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A Counselor's First Encounter with Non-Death Loss: A Phenomenological Case Study on New Counselor Preparation and Experience in Working with Non-Death Loss

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A COUNSELOR'S FIRST ENCOUNTER WITH NON-DEATH LOSS: A

PHENOMENOLOGICAL CASE STUDY ON NEW COUNSELOR PREPARATION AND

EXPERIENCE IN WORKING WITH NON-DEATH LOSS.

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ABSTRACT

A COUNSELOR'S FIRST ENCOUNTER WITH NON-DEATH LOSS: A PHENOMENOLOGICAL CASE STUDY ON NEW COUNSELOR PREPARATION AND EXPERIENCE IN WORKING WITH NON-DEATH LOSS.

Charles P. Carrington
Old Dominion University, 2016
Chair: Dr. Nina Brown

New counselors graduating from a CACREP master's program are presumed to have competency to work with the common issues seen in clients. This study examined the lived experience and impact on new counselors when working with clients struggling with overt or covert non-death losses. Through qualitative case study of multiple (n=8) new counselors, the study presents the phenomenon of real-life experiences of counselors when first encountering clients with an issue of loss. Of primary interest was how new counselors identified loss in client's issues, how they applied theory of interventions, the counselors level of confidence in training and preparedness to deal with loss, and how they were personally affected. Convergent themes as demonstrated by consensus coding are demonstrated in a between case display with interpretations supported by current literature in themes of loss, training, and impacts on counselors.

This dissertation is dedicated to my grandfather, Tony Uchytil. You were right.

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There are many without whose help this dissertation would not have reached conclusion. I would like than my committee for their dedication of hours or reading and editing, assistance with research and guidance, and unwavering support. I would like to extend special thanks to Dr. Brown, my Chair for helping me arrive at the final topic which has become a passion for me. Through both support and challenge, Dr. Brown raised the bar and helped reach a higher level. I am also thankful for her continuous mentorship throughout the course of my studies. Dr. Myran provided new insight into the method which was new to me, giving me the confidence to continue, stretching my skills to a new level. And to Dr. Moe, who has been an inspiration in my continued studies and quest to become a competent researcher.

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CHAPTER 1

INTRODUCTION

There are numerous kinds of losses that people can encounter as they navigate life. These many presentations of loss make it difficult to accurately estimate how clients, who have encountered losses, may continue to experience the effect of loss, in direct and indirect ways, when loss may not be the focus for the presenting problem for counseling. For this study, loss is defined as a change or break with a person, object, or mental construction to which an individual has assigned meaning, and that such meaning is of such significance that the change or break produces anxiety and the need to cope with and adjust to the change (Gunzburg, 1993; Hansen, 2004; Humphrey 2009; Rando, 1984, 1993; Worden, 2009). These losses can be as mundane as change of employment or as life altering as divorce or incarceration.

There are two primary categories for loss; death related and non-death related. This study focused solely on non-death losses. Within non-death loss, three categories subsume the various loss presentations: tangible, intangible, and anticipatory losses (Harris, 2011; Hansen, 2004; Humphrey, 2009; Rando, 1984, 1993; Worden, 2009). In working with clients on a wide variety of issues, the underlying presence of loss may be unknown to the client, as might any co-morbidity between the loss and the presenting problem or primary compliant (Humphrey, 2009). In these cases, when hidden below the surface, the presence of loss may be overlooked.

Facing loss and grief associated with loss is a common theme among counseling clients (Goldman, 2001; House 2003; O'Tool, 1989; Stevenson, 2002; Webb, 2002). Adjusting to major loss, or a series of losses has a disruptive influence on individuals, couples and families. Understanding client loss impacts on the individual can be vital to effective interventions for both specialists and generalists (McAdams and Keener, 2008).

Within the literature, grief experts reported that they received no formal or targeted training in client loss, with exception to brief inclusion within the progress of some coursework (Harrawood, Doughty, & Wilde, 2011; Ober, Granello, and Wheaton, 2012; Sawyer, Peters, & Willis, 2013). Research suggests that over time, counselors who specialized in treating grief find their training through continuing educational sources, reading books, or as a culmination of experience. (Dunphy and Schniering, 2009). Supervision and experience over time may provide some counselors with a functional understanding of loss in clients. However, new counselors, those post-master graduates entering the field as residents working towards licensure, would not necessarily have these advantages. This study sought to understand how new counselors work with non-death loss based on their preparatory education.

There is a scarcity of literature, and most particularly of recent studies, on the extent to which new counselors encounter loss and grief or how these are recognized and presented when beginning practice in counseling. Moreover, there is a no contemporary body of work that looks at how or if new counselors identify or recognize loss or understand its companion issue of grief in commonplace issues of life. My interest was in the real-life experience of new counselors understanding of loss, their first encounter with client loss and how this has impacted their perception of counseling.

This study looked specifically at the real-life experiences of new counselors in relation to loss and grief and how these practitioners recognized, framed, or applied skills in the face of loss. I used the data from this study to determine how new counselors view or evaluate the presence of loss as a therapeutic need, how they serve their client's loss-directed needs, and if a new counselor had an informed approach or skill set from which they attempted to attend to loss. It is important to the field of counselor education to understand how new counselors develop

skill to interact with loss and grief so as to better prepare counselors-in-training (Seibert, Drolet, & Fetro, 2003).

Background

Research suggests that there may be a loss component in most all counseling encounters (Harris, 2004; Humphrey 2009; Freeman & Ward, 1993), although these may potentially be overlooked (Humphrey, 2009). The client may fail to understand personal issues as loss related. The neglect of loss as a factor in client issues could potentially subject clients to irrelevant, even harmful intervention strategies, diagnosis, or labeling (Hanson, 2004; Harris, 2011; Humphrey, 2009).

Brief Summary of the Literature

Scant contemporary literature was available on non-death loss and new counselor's handling of such loss. In response, a broader review of the literature was conducted to support the conceptual framework for the study. Based on the related literature surrounding non-death loss in general, it was possible to distill the manifestations of non-death loss into three primary categories: tangible, non-tangible, and anticipatory losses (Hansen, 2004, Humphrey, 2009). The available literature focused this study on incidences of loss rising to a level where the grief process was activated as primarily determined by the level of meaning or significance that the individual assigned to the loss (Humphrey, 2009). Once meaning has triggered grief, some level of emotional and mental processing becomes necessary for the bereft to recover and proceed with life (Hansen, 2004). It is in this recovery that sufferers may enlist the assistance of a counselor.

Tangible Loss of a Relationship

Generally recognized tangible non-death loss includes loss of relationships. These losses may come in the form of divorce, relationship breakups, or physical separations, such as military deployments, incarceration, and similar interferences with relationships (Afifi & Keith, 2004; Faber, Willerton, Clymer, MacDermid, & Weiss 2008; Finkelsteitn, 2014; Huebner, Mancini, Wilcox, Grass & Grass, 2007). Secondary loss due to relationship loss extends into loss of status, affection, parenting partnerships, economic changes, and loss of roles (Afifi & Keith, 2004; Boss, 1984; Faber, Willerton, Clymer, MacDermid, and Weiss, 2008; Harris, 2011; Landau & Hissett, 2008; Huebner, Mancini, Wilcox, Grass & Grass, 2007; Msimanga & Mberengwa 2015). Based on how secondary losses affect the individual, distress can be acted out in ways that are not obviously loss related. The manner in which the loss is understood can also impact behavior (Ritucci, Grattagliano, & Orsi, 2014); McCloud, 2011).

Other Tangible Losses

Other non-death tangible losses might include loss of ability, loss of freedom, loss of places, or loss of the familiar (Boss, 1999; Clute, 2015; Hanson, 2004; Harris, 2011; Humphrey, 2009; Pillai-Friedman, & Ashline, 2014; Sheffer, 2015; Masterton, 2014). Such losses can cause chronic sorrow, where reconciliation of memories necessary for completion of grief is blocked (Blieszner, Roberto, Wilcox, Barham, & Winston, 2007).

Intangible Losses

A second category found in the loss literature is that of intangible loss (Hansen, 2004). These intrapsychic losses tend to focus on issues of present and future attributions less visible to outsiders. Intangible attachments, such as future plans, dreams, ideas, values, trust, environments, shifts in values, shifts in roles, or other absences of significance are examples of

such losses (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008; Hansen, 2004; Powell & Afifi, 2005; Rando, 2009). Intangible losses are often associated with a primary tangible loss, such as military deployment (Faber et al., 2008), incarceration (Bailey, 2015; Bocknek, Sanderson, & Britner, 2009), and loss of status which triggers a more existential loss (Harris, 2011; Landau & Hissett, 2008; Pillai-Friedman & Ashline, 2014; Worden, 2009). Of note in the literature are the more unique needs of children in regard to loss. Children are routinely affected by choices that are made by adults who fail to recognize the significance of the loss impact on younger children (Abicht, 2014), viewing the loss indicators as willful misbehavior (Boss, & Carnes, 2012; Boss, 2002, 2006, 2007; Lee & Whiting. 2007). It may be inferred that unresolved childhood loss may continue into adulthood, affecting life and manifesting in other forms, which may become recognized in the course of counseling.

Anticipatory Loss

Finally, anticipatory loss includes anticipation of a pending loss, activating the grief process before the actual loss is experienced (Humphrey, 2009). Anticipatory loss is a reaction to a presumed cluster of losses, and activates regret, remorse, and grief prior to the actual loss. For example, a diagnosis of a degenerative disease triggers the loss in advance of the manifestation of the actual loss.

Treating Loss

The collective understanding of how to treat loss and grief has changed over time, and past preoccupations with stages have been rejected, followed by a more flexible task oriented notion of the process of grief. Contemporary theories now include the understanding that more than simple tasks must occur. The development of the Dual Process Model (Stroebe & Schut, 1999, 2001) of treatment has embraced the tasks as part of a continuous encounter with both

emotional and cognitive adjustments which overlap, cycle back, and continuously accommodate new information and feelings (Folkman, 2001; Neimeyer 2001); Bonanno & Kaltman, 1999; Litz, 2004; Malkinson & Rubin, 2007; Stroebe & Schut, 1999, 2001).

The literature revealed several holes in the continuity between the need of the client, the application of theory, and the activities of counselors surrounding loss. Moreover, the role of the counselor supported in theoretical research appears to be missing in the application of training and practice. This supported the primary research assumption that new counselors may struggle to meet the needs of clients suffering from loss issues. While some clients may perceive a loss, the literature indicates that with some losses, there is a prevalence of secondary loss and complications which often go unnoticed by the client, but may impact the client's life and functioning in hidden ways (Abicht, 2014, Hansen, 2004; Humphrey, 2009; Rando, 1984, 1993; Worden, 2002). When left unresolved the literature showed that complications to the grieving process can delay, or in some cases, halt loss reconciliation, produced distress in clients (Rando, 1984, 1993). In considering the available literature, it becomes clear that there is a general body of work that points to the need for competency and awareness in counselors, but little evidence that such competency existed as a result of intentionality within the profession.

Statement of the Problem and Research Questions

Research Problem

New counselors face many challenges when first entering the field out of their formal graduate training. Research shows that non-death loss is among those most common client issues. The research also indicates that new counselors first entering the field are unlikely to have loss specific training which would allow them to identify loss as the etiological basis of client distress. When lack of accurate assessment is present, clients may be subjected to improper or

ineffective treatment. New counselors who are underprepared may be negatively impacted by facing strong loss components in clients. Research has suggested that preparation of counselors to increase both competency and confidence is absent in the topic of loss and grief.

Research Questions

This study was guided by the following questions:

- RQ1. To what extent are new counselors aware of the presence and impact of non-death loss in resolving client issues?

- RQ2. To what extent do new counselors feel confident that they can identify client's non-death losses and work with these?

- RQ3. How does working with non-death loss directly, or indirectly, affect a new counselor?

Purpose of the study

The purpose of the study was to examine the experience and impact on new counselors when working with clients struggling with overt or covert non-death losses. The study used the real-life experiences of counselors when they first encounter clients' issue of loss and grief. Of primary interest was how new counselors identified loss in client's issues, how they applied theory of interventions, the counselors level of confidence in training and preparedness to deal with loss, and how they were personally affected.

Rationale

Significance

Findings from this study may heighten counselor awareness about the possible relationship of non-death loss to a client's presenting problems, even when loss as etiology is not known by the client. This study provides a backdrop for future pedagogies in counselor

preparation, and confirms that current pedagogies are not sufficient in preparing new counselors for work in the presence of grief and loss. By examining other counselor's perspective on their level of preparedness, the study demonstrates the level of competency present in new counselors, and answers the question of if new counselors feel that they are competent, or if not, how was loss addressed, as well as how they achieved competency in the area of grief and loss, if at all.

Delimitations

This study focused on new counselors, not counselors with advanced experience or additional loss or grief training beyond that which they acquired in their program or internship. The focus on new counselors was chosen out of interest in how application of loss and grief skills occurred for those counselors who primarily relied on their master's level training from a Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited university.

The study examined counselors who had graduated from an CACREP accredited universities within the United States, and who were currently in residency in counseling working towards licensure. Participants were recruited from regional clinics, organizations, practices, and institutions directly by the researcher using purposive convenience sampling to attain a representatively diverse sample. Eight (n=8) final participants were be chosen from the pool of respondents to provide maximum diversity. All participants were asked to compete a demographic profile which described basic demographic information, plus specific questions pertaining to their training, exposure level, and attitudes surrounding the nature of loss, grief, and trauma in clients.

Limitations

Limitations inherent in this study included the inability to control for extra-curricular loss and grief preparation by the participating new counselors. Likewise, personal experience with loss and grief, and personal counseling may have altered the new counselor's view and understanding of loss. Finally, some new counselor participants were not aware of loss or grief components in counseling, other than when presented directly, and were oblivious to the impacts and insinuations of loss in their work. To reduce these uncontrolled issues, a demographic survey asked for information on additional training and personal loss or grief experiences outside of the participant's program training.

The participants were drawn from a convenience sample of respondents. It was assumed that those who responded had some interest in participating in a study on loss and grief. This may have increased the representation of an effective level of loss and grief awareness. Analysis was limited to the data collected and the literature based on structural themes as identified. Personal accounts by participants, however well intended, are prone to participant memory and image maintenance. Certain assumptions were made that participants would likely avoid looking inadequate or insufficient when reporting presumed weaknesses in application of skills.

Finally, qualitative case study methodology is influenced by the researcher in prolonged engagement and the identification of themes. Based on these influences, the level of generalizability from this study is limited.

Assumptions

In preparing this study, three defining study propositions (Yin, 2014) framed the study: 1) The presence of loss is common in the lives of clients (Humphrey, 2009; Niemeyer, 2000) and grief is usually present when loss is experienced, and when the break with attachment to the

person or object of loss has significant meaning attached (Hansen, 2004). 2) Losses may be unrecognized by clients and counselors when not the stated issue. New counselors may find it difficult to perceive issues of loss unless they have developed skill in listing for structural themes of loss components. Loss is often overlooked when presented as normative issues until taken into a thematic whole (Humphrey, 2009). 3) New counselors may be impacted by working with client loss issues and feel unprepared (Eckerd, 2009; LaFayette & Stern, 2004; Kirchberg & Neimeyer, 1991, 1998; McAdams & Foster, 2000, 2002; Wass, 2004)

Definition of Key Terms

Ambiguous loss. A loss without a clear or discernable end, is not verifiable, cannot be cured or fixed. A dissonance is usually present where there is a psychological loss with physical presence, or a physical loss with psychological presence, or a life in transition with no predictable outcome. The client cannot get a sense of closure or move forward. (Boss 1999, 2006, 2011; Boss & Carnes, 2012)

Anticipatory Grief. Grief that begins in anticipation of a loss. Often associated with death-related loss through terminal illness. (Humphrey, 2009).

Attachment. An affectual intrapsychic bond to a person, place, object, or ideal which is held as significant by the individual, and to which one's behaviors and emotional efforts are accustomed to, and seek to maintain. (Hansen, 2004)

Chronic sorrow. Experience across the lifespan of those with ongoing disparity caused by a significant loss.

Complicated Loss. When a grief reaction becomes extreme or blocked, effectively pathologizing and complication the reconciliation process connected to a loss. (Rando, 1993; Worden 2009)

Disenfranchised loss. A loss that cannot be, or is not openly acknowledged or publically mourned, or is not socially supported but which still resonate as a loss for the individual, triggering a grief process. (Doka, 1989, 2002).

Grief. The process of coming to terms psychologically and emotionally with a loss.

Intangible Loss. Intrapsychic losses which tend to focus on issues of present and future attributions less visible to outsiders (Hansen, 2004).

Non-death loss. An individual's experience of being deprived or bereft of someone, something, some opportunity, ideal, or plan which has sufficient meaning to the individual as to trigger a psychological void or yearning, accompanied by some level of grief.

Primary Loss. A significant loss event, which may be the antecedent to change and secondary losses.

Resident in Counseling (**Residency**). Post-master's status of pre-licensure under supervision of a licensed supervisor, generally sanctioned a state's licensing authority, leading to licensure as a professional counselor after completion of a proscribed number of hours of practice.

Secondary Loss. "Losses that are the consequence of a primary loss, and vary according to the individual and the contexts in which loss occurs" (Humphrey, 2009. p. 20).

Tangible loss. A loss which directly deprives an individual of a person, place, or object, and which is generally an observable event, such as divorce, injury, financial loss. (Humphry, 2009).

Overview of Remaining Chapters

In the following two chapters, an overview of the current relevant literature and the study methodology will be presented. Chapter Two presents the relevant literature from which the

study propositions were developed, as well as informative studies on the topic of working in the presence of client loss. The literature review focuses on structural themes of loss and grief when working with clients, bounded by the anticipated relevant factors of training, responding to loss, and a presumption of affective responses by new counselors. Theoretical propositions were assumed to frame this study, based on researcher assumptions inferred from missing or scarce literature about new counselors pertaining to loss and grief competencies.

In chapter three, the methodological approach to the study is outlined in detail. The chapter covers the purpose and boundaries of the case study, and outlines the selection of participants, the development of interview protocols, and data analysis to present a robust study. Within chapter three, a detailed plan for structuring a trustworthy qualitative design is presented. Researcher biases and assumptions bracketed the study, with safeguards to promote trustworthiness and replication for credibility.

Summary

This qualitative study looked at how new counselors perceive, identify, and address non-death loss in clients during the beginning stages of their career. It attempted to address the gap in the literature regarding the capacity of new counselors to recognize and treat non-death loss events effectively. This study is significant in determining the gap which exists between graduate level preparation and capacity to treat common loss events. This study was built on the current literature which demonstrated an evolution in understanding how loss affects individuals, and the role of counselors in reconciling those losses. Based on the available literature, a demonstrated gap between theory and application was implied. New counselors were suspected of being less prepared to recognize and treat non-death loss issues that seasoned counselors, but are likely to encounter them all the same.

CHAPTER 2

REVIEW OF LITERATURE

Conceptual Framework

The purpose of the study was to examine the experience and impact on new counselors when working with clients struggling with overt or covert non-death losses. The study used the real-life experiences of counselors when they first encounter clients' issue of loss and grief. Of primary interest was how new counselors identified loss in client's issues, how they applied theory of interventions, the counselors level of confidence in training and preparedness to deal with loss, and how they were personally affected.

A keyword search of available literature was made, yielding no direct or seminal studies on new counselor's experience in working with non-death losses. From this search, it was concluded that prior research into the lived experience of new counselor's first encounters with loss as a client issue is under studied. Indirectly related research on contributory topics, such as counselor training and application of loss theory, were equally thin. In the absence of current research, it became necessary to cast a wider net. In doing so, this literature review now contains some older literature, as well as relevant contributory literature to help establish the propositions to this case study. Presented is literature on related issues to broaden understanding of the issues of non-loss and grief. Within this literature review, definitions of non-death losses, how loss and grief may present in clients and the potential impacts of working with loss will be considered. Finally, the available current literature is presented to establish the study propositions.

Data Bases Searched included APA PsycNET, ProQuest, EBSCOhost and Psy-Info. Finding no direct studies, an open search of all databases available, including Google Scholar was added.

Definitions and Classifications of Loss

Loss is experienced when an individual is deprived, or believes themselves to be deprived, of something which they deem meaningful, often described as either a death or non-death loss (Humphrey, 2009). Death is typically understood as a legitimate loss demanding some level of coping and adjustment. However, non-death losses can also place significant challenges on the lives of people (Humphrey, 2009). Social constructs, cultural norms, and personal framing of loss events can negate or complicate the recognition and processing of non-death loss. This study focuses on these non-death losses. To better understand the impacts of non-death loss, three loss categories recognized in the literature have been established which subsume losses expected to be seen in counseling clients; tangible, intangible, and anticipatory losses. Definitions for these constructs were defined in chapter one.

Typical Loss Experiences in Adulthood

Loss can be a powerful agent of change for adults. Loss may be reconciled, avoided or ignored altogether. Reconciled losses bring about a sense of acceptance and the ability to move forward. Avoidance will not resolve loss, or prevent it. Ignoring loss can trigger life complications. The significance of a loss is tied directly to the level of meaning the individual has attached to the loss (Hansen, 2004), and some losses are much more meaningful than others. Meaning is assigned based on a subjective assessment of the object or person. Some losses can be self-assessed as insignificant, and not activate the need for grief, sorrow, or sadness. Other losses are deemed much more significant, and are easily recognized as major events, requiring some level of emotional and mental processing. Hansen (2004) describes attachment with people, things, places, events, and intangibles such as hopes and dreams, as potential losses.

Non-death primary losses may be accompanied by secondary losses. Typically, the identified or primary loss will be obvious, but of equal importance to long-term mental health are the secondary losses triggered by the primary loss. A loss may trigger smaller losses creating a ripple effect of secondary loss. Adults may often dismiss these secondary losses, only to later experience complicated grief elsewhere, triggering distress, anxiety, and depression, or other symptoms seen in counseling. The next section illustrates common primary adult loss and examples of various secondary losses which may occur and go un/under attended, but which trigger grief or pathological complications none the less.

<div align="center">**Tangible Losses**</div>

Tangible non-death losses are those which are more easily identified: disablement, financial loss, job firings, theft, and divorce. A tangible loss is the deprivation of a person, place, thing, or an event to which the individual is attached, and has assigned significant meaning (Hanson, 2004; Humphrey, 2009). Most sufferers can describe the loss accurately, and recognize the emotion of grief, sadness, or sorrow that is connected to a tangible loss. Tangible losses are typically understood and recognized by others. Socially and culturally, tangible losses tend to be granted some level of empathy and space for the sufferer to adjust to the change demanded by the loss.

Loss of Relationships

One major category for tangible loss is the loss of relationships. These can include divorce, breakups, and physical absences.

Divorce. Divorce is perhaps the most common relationship loss that comes near the importance of death for many adults. The loss of the relationship is obvious. However, with that primary loss, which may in fact be viewed as a positive loss, there are secondary losses which

are not so welcome. In a study of post-divorce families, Afifi and Keith, (2004) interviewed 81

stepfamily members to assess perceived loss. The results of that study indicated three secondary

losses typical in divorce where there are children present: loss of previous family makeup, loss of

a child-parent bond with the absent parent, and loss of the child-single parent bond when that

parent remarries or re-partners. While children significantly complicate divorce related loss,

those without children suffer the loss of companion ship and identity as seen in the next

paragraph.

In addition to those child-related secondary losses, divorced individuals may also face

loss of meaningful companionship (Huebner, Mancini, Wilcox, Grass, & Grass, 2007),

relationship status, family identity (Afifi & Keith, 2004; Boss & Greenberg, 1984; Landau, &

Hissett, 2008), the active parent role (Afifi, & Keith, 2004), and family or cultural boundaries

inhibiting the grief process over the loss (Boss & Greenberg, 1984; Msimanga & Mberengwa,

2015). In relationship breakups, significant relationships which are marriages in all but name,

can exist. Until recently, same sex partners have not enjoyed the benefits of marriage protection,

spousal rights, and partnership latitude that heterosexual couples have as an established privilege.

While research on divorce among same sex partners is not available due to the more recent

phenomenon associated with the right of same sex couples to marry in the United States, the

same issues would most likely apply. However, secondary losses would also add additional

complication due to the lack of social sanctioning of relationship loss in some people's opinions.

Relationship Breakups. Similar to divorce, a relationship breakup of non-partnered

adults may go under attended, leading to disenfranchisement. In a qualitative study, Finkelstein

(2014) explored how the initiators of relationship dissolutions (n=6) experienced their grief, and

how social support impacted the process. Finkelstein found that as these relationships were

minimized, grief was experienced, even though the loss was by choice, and that the participant's grief was often disenfranchised.

   Physical Absences. Temporary loss of relationships becomes significant when the deprivation of the physical presence of another is prolonged, such as is seen with military deployments. Deployment losses impact the spouse remaining behind, the children if present, and the family or support systems which may exist. A shift in support and expectations trigger loss and grief as the loss impacts meaningful facets of life. Individual resiliency, and the uncertainty or ambiguity surrounding the loss, as well as shifting family boundaries affects those left behind (Faber, Willerton, Clymer, MacDermid, and Weiss 2008; Huebner, Mancini, Wilcox, Grass & Grass, 2007). How distress caused by the loss of a relationship is mentalized by the individual contributes to the manner in which that loss is acted out (Ritucci, Grattagliano, & Orsi, 2014); McCloud, 2011).

   Hart-Johnson (2014) conducted a qualitative grounded theory study (n=18) examining how African American females experienced adverse psychological responses do to separation by incarceration of a mate. This study demonstrated impacts of social isolation brought on by shame and guilt, as well as the grief over the loss of physical companionship and need for meaningful touch (Worden, 2009). Hart-Johnson also identifies a unique psychological impact based on the individuals continuing identification with the incarcerated spouse, creating a symbolic imprisonment concurrent with the spouse. The findings of the study indicate that the level of grieving in incarceration caused relational loss is similar to experiencing the death of a spouse.

Loss of Familiar Places

   Losses of familiar places can be related to both positive and negative events. Relocation to a new home, new town, or new job can be a grand success, but carries with it the secondary

loss of the familiar (Hanson, 2004; Humphrey, 2009). Leaving an environment includes leaving

the habituation to that environment, demanding mental and emotional accommodation. The loss

is triggered by the level of attachments left behind. With this in mind, an advancement in life can

be shrouded by an unrealized loss as secondary losses, and may therefore go unaided or attended.

Loss of the familiar can also occur when liberty has been denied. A special population,

the incarcerated (Sheffer, 2015; Masterton, 2014), find that loss of the familiar to be

overwhelming, demanding loss negotiation and grieving what is no longer accessible, but which

remains psychologically present (Boss, 2006; Boss, 1999; Lee & Whiting, 2007). Incarceration

caused loss is ever-present and recursive in the mind of those affected, due to the presence of

daily reminders in living conditions, treatment, and limitations. Those affected are at risk of

developing chronic loss, where connectivity is lost, demanding cognitive changes, but the actual

persons, objects, and events continue beyond the individual's access, which limits the

reconciliation of memories, blocking the grief process (Blieszner, Roberto, Wilcox, Barham, &

Winston, 2007).

Changes in Ability

Mental acuity, ableness, and degenerating illness are a reality for many adults. (Boss,

1999; Clute, 2015; Harris, 2011). Sexual changes due to breast cancer (Pillai-Friedman, &

Ashline, 2014) and other illnesses which alter sexual performance, libido, or confidence are

losses due to illness. Boss (2002) asserts that lack of clarity about a medical prognosis or

changes in physical capabilities can result in a loss, potentially an ambiguous loss, where the

doubt surrounding the future creates a pervasive or chronic loss and preoccupation. Injury to the

body can also alter lifestyle and ability. In the case of prolonged or permanent injury or illness,

such as with traumatic brain injuries, stroke, arthritis, lung disease, and other injuries producing

chronic pain, perceptions of ableness is affected. With changes in ableness, the alteration of prior ability can produce a strong sense of loss.

Similar to chronic pain and ability, common changes as end of life grows closer can produce significant loss (Hansen, 2004; Harris, 2011; Humphrey, 2009). Older persons typically must face and reconcile reduction of cognitive processing. Loss of partner connectivity may occur when cognitive changes limit, alter, or obliterate access to memories (Blieszner, Roberto, Wilcox, Barham, & Winston, 2007). Overall, becoming otherwise abled from a level to which an individual is accustomed alters capacity, ability, access, assumptive world views, and future goals (Young & Garrard, 2015).

Intangible Loss

Intangible non-death losses are those losses which are less obvious, and tend to be based on an intrapsychic phenomenon (Hansen, 2004). These losses tend to focus on issues of present and future attributions. Intangible attachments, such as future plans, dreams, ideas, values, trust, environments, or shifts in values, environments, or other absences of significance are examples of such losses (Hansen, 2004, Rando, 2009). A parent's hopes for their children are strongly held beliefs which can be impacted by real world interference. Realization of a thwarted dream represents a loss of future potential. It is this type of loss that defines the intangible loss.

Loss of Identity

Losses to identity are necessarily subjective. A loss that denies or alters core identification is often under-recognized by the individual and society. This disenfranchisement of loss can produce symptoms in adults. Powell and Afifi (2005) interviewed 53 adults who were adopted in relation to ambiguous loss and coping with unresolved grief. 70% reported moderate (n=19) to significant (n=18) levels of ambiguous loss. The study illustrates how personal

ambiguity influences perceptions on a broader, more subjective level. In this study, participants were found to be experiencing uncertainty and showed signs of ambiguous loss in relation to birth parents. The presence of ambiguity is a potential enhancement of loss when there is hope assigned to recovering what is lost, but no actual indication that this will ever occur. This dissonance serves to freeze the individual's grief, disallowing resolution of the loss (Boss, 1999; Boss 2006, Lee & Whiting, 2007). With this in mind, a sensitivity towards loss, real or imagined, is necessary for clinicians to hear a loss, which may otherwise escape attention.

Less innate, but equally impactful are military deployments. When a spouse has been deployed, the family and the remaining spouse must endure a change of status and family composition. Of particular impact are revisions of family roles. Faber, Willerton, Clymer, MacDermid, and Weiss (2008) sampled (n=3) reservist, spouses, and parents, and found that family boundary ambiguity was present, where members were uncertain about the family constellation, or who was currently inside or outside the current family. Spousal roles for the remaining partner changes to accommodate the absence of the deployed spouse. This change is intended to be temporary, and with the return of the deployed spouse, a re-constitution of the family occurs once again. During times of deployment, the remaining spouse, while still married, must function primarily as a single parent, and children must rely solely on the remaining parent. The family boundaries have shifted and the ambiguous loss ensues (Boss, 2007). Faber, et al. (2008) found that once the deployed member returned, over time the ambiguities dissipated and the family was able to re-stabilize once routines were readjusted. However, it is also true that in some families, repeated deployment demands a cycle of loss and adjustment.

Other losses of identity can include changes in marital and relationship status where the roles associated with that status is no longer actively present. Changes in family composition,

brought on by childhood transitions into adolescence, college, or launching into adulthood, and the empty nest can become an event of significance (Boss, 1999; Hansen, 2004; Harris, 2011; Humphrey, 2009). Career changes, financial changes, and retirement, provoke some level of loss negotiation.

Loss of Status

Self-identification can be affected due to changes in marital or relationship status, advancing into a new age group, experiencing career success, lowering of income level, changes in residence neighborhood, sexual incapacities or side effects of illness, and other external representations of existential identifications once held. Changes in any of these areas can trigger feelings of loss. (Harris, 2011; Landau & Hissett, 2008; Pillai-Friedman & Ashline, 2014; Worden, 2009). Changes that impact one's identity or status which go unreconciled can freeze the sufferer into complicated loss, reducing the perception of possible restoration of self (Boss & Carnes, 2012).

Incarceration. Bocknek, Sanderson, and Britner (2009) studied children (N=35) of incarcerated parents. The primary loss is understandable, with the absence of the social-emotional support that the missing person might have provided. A secondary loss exists in the impacts on, or alteration of the mother-child bond. Bocknek et al., (2009) found that the remaining parent, generally the mother, must now negotiate life as a single parent, while keeping the ambiguous relationship psychologically connected, despite the physical absence. Mothers who remain married while the father is incarcerated has an alteration to her role as the sole parent. Secondary losses associated with incarceration such as changing family boundaries, loss of income and social stigma offer additional complications to the family system and the individuals left behind. Mothers who are themselves incarcerated are physically separated from

their children and family, but are psychologically connected to and by their children. Secondary loss includes loss of the role of active parenting one's own child. In a study of sex offenders post incarceration (Bailey, 2015) found that offender reintegration demonstrated both primary and secondary losses due to criminal adjudications. Shame, stigma, loss of employability, long-term loss of privacy, and other life complicating outcomes of being on a sex offender registry impacted the offender, the offender's family, and those who choose to associate with the offender.

Anticipatory Loss

Anticipatory non-death losses are those which can contain elements of both tangible and intangible loss. It begins in anticipation of a pending loss, activating the grief process before the actual loss is experienced (Humphrey, 2009). This pre-loss grief is often associated with terminal illnesses. With death will come major change of relationship, perhaps of financial security, companionship, and of future plans. Anticipatory loss is a reaction to a presumed cluster of losses, and activates regret, remorse, and grief prior to the actual loss.

Loss of Capacity. Experiencing a loss of capacity can alter the assumptive world of the individual. Loss of capacity occurs when receiving a diagnosis, or experiencing the degenerative effects of already present disease, or even typical changes associated with aging. Sudden or progressive onset of illness or degenerating abilities brings secondary losses. Secondary losses can include immediate and future focused assumptions. Examples of life altering, future focused loss can include diagnosis of diseases such as Alzheimer's or Autism in a child (Boss 1999; Forrester-Jones, 2014). Rapid onset changes triggering loss of capacity can occur in young or otherwise healthy individuals, such as is seen with traumatic brain injury (Laundau & Hissett

2008), and secondary loss even when a disease is defeated can occur, such as altered sexual self-perceptions in those who survive breast cancer (Pillai-Friedman, & Ashline, 2014).

Complications in Childhood

Not all adult loss occurs in adulthood. There can be unnoticed lingering losses and their effects from event that occurred in childhood which continue to affect them as adults. This can be especially true for a childhood loss that was unrecognized at the time, which carries unresolved grief, or which was denied. Children are impacted by additional secondary losses and commonly suffer from complicated grief, with recognition of their losses going unattended and misunderstood (Abicht, 2014). An example is seen in unrecognized loss from parent decisions, which seem innocuous to the adult, but have significant secondary loss impacts on the child. With a less developed capacity for cognitive expression and articulation of feeling, children often express grief differently than adults. This has a dual outcome of causing adults to overlook the impact of losses and concomitant grief in children, and to mistake grief reactions as willful misbehavior (Boss, & Carnes, 2012; Boss, 2002, 2006, 2007; Lee & Whiting. 2007).

Ambiguity in Childhood Losses

Childhood losses categorized as physical absences, psychological absences, and transitions establish the potential for ambiguous loss for a child since often, one meaningful attribution is present while another is absent (Lee & Whiting, 2007; Boss, 1984, 1999, 2006). In ambiguous loss, often the longed for person is psychologically present, meaning he or she is still alive, but physically absent due to divorce, incarceration, or altered family makeup. Others are physically present, but can be psychologically absent such as a neglectful or inebriated parent. Transitions include changes in family boundaries as parent relationships change, new siblings may be added, others removed, and adults transition in or out of the home.

Other common losses for children which may escape the attention of adults include changing familial boundaries and composition as new siblings, parents, extended family and others enter and exit the child's world (Boss, 2006, 2007). As social constructs continue to change, children are likely to be included in some family systems that were once outside what was once considered the norm for American families. This can present challenges to children when their parents choose to alter the family constellation. Children begin to experience secondary loss of self-image as peer driven pejoratives and social judgments become known to the child (Tubbs & Boss, 2000).

Fear Perspective in Assumptive World View. In a Study, Burnham (2009) considered contemporary fears of children, such as shootings, racial tension, poverty, and gangs. Burnham examined school children (n=1033), grades 2-12, in 23 schools over a three-year period following the 9/11 attacks. He concluded that contemporary issues such as war, terrorism, and personal attack, along with historic fears like natural disasters, were prevalent in the minds of students. Such fear of disaster alters the child's assumptive world of safety and security. For children, disaster fear may be increased by viewing television news, as well as personal exposure in school. In considering personal loss in children, Faber, Willerton, Clymer, MacDermid, and Weiss and (2008) considered the impacts of military deployment on families in a study of reservists (n=16) and family members (n=18). Faber, et al., found that boundary ambiguity was present and associated concerns for the safety of the deployed family member was the key concern. Children are affected by the change of roles in the remaining parent, fear for the absent parent, and an ambiguous loss where a parent is psychologically present while physically absent (Huebner, Mancini, Wilcox, Grass & Grass, 2007).

Ableness. As children age, peers and acceptance become a central consideration in the development of self. Children with long-term health or other ability constraints may find that they become progressively excluded from the social support and interaction of other children. Parents accommodate and assimilate the reality of their child's needs and limitations early as they care for and raise the child. When the child's expectations outside the home no longer align with expectations learned in a supporting environment, loss may be triggered. Parents may not attend to the loss out of good intentions, attempting to assure the child. However, real-world children are not so kind. Social ostracizing and negative behavior will be present. The dissonance created from such an encounter is a primary loss, followed by a legacy of secondary losses. The child may not openly confront the loss with parents who can only view their child through filters of support, and instead behave the loss out with negative expressions.

Counseling Non-Death Loss

Non-death loss presents itself in much the same way as death related loss. For a new counselor, counseling of non-death loss requires and understanding of how loss presents in general, including the symptoms often seen in loss. Since non-death loss can go overlooked by the client and a new counselor, the application of appropriate loss-oriented theory assists the new counselor to assess for and treat loss, regardless of its origin. The emergent view of loss is now a perspective that encompasses the understanding of traumatic loss, cognitive stress, constructivism, social functional perspectives, trauma, and other factors which impact the individual's processing needs (Folkman, 2001; Neimeyer 2001; Bonanno & Kaltman, 1999; Litz, 2004). The current best practice of loss and grief treatment includes two-track and dual process models (Malkinson & Rubin, 2007; Stroebe & Schut, 1999, 2001), which attend to both cognitive and emotive negotiation and reprocessing.

Presentation of Loss in Clients

When loss is deemed significant by the individual, then the loss requires change (Niemeyer, 2000). While primary losses are generally recognized when they occur, the ripples of change that may accompany obvious losses, such as death, loss of a job, or divorce, are frequently under attended. Change seldom occurs in a vacuum. In reality, most losses contain layers of secondary losses which co-occur with the primary loss (Harris, 2011, Humphrey, 2009). These secondary losses can be easily overlooked.

Identification of Possible Loss Issues

Secondary Symptoms of Loss

Psychological Symptoms. The level of psychological attachment assigned to a person, an object, a place, or an ideal prefaces the degree to which an individual experiences a loss. When the attachment is of a significant level, grief is activated in the presence of loss (Warden, 2009 in Harris). When grief at some level is activated, the purpose is to adjust to the loss, a process known as "loss-adaptation" (Humphry, 2009, p.5). At one extreme, frozen grief (Boss, 2010) may occur, creating an inability to move on, as seen in unresolved grief referred to diagnostically as complicated grief (Hansen, 2004; Humphrey, 2009; Rando, 1984, 1993). The presence of frozen grief can include outward directed expressions, such as outrage expressed towards people and events. On the opposite extreme is an inward focus where usual coping processes are blocked, seen often as uncertainty and emotional or cognitive immobilization (Lee & Whiting, 2007). Other cognitive alterations can include absolute thinking, denial, resistance to change, and boundary confusion (Lee & Whiting, 2007).

Emotional Symptoms. Significant loss requires an individually unique convergence of context and attachment, which triggers an intrapersonal perception of loss, which in turn triggers

and emotional experience of sorrow or distress (Humphrey, 2009). Typical in grief, a sense of

helplessness over the loss, accompanied by depression, anxiety, and relationship conflicts can be

present (Lee & Whiting, 2007; Rando, 1984, 1993; Harris, 2011; Humphrey, 2009; Worden,

2009), often demonstrated as distress or ambivalence (Lee & Whiting, 2007). When loss

continues unresolved, or cultural supports are absent, or constant reminders of the loss are

present, chronic losses can pathologize and go unrecognized as it affects other areas of life.

(Gunzburg, 1993; Hansen, 2004; Harris, 2011; Humphrey, 2009, Rando, 1993; Worden, 2009).

Behavioral Symptoms. Lee and Whiting (2007) describe observable symptoms of loss as

rigidity in adhering to family or accustomed roles, attempts to keep the status quo, engaging in

rituals, and avoidance of the loss in conversation or action, and refusal to share, hear, or tolerate

talk about the loss. Other more ordinary behavior symptoms include crying and sorrowful

affectations, low energy levels, and potential somatic affectations (Worden, 2009).

Theories

The literature suggests that counselors focus on outcomes rather than a unified theoretical

process when working with loss. Breen (2010) found in a study of counselor's practices that

older theories are still used. Such practices, such as the Kubler-Ross five stages of grief model

(Kübler-Ross, 2009) are still presumed by some as a treatment approach for the bereft.

Contemporary grief theorists eschew such stage models. Contemporary loss and grief work

focuses on application of the Dual Process Model (Stroebe & Schut, 1999, 2001; Stroebe, Schut,

& Stroebe, 1998) where both emotional and cognitive components are treated with simultaneous

attending to the sorrow of loss, and the re-story of present and future life through cognitive

restructuring.

The experience of seasoned grief counselors helps frame the demands and impacts of counseling loss issues. Dunphy and Schniering (2009) conducted a grounded theory study of two (n=2) experienced grief counselors, and found counselor's own loss experiences had an impact on choices in their career path. Despite self-reports of competency and strong motivation to provide grief oriented counseling, the same counselors also felt affected by the work. The study found that over identification was a risk, and managing one's emotions in session was necessary.

In another qualitative study of bereavement counselors (n=6), Coyne and Ryan (2007) found that counselors drew from a range of perspectives and theoretical understanding, but at the same time made no discernable use of this knowledge from such research findings. Instead, the manner in which counselors apply skills to grief counseling seems to be derived from personal perspectives and personal choices rather than on the evidence presented by research.

When clients recognize loss, and begin to process their grief, counselors provide support to clients with three essential roles: witness, facilitator, and collaborator (Humphrey, 2009). Humphrey (2009) wrote "the past 20 years have brought an evolution of understanding in the presentation and experiences of loss, grief, and bereavement" (p. 7). Of significance is a new understanding that loss and grief are uniquely individual and subjective, which then reinforces the understanding that the process of adjustment and adaptation to loss is also unique. Listening for loss in counseling is a skill that counselors must employ to distinguish the themes of loss which may be framed by the client as normative, and therefore go unrecognized as a loss by the client (Humphrey, 2009,).

Need for Specialized Training

Working with loss requires some level of understanding and training for the new counselor, as well as instilling confidence in new counselors when working with non-death loss.

New counselors benefit from developing an awareness of how client loss can impact the them personally. Within that awareness, new counselor might consider the presence of rescue fantasies and how these may impact counseling choices. Disregarded or under attended personal biases and multicultural insensitivities may add to complications between the counselor and client. In addition, unresolved personal losses may also interfere with a new counselor's ability to meet client needs. To increase mitigate negative issues, and increase in self-care, and personal introspection provides a benefit to the counselor, and the client.

Impacts of Loss on Counselors

Ober, Granello, and Wheaton (2012) concluded in a study of counselors (n=369) that in treatment of clients, within the context of grief counseling, that proper training was the clear predictor of counselor confidence. Counselor perceptions of self-efficacy, particularly among newer counselors, is indicated as a component of treatment success. (Sawyer, Peters, & Willis, 2013).

The experiences of seasoned grief counselors helped frame the demands and impacts of counseling loss issues. Dunphy and Schniering, (2009) studied the experiences of grief counselors (n=2), and found that there is a parallel between the counselor's resolution process and their intervention style, basing client interventions on the counselor's own loss resolution experiences. They concluded that in supervision and training, the supervisee or student should be advised to explore personal loss experiences and reflect on their own resolution process, as well as application of theory, for mindful insight into self and areas where recognition of loss, or skill to counsel loss or grief, may be impacted. This provides them with the skills to take an informed approach, to know their own beliefs surrounding loss, and identify those factors which may place them at risk of encountering or experiences vicarious trauma and compassion fatigue.

Rescue fantasies. New counselors who work with clients who have recognized or unrecognized losses can experience rescue fantasies, fear and avoidance, biases, and their unconscious unresolved personal issues around their losses. Rescue fantasies (Neumann & Gamble, 1995) occur when new counselors struggle against a natural tendency to rescue or remedy client issues. Neumann and Gamble (1995) found that new therapists harbor certain rescue fantasies.

Harraway, Doughty, and Wilde (2001) studied the attitudes of counselors in training (n=11), and found that post-coursework in death and dying, and grief and loss, there was a reduction of negative affectation around the topics. Avoiding issues and situations which distress the counselor are reduced through training.

Biases. Counselor bias has been shown to affect counselor views of a client Loss associated with clients who do not fit the counselor's own worldview are inevitable (Barrett & McWhirter, 2002). Disenfranchised losses among those who identify as LGBT is common due to lack of family and social support. Barrett and McWhirter, (2002) studied counselor trainees (n=162) for positive and negative impressions of client with regard to sexual orientation. They found that factors such as counselor gender, levels of homophobia significantly predicted the perceptions of the client by the counselor. However, post-training, these biases were reduced. The study supports that training significantly predict trainee perceptions and reduction of such biases.

Unresolved personal issues. Counselors are not immune to depression and negative life issues which, when present, can strongly affect one's perception. In a random sampling (n=1000) of psychologist's, researchers found that dysthymia was often present, with a 3 to 2 ratio of females over males (Gilroy, Carroll, & Murra, 2002). These psychologists reported that they

perceived that their experience with dysthymia added to their ability to empathy more deeply with their clients. However, the study also found that these same practitioners felt more isolated from their peers, had lower energy and less concentration in session because of unresolved issues of depression. Despite their belief that their own struggle was a benefit to their client through personal empathy, the study demonstrates that among this sample group, there was a general unawareness of how unresolved personal issues were active in the application of their profession in favor of a presumption that counselor issues were a benefit, not a complication.

Caring and Self-Care. To adequately treat clients who suffer from loss, a counselor is required to give of self-resources through compassion, attending, and patience. Among concerns for counselors, particularly newer counselors, the negative impacts of caring for clients are as vital as client care itself. Adams Boscarino, and Figley (2006) studied compassion fatigue as a concern in counselor client care. Compassion fatigue is known to occur when the application of empathy for others, combined with vicarious traumatization through emotional contagion, combine to produce secondary traumatic stress (Figley, 1995; Rothschild, 2006; Stamm, 1995, 1999). The known mitigations of compassion fatigue include training and self-care. Contributors to the development of compassion fatigue include the helpers own loss and trauma history (Figley, 1995; Stamm, 1995, 1999; Rothschild, 2006).

Multicultural Considerations. Culture impacts all areas of an individual's life. Counselors are not immune to the influences of personal culture. Barrett and McWhirter (2002) considered the training and perceptions of counselors and how countertransference impacted their work with clients suffering from loss. Cultural identity, including sexual orientation, can affect loss perceptions.

Summary

While no studies seem to exist dealing directly with new counselors and non-death losses, it was presumed that many new counselors will be challenged with how to cope with clients on this topic. Non-death losses are prevalent in everyday life. While many never reach a level of significance requiring professional counseling, many non-death losses might. The level of meaning assigned to the loss will determine how the individual perceives the intensity of the loss, and how that loss may need to be attended to. In the absence of keen insight on the part of a client, it is supposed that the counselor may be required to become the witness of the loss, and guide the client to recognize and reconcile that loss. In the absence of valid contemporary studies on how new counselors experience treating non-death loss, this chapter has explored the concept of non-death related loss, presenting relevant issues and studies as the conceptual framework from which the study proceeded. Consistent with case study tradition, there is no true exhaustive method of presupposing where the data will take the study. The preceding review of relevant literature served to bound the assumptions and guided the development of the study. In the next chapter, the methodology used will be outlined to demonstrate how this conceptual framework guided the study.

CHAPTER 3

METHODOLOGY

Purpose of Study

Understanding client loss and the grieving process which accompanies it are vital components in counseling. For this study, loss was defined as a change or break with a person, object, or mental construction to which an individual has assigned meaning, and that such meaning is of such significance that the change or break produces anxiety and the need to cope with, and adjust to the change (Gunzburg, 1993; Hansen, 2004; Humphrey 2009; Rando, 1984, 1993; Worden, 2009). The purposes of this study were to investigate and understand how non-loss was framed by new counselors, to determine if new counselors know and understand how loss is common-place, and to describe how they approached or avoided the discussions about loss. It was helpful to determine how new counselor's personal loss histories and education prepare them to work with loss, how these histories related to their willingness to engage loss or an avoidance of loss in counseling, and how or if these determined the selection of therapeutic interventions.

There was a scarcity of literature, and most particularly of recent studies, on the topic of new counselor encounters with loss. Moreover, no contemporary body of work that looks at how or if new counselors identify or recognize loss, understand its companion issue of grief, in commonplace issues of life was found.

Research Questions

This study was guided by the following questions:

- RQ1. To what extent are new counselors aware of the presence and impact of non-death loss in resolving client issues?

- RQ2. To what extent do new counselors feel confident that they can identify client's non-death losses and work with these?

- RQ3. How does working with non-death loss directly, or indirectly, affect a new counselor?

Research Design

For this study, I used Qualitative Case Study design as my methodological tradition. This tradition allowed the exploration of a phenomenon within the context provided by multiple data sources, with the goal of identifying and understanding convergences of the data to better analyze and synthesize information about a topic. From the case study, inferences were made that may be generalized to a broader application. In this case, I looked at how loss and grief in clients was experienced and treated by new counselors, as well as the impact of such encounters on the new counselor.

Defining the Case

Case study methodology is a constructivist paradigm (Stake, 1995; Yin, 2006) that views truth as relative and dependent on one's perspective and reality is socially constructed. The case study method allows the researcher to collaborate closely with the participants to allow their stories to be understood (Crabtree & Miller, 1999). To establish a robust study, the study viewed the phenomenon through the lens of multiple participants, in an effort to understand the real-life experiences they revealed, leading to a convergence of experiences which was demonstrated in a convergent case display.

Rationale for Case Study Design

Case study design was appropriate for this study to understand why and how questions, where no contextual conditions appeared to be relevant to the understanding of a phenomenon,

and where there was no clear boundary between that context and the phenomenon (Yin, 2003). Case study is also appropriate when there will be no manipulation of behavior, as in this study, because the phenomenon studied and its contextual conditions had already occurred. This design allowed for the discovery and understanding of the experiences of the participants, allowing their voices to come through, and provided a guide for the interpretations on findings. (Hays & Singh, 2012). The approach was non-manipulative, offering participants an opportunity to provide detailed explanations of their answers, capturing the essences of the phenomenon in each participant's story. This allowed a deeper understanding into the experience of new counselors when entering the field as graduates, and their first encounters with issues of non-death loss.

Case Boundaries

For effective case study design, the case must first be bounded to focus the study and prevent the research from overreaching (Stake, 1995; Yin, 2003). This study was bounded in time and activity (Stake, 1995) by the participant's real-life experiences in counselor training, and by their first recalled encounter with loss and grief in their pre-license residency. The case was further bounded by definition of the phenomenon under study, which was the new counselor's perception of loss when encountered early in their career, and the context in which that encounter occurred (Miles & Huberman, 1994).

Application of Conceptual Framework

Miles and Huberman (1994) outline the purpose of a conceptual framework in qualitative case study as three-fold: to identify who will and who will not be included in the study, the relationships between participants and the topic that are present, and to establish a procedure to gather the constructs within the data into collective groups. Included in the study were participants who were in pre-license residency, and who were currently working with clients.

Their recollections of their first real-life experience with loss and subsequent grief processing were collected through live interviews.

Study Propositions

Yin (2014) asserts that case study design may emanate from the identification of study propositions from the literature available. In preparing this study, three defining study propositions framed the study: 1) The professional standards for training that suggest that new counselors training prepares them to work with common or typical client issues, including issues of trauma, which often has a strong loss and grief component. (ACA, 2005, 2010; CACREP, 2009; NBCC, 1997). 2) The presence of loss is common in the lives of clients (Humphrey, 2009; Niemeyer, 2000) and grief is present when loss is experienced and the break with attachment to the person or object of loss has significant meaning attached (Hansen, 2004). According to Humphrey (2009), losses may be unrecognized by clients and counselors when not primary or the stated issue. New counselors may find it difficult to perceive issues of loss unless they have developed skill in listening for structural themes of loss. Components of loss are often overlooked when presented as normative issues until taken into a thematic whole. 3) New counselors may be impacted by working with client loss issues and feel unprepared.

Role of Researcher

In qualitative research, it is necessary to define the role of the researcher clearly to support trustworthiness in the study. It was my role to identify the topic, design the study, create the research questions, and develop the interview protocol. I was the only individual who interviewed and observed each participant. My goal was to capture the real-life experiences of the participants.

To function in the role of qualitative researcher, it is necessary to establish "empathic neutrality" (Patton, 2002, p. 50). According to Patton (2002) empathic neutrality positions the research along a "middle ground" between being too close, which obscures judgment, to being too distant, which reduces understanding (p. 50). Empathic neutrality was maintained by engaging with the participants and establishing a collegial relationship, and through using minimal encouragers and a flexible interview protocol. The prolonged engagement with the participants to probe for details based on the overarching research questions helped to gain insight, and care was taken to limit exploration to the protocol topics to maintain the purity of the data, and to prevent a drift into a direction that supported my personal assumptions.

Units of Analysis

In seeking to understand how new counselors experience non-death loss, I looked at real-life experiences rather than quantitatively measurable data. Qualitative research supports this effort and through phenomenological inquiry, supports the study by eliciting the participants story and perception of preparedness. I considered other qualitative methods, including a single case study design and grounded theory. Qualitative case study research was determined to be the most appropriate approach in method because I was exploring a topic that is not well known or well-studied (Padgett, 1998). I concluded that a single case study would be too limited in perspective to adequately demonstrate commonalities for new counselors, which could be useful in theory building or generalizability. Instead, a holistic multiple-case design allowed a broader sample of experiences. The convergence of individual experiences, coded as individual units of analysis, provided a robust study and analysis with increased generalizability. With sparse literature regarding the perspectives of new counselors in confronting loss issues early in a career

available, choosing multiple-case study methodology to understand the phenomenon of

encountering loss early in a counselor's career is the most appropriate method.

The advantage of constructing a study within the multiple-case study tradition allows for

replication of experiences when the collected data begins to converge. The phenomenon of

under-studied topics can be best presented when a natural convergence between experiences is

demonstrated from an organic emergence. Theory building from such convergences would then

be possible, suggesting future studies using qualitative grounded theory or quantitative

experimental designs. For this study, this future focus was considered premature, based on the

scant level of understanding that exists in contemporary literature.

Researcher Assumptions and Biases

In qualitative methods, researchers must disclose their assumptions that might influence

their interpretations, inferences, or findings (Creswell, 2007). The researcher paradigm must be

clearly stated so that underlying influences become known, as these paradigms have the power to

frame and shape researcher decisions within the method. With the stated goal of understanding

new counselor preparedness to work with loss, my goal was collect real experiences, analyze

these based on the research questions, and to synthesize the findings.

When considering my own paradigm, certain assumptions were made with regard to the

ontological, epistemological, rhetorical, and axiological framing. Within the bounds of

qualitative inquiry, ontology speaks to the assumptions of the researcher regarding the nature of

truth. For qualitative research, there is not inherent truth. Truth is subjective, constructed from

the reality of experience as perceived by the individual (Creswell, 2007). While certain

commonalities were present and expected for new counselors encountering the ambiguous or

unknown, such as heightened anxiety, self-doubt, or even avoidance, no one truth could be ascribed to all participants in anticipation of subjective experiences.

Epistemological assumptions concern the relationship between the researcher and the participants (Creswell, 2007). In this study, that relationship was collaborative. My goal was to increase collaboration by meeting with participants face to face, in a setting that is familiar to them, such as their home, office, or campus. I hoped that the interview became a time when the participant could tell their story, while my role remained the interested and curious audience. By offering the participants an opportunity to review the case display created from their interview, as a member checking strategy, the collaborative relationship was also enhanced. The participants as informant offered their own narratives, leading to my deeper understanding of what it was they had to tell. In this way, we constructed an understanding of their experience together, giving a voice to the participant within the study.

Rhetorical assumptions in qualitative design are informal in contrast to quantitative design (Creswell, 2007). The study results are presented in a narrative rather than in tables of data, using participant quotes where clarity by example was desirable or needed. In qualitative design, first person is permissible and preferred when reporting on the co-constructed or shared experiences within the data collection, team consensus and final reporting is offered.

Axiological assumptions in qualitative design include consideration of the researcher's values and biases, and their potential influence upon the research in general. Knowing that this influence exists, researchers in qualitative inquiry should openly acknowledge and disclose such biases and values.

Researcher Bracketing

Bracketing researcher assumptions includes revealing researcher expectations of findings prior to beginning interviews of participants. In this study, I expected to find that new counselors would have encountered recognized and unrecognized losses early in their careers. Other expectations were that new counselors would use rescue fantasies when loss is a presenting issue, and that the new counselor may have had some personal reaction to the emotional content or context of the loss. I expected that many new counselors would not recognize loss components unless obvious or disclosed. I expected to hear participants respond to questions about how they assessed for loss during initial intake or early sessions by explaining that they do not do so as a rule. I also expected that new counselors would be unaware of the signs and symptoms of loss that are commonly mistaken for other issues. While I believe that the etiology of client presenting issues is a complex subject, and that comprehensive assessment is required, I also believe that in general, that loss is present in most, if not all, expressions of anxiety, depression, and personal distress, often labeled euphemistically as adjustment disorder.

Characteristics of Qualitative Research

Consistent with Rossman and Rallis (2003) necessary qualitative study characteristics must include data collection in a natural setting, use of multiple methods for data gathering, a focuses on the context of the data, and an analysis of the data which is fundamentally interpretive versus presupposed. This study was designed to conform with these characteristics. Data collection was conducted in the natural world by conducting interviews with participants in their homes, work location, and when necessary by phone. I used multiple methods to gather the data in addition to interviews, such as using post-interview member checking to assure fidelity to the participant's experience within my understanding, written requests for participant review of

interview transcriptions as additional member checking, and a survey to collect loss-specific training and experience levels prior to the interviews.

Using an open coding method, and semi-structured interview protocols, I attempted to capture personal meaning, rather than to shape the data to conform to preconceived assumptions. As the researcher, my primary role in the data collection was to collect data as offered by the participants, using both demographic survey and recorded interviews. I avoided using tightly structured instruments for collection of interview data, as well as constructed the demographic surveys as loosely as practical to allow for individual variations in responses, offering Likert scaling wherever possible (Creswell, 2007).

The context of the data is the focus of Qualitative research studies (Rossman & Rallis, 2003). The researcher must take a holistic view to understand the contextual factors which are not directly observable, but which flavor the participant's experiences (Marshall & Rossman, 2006; Creswell, 2007). Simply put, the collected narrative data was thematically coded and interpreted using the contextual cues within the narrative, and compared to the demographic survey provided by the participant for accurate analysis and interpretation.

Given the interpretive nature of qualitative design (Rossman & Rallis, 2003), some level of flexibility must be established. Emergent coding was used to allow the participant's voice to be heard when considering their real-life experiences (Rossman & Rallis, 2003). Following the goal of emergent coding, I used a pre-constructed interview protocol for rigor, but remained flexible and open to necessary changes once I had entered the field, allowing the participant's own experiences guide the data collection. As codes were identified from an analysis of early interviews, revisions to the protocol were made to capture unexpected data in the subsequent interviews. While flexible and open to altering the progression of questions and addition of

probing questions to assure accuracy of understanding, there remained an adherence to the overall format of the interview bracketed by the research questions to ensure rigor in the design.

Trustworthiness Strategies

In all forms of research, qualitative or quantitative, to claim total objectivity is naïve. No study is value-free (Patton, 2002). In qualitative research, the researcher brackets personal biases, values, and assumptions and seeks to collect and present the data as authentically as possible. Trustworthiness is reinforced by researcher reflexivity, transparency, and ability to confront personal biases and values with the potential to influence the study. I used continual bracketing to detect researcher bias. Bracketing continued throughout the study through documentation of the thought processes of the researcher from the beginning of a qualitative research process (Moustakas, 1994). I began bracketing my bias in this document as a proposal, and continued to do so in the study notes and reflexive journal as the process unfolded. This reflexive journal contained documentation of thoughts, ideas, and repeated questions as they occurred. Entries were recorded at critical points beginning with this document, and proceeding through development of the study, the data analysis, synthesis of findings and final reporting as needed. I remained mindful that a key focus of qualitative research method is on maintaining trustworthiness and authenticity (Patton, 2002, p. 51).

Strategies to Maintain Objectivity

Heuristic inquiry focuses on intense human experiences between the investigator and participants, and has two essential elements: 1) the researcher must have personal experience with, and intense interest in the phenomenon under study. 2) Participants must share an intensity of experience in the phenomenon (Patton, 2002, p. 107). I have taken specialized additional training outside my master's program to be prepared to meet with loss in sessions. This

additional preparation was in response to my own personal loss experiences. I am therefore aware of the potential impacts of loss as a counselor and as a client. These experiences bias me towards a belief that loss is an important and often co-occurring issue in counseling, and that competent counselors should be prepared to meet this need for clients.

To maintain objectivity (Eisner, 1997), the researcher must maintain a sense of one who defends the true nature of the object, in this case, the participant's experiences (Van Manen, 2001). This role supports maintenance of empathic neutrality (Patton, 2002) by staying close to the data and the participant to assure fidelity to the study goals, without overly-investing in a specific outcome. My interest in this study was to uncover the truth about new counselor experiences with loss. I used a naturalistic approach, which presupposed that a complete design cannot be fully specified in advance of fieldwork. A flexibility had to exist to make decisions in the field about the design, so that research follows the data, rather than have the data confirm assumptions (Patton, 2002, p. 44).

Procedure

The following describes the procedure used to conduct this study. Details on the specific components and support for the procedural choices will follow this outline.

Bracketing of researcher assumptions began with this document, and continued in a reflexive journal, using memos and notes of notable questions, thought processes, and meetings throughout the study.

Research Questions were developed cooperatively with the dissertation chair and a panel of Counselor Educators known to the researcher from various universities.

Study Design. A qualitative study design was used based on the most appropriate tradition, and this choice was defended in this document and to the dissertation committee for appropriateness.

Interview Protocol. The preliminary interview protocol (Appendix F) was constructed under the advice and consent of my Chair and the impaneled Counselor Educators assisting on the research questions.

Demographic Questionnaire. This simple survey was developed to gather basic demographic information on the participants, containing general demographic questions, plus a Likert scale of assumptions, beliefs, and attitudes surrounding the topic of treating loss.

Informed Consent. An informed consent (Appendix B) was developed to adequately inform potential participants and ensure safety wherever possible, and outline the benefits and risks known to the researcher. Participants were advised of their right to withdraw at any time without penalty.

IRB Approval. Request was made of the Institutional Review Board at Old Dominion University for approval as an exempt study, and the exemption status was granted.

Gatekeeper Identification. Gatekeepers were identified from local agencies, universities, and organizations known to the researcher to approach for help in recruiting participants.

Participant Recruitment. I constructed a general email appeal to potential participants (Appendix C), to solicit a participant pool. Minimal response from these attempts caused me to use personal appeal to known residents in counseling and the use of snowball recruitment to form a pool of eight (n=8) qualified participants from the population of new counselors within the metropolitan area of Hampton Roads, in the Commonwealth of Virginia.

Participant Selection. I used purposive sampling to form a pool (n=4) of identified residents in counseling known to me. Snowball sampling broadened the pool, gaining diversity in the sample of ethnicity, gender, and education. I contacted potential participants in person, by phone, or by email to request participation. The final participants (n=8) represent those individuals who completed the demographic form and opinion survey, and who agreed to a follow-up interview in person or by phone.

Consensus Coders. I recruited two consensus coders from pool of known graduate students in counseling to assist in the coding of the data set. Coders were trained on how to thematically code the data, and were instrumental in the development of the codebook, based on the initial coding frame established by the researcher. Consensus was reached in face to face consensus meetings at various stages of the study.

External Auditor. An external auditor was recruited from pool of known professionals with an understanding of qualitative inquiry. The auditor was asked to meet with me to discuss my efforts and documentation of the data collection and analysis process, and to review the final audit trail.

Data Collection. Data was collected in four rounds of individual participant interviews, with 2 participants in each round until saturation was achieve at six (n=6) interviews. At direction for my chair, the remaining two potential participants in the pool were added to increase the trustworthiness and thicken the data. The final number of participants in the study was eight (n=8) which exhausted the pool of appropriate candidates. Collected data was transcribed by me personally, immediately following each interview.

Coding procedures. Open coding was used for the first round of interviews to establish initial coding frame. Consensus coding of round one tested the coding frame. Codes were then

applied to round two. A consensus meeting of round two refined the coding frame to establish a code book for round three. A third consensus meeting updated and revised the codebook to a final consensus codebook. The entire dataset was then recoded and consensus reached with the final iteration of the codebook.

Data Analysis. Data was segmented into units of analysis based structural and textual themes as they were identified by me during open coding. The units were then consensus coded, and gathered into a case display by structural themes based on convergence of themes, and into subcategories as textual themes, with supporting quotes for both convergent and contrary data.

Reporting Findings. Thematic findings were reported for each structural and textural theme individually as a narrative. Interpretations were made based on the data convergences and compared to the known literature. All findings were supported by participant quotes. The findings are presented in first person narrative with supporting participant's quotes to maintain fidelity to the participant's voice and lived experiences, and is used to demonstrate the conclusions.

Entering the Field

To gain entry, I used previously established professional relationships to access local residents in counseling. I used emails and personal entreaties to *residents in counseling* and colleagues to enlist potential participants. I ended up with a convenience sample, relying on snowball recruitment for fifty percent of the available data pool since the number of initial respondents was insufficient.

Once identified, each potential participant was emailed with a formal request for participation. This email included a digital survey to be completed on-line, as well as a request

for a personal interview. Participants were selected based on purposive sampling methods to achieve as close to a representative sample as possible within the pool.

Natural setting. In keeping with Patton (2002) for data collection, choosing to conduct interviews in a natural setting allowed the participant to be comfortable and congruent within their own environment. Avoiding the power differential of having participants come to me, participants were asked where and how they preferred to be interviewed. Five chose to meet me face to face, one at my office, and four on campus. The remaining three opted for a phone interview. By allowing choice of location and method, I hoped to demystify the process and reduce environmental influences potentially created by subjecting a participant to a foreign or formal space, which may corrupt the narrative of the participant.

Ensuring Confidentiality and Safety. The Institutional Review Board (IRB) application was submitted and approved prior to conducting the data collection portion of this study. I used a digitally delivered written informed consent which was presented to and approved by the Human Subjects Review Board. Receipt and agreement was acknowledged by each participant by an affirmative response at the onset of the electronic survey before being allowed to proceed to the rest of the survey. At the interview, I re-presented the informed consent prior to conducting the interview to assure that the participant understood and was fully informed of the rights and demands of participation in this study. The informed consent included the purpose of the study, the potential benefits and risks that might be involved from their participation, as well as a strong statement that participation was voluntary and that the participant may withdraw at any time. Along with the informed consent document, the potential participant received a cover letter requesting their participation and explaining the study itself.

Potential benefits of this study included the possibility of new insights into counselor preparation needs and best practices in meeting the needs of clients who are suffering from some form of loss. Participants may have benefited directly from realization of their own need to be better informed, or empowered from their discovery that they are adequately prepared. In addition, participation in this study might have prompted the participants to consider additional factors in future assessment of clients pertaining to loss, enhancing their own application of counseling.

Potential risks to participants might have included the suggestibility of a participant who may infer a power differential between the researcher and the participant, which might influence their perception of personal competency and adequacy in the level of training they had received. This in turn might have triggered feelings or awareness of personal inadequacy or deficiency in working with non-death loss issues. I was aware of this risk and was cognizant not to push participants toward adding competencies to their training, or suggest that they might have missed out in some way, or mistreated their clients in any way.

There was no paid compensation for participation in this study.

Right to privacy. I audio recorded each interview and assigned to my written notes a code at that time which allowed me to match notes to the audio recording, and for identification of the participant by me for use in member checking. This code was as a pseudonym for the participant throughout the transcription, all coding, and in the final write up. The identity of each participant is known only to me, and was not made available to consensus coders. Once the transcript had been fully transcribed and checked for accuracy, the recording was deleted. All transcripts, memos, and field notes were tagged with the participant's code and is now kept together in a

locked file. Electronic versions are kept in an encrypted file and password protected on the hard drive of my personal computer, located in my counselling office.

Protection from Harm. The participants were not part of a vulnerable population, and as such, did not require special measures to prevent harm. I am cognizant of the potential harm of any study. I was prepared to take any necessary step to reveal, inform, and mitigate any potential harm.

Data Collection Procedures

The study collected data through a structured demographic survey, semi-structured live interviews, and field notes with pre-licensed new counselors in residency.

Demographic information. Participants completed a demographic sheet (Appendix D) prior to participating in the live interview. This demographic sheet contained a section pertaining to basic demographics such as age, gender, race, and other related information. A second section inquired about the participant's self-perception of encounters with client loss issues. The purpose of this questionnaire was to help establish a thick representation of the participant's framing of loss in general, and factors which might impact choices in the practice of counseling clients where loss may be present.

Interviews. I collected data through semi-structured interviews of 20-35 minutes in length, with a total of 8 participants who meet the basic criteria for the sample. To conduct interviews in a natural setting is important to allow the participant to be in an environment that is comfortable and familiar. Therefore, I interviewed a location convenient to the participant, or by phone if preferred by the participant. This helped limit the intimidation and formality factors of unfamiliarity, which might have altered the participant's comfort, or affect my ability to keenly

understand the client. I scheduled interviews in four rounds. Each round included two participants.

Researcher Subjectivity

Subjectivity, much like objectivity, influences a study. To remain objective is to keep true to the experience of the participants. To be subjective is to be close enough to the participants to gain a true understanding. As the key instrument, it was ultimately my job to make the participants voice audible in the study findings. Qualitative method allows for close prolonged contact with participants to allow me to understand deeply.

In an effort to maintain effective objectivity and subjectivity, I used multiple techniques including, consensus coding of data, reflexive journaling, bracketing, peer debriefing, coherence, and a complete audit trail. Consensus coding between research team members refers to the process of arriving at a consensus on what the data is saying. Each coder completed a separate coding of each transcript, then post-coding consensus was achieved through team debriefing, and finally re-coding of the data was completed once consensus reached 100%. Reflective journaling is the process of recording researcher's reactions and processes in working on all stages of the data collection, beginning with decision on protocol and instrument development, extending through the entire analysis and interpretation of findings. Bracketing refers to the intentional disclosure and suspension of the researcher's biases and expectations, based on prior knowledge of the phenomenon under study. Peer debriefing refers to the process of verifying that the findings of the study accurately present a truthful and believable representation of the participant's experiences. Coherence refers to the believability of the information provided. To establish a full understanding of client data and the interpretation of the data, coherence demands a thick description of the findings that provides the audience with an accurate and believable

understanding of the participant experience. All these trustworthy strategies were retained, along with each iteration of the codebook, disclosures, protocols, and analysis process in an audit trail.

Data Analysis

Descriptive case studies seek to describe real-life or real-life phenomenon within the context in which it occurred (Yin, 2003). The goal is to identify and present the real-life experience of the participants within the case, bounded as a group.

Data Management and Reduction

The management of data requires organizing data into meaningful form where the patterns and themes are visible. With *horizontalization*, data was grouped into clusters or themes. Based on these themes, I developed *textural* descriptions of the presenting data. Textural descriptions served to illustrate the phenomenological perspective of the participants (Patton, 2002) with clarity, and contextually group the repetitive experiences into observable units. From the textural themes, I constructed a *structural* description which presented the participant's experience of the phenomenon (Patton, 2002). The final synthesis of the data brought the full scope of the essence of the phenomenon as discerned by me into a narrative description of the essences of the experiences. I used the above process to reduce the data into cohesive and informative synthesis, which gave voice to the experience, focusing on the fidelity of the meaning ascribed to the phenomenon by the participants.

Coding Procedures

All coding was performed manually. No qualitative coding software was used beyond Microsoft Word and Excel. The data collected from each interview was first coded by me, using open coding, allowing themes to emerge naturally without presuming what might be found. I then segmented data into discernable coding units, which were provided in printed form to the consensus coders, along with the complete transcript for contextual fidelity to the intended

meaning. Codes were recorded onto separate coding sheets for ease of data entry. Transcripts were returned once coded, and were retained if the coder had made written notes directly on the transcriptions. The assigned codes were then transferred by me to an excel spreadsheet for ease of analysis.

Qualitative research is a flexible and cyclical process where the researchers become immersed in the data and gain keen understanding through prolonged exposure (Stake, 2010; Yin, 2014). To fully understand the participant's experience, a semi-structured interview process allowed participants to offer information that may not conform to researcher assumptions. This freedom added to the naturalistic goal of the study of the phenomenon. Open coding allowed textual and structural meaning to naturally emerge from the data (Chamaz, 2006). While using open or emergent coding processes, it was expected that there would be a "cyclical or recursive" (Johnson & Christiansen, 2008, p. 531) experience where data analysis informed future data collections, and data collected informed revisions of data analysis.

Patton (2002) asserts that there must be an attitude of openness by the researchers as they begin to analyze the data. Using Moustakas (1994) procedure for phenomenological data analysis, I first bracketed my prior experiences and assumptions and those of my co-coders by describing our biases. Next, I described the individual and collective experiences with the data collection and memo the coding analysis process.

The data analysis process followed an interim analysis protocol where data was transcribed and analyzed immediately after collection, prior to subsequent data collection rounds. The process continued throughout the data collection process with new data analysis revising protocols and codebooks in a cyclical and recursive fashion, which allowed me to better understand participant experiences (Johnson & Christiansen, 2008).

Following the initial open coding, a coding frame was established for use by me as research her, and the recruited consensus coders. Coding and the development of the coding frame was an ongoing process developed by team consensus. Open coding for initial data was individually developed by me. In ongoing consensus meetings, codes were compared, operationalized, and revised to establish consensus coding. From those meetings, a final coding frame was codified for use in recoding the entire data set for analysis. I used two coders other than myself, and 100% consensus was the goal. By using three coders, open coding, and consensus meeting dialogue, I was able to continually bracket biases and assumptions, reinforcing trustworthiness of the analysis.

Data Display

The results of the data were gathered into a case display which identified both structural and textual themes, based on final consensus coding choices. From the case display, the data was collapsed into common themes for final synthesis and interpretation. The final interpretation is presented in first person narrative format in chapter five, which conveys the real-life experience of the phenomenon, based on the understanding I gained from the data (Creswell, 2007). First person is appropriate to be consistent with my personal interaction in the research as a measure of transparency and my role as key instrument in the study. Within this narrative, direct quotes from the transcripts were used to illustrate to the audience the accuracy of thematic interpretations (Moustakas, 1994).

<center>**Verification Procedures**</center>

Trustworthiness in qualitative research is established by the manner in which the study is conducted; ethically, competently, and transparently. Rather than speaking of validity as in

quantitative research, qualitative researchers speak of credibility, transferability, dependability, and confirmability.

Credibility

Credibility is best established by member checking, in conjunction with triangulation of the data. It is incumbent upon the researcher to demonstrate that the study is conducted and reported appropriately in order to be credible (Marshall & Rossman, 2006). My intention was to ask participants to take member checking seriously, not as a casual experience. To facilitate effective yet efficient member checking, I asked participants to discuss the interview immediately upon completion, explaining in synopsis my gained understanding of the meaning of their experience, and a discussion on the goals and expectations in the study. I also asked them to review the verbatim transcript for errors or need to change responses to be more accurate to the meaning within their lived experience. This resulted in two levels of member checking and fidelity to the meaning as understood by each participant. This in turn provide the basis of confirmation of the dependability of the coding process when reviewed against the post-interview and data collection processes. Triangulation occurred through the use of multiple researchers coding independently (Lincoln & Guba, 1995). Through the lens of others, the credibility of interpretation was increased.

Transferability

Transferability describes the limiting of idiosyncrasy of participant experiences by finding commonality between two contexts for "fittingness" (Patton, 2002, p. 584). Patton, references Lincoln and Guba (1985) who describe fittingness as a degree of congruence between "context A and context B" in comparing data when the data are "sufficiently congruent" (p. 124). To promote transferability, I sought to demonstrate congruency where it existed, and displayed

disconfirming data where it exists. I used thick description of the process, the participants, and

the context of the study to provide multiple opportunities for the readers to conclude

transferability. This was made possible by my choice to use multiple cases to study the

phenomenon. This strengthened the usefulness of the study beyond a single case or informant

(Hays & Singh, 2012).

Dependability

Dependability in qualitative research is the equivalent of reliability in quantitative

research. Creswell (2007) recommends persistent observation to build trust. To establish

dependability, I used and external auditor who has knowledge of counseling, and no direct

investment in the outcomes of this study. The auditor was asked to examine the research process,

the final consensus codes, and themes to determine if they accurately represent the data as

collected. In addition to this outside observation of the process, continuous consultation with

peer de-briefers and consensus meetings helped to maintain consistency necessary for

dependability within the study.

Confirmability

Confirmability is to qualitative research what objectivity is to quantitative research,

determining the level of fidelity to the participant's perspectives (Hays & Singh, 2012; Lincoln

and Guba, 1985). To establish confirmability, a complete audit trail was kept. The audit trail

describes the entire research process. Included in the audit trail are initial and revised protocols,

demographic sheets, field notes, data reduction, process notes, and initial impressions, drafts of

codebooks, consensus memos, and methodological strategies applied. The audit trail was

provided to the external auditor, recruited from known professionals familiar with qualitative

research, at the conclusion of the study for verification of the findings and the fidelity to the data (Creswell, 2007). No identifying information on participants was be included.

Summary

This case study sought to understand the real-life experiences of new counselors when confronted by client issues of loss and grief. Using qualitative method, I attempted to gain keen understanding into the real-life experiences of the participants, and through narrative demonstration of my findings, giving voice to the participants regarding this phenomenon. By exploring the real-life experiences of new counselors, I sought to understand if and how new counselors experience non-death loss issues in their clients.

CHAPTER 5

ANALYSIS OF DATA

The purpose of the study was to examine the experience and impact on new counselors when working with clients struggling with overt or covert non-death losses. The study used the real-life experiences of counselors when they first encounter clients' issue of loss and grief. Of primary interest was how new counselors identified loss in client's issues, how they applied theory of interventions, the counselors level of confidence in training and preparedness to deal with loss, and how they were personally affected.

For this study, I chose a Qualitative Case Study design as my methodological tradition. Case study methodology is a constructivist paradigm (Stake, 1995; Yin, 2006) that views truth as relative and dependent on one's perspective and reality is socially constructed (Searle, 1995). The case study method allows the research to collaborate closely with the participants to allow their stories to be understood (Crabtree & Miller, 1999). The choice of using case study design is appropriate since the goal was to understand why and how questions, and where there are no contextual conditions appear to be relevant to the understanding of a phenomenon, and where there is no clear boundary between that context and the phenomenon (Yin, 2003). Case study is also appropriate when there will be no manipulation of behavior, as in this case because the phenomenon under study and its contextual conditions have already occurred. This design will allow for the discovery and understanding of the experiences of the participants, allowing their voices to come through, and provide a guide for the interpretations on findings. (Hays & Singh, 2012). The approach is non-manipulative, offering participants an opportunity to provide detailed explanations of their answers, capturing the essences of the phenomenon in each participant's story.

For effective case study design, the case must first be bounded to focus the study and prevent the research from overreaching (Stake, 1995; Yin, 2003). This study will be bound in time and activity (Stake, 1995) by the participant's real-life experiences in counselor training, and by their first recalled encounter with loss and grief in their pre-license residency. The case is further bounded by definition of the phenomenon under study, which is the new counselor's perception of loss when encountered early in their career, and the context in which that encounter occurred (Miles & Huberman, 1994). Additionally, the case is bound by the size and scope of the convenience sample available to me. The study explored the lived experiences of new counselors when working with a client's non-death loss issues at the beginning of their post-master's residency.

The research questions guiding the study are as follows:

- RQ1. To what extent are new counselors aware of the presence and impact of non-death loss in resolving client issues?

- RQ2. To what extent do new counselors feel confident that they can identify client's non-death losses and work with these?

- RQ3. How does working with non-death loss directly, or indirectly, affect a new counselor?

I collected data from eight participants, which allowed me to examine the phenomenon of first encounters with non-death loss in clients. The participants completed a brief demographic form and a survey on opinions on the nature and impact of non-death loss (Appendix E), in addition to individual semi-structured interviews. The analysis included an examination for emerging codes and themes in order to create a description of the essence of the shared experiences for new counselors'.

This chapter outlines the data collection and analysis procedures used. Presented are an overview of the participant's demographic and attitudes responses, a brief profile of the participants, the results of the study, including the structural and textual themes identified during analysis, interpretation of data, and conclusions.

Prior to implementing the study, I applied to the Institutional Review Board (IRB) at the Darden College of Education, Old Dominion University to assure protection of participants from harm, and adherence to ethical research practice. The IRB granted the exemption and authorized the study.

Data Collection and Analysis Procedures

For this case study, I used purposive sampling to form a pool of identified residents in counseling known to me. Snowball sampling broadened the pool, gaining diversity in the sample of ethnicity, gender, and education. I contacted participants in person, by phone, or by email to request participation. The final participants (n=8) represent those individuals who completed the demographic form and opinion survey, and who agreed to a follow-up interview in person or by phone.

Data Collection

Demographic Survey. The demographic survey (Appendix D) collected basic information on the participants' identified gender, age, CACREP education, time since graduation, number of completed residency hours, typical population treated, loss-oriented client experience, and loss-specific training. This allowed me to compare experience within the group to identify where differences in application of loss-oriented treatment might be a result of training and experience, if any. I identified ethnicity or race in conversation with the participant during interview preparation to assure diversity. Participants completed a digitized online survey

trough an email link. Included in the survey was a copy of the informed consent. At the start of

the survey, participants were required to confirm receipt of, and understanding and acceptance of

the informed consent within the survey as question number one, before continuing.

   Attitudes on Non-Death Loss Survey. Included in the electronic survey was Likert scaled

survey sampling the participant's attitudes, beliefs, exposure to loss theory or application. This

was included to help understand the differences between clients, and to help frame the post-

interview analysis of the interview data.

   Interview. I scheduled individual interviews at the convenience of the participants,

meeting them in a place of their choice, or by phone, or two-way video conferencing. I

conducted a separate interview with each participant, first confirming their understanding of the

informed consent, and their willingness to proceed. Digital recording captured all interview

interactions from the onset of the interview. However, I did not record post-interview

conversations were not recorded or included in the data collection or analysis. The post interview

conversations served to further check my understanding, and to provide additional

trustworthiness. I transcribed each of the interviews, and provided copies to the participant for a

final opportunity to review as additional member checking. None of the participants reported any

concerns about the final transcriptions.

   Following basic rapport building and consent, I began the structured interview following

the established protocol. During the interview, I included probing questions to aid in clarification

of the narrative if needed. In some cases, the participant added unsolicited information in

advance of the specific interview questions. The interviews were conversational nature, in effort

to collect data from lived experiences. This caused me to be flexible with the protocol,

occasionally asking questions out of sequence. Interviews were transcribed by me personally. At

the completion of every two data collections, I examined the responses and revised the protocol, resulting in four progressive iterations of the protocol. Changes to the protocol included revising the order of questions, creating a more natural flow. Each new iteration added to or revised existing questions. No questions were deleted. The final iteration of the protocol included the following questions:

1. How would you define loss, as you have seen it in your career as a counselor?

2. Tell me about the first time when you became aware of a client's issue of loss or grief?

3. How do you know when a client has loss as an issue?

4. What was the impact of this revealed loss on you as a new counselor?

5. How did you help your client with their loss issue?

6. How prepared did you feel at the time to deal with the client's loss, and the surrounding factors, or issues of loss at the beginning of your residency? (Alternatively, tell me about how you felt when working with issues of loss when you first completed your training.)

7. How often would you say loss is present for clients? (percentage of clients)

8. What assessment method or tools does the participant use to assess for loss, if any?

9. Did your own losses sensitize you? (That is, does your personal loss history or prior experience inform the participant's practice?)

10. What theory did you apply in working with that first loss client?

11. What has anything changed for you, or how you practice, when working with loss issues since that first time your encountered issue of loss in a client?

12. Now that you have progressed from those early days in residency, have you chosen

and particular approach or theoretical preference specifically for loss issues?

I used active listening skills and responded to the participants with minimal encouragers to attend to the participant, and to encourage or probe for more in-depth descriptions to increase my comprehension of the described experiences. On occasion, I used reflection to ascertain the accuracy of my comprehension to ensure clarity and fidelity to the participant's voice.

Data Analysis

The digital recordings were uploaded to a secure drive with encryption for the purpose of transcription. All recordings were then erased from the recording device once transferred. I personally transcribed each interview within 24 hours of the interview to ensure fidelity to the lived experience of the interview. The data collection took place over the span of three weeks. After transcribing the interviews, I began immersing myself in the data by reviewing each transcription for each participant separately, taking note of themes that were present. I then reviewed transcripts in pairs and updated the protocol accordingly before proceeding to the next set of interviews. I continued this process through four sets of paired interviews, and four iterations of the protocol. I constructed the first iteration of the codebook from the initial two interviews and revised the codebook after each successive pair of consecutive interviews.

Once the interviews and transcriptions were completed, I re-immersed myself in the data multiple times, bracketing out as many personal experiential biases as I could identify. Hays and Singh (2012) explain the immersion into the data, and bracketing of researcher bias by setting aside "prior explanations of phenomena" (p. 50) as *epoche*, a word that implies that the researcher has chosen to refrain from judgment by suspending and invalidating personal attitudes and commitments (Mustakas, 1994). Using epoche, I continued to review the data and bracket,

noting my feelings, challenges, biases, and concerns as I gained a sense of what the data was conveying to me. I continued to immerse in the data until I was convinced that my bracketing was complete, and the focus was purely on the voice of the participants. At this point, I began open coding to locate words, phrases, and narrative points that conveyed meaning. I segmented the data set into units of coding, based on these points of meaning. Units of coding included brief sentence fragments, full sentences, multiple sentences, and full paragraphs, based on the structural theme or textural then. From this reading, I constructed an initial codebook which was based loosely on the protocol questions. I independently coded the entire data set to codify an effective codebook prior to soliciting consensus coding.

Consensus Coding

Using a team of myself plus two co-coders, we coded the entire data set using the initial codebook. The co-coders were master's interns known to me. I coached them on coding procedures and the nature of qualitative research, and asked each to code separately. I recorded identified codes on a coding matrix that coded each data collection individually. Final consensus coding after conferencing resulted in a 90% consensus. I then used *horizonalization*, a process of considering each experiential horizon within the data individually, and moving on to new horizons as each prior horizon recedes (Mustakas, 1994, p.95). These horizons are gathered and grouped as structural themes for the purpose of analysis.

As I reviewed the coded data, and placed the results into the case display, I became aware of a lack of continuity between the manner in which the coding frame clustered the data and my understanding of the data through epoche. I realized that I had drifted from my established methodological plan, and was not fully engaging the premise of open coding. My internal sense of the phenomenon was different from that of the analysis I was providing, which was limited to

the coding frame assumptions. I recognized that to stay true to the intention of the study, I would need to discard the analysis and coding frame, and begin again with veracity to the open coding process, seeking horizons as they emerged naturally, without regard to a priori constructs.

I noted my concerns in the reflexive journal and re-immersed myself into the data seeking clarification of what was missing. It was at this point that I realized that the coding frame was tied to the protocol questions, which interrupted the natural voice of the data. I then chose to start over and used open coding to identify structural themes that attended to the study propositions, clustering textual themes according to this new matrix. The new matrix provided a more dynamic coding frame, with less structure, allowing the coding to maintain a higher fidelity to the actual participant meaning.

Using this new coding frame, I re-engaged one of the two former co-coders and asked him to recode the entire data set. I did the same. Appendix H reports the final coding with consensus for inter-reliability of coding. The result was a clearer picture of the essence of the phenomenon I was exploring, and better reflected the participant's own voiced experiences. The structural themes identified demonstrate the participants shared experiences along four structural themes, with nine textural sub-themes describing the essence of personal experiences of positive or negative cases. The final case display synthesized the essence of new counselor's early exposure to working with clients suffering from a non-death loss.

Verification Procedures

Bracketing and Reflexive Journaling

Prior to commencing data collection, I bracketed my assumptions and biases in order to be present with the participants, hearing their perspective, and immersing myself in their lived experiences. I used reflexive journaling in the form of memos and reactions to the process

throughout the data collection and analysis. I used this as a place to chronicle my thoughts and decisions to express my own self, and keep that expression external of the voice of the participants. In this process of bracketing my thoughts and assumptions, I separated myself in order to notice how the research process affected me (Hays & Singh, 2012; Watt, 2007). My study propositions were paramount in my mind throughout the process. I was aware that my assumptions, which create a bias towards viewing new counselor concerns through personal past observations, are not scientific in nature and may be wholly incorrect.

Member Checking

Member checking was done during the semi-structured interview in the form of clarifying questions and reflections, as well as post-interview review with each participant. During the review, I shared with the participants what the literature suggests about the topic, and some of the observations I had made. Using this opportunity to converse outside the interview, I was able to confirm the participant's descriptions and check my own interpretation of their meaning. Participants were both challenged and encouraged to be self-reflexive about the topic of non-death loss after the interview, with most recognizing that they were under-informed on the topic. The in-session member checking with reflection of content and clarification of meaning was the most beneficial in hearing the participant's voice clearly. I also offered each participant the opportunity to review the transcript of their interview in order to correct any misstatements that might exist through an email with attachment (Appendix G). I personally transcribed each interview within 24 hours of completing the interview. I created two sets of transcripts, one verbatim and one segmented for coding with the superfluous information in strike out text for contextual reference if needed. The unsegmented verbatim was provided to the participant. None of the participants requested or required any changes.

Thick Description

      The purpose of qualitative research design is to provide a thick description of the participants lived experience and perceptions (Hays & Singh, 2012). This requires an effort on the part of the researcher to identify the meaning behind the data provided. To accomplish a thick description, I immersed myself in the data for a prolonged period throughout the data collection and analysis process. I spent time with each participant post-interview, to allow them to reflect on the interview, hear some of the research, and assimilate this into their own understanding. Using this form of member checking, I was able to grasp the essence of meaning that each participant was attempting to transmit. To enhance the thick description, I used the initial survey data to help me frame the level of exposure to non-death loss and loss theory each participant reported. This allowed me to frame the participants' descriptions, and in some cases, struggles in describing, their own lived experiences. The collaborative nature of case study and qualitative design allowed the participants individual voices to combine and produce a chorus that describes the phenomenon of new counselor's early encounters with non-death loss issues in client treatment.

Consensus Coding

      To establish trustworthiness, I chose to use co-coders to help analyze the data. The use of a team of coders helped me to frame the participant's expressions from multiple perspectives, adding cognitive complexity to the analysis. My co-coders were master's level students of counseling, who were completing their internship at my worksite. This gave us ample time to consult after coding, conduct consensus meetings as needed, and review the findings multiple times. In the final re-coding of the entire data set, I used peer debriefing to check my biases and assumptions. My co-coder selected for as the peer debriefer has not studied the essence of non-

death loss, nor has he participated in loss work to date, so his biases were minimal and not contributing to my own. This allowed a fresh perspective on the meaning of the data.

Audit Trail

I maintained an audit trail throughout the construction of the study, and it's completing. The purpose of the audit trail was to establish the fidelity of the study and undergird the research and the process throughout the study. The audit trail includes the following: informed consent, contact email, participant surveys, participant demographics and survey results, semi-structured interview protocols, individual participant transcriptions, coding matrices, final case display, and final codebook. In addition, the codebook contains information on the data collection process used, and the analysis of the data.

Auditor

My auditor was a second year doctoral student in counseling at a university in the Hampton Roads area familiar with qualitative research methodology. We discussed the process of bracketing my assumptions, and stayed in contact during the construction of the study. Once data collection and analysis was completed, I engaged the auditor to detect biases I might have introduced into the analysis.

<div align="center">Demographic Overview of Participants</div>

Group Profile

Eight participants completed the survey and interviews. Five self-identified as female, three as male. Ages of participants were; 25, 30, 32, 35, 36, 38, 51, 54. All participants confirmed they graduated from a CACREP accredited university. Participant graduation dates ranged from 2009-2015. Each participant is actively in residency, earning hours towards licensure. The participants ranged from one month to three years in residency, with earned direct

client hours from 100 to 5000 reported hours. The majority had 1000 hours or more of direct client hours.

The participants came from a diverse experiential background, including school and college counseling, private practice, non-profit, and government organizations. The clients served and issues treated were equally diverse, with anxiety and/or depression as treatment focus present in six of eight participants. Other issues included trauma, PTSD, stress, anger, relationships, social skills, and emotional disturbances, among other mental health diagnosis.

Table 1 provides a demographic display of personal demographics, master's program, post-masters training and loss-specific training.

Table 1

Personal & Educational Demographics

	P1	P2	P3	P4	P5	P6	P7	P8
Gender	F	F	F	F	F	M	M	M
Age	25	38	32	36	35	54	51	30
Ethnicity	A.A.	WHT	WHT	WHT	WHT	HISP	WHT	WHT
M.A. Degree Completion	2014	2013	2015	2009	2009	2013	2012	2012
Post-Masters Training	No	No	Yes	No	Yes	Yes	Yes	Yes
Loss Oriented Post-Master's Training	Yes	No	No	No	No	Yes	No	No

Table 2 provides a demographic display of the participant's residency site type, the populations served, actual months of residency experience, number of hours earned, and number of loss-specific clients treated.

Table 2

Residency Demographics

	P1	P2	P3	P4	P5	P6	P7	P8
Site	College	Private	Gov't	Public School	Res. Treat.	Private	Private	Public School
Pop	18-22	All	Mandated & Volunteer	Students	All Types	Military	Adults	College
Mo's in Res.	5	24	6	1	24	18	36	36
Client Hrs.	120	5000	750	100	1000	3000	2700	1000
# of Loss-Clients	13	n/a	2	n/a	10	4	26	n/a

At the beginning, I asked all participants to complete a Likert scale survey of attitudes and beliefs pertaining to loss and grief work with clients as part of the pre-interview profile. Participants were asked to rank their responses as: 1= not at all, 2= somewhat agree, 3=neutral, 4=agree, 5=strongly agree. Table 3 presents the questions on the survey. Table 4 lists the results of the survey on attitudes and beliefs.

Table 3

Attitudes and Beliefs Questionnaire

Short Title	Survey Question
Theory	I have a working knowledge of grief theory.
Competent	I know how to work with clients who are suffering from a loss.
Trained	I have been trained in loss and grief work.
Loss v Grief	I see a difference between loss and grief work.
Assess	It is my job as the counselor to assess for loss, even if it is not reported.
Prevalent	I find that Loss is present in most client issues.
Client Stated	Clients usually tell me when they have a loss that is a problem for them.
Grief=Loss	Loss is indicated by grief.
Hidden	People can be unaware of the impact of loss on their lives or the presenting issue.

Table 4

Results of Attitude and Beliefs Survey

Short Title	P1	P2	P3	P4	P5	P6	P7	P8
Theory	1	4	1	2	2	5	2	3
Competent	2	2	1	2	2	5	2	4
Trained	2	2	1	3	2	5	3	2
Assess	4	4	4	4	4	5	2	2
Prevalent	4	2	1	2	4	5	3	1
Client Stated	4	4	5	3	4	2	2	2
Grief=Loss	1	2	3	1	2	2	5	2
Hidden	2	4	2	4	4	4	5	5
5 Stages	4	4	3	3	2	3	4	3

Grief=Death	1	1	4	1	1	1	1	1
Visible	2	4	2	2	4	3	3	2
Pers. Exper.	5	1	4	4	5	5	5	5

Individual Profiles

This section consists of an individual profile for each participant. The criteria applied for selection was to be a graduate from a CACREP accredited master's program, and to be in residency earning hours towards licensure. I did not ask about ethnicity in the demographic survey, because I had this information from prior association with the participants.

Participant 1. P1 is a 25-year-old doctoral student in her first year of study at a mid-Atlantic state public university. Her ethnic identity is African American. She self-identified as cisgender heterosexual female. P1 graduated from her master's program in 2014. She has been in residency for five months, and has completed 120 direct client hours. During that time, she has had 2 supervisors, and has treated 13 clients with known loss related issues. She reports no additional post-masters training outside her current program, but does report she has had some loss specific training. Her current residency setting is a college counseling center, where her clients are typically 18-22 years of age. The issues she sees most often are anxiety, depression, relationship issues, sexual assault, and trauma.

Participant 2. P2 is a 38-year-old White female. P2 graduated from her master's program in 2013. She has been in residency for two years, and has completed 5000 direct client hours. During that time, she has had two supervisors, and has treated no clients with known loss related issues. However, she reports loss-specific client experience. She reports no additional post-

masters training outside her current program, or any loss specific training. Her current residency setting is a major private practice counseling center, where her clients are of all ages, and who are Medicaid paid clients, typically representing lower economic status or disability. The issues she sees most often are anxiety, major depression, body image, self-esteem, and other general mental health issues.

Participant 3. P3 is a 32-year-old White female. P3 graduated from her master's program in 2015 and is a doctoral student in her second year of study at a mid-Atlantic public university, and is in her second year as a doctoral student. She has been in residency for six months, and has completed 750 direct client hours. During that time, she has had one supervisor, and has treated two clients with known loss related issues. She reports no additional post-masters training outside her current program, or any loss specific training. Her current residency setting is a government-counseling center, where her clients are adults, many of which are mandated attendees, dealing with issues of substance abuse. The issue she sees is substance abuse.

Participant 4. P4 is a 36-year-old White female. She has been in residency for one month, and has completed less than 100 direct client hours. She has had one supervisor, and has treated no clients with known loss related issues. She reports no additional post-masters training outside her current program, or any loss specific training. Her current residency setting is a college coaching center, where her clients are students. The issue reports that she works primarily with anxiety in students who are struggling with their program.

Participant 5. P5 is a 35-year-old White female doctoral student in her second year of study at a mid-Atlantic state public university. She has been in residency for two years, and has completed 1000 hours of direct client care. During that time, she has had 2 supervisors, and has treated 10 clients with known loss related issues. She reports no a loss specific training, other

than the comprehensive nature of her master's program. Her current residency setting is a residential treatment center, where her clients are of any age. The issues she sees most often in adults include Major Depressive Disorder, Bipolar disorder, Schizophrenia, Anxiety disorders. In Children, she treats ADHD, ODD, emotional disturbance and PTSD.

Participant 6. P6 is a 54-year-old Latino male who graduated from his master's program in 2013. He has been in residency for two years, and has completed 3000 direct client hours. During that time, he has had one supervisor, and has treated 4 clients with known loss related issues. He reports post-masters training to include EMDR and other PTSD specific treatment, as well as self-study on loss treatment. His current residency setting is a major private-practice counseling center, where he works mostly with military clients suffering from anxiety, depression, and marriage counseling.

Participant 7. P7 is a 51-year-old White male. P7 graduated from his master's program in 2012. He has been in residency for three years, and has completed 2700 direct client hours. During that time, he has had one supervisor, and has treated one client with known loss related issues. He reports additional post-masters training but no loss specific training. His current residency setting is a major private-practice counseling center, where his clients are primarily adults. The issues she sees most often are anxiety, depression, and trauma.

Participant 8. P8 is a 30-year-old PhD graduate from a mid-Atlantic state university. P8 graduated from his master's program in 2012 and his PhD in 2015. He has been in residency for three years, and reports having three different supervisors during that time. He has completed 1000 direct hours to date. He reports that he has no loss-specific training outside of his program, and does not report having worked with any clients who presented with loss issues in his demographic survey responses.

Results

The following section presents the results from the collected data, and the analysis of the

data set. After segmentation of data and use of open coding, I identified four structural themes,

with nine sub-themes. The first of the four themes, Identification of Non-Death Loss in Clients

contained three sub-themes: Loss definition, Methods of Assessment, Perception of Frequency in

Clients. The second theme, Subjective Experience in Working with Loss contained two sub-

themes: Past Personal Experience, Impact of Client Loss on Participant. The third theme, Sense

of Competence Post-Master's Program contained two sub-themes: Training, Confidence. The

fourth and final theme, Application of Theoretical Models in the Presence of Loss contained two

sub-themes: Theoretical Basis for Treatment of Loss, Revision of Loss Theory over Time.

Thirty-three textural themes represented as codes in the final codebook support the subthemes.

Theme 1: Identification of Non-Death Loss in Clients

Prior to the individual interview, participants completed a demographic survey, which

included the informed consent document (Appendix B) outlining the nature of the study, with

specific emphasis on non-death loss. I reminded participants of the non-death loss focus of the

study prior to answering interview questions during the introduction and greetings. I then

proceeded to ask a series of questions to ascertain how they define loss, how they assess for loss

in a client, and how often they would expect to see elements of loss in their clients. The sub-

themes below describe the participant reported experiences in identification of loss and

frequency that they would expect to see loss.

Sub-theme 1: Definition of Loss

Death-Focused Framing. Four out of the eight participants used death-related language

in describing their personal experiences and description of loss. All four used non-death

language as well. However, the participants continued to frame responses in death-oriented language at different points of the interview, demonstrating a strong death focus when discussing loss in general. P8 expressed a death-focused paradigm while attempting to explain non-death loss:

> I would say that loss can take a number of forms. It doesn't always have to deal with grief, like, I couldn't tell from the survey if you are getting at loss in terms as in handling a death, but there are other kinds of loss as well. I think it's really about first and foremost actually, understanding a client's inner world, and the loss they are experiencing.

Non-Death Focused Framing. All eight participants were able to articulate non-death loss in at least one or more examples of loss not related to death. Several participants included only the loss of connection with a person in their examples of non-death loss, e.g. divorce, children lost to foster care, relationship breakups. Two participants were clear in their framing of non-death loss. "Loss is a simple word. It's when a person has something of value, and no longer has it, or it has been taken away. And, there are psychological ramifications for that person".

No Definition. In two cases, the participant's responses were very short, "It doesn't always have to be tangible" (P1), and "The only thing I can think of is like divorce, or with a child in foster care" (P3).

Sub-theme 2: Assessment of Loss

Reliance on Client Disclosure of Loss. Of the eight participants, one reported that their client came in because of loss: "It was very point blank. It was like, she was like, 'this is why I'm here'". However, the same participant also reported that this is unusual.

Reliance on Assessment Tool to Prompt Client Report of Loss. Four of the participants reported relying on their diagnostic intake forms to discover loss issues. One of four was directive in her assessment of clients reporting. P1 explained her method as:

> I assess for it. We've got a brief intake form, um, where we ask if there have been any losses. I generally frame that in a general standpoint, "that could be death, that could be a relationship ending," or something along those lines.

When asked about how the form defines loss, three of the four participants using forms for assessment did not define loss in layman's terms or provide an explanation on what "loss" might look like, relying primarily on client interpretation and ability to report. The consensus of those who used intake forms was that the form was only a guide, and that issues of importance would emerge during counseling. "I think during intake, people report having lost somebody, more so than they do I my groups. So, maybe it will come it, like I said, it's come up once so far" (P3).

Identifies Loss In-session. All participants reported that loss *emerged* in the course of therapy, relying on this as the primary method of assessment. While not all participants reported an ability to see loss as it emerged as a contributory issue, all felt that they would be able to see it if it were present. "Um, and I think that was the first time that I became, that it was kinda like the main focus of counseling…I guess, you know it comes up with, especially on a college campus with relationship losses" (P1). "It came out as we were talking…When I see it. You know. Typically, it comes out when during my initial interview with the client" (P2). "I wait until it becomes visible to me" (P4). "It's more intuitive" (P5).

Does Not Actively Assess for Loss. Participants P3 and P8 reported that they do not assess specifically for loss. When asked about how the participant knows if the client is suffering

from a loss if the client does not report it directly, P3 responded, "I guess I don't." P7 reported, "Um, no I don't assess specifically." P8, after considering the line of questions and the topic added:

> And, actually, thinking about it, you know, considering I never even thought of it as a fact but yeah, half the students I worked with at the middle school setting were probably dealing with some type of loss. Or experiencing some type of loss in one form or another (P8).

Sub-theme 3: Prevalence of Loss

I asked each participant to estimate the prevalence of loss expected in clients. I asked the following probing question in some form, "If you had, say 100 clients, what percentage would you say would have a loss issue?"

High Levels of Occurrence. Three out of eight reported that high percentage or majority of clients likely had a loss issue. P4 projected a "majority" and P6 estimated 8 out of 10 clients.

Of the three that anticipated higher incidents of loss, P5 responded consistent with their definition of loss being a major part of the human experience, and therefore was common in counseling, whether framed as loss or not by the client:

> I would expect to see it in everybody. It is just I see it as part of the basic human experience. We go through certain losses every single day. And, um, it doesn't have to be a traumatic loss to affect a client, to affect the person, um, so traumatic loss, not in all of them, but everyday loss? In all ten

> ***Moderate Level of Occurrence.*** P1 and P8 estimated about one-half of their client population might have loss issues, which was coded as moderate occurrence.

Low Level of Occurrence. The three participants reported a projection of low occurrence of loss in clients. "Um, but I would. I just don't seem to have a whole lot of clients that have had losses. Or at least that they have not come into therapy, you know, to talk about" (P2). "To one degree or another, probably at least a third" (P7). Participant P8 offered a different percentage when working with career counseling clients at 20%. P3 did not provide a clear answer to this question or probe.

Theme 2: Subjective Experience in Working with Loss

I asked all participants to recall the first time they identified or worked with a client where loss became evident. Participants were then asked to describe any impact that working with loss had on them based on past personal experiences. They were also asked to report on how those experiences affected them and their work with the client. The sub-themes below describe the participant reported subjective experiences in working with loss.

Sub-theme 1: Reaction to Working with Loss

I asked participants to consider their first encounter with loss in a client, and report on how their own loss experiences affected their interaction with the client.

Provided Empathy. Seven of eight participants reported that their own loss history was helpful in establishing some level of empathy for their client. In most cases, this was a positive experience. "To some extent I can understand what you're going through, having experienced loss myself" P1). P4 reported, I think it helped me empathize with them. It helped me kind of take away the judgment and give that positive regard." However, some participants, while describing an increase in their empathy with clients also reported a negative reaction that led to empathy. In one strong example, the participant P3 reports having imagined that she was in her client's shoes, and it was her son that was lost to foster care:

Yes, and when I imagine that, I imagine it being very hard and very sad and I would tell

her what a great job she was doing to stay in there, and be there for her son, and to try to

get him back. Because I think I would be in the insane asylum.

Created Avoidance. Participant P2 had a strong reaction to the issue of loss. She reported

a certain level of avoidance to working purposefully with clients who had loss as the stated issue:

Not a lot. Not a lot at all. I, yeah, it's not something that I welcome, I don't necessarily

like working with loss. (laughs)...I do not look forward to working with it… if someone

gives me as an option, 'Hey do you want this grief and loss client?' I'm going to say no.

But if they end up on my schedule, and I have no choice, then I do the best I can…

No Affective Response Reported. One participant reported that there is an expectation of

working with loss, and that she brackets her own loss history out of the session. "I could put

myself in the client's shoes very readily, very easily. And so, um, it some, and always take a

little bit of bracketing to keep the counselor's loss out of it" (P5).

Recognition of Countertransference. Three participants divulged some level of

countertransference awareness in the face of client loss. Of note, these participants were self-

aware of projecting personal beliefs on "because I was wondering if maybe I put some of my

own beliefs about loss on the client, in terms of how they should deal with it" (P1). One

participant in particular reported his own thought process as follows:

I'm really cognizant of checking my issues at the door. And when a client brought

something up that got hold of me, that I felt a personal piece, to kind of just think about it

almost as a switch. Okay, that's there. Turn it off, and refocus, stay present with the client

in the session. (P8).

Sub-theme 2: Personal Impact

When asked to reflect on how working with a client expressing loss affected the participant personally, five of eight reported either a negative impact or a positive one. None reported the absence of a personal impact. Three participants did not respond with enough specificity to code this question.

Negative Impact. Three participants reported a negative impact on self from working with client loss, describing fear, anxiety, and sadness. P1 and P2 reacted to the client contend: "But um, in terms of just dealing with loss and grief, I guess, scared is what I remember" (P1). "Uh, knowing that I have to deal with my own issues. Knowing that that is an area of weakness in me. Knowing that it makes me really nervous" (P2). While P3 reported lingering feelings due to the failure of the client to continue in treatment:

> …the fact that you know that this absolutely crushed her, um, I still feel sad, and I hope to see her come back and try again. You never get to see them, or say goodbye, or anything, you just know that they are out there and they are not okay.

Positive Impact. Two participants, P6 and P7, reported positive impacts when working client loss for the first time. P6 recalled a sense of excitement in having an opportunity to tackle a new client issue: "I think the impact it had on me was a positive impact in that it was challenging. Ah, I couldn't wait to just, you know, begin working with this individual, with this client, um, based on the little bit of information that I had." P7 responded with "definitely positive' when asked to reflect his experience. These two participants were both males, and older than the rest of the group, at ages 54 and 51 respectively.

Theme 3: Sense of Competence Post-Master's Program

All eight participants were asked to recall the first time they worked with a client where loss was a central issue of treatment. Participants described their level of training and confidence in working with their first loss clients. The sub-themes below describe the participant's self-described levels of training and confidence at the onset of their residency.

Sub-theme 1: Loss-Specific Training

This sub-theme addresses the participants' recall of training, both inside and outside their

master's program, which provided them with help in dealing with issues of loss. One participant reported some level of training within their master's program. Three reported having never received any loss-oriented training at any time prior to meeting their first client expressing loss issues. Four participants reported self-study to help them post-graduation, and three reported no loss-specific training at any level.

Program Specific Training in Loss. P1 recalled the topic of grief being introduced in the course of one class in the master's program, describing the event as, I think I had attended one, um, we had one person who was, um, we called him the grief guy, who came in and did a talk for us."

Self-Study. Four participants reported a sense of need to self-educate in an effort to meet the needs of their clients. From the data, it was not clear in some cases if this self-study came prior to, or after the first encounter with loss as clients as participants recollected feelings and efforts to assist loss in clients. P2 reported, "…I felt *un*-prepared (heavily emphasized "un") because I have done some research on grief, because it tends to be one of those subjects that as a counselor, I don't look forward to working with it."

P6 explained his efforts to self-prepare, "I went and did extra reading, you know, education. I educated myself so I could actually assist them, and better help them" No participants reported formal post-master's training, workshops, or seminars pertaining to working with client loss or grief.

No Specific Training. Seven of eight participants reported having no loss-specific training within their program, or were unable to recall any specific loss training. One participant did report that although there was no specific training, her program provided sufficient training in skills that the participant felt made her competent to deal with loss or grief. She stated, "I

don't remember any specific training about grief and loss in my master's program. Um, the preparedness came from the comprehensive nature of my program though, in the way it emphasized basic counseling skills to attend, provide empathy," This sub-theme was continued throughout the participant interviews in some fashion, seen in various responses: "I don't think there was a specific training in that. If memory serves." In addition, "for loss, for this kind of loss specifically, probably [I was] underprepared."

Sub-theme 2: Confidence Level

This sub-theme reflects participant self-report on their subjective confidence to work with loss post-graduation. I classified the responses thematically into high, medium, low, and no confidence.

High Confidence. Three participants reported a high confidence to work with loss, based on experiences and training. P1 and P 4 were hesitant to declare high confidence in the general sense, but instead, framed loss as seen in their specific client populations. For P1, this was relationship struggles among the college students, "I think it depends on the type of loss. Because I'm still working with college students. …if it's the loss of relationship, if it's the loss of the sense of future, um, I feel very prepared." P4 reported high confidence entering residency due to prior experience working with the older persons, which was the population of her residency. While reporting high confidence, P6 cautiously stated that his confidence is based on additional reading, "…not too much experience dealing with grief and loss…I went and did extra reading…I educated myself so I could actually assist them…"

Low Confidence. P1 also reported low confidence in working with loss other than relationships. While recalling one loss related client, P1 reported, "I didn't know what to do. I didn't know what to do because, um, it wasn't, it was a loss that occurred a couple of years ago,

and two because I just didn't have much training." P2 reports low confidence to the level of avoidance. P2 actively discourages the booking of loss clients, taking them on only when there is no choice. "But if they end up on my schedule, and I have no choice, then, I do the best I can and, you know, that's kind of my plan. You know, do the best you can."

No Confidence. No confidence represents participant statements that they felt un-prepared. P1 continued considering preparedness in other areas of counseling other than relationship issues. "But in terms of just methods for, or techniques for addressing grief and loss, I didn't feel prepared in that respect." P8 took a broader perspective on counselor training and on loss:

> I had a lot self-doubt because it was still so new. And, you know, having only had um, a
> 600-hour internship, and 100-hour practicum, and having only half of those hours at most
> being direct hours with clients, it's hard to have a lot of self-confidence at that point. At
> least it was for me (P8).

Theme 4: Application of Theoretical Models

I added a new question to the protocol at the second iteration of the semi-structured interview protocol. I asked six of the eight participants to consider how their theoretical understanding might have changed or evolved since their initial experiences. The sub-themes below describe the participant's consideration of their theoretical choices and any revisions that came over time.

Sub-theme 1: Theoretical Basis of Treating Loss

I asked participants to discuss how they helped clients, allowing the participant to describe their primary approach. When necessary, I added a prompting question about technique. The results were a series of description of the application or absence of loss specific theory.

Basic Skills Training. I assigned the code of *basic skills* to those who did not define a specific theoretical approach, or relied primarily on basic attending skills, and/or loose definitions of humanistic or person centered therapy. P1, P2, P3, P4, P5, P6, and P8 began with vague descriptions of approaches. P3 responded, "I'm still kinda winging it. But I just try to rely on that person-centered holding the space and letting them have their moment." P1 shared confidence in basic skills, "I had my basic skills, um I felt really, I felt grounded in those."

General Theoretical Understanding. P5 identified use of solution-focused techniques in conjunction with basic attending skills, "so there's some really quick empathy, and some sitting with the client about what he or she is experiencing. And then, in a solution-focused way…" P8 was the most specific in theoretical grounding, based on work primarily in schools, "Typically, I never followed a loss or grief model. I did understand stages, but that wasn't something that I have typically focused on. I usually let my theoretical perspective guide me."

Loss-Specific Theory. One participant, P7, referred to a specific loss-oriented theory:

The first thing I did was I reached for my Kubler-Ross. Un, and tried to gain some articulation for the sorts of insights that I was getting out of just working with the client… a lot of it was just coming to terms with just the existential fact of the loss. And its implications, and almost working through the stages of the Kubler-Ross grief cycle.

When asked if this was a preferred theoretical approach, P7 continued, "I just stuck with that one theory [Kubler-Ross] because it seemed to fit so well. If it's appropriate, yes. I can imagine circumstances where it wouldn't be. But it seemed to be just the trick for this one."

No Theory reported. P6 was the only participant that reported no particular theory, but instead used an array of theories, "I have many theories that I individualize depending on the person."

Personal Theoretical Choice Applied. P8 reported that his grounding theoretical understanding was appropriate for most work within his public school residency site. "My primary theoretical model was an integrative approach. I used MMT, and with MMT, an integrative approach, you ground it in your primary approach. Which for me was solution focused."

Sub-theme 2: Revision of Theoretical Understanding over Time

In the second iteration of the semi-structured protocol, I added a follow-up question to determine if there was any evolution of theoretical preferences later in residency, based on the first encounters with loss. No participants reported a revision of theoretical perspective. However, perspectives on loss did change according to four of the participants. I assigned the code of *no revisions* to these responses. However, the altered perspective is noteworthy

No Revisions. P5 reported a change in awareness of individual needs across the spectrum of counseling, based on multicultural experiences:

> I think what's changed most dramatically is that I've had the opportunity to work with different populations…so the way that I approach them with their losses is different. And I have had to change the cultural lens through which I view my clients in how they are experiencing their particular losses." P7 reflected on their ability to work with loss, "I would say that once I am able to identify it, or once it seems to come up in the therapeutic relationship, I, that becomes my focus. That becomes the focus of therapy.

P8 provided his introspection on working with loss in terms of future strategies:

> I think what I would change the most if I knew that I would be working with clients specifically for loss, is that I would supplement my theoretical approach with additional education in treatment strategies in working with individuals with loss.

Summary

This chapter presented an overview of the data collected, and the analysis procedures and results in examining the phenomenon of new counselor experiences in working with clients with loss issues at the beginning of their residency. In providing a thick description of the phenomenon as described by the participants, an overview of each participant outlined individual experience, training, and residency settings. I used semi-structured interviews to identify structural themes and textual themes relating to the study propositions. The data analysis, through use of horizontalization, revealed four major structural themes as follows: Identification of Non-Death Loss in Clients, Subjective Experience in Working with Loss, Sense of Competence Post-Master's Program, and Application of Theoretical Models in the Presence of Loss. Table 5 depicts the structural themes and sub-themes revealed in the horizonalization process.

Table 5

Thematic Analysis of Structural and Sub-Themes

Theme One: Identification of Non-Death Loss	Theme Two: Subjective Experience	Theme Three: Sense of Competence	Theme Four: Application of Theoretical Models
Loss definition • Death Focused • Non-Death Focused • No definition **Methods of assessment** • Relies on client to disclose or identify • Relies on General Tool/Form	**Past personal experience.** • Provided Empathy • Created Avoidance • No Affect **Impact of client's loss on participant.** • Negative impact • Neutral Impact • Positive Impact	**Training level** • Program Specific Training in MA • Self-Study • Post-Master's Study with others. • No Specific Training **Perception of competence** • High Confidence	**Theoretical basis for treating loss** • Basic Skills • General Theoretical Foundation • Loss-Specific Theory Applied • Other Theories **Revised theoretical understanding**

• Identifies when loss appears in session. **Prevalence of loss** • High • Medium • Low		• Low Confidence • No Confidence	• No Revisions

In an effort to promote effective trustworthiness, I used member checking at three levels: Reflection of content and meaning within the interview, post-interview checking with the participant, and post-transcription review by the participants of their interview. For the post-transcription member checking review, I provided each participant with a transcribed copy of their individual interview, asking them to review if for accuracy and veracity to their intended meaning and experience. I was prepared to make any necessary changes to the interview transcript as indicated by the participant to assure maximum fidelity to their lived experience. However, the participants unanimously indicated that they were satisfied with their transcript so no changes were needed.

To further assure trustworthiness, I used consensus coding, peer debriefing, reflexive journaling, and bracketing of bias. In the audit trail, I maintained all iterations of the interview protocols, coding matrices, consensus coding, and the case display. The consensus coding display is presented in Appendix H.

CHAPTER V

CONCLUSIONS, DISCUSSION AND RECOMMENDATIONS

Overview

This chapter presents the conclusions, discussion and recommendations for the study. First will be a review of the purpose for the study, the methodology and analyses, and findings. Also included in this chapter are a discussion of the limitations of this study and the implications for future study, as well as a personal reflection on the process of the study.

Purpose of the study

The purpose of the study was to examine the experience and impact on new counselors when working with clients struggling with overt or covert non-death losses. The study used the real-life experiences of counselors when they first encounter clients' issue of loss and grief. Of primary interest was how new counselors identified loss in client's issues, how they applied theory of interventions, the counselors level of confidence in training and preparedness to deal with loss, and how they were personally affected.

Methodology

Case study design is a research method that is used to study and understand why and how questions where there are no contextual conditions that appear to be relevant to the understanding of a phenomenon, and where there is no clear boundary between that context and the phenomenon (Yin, 2003). This study used bounded qualitative case study methodology because it met the criteria defined by Ying (2003) to understand the lived experiences of a sample, and when the essence of a phenomenon is not well known (Padgett, 1998). Through case study, the researcher joins the participants through the use of epoche, a process of setting aside or suspend personal attitudes and commitments to assumed outcomes (Moustaks, 1994), to which

then allows the story to emerge with veracity to the participants' experience. Open coding was used to allow structural and textual themes to stand out as each structural horizon was experienced. Each horizon was examined until it receded and was replaced by new horizons. Through this horizonalization, an aggregation of corresponding themes was captured for analysis.

Procedure

First, eight individual counselors at various stages of experience in residency were recruited using a convenience sample. Each participant participated two step screening; a demographic survey was completed to determine their experiences with clients, their attitudes and beliefs about non-death loss, that they met the basic requirements of graduating from a CACREP Master's program and were in residency earning experience towards licensing. The second part of the study was a semi-structured interview with each participant. From the narrative data collected and transcribed, I used open coding to understand and identify structural themes and textual after first bracketing my assumptions and biases. Using epoche, I purposefully set aside my interpretations and judgments prior to the interview and coding process to allow the participant's individual meaning **to** present itself with fidelity. Next**,** I used co-coders to increase trustworthiness. The co-coders were asked to code the essence of the interviews using a coding frame derived from the open coding process, and were not given the literature review to keep them from developing bias towards an outcome. Initial consensus coding reached 93.5% consensus prior to the final consensus meeting to achieve 100% agreement. To enhance the trustworthiness of the study, I used member checking at three levels: 1) during the course of the interview to test my understanding of the meaning as held by the participant, 2) post-interview debriefing, and 3) post-transcription review of the individual

transcripts by the participants. In addition, I used a peer de-briefer, provided a thick description of the participant's experience by case display, and used bracketing by recording personal thoughts and experiences in reflexive journaling. All the steps and instruments, reflexive journal and case display were maintained in an audit trail. The final enhancement of trustworthiness was the inclusion of an auditor who joined me in debriefing the study.

Summary of Findings

This study was constructed to explore the following questions: 1) To what extent are new counselors aware of the presence and impact of non-death loss in resolving client issues? 2) To what extent do new counselors feel confident that they can identify client's non-death losses and work with these? 3) How does working with non-death loss directly, or indirectly, affect a new counselor? The following is a summary of the findings, with identified convergences with existing literature. The findings are presented according to the four structural themes identified in the data analysis; identification of non-death loss for clients, subjective experience when working with loss, sense of competence, and application of theoretical models.

Theme 1: Identification of Non-Death Loss in Clients

This theme has three sub-themes; defining loss, assessment of loss and prevalence of loss in client issues. Examined were how the sample defined and described loss, the methods by which they assessed loss, and an estimate of the presence of loss for clients.

Defining Loss. New counselor's perception of loss, or as the etiology of the presenting issue was limited in those studied. Of the eight participants, four used death-oriented language and imagery to frame loss in general. While all were able to articulate non-death losses by example, only two participants were able to provide clear definitions of loss at the onset of the interview in non-death language. The remaining two participants used inference to guess at

possible definitions by example. This is supported by Worden (2009) where counselors fail to differentiate between loss-oriented behavioral symptoms and ordinary sorrowful affectations. Loss as a presumed etiology is still enigmatic to the participants in this study.

   Assessment of loss. New counselor's in the study relied primarily on client self-report, in some cases through intake instruments, to assess the presence of loss. Only one participant reports sensing loss and guiding the client to explore and discover the loss. Four relied solely on instruments as a way of rooting out the cause of client distress. Two participants reported not assessing for loss at all, unless it is presented. All participants felt that they would see loss if it was demonstrated in session, relying on the "I'll know it if I see it" strategy. With their majority of the participants unaware of the nature and signs of non-death loss, such assumptions might leave the issue unexplored or under-attended.

   Prevalence of Loss. The participants were asked report, in their estimation, how many clients coming to counseling might have an issue connected with loss. Three reported that they expected the number would be high, two estimated about half would have loss issues, and three reported that they don't see much loss in clients or were unable to give a clear estimate. Based on the demographic survey, prior to the interview, the evidence suggested that the participants were not aware of much loss as an issue in their own clients under treatment. With the expanded understanding that loss and grief are uniquely individual and subjective, then expecting the presence of loss in clients should be central. Counselors must learn to distinguish the themes of loss which may be framed by the client as inconsequential, going unrecognized as a debilitating or complicating loss (Humphrey, 2009).

Findings from the Literature.

The study confirmed themes found in the literature where new counselors have an incomplete or

absence of loss definition, a deficient level of assessment for loss, and a low level expectation

that loss may be prevalent, or even present as a cause of stated issues and symptoms (Gunzburg,

1993; Hansen, 2004; Harris, 2011; Humphrey, 2009, Rando, 1993; Worden, 2009).

Theme 2: Subjective Experience in Working with Loss

When reporting on subjective experiences in working with loss clients, seven of eight

framed their own loss history as helpful in building empathy. For these participants, this

awareness fostered positive and negative feelings about their loss. Two in particular found that

imagining the client's loss was a negative experience. One reported strong reaction to the idea of

coming close to loss, and suggested that avoidance was her strategy when possible.

Reactions to Loss. Varied understanding and framing of loss influenced how new

counselors responded or reacted in the presence of loss. Seven of eight participants felt that their

personal loss history created a higher level of empathy toward client loss, reporting mostly

positive empathic conditions. However, in one negative case example, a participant reported that

personal loss history and attributions around loss triggered a strong avoidance reaction. This

confirms Gilroy, Carroll, and Murra (2002) findings that there is an unawareness among

counselors of how personal issues can have a negative effect, despite the reports of positive

presumption that struggles in one's personal history increases sensitivity and the ability to treat

loss in clients.

Personal Impacts. Participants report on how working with loss directly impacted them

personally was mixed. Three of the eight reported fear, anxiety, and sadness connected to their

limited experiences working with loss clients. This included doubt about the effectiveness of the

treatment they provided, and future intentions to avoid, re-educate, or reconsider how the participant might work with loss in the future. In two cases, participants reported positive personal impact, framed as excitement to work with loss. These two participants also reported that they had personal loss experience and that working with loss was an area of interest.

Findings from the Literature

The literature suggests that counselors experience discomfort, possibly leading to avoidance, often founded on lack of training and understanding of loss (Harraway, Doughty, and Wiled, 2001). Negative reactions are consistent with grief counseling specialist's beliefs (Dunphy & Schniering, 2009).

Theme 3: Sense of Competence Post-Master's Program

There was an expectation that participants would report training levels consistent with the literature, and that confidence for working with loss would be low.

Loss Specific Training. Past reports and findings note that loss-specific training is usually presented as a component of another subject, or as an elective, or a special topics module (Ober, Granello, and Wheaton 2012). In the study, one participant reported recalling a grief specialist coming to her class and presenting on loss. The remainder of the participants reported no recollection of loss training. Consistent with the literature, four participants reported self-study as their only exposure to loss treatment. None of the participants reported attending any workshops or seminars regarding the assessment and treatment of loss. Only one participant believed that her training was sufficient to treat loss, based solely on the comprehensive nature of her program. However, no loss-specific training was reported in that program.

Counselor Confidence. This study used new counselors and it was expected that their confidence levels would be low. However, the self-reports showed mixed levels of confidence.

Three participants reported high levels of confidence that their personal experience and training would be enough. This is consistent with the literature that indicates a false assumption of confidence among some counselors, based on personal experiences (Gilroy, Carroll, & Murra, 2002). In the interviews, it became clear that some of this confidence was based on the minimal understanding and definition of loss held by the new counselors, and on post-master's reading**s** for self-education. Confidence was highest in those who framed loss as tangible relationship changes, based on a familiarity with college aged students, whose age and experiences were close to her own, and a population she was familiar with as part of her internship. However, one of the high confidence reporters also reported low confidence when defining loss where deeper meaning of the loss was indicated. One participant reported that loss triggered fear and avoidance, also consistent with expectations found in the literature.

Theme 4: Application of Theoretical Models

There are several theories and theoretical models focused on loss and grief counseling. Some are the older theories that emphasize stages and tasks, and some are the more contemporary theories that emphasize evidence based dual process. Lack of specific training in loss led the sample to deficiencies in application of theoretical models.

Use of Theory. Seven of the eight participants framed application of theory in general terms, such as basic attending, holding space, unconditional positive regard, and other fundamental counseling skills language. These participants felt adequately grounded in their basic skills, trusting that those skills would carry them through any client issue. One participant focused on his use of MMT and solution-focused treatment due to his unique role as a school counselor. Of the eight that reported no specific theoretical application to loss issues, one added

that he applied a stage theory in one case, Kubbler-Ross, to help his client, but qualified that only in this case was did it seem to be appropriate.

Theoretical Development Over Time. In the second iteration of the protocol, six out of eight participants were asked specifically if their theoretical preferences related to loss had changed over time since their first encounter. None reported any substantial change. However, two gave additional information that suggests that their early encounter with loss had impacted their awareness of a limitation in their own capacity to work with loss. One reported a new cultural lens that broadened her perspective, while the other considered what he might do differently in the future through additional studies. The implications from these two is consistent with the literature that indicates that counselors who encounter new information may choose to expand their loss education through intentional self-study (Humphrey, 2009). The participants in this study use of theory was consistent with findings that show that counselors tend to focus on personal choice or misinformation about appropriate loss-specific theory (Breen, 2010; Coyne & Ryan, 2007).

Findings from the Literature

A perusal of the literature shows that there is ample evidence that loss-specific theories are available to counselors-in-training and afterwards (Stroebe & Schut, 1999, 2001; Stroebe, S., Schut, H. & Stroebe, 1998). Among those theories, older stage and task theories have been replaced in favor of evidence based dual process models. (Humphrey, 2009*)* However, there is also evidence that demonstrate**s** that counselors in general d**o** not use contemporary theoretical models, but rely on old stage models, or on general counseling theories (Coyne & Ryan, 2007; Breen, 2010). There was an expectation that the participants would confirm a lack of insight into contemporary loss treatment which was confirmed.

Conclusions and Implications

This section presents the conclusions for each research question and the implications. While the conclusions are derived from the findings for this study, they cannot be generalized to other groups because of the sample size.

RQ1. To what extent are new counselors aware of the presence and impact of non-death loss in resolving client issues?

The findings for Themes 1 and 2 show that the sample had a low level of understanding into the nature and prevalence of loss in clients. This is consistent with the literature that suggests that many counselors have not been prepared in their training programs to identify the symptomology of loss, and/or to assess loss, or the forms in which loss is commonly present in client's issues.

RQ2. To what extent do new counselors feel confident that they can identify client's non-death losses and work with these?

The findings for Theme 3 were consistent with the findings by Ober, Granello, and Wheaton (2012) in the study that examined counselors (n=369) on the competence of grief counselors. The findings indicated that over the majority (54.8%) reported no specific training on grief. However, 73.2% indicated that they had received at least one course where grief was infused with some significance. The major portion (69.4%) had participated in some level of professional development training hours. 91% indicated that they felt specific training in grief was needed or should be required of counselors.

Theme 4 findings on application of theoretical models also relates to this research question.

Theoretical knowledge of treating loss was minimal or absent. Consistent with the literature, new counselors in this study showed a lack of theoretical competence, or reliance on outdated or generalized theories. This places the client at risk of mistreatment or ineffective treatment, or treatment for misdiagnosis when loss is the central issue (Coyne & Ryan, 2007).

RQ3. How does working with non-death loss directly, or indirectly, affect a new counselor?

Theme 2 findings address the subjective experience when working with loss for the sample. The mixed reactions that included avoidance, stress, and feelings of inadequacy are consistent with previous research findings. This shows that it is important to consider an awareness of loss or competency to treat loss, and the impact of working with loss clients on the new counselor. Theory and application are secondary when confronted with the assumptions held by new counselors regarding working with loss. Conye and Ryan (2007) showed a reliance on preferred treatment theories, despite contemporary research, while Dunphy and Shniering (2009) found that counselor's personal loss history emboldened counselor's in their application of personal experiences when working with loss, citing enhanced empathy with clients. The risk of negative impacts such as burnout, compassion fatigue, vicarious trauma and other counter transference events is found in contemporary research (Adams, Boscarino, and Figley (2006); Figley 1995; Rothschild, 2006; Stamm, 1995, 1999). Working closely with loss when under-trained places new counselors at high risk of negative impact.

Discussion

Previous findings consistently suggest that limited training and understanding for framing and treating loss, including death, is problematic for effective treatment. In addition, there is evidence that reveal the scope of the deficiency in formal training among universities.

Each of the deficiencies revealed in the study, consistent with the expectations as found in the literature, could be addressed by the inclusion of loss-specific training during graduate training and internship. The literature confirms that simple awareness training will increase the application of proper treatment while mitigating negative impacts on counselors (Sawyer, Peters, & Willis, 2013; Ober, Granello, & Wheaton, 2012). With an absence of direct education in theory and education in working with loss, supervision become the important first level of protection for both client and counselor as new counselors experience the issue of loss for the first time.

Training has added advantages beyond the focus of this study, but relevant to the practice of loss related treatment. Working with loss places the counselor at risk of negative emotional impact. The implications of loss-specific training are seen in studies of new counselor efficacy, confidence, and resistance to vicarious trauma (Adams, 2008; Ober, Granello, and Wheaton, 2012; Sawyer, Peters, & Willis, 2013) as well as mitigation of compassion fatigue (Adams, 2004, Figley 1995, Rothschild, 2006) and an ability to overcome avoidance triggered by painful topics and multicultural biases inherent in a counselor (Krichberg, 1998, Barrett, McWhirter, 2002). The implications of these studies suggest that counselors who receive specific training in how to work with grief experience higher self-confidence and self-efficacy, will report a positive increase in preparedness.

In their study, Sawyer, Peters, and Willis (2013) sampled (n=34) master's level counseling students to study preparedness to counsel clients in crisis. The results showed the connection between perception of proper training and perceived self-efficacy. While this study was crisis training specific, the implication for counselor perceptions of preparedness as a component of counselor capacity should not be lost.

Avoidance is less likely to occur when a new counselor is prepared to work with a multiplicity of unexpected occurrences. This is further supported by a study (Adams, & Riggs, 2008) conducted examining the defense styles of therapists in relation to the level of healthy coping strategies applied in association with vicarious trauma. The study found that the commonly reported self-sacrificing defense style increased the risk of vicarious trauma. Adams and Riggs (2008) further suggest that discussion of new counselor defense style and coping mechanisms are necessary in supervision to reduce counter transference and vicarious trauma.

A safety net or supervised residency is provided to new counselors preceding licensure. Such supervision is designed to provide assistance to new counselors, support. In working with clients suffering from loss, supervision serves to help new counselors retain hope and heath while applying best practices (Abassary, 2014). While writing specifically towards crisis work, Abassary' s point regarding the need for quality supervision can be generalized to working with loss. This presupposes that supervisors have familiarized themselves with the topic of loss in order to pass that information on to supervisees.

Limitations

The primary limitations for the study are researcher bias, experience with the methodology, and the sample size and selection. The conclusions and recommendations take into account these limitations.

Researcher Bias

As a researcher, I am naturally motivated to study topics in which I have some experience or concern. My own interest in non-death loss, and the treatment of such comes from personal loss exposure. I have seen firsthand how loss can be an underpinning of secondary issues and behavior. When the effects of loss are dismissed or unknown, I believe that individuals can act or think irrationally, reacting both out of character and in a manner suggestive of a diagnosis which is wrongly determined. Based on this bias, and years of working with foster children who were habitually mishandled due to the absence of counselor understanding of loss etiology, I approached this topic with the hope of establishing that there was a need to reassess how counselors are educated on loss. I have taken care to bracket those biases by limiting my research methodology and interview protocols to collect direct real life experiences without leading the participants, or assuming meaning. I have actively looked for negative cases, identifying them where they appeared. I have taken care to judge the outcomes of the study against the literature, and making my conclusions as supported by that analysis.

Researcher Experience with Methodology

While qualitative inquiry is still new to me, I have had training in qualitative methods in my program, completing a qualitative research cognate. During the training, I have studied case study, phenomenology, grounded theory, bricolage, and other methods. I have conducted a grounded theory, and a contentment analysis study, and a single participant case study as a pilot study for a grounded theory study. I have served as an auditor on two quantitative case studies for colleagues. This is my first fully executed bounded case study, and was unique due to the multiple participants, and goal of understanding why and how loss is experienced by new

counselors where there are no relevant contextual conditions and where there is no clear boundary between that context and the phenomenon (Yin, 2003).

Sample Size and Selection

By using a convenience sample, with limited ability to purposefully represent the full population of new counselors, my study is limited in its generalizability. However, it was not the purpose of this study was instead to understand and report on lived experiences of a selected group of new counselors, and then to determine if trends and findings in closely related literature on loss treatment was applicable and accurate in supporting the findings on the experiences of new counselors. For that purpose, the selection and sample size met the criteria and needs of the study.

<div align="center">**Discussion and Recommendations**</div>

Since non-death loss can go overlooked by the client and a new counselor, the application of appropriate loss-oriented theory assists the new counselor to assess for and treat loss, regardless of its origin. When educated in the need for and methods of intentional loss assessment, counselors may find they acquire a revision of understanding into loss in general, one that encompasses traumatic loss, cognitive stress, constructivism, social functional perspectives, trauma, and other factors (Folkman, 2001; Neimeyer 1999; Bonanno & Kaltman, 1999; Litz, 2004).

The literature was clear on the lack of loss-specific training among universities in general. In all eight cases, participant's reports were consistent with the expectations of training. The literature also suggested that confidence, a necessary component in the treatment of clients, would be low without proper training (Ober, Granells, & Wheaton, 2012; Sawyer, Peters, &

Willis, 2003). The exception would be seen in higher confidence based on faulty assumptