 2.2 continued

BMS-WBCI Item	Factor Loading		
Mind9: I focus on reality.	0.05	0.67	0.02
Mind11: I have strong morals and healthy values.	0.13	0.55	-0.05
Mind18: I analyze my thoughts (I think, question, and evaluate) before I act.	0.24	0.49	0.07
Factor 3: New Body			
Body2: I maintain my fitness by exercising regularly and maintaining my weight.	0.03	0.10	0.69
Body3: I have a reasonable amount of flexibility and do exercises that help maintain my range of motion.	0.14	0.05	0.47
Body4: I use warm-up activities before exercising to help prevent injuries.	0.13	0.01	0.54
Body5: I eat a variety of foods and get the recommended number of servings from each food group.	0.09	0.18	0.50
Body6: I eat a balanced diet low in saturated fat and cholesterol.	-0.06	0.14	0.63
Body7: I participate in recreational sports or activities that help maintain my fitness.	0.04	-0.21	0.70
Body9: I surround myself with physically healthy people.	0.18	0.06	0.41

Appendix D: Table 2.3 RTL EFA Results

Table 2.3

Results from an Exploratory Factor Analysis on the Reactions to Loss Scale (RTL)

RTL Item	Factor Loading	
	1	2
Factor 1: Loss Impact Behaviors		
A3: I thought about how things would be if this had not happened	0.59	0.00
A4: I refused to believe this had happened	0.54	0.21
A7: I wished this was all over and behind me	0.53	0.11
A8: Talking about the loss(es) only made me feel worse about it	0.61	0.01
A9: I tried hard not to think about the loss(es)	0.41	0.17
A10: I wished I could change how I was feeling	0.63	-0.05
LC1: Slept more or less because of the loss(es)	0.67	-0.18
LC2: I felt hopeless about anything improving in my life	0.51	-0.02
LC3: Ate more or less than usual because of the loss(es)	0.59	0.08
LC4: I felt my emotions were out of control after the loss(es)	0.60	0.03
LC5: Used alcohol or drugs to cope with the loss(es)	0.57	0.09
LC6: Change in amount of sexual activity following the loss(es)	0.48	0.21
LC7: Had trouble concentrating on work or my studies because of the loss(es)	0.72	-0.02
LC8: Engaged in decreased physical activity after the loss(es)	0.54	0.01
LC9: Withdrew from friends and family because of the loss(es)	0.76	-0.08
LC10: I could not stop thinking about the loss(es)	0.66	-0.05
Factor 2: New Positive Reappraisal		
PR1: I continued to be optimistic about my future even after the loss(es)	-0.10	0.64

Table 2.3 continued

RTL Item	Factor Loading	
PR2: Engaged in religious, spiritual, or personally meaningful activities to make sense of the loss(es)	0.13	0.59
PR4: I started to see some positives in my life after the loss(es)	-0.04	0.74
PR5: I rediscovered what is important in life	-0.09	0.77
PR6: I became a more tolerant person following the loss(es)	0.16	0.64
PR7: Increased desire to help others in need after the loss(es)	0.22	0.46
PR8: I began to feel stronger because of dealing with the loss(es)	-0.03	0.82
PR9: I am better able to empathize with others after the loss(es) I tried hard not to think about the loss(es)	0.26	0.46
PR10: Changed or grew as a person in a good way	-0.01	0.75

Appendix E: Figure 2.2 SEM Model A1

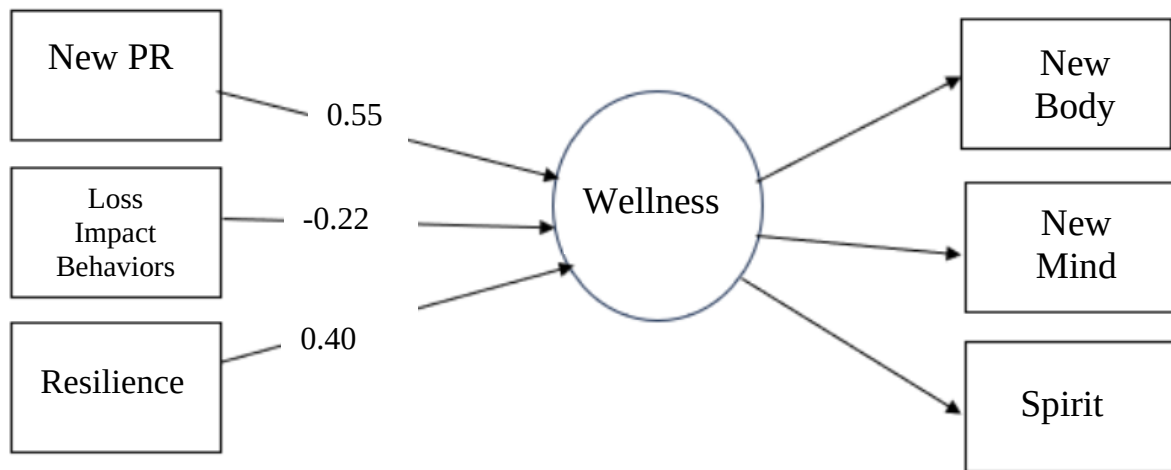


Figure 2.2

SEM Model A1

Appendix F: Descriptive Statistics of Variables

Table 2.4

Descriptive Statistics of Variables

	Mean	Median	SD
Initial Model			
Body	18.38	19	4.05
Mind	47.75	49	7.36
Spirit	32.57	33	7.29
Resilience	24.94	25	6.95
Positive Reappraisal	37.08	37	9.47
Loss of Control	36.22	37	10.29
Avoidance	38.09	38	8.69
New Model			
New Body	14.04	14	3.58
New Mind	26.93	27.22	4.52
New Positive Reappraisal	33.12	33	8.99
Loss Impact Behaviors	59.52	61	15.35

Appendix G: Figure 2.3 SEM Model C

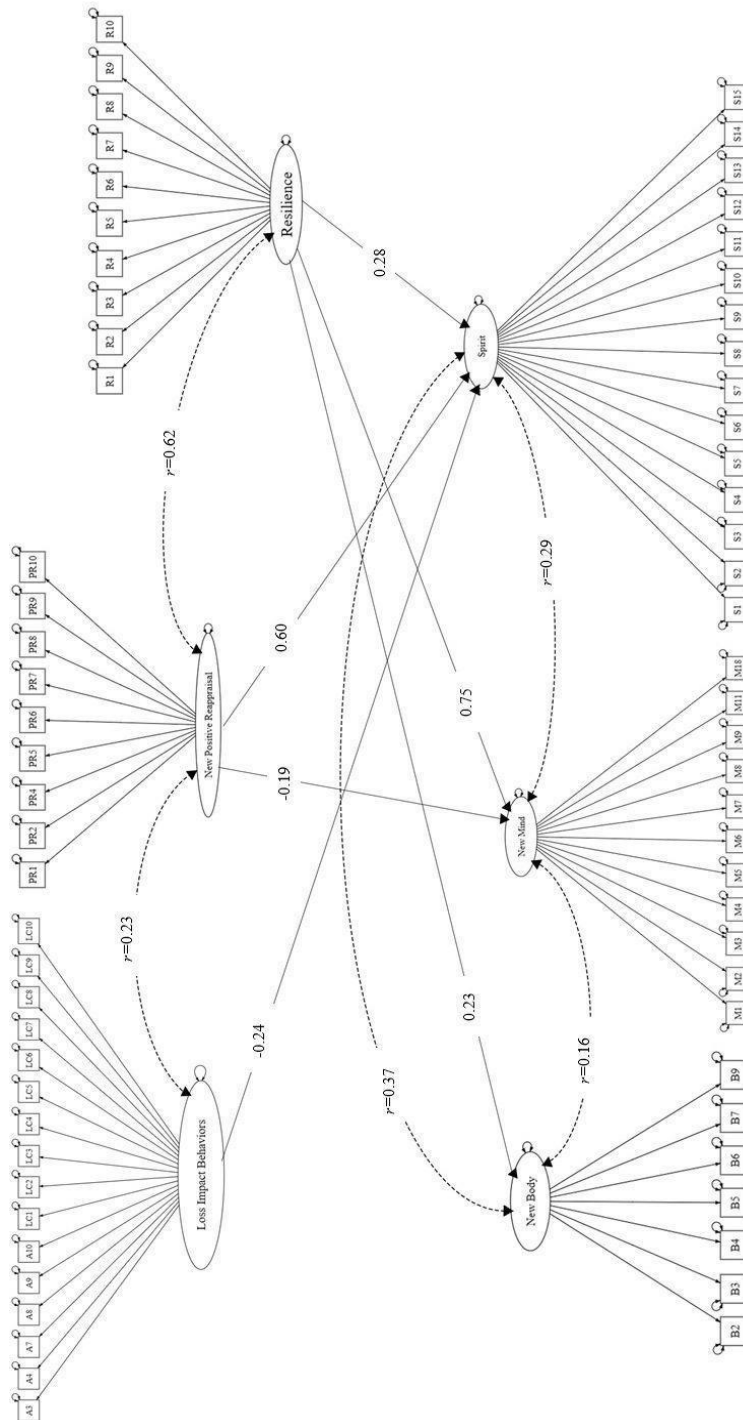


Figure 2.3

SEM Model C

Appendix H: Variable Correlation Table

Table 2.5

Variable Correlation Table

	New Body	New Mind	Spirit	Resilience	New Positive Reappraisal	Loss Impact Behaviors
New Body	0.81					
New Mind	0.36**	0.83				
Spirit	0.64**	0.49**	0.92			
Resilience	0.50**	0.63**	0.66**	0.87		
New Positive Reappraisal	0.56**	0.27**	0.71**	0.62**	0.88	
Loss Impact Behaviors	0.02	-0.09	-0.12	-0.06	0.23*	0.92

* $p < 0.05$

** $p < 0.01$

¹ Cronbach alphas are reported along the diagonal

Appendix I: Screening Procedure

- Are you at least 18 years of age?
 - If yes – continue to next set of questions.
 - If no – Thank you, but not a good fit message:

Thank you for your time. We genuinely appreciate your help in learning more about non-death losses. Unfortunately, you are not a good fit for our survey at this time.

We're sorry for the loss you've experienced. For assistance managing your loss(es), you can find resources here:

<https://whatsyourgrief.com/>

<https://modernloss.com/>

- Do you currently live in the United States or US Territory?
 - If yes – continue to next set of questions.
 - If no – Thank you but not a good fit message, see box above
- Have you experienced a significant death loss in the past 24 months?
 - If no – continue to next set of questions
 - If yes – Thank you but not a good fit message, see box above
- The following is a list of losses some people experience. Please indicate any losses you have experienced in the last 12 months.
 - If participants select “I have not experienced any non-death losses in the past 12 months,” they will be sent to the termination page, see above
 - If participants select any of the following NDLs, they will be sent to the survey welcome page.

○ Loss History Checklist Revised (modified)

	My own divorce, separation, or loss of romantic partner		Loss of independence, freedom, and/or control
	Divorce or separation of parents		Loss of potential, dreams, and/or goals
	Loss of neighbor(s) or coworkers		Loss of mental health
	Loss of doctor(s), counselor/therapist, support person(s)		Loss of physical health and/or functioning
	Loss of contact with parent(s), sibling(s), or child(ren) (biological/adopted/foster)		Loss of a life as it was and/or hope
	Inability to have children (infertility or other reason)		Loss of personhood, respect, and/or privacy
	Temporary separation due to employment, military development, or other reason		Loss of spirituality/faith
	Loss of home/residence, neighborhood, and/or being houseless		Loss of trust, safety, and/or security
	Loss of support services or comfort		Loss of childhood/innocence
	Loss of possessions		Loss of country/homeland (refugee/resettlement)
	Loss of identity		Loss of confidence and/or self-esteem
	Abuse (all forms)		Acts of war or terrorism
	Loss of job/career/ability to work		Any other non-death losses not mentioned?

Appendix J: Demographic Survey

Thank you for choosing to participate in this study. The purpose of this section is to collect basic information that provides important context to our study. Please answer to the best of your ability.

- Gender Identity (select all that apply):
 - Agender
 - Genderqueer or genderfluid
 - Indigenous conception of gender (e.g. māhū, muxe, or two spirit)
 - Man
 - Non-binary
 - Questioning or unsure
 - Woman
 - Another gender identity [Fill in the blank space]
 - Prefer not to say.
- Do you consider yourself to be transgender?
 - Yes
 - No
 - Questioning
 - Prefer not to say.
- Sexual identity/orientation (select all that apply):
 - Aromantic/Asexual
 - Bisexual/Pansexual/Fluid
 - Gay

- Lesbian
- Queer
- Questioning/Unsure
- Straight (heterosexual)
- Another sexual identity/orientation (please specify below)
- Prefer not to say
- What is your age?
 - _____
- How would you describe yourself? Choose as many as needed.
 - Asian/Asian American
 - Black/African American
 - Indigenous (American) or Alaska Native
 - Latinx, Hispanic, or Spanish Origin
 - Multiracial or Biracial
 - Native Hawaiian or Pacific Islander
 - White / Caucasian
 - Another race or ethnicity [Please self-identify]
 - Prefer not to say
- What is your marital status? [drop down bar]
 - Single (never married)
 - Married or in a domestic partnership
 - Widowed
 - Divorced

- Separated
 - I prefer not to disclose
- What is your present religion, if any?
 - Agnostic
 - Atheist
 - Buddhist
 - Christian (any denomination)
 - Hindu
 - Islam
 - Judaism
 - Sikh
 - Traditional or Indigenous Belief System
 - Not Religious
 - Another religious system [A blank entry field for the participant to self-identify]
- Where do you currently live? [drop down bar]
 - Alabama
 - Alaska
 - American Samoa
 - Arkansas
 - California
 - Colorado
 - Connecticut
 - Delaware

- District of Columbia (DC)
- Florida
- Georgia
- Guam
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire

- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Northern Mariana Islands
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Virgin Islands
- Washington
- West Virginia
- Wisconsin

- Wyoming

Appendix K: Body-Mind-Spirit: Wellness Behavioral

Instructions: This section should be representative of your current behaviors. Please rate on a scale of 1 (rarely/seldom) to 3 (often/always), the extent to which the following statements fit for YOU in your daily life since your non-death loss experiences.

- **Body**
 - I limit risky behaviors (i.e., drive fast, bungee jumping, parachute, etc.).
 - I maintain my fitness by exercising regularly and maintaining my weight.
 - I have a reasonable amount of flexibility and do exercises that help maintain my range of motion.
 - I use warm-up activities before exercising to help prevent injuries.
 - I eat a variety of foods and get the recommended number of servings from each food group.
 - I eat a balanced diet low in saturated fat and cholesterol.
 - I participate in recreational sports or activities that help maintain my fitness.
 - I drink at least eight glasses of water a day.
 - I surround myself with physically healthy people.
- **Mind**
 - I learn from my past life experiences.
 - I am open to new ideas.
 - I learn from my mistakes and try to behave differently the next time.
 - I talk with people rather than talk at people.
 - I accept responsibility for my actions.

- I understand and accept the existence of cultural diversity and its contribution to the quality of living.
- I make good ethical decisions.
- I consider alternatives before making decisions.
- I focus on reality.
- I am flexible to changes and can maintain stability in my life in healthy ways.
- I have strong morals and healthy values.
- I learn from the mistakes of others.
- I have satisfying interpersonal relationships.
- I feel loved and supported by family and friends.
- I am tolerant of others whether or not I approve of their behavior or beliefs.
- I set achievable goals for myself.
- I handle various social settings well.
- I analyze my thoughts (I think, question, and evaluate) before I act.
- I make the best of bad situations.
- I express my feelings with others and consider their feelings.
- Spirit
 - I experience harmony within.
 - I experience peace of mind.
 - I am in touch with the soul within.
 - I experience happiness within
 - I experience joy within.
 - I experience self-satisfaction.

- I express my spirituality appropriately and in healthy ways.
- My spirituality helps me remain calm and strong and helps me to better deal with difficult times.
- I recognize the positive contribution faith can make to the quality of my life.
- I routinely undertake new experiences to enhance my spiritual health.
- I have a positive outlook on life.
- I am content with who I am.
- I know my purpose in life.
- I read some form of spiritual literature on a regular basis.
- I experience love of others and myself.

Appendix L: Reactions to Loss Scale – Modified

Note: The Reactions to Loss Scale (RTL) is under copyright by the creators. You can get additional information on the RTL by contacting an author, Dr. Toray at torayt@wou.edu. The following scale represents the final items used for analysis but must not be used as an assessment on its own.

Instructions: These questions focus on your reactions to your loss. Think about your loss experience(s) as you complete this section. Following my loss(es), I reacted in the following ways:

Factor	Prompt
New PR	I continued to be optimistic about my future even after the loss(es)
New PR	Engaged in religious, spiritual, or personally meaningful activities to make sense of the loss(es)
New PR	I started to see some positives in my life after the loss(es)
New PR	I rediscovered what is important in life
New PR	I became a more tolerant person following the loss(es)
New PR	Increased desire to help others in need after the loss(es)
New PR	I began to feel stronger because of dealing with the loss(es)
New PR	I am better able to empathize with others after the loss(es) I tried hard not to think about the loss(es)
New PR	Changed or grew as a person in a good way
Impacts of Loss Behaviors	I thought about how things would be if this had not happened
Impacts of Loss Behaviors	I refused to believe this had happened
Impacts of Loss Behaviors	I wished this was all over and behind me

Impacts of Loss Behaviors	Talking about the loss(es) only made me feel worse about it
Impacts of Loss Behaviors	I tried hard not to think about the loss(es)
Impacts of Loss Behaviors	I wished I could change how I was feeling
Impacts of Loss Behaviors	Slept more or less because of the loss(es)
Impacts of Loss Behaviors	I felt hopeless about anything improving in my life
Impacts of Loss Behaviors	Ate more or less than usual because of the loss(es)
Impacts of Loss Behaviors	I felt my emotions were out of control after the loss(es)
Impacts of Loss Behaviors	Used alcohol or drugs to cope with the loss(es)
Impacts of Loss Behaviors	Change in amount of sexual activity following the loss(es)
Impacts of Loss Behaviors	Had trouble concentrating on work or my studies because of the loss(es)
Impacts of Loss Behaviors	Engaged in decreased physical activity after the loss(es)
Impacts of Loss Behaviors	Withdrew from friends and family because of the loss(es)
Impacts of Loss Behaviors	I could not stop thinking about the loss(es)

Appendix M: Connor Davidson Resilience Scale (CD-RISC)

Note: The CD-RISC has been redacted to respect the copyright of the creators.

Instructions: Please indicate how much you agree with the following statements as they apply to you. If a particular situation has not occurred recently, answer according to how you think you would have felt.

Appendix N: Exempt Informed Consent

Consent for Research Participation

Research Study Title: Exploring Wellness Behaviors following a Non-Death Loss Experience:
A Structural Equation Model

Researcher(s): Covington Hanley, MS, University of Tennessee, Knoxville

Casey Barrio Minton, PhD, University of Tennessee, Knoxville

I am asking you to be in this research study because you reported experiencing one or more non-death losses in the last year. You must be age 18 or older and live in the United States to participate in the study. The information in this consent form is to help you decide if you want to be in this research study. Please take your time reading this form and contact the researchers to ask questions if there is anything you do not understand.

Why is the research being done?

The purpose of the research study is to learn about the relationships between non-death loss, resilience, and wellness.

What will I do in this study?

If you agree to be in this study, you will complete an online survey. The survey includes questions about your experiences following non-death loss experiences, wellness behaviors, and overall resilience and should take you about 15 minutes to complete. You can skip questions that you do not want to answer.

Can I say “No”?

Being in this study is up to you. You can stop up until you submit the survey. After you submit the survey, we cannot remove your responses because we will not know which responses came from you.

Are there any risks to me?

Some of the survey questions are personal in nature and may make you feel uncomfortable, especially if they remind you of your loss. We don't know of any risks to you from being in the study that are greater than the risks you encounter in everyday life.

Are there any benefits to me?

We do not expect you to benefit from being in this study. Your participation may help us to learn more about the impact of non-death loss on individual wellness. We hope the knowledge gained from this study will benefit others in the future.

What will happen with the information collected for this study?

The survey is anonymous, and no one will be able to link your responses back to you. Your responses to the survey will not be linked to your computer, email address or other electronic identifiers beyond the identifier provided by Qualtrics. Information collected for this study will be published and possibly presented at scientific meetings.

Will I be paid for being in this research study?

Qualtrics emailed you with information about compensation for participating in the study. You will be compensated directly through Qualtrics for your participation.

Who can answer my questions about this research study?

If you have questions or concerns about this study, or have experienced a research related problem or injury, contact the researchers, Covington Hanley, chanley@vols.utk.edu, 865-213-1597; Casey Barrio Minton (Dissertation Chair), cbarrio@utk.edu, 865-974-8382.

For questions or concerns about your rights or to speak with someone other than the research team about the study, please contact:

Institutional Review Board

The University of Tennessee, Knoxville

1534 White Avenue Blount Hall, Room 408

Knoxville, TN 37996-1529

Phone: 865-974-7697

Email: utkirb@utk.edu

Statement of Consent

I have read this form, been given the chance to ask questions and have my questions answered. If I have more questions, I have been told who to contact. By selecting “I Agree” below, I am providing my signature by electronic means and agree to be in this study. I can print or save a copy of this consent information for future reference. If I do not want to be in this study, I can select “I Do Not Agree” to exit out of the survey.

- I agree to participate.
- I do not agree to participate.

CONCLUSION

The first manuscript defined and established a basic understanding of NDL, creating a primer for counselors. That manuscript reviewed the historical theoretical processes, conceptual processes, and interventions for working with NDL. Existing literature led to suggestions on future research. This first manuscript identified a gap in the literature which the second manuscript filled. The second manuscript shed light on the relationships between resilience, NDL, and wellness. It provided empirical evidence supporting the positive impact of resilience and positive reappraisal on mental and spiritual well-being. Additionally, the findings support the validity of the Dual Process Model (DPM) in understanding and addressing NDL presenting concerns. The implications of this research for counseling practice are significant, highlighting the importance of interventions that foster resilience and meaning-making in the context of NDL. Furthermore, the study suggests avenues for future research, including longitudinal studies, alternative models, and the development of tools and assessments to enhance our understanding of NDL and its implications for well-being.

VITA

Covington is a licensed professional counselor, who has worked in multiple environments primarily with adolescents and adults. She is doctoral candidate in Counselor Education at the University of Tennessee, with additional degrees including an MS in Counseling from Carson-Newman University and a B.S. in Psychology from Wofford College. Her areas of expertise lie in Clinical Mental Health Counseling, Counselor Education, and Grief and Loss Education & Counseling. Covington's professional experience includes professional mental health counseling as well as graduate assistantships. Covington most recently developed The Science of Wellness course during her tenure as a Graduate Teaching Assistant. Her research interests include loss and grief, wellness, multiculturalism, teaching and counseling practices, and supervision.

Throughout her time at the University of Tennessee, Covington has garnered several honors and awards, such as the Association for Death and Dying (ADEC) Student Conference Scholarship, the OIT GTA Grant, the department's Graduate Student Teaching Excellence award, and the program's Outstanding Supervision Award. She has maintained active involvement in numerous professional organizations and has contributed to her field by delivering presentations and poster sessions at various conferences. Covington's instructional and supervisory roles have seen her serve as a doctoral supervisor for master's level counselors and teaching several counseling courses.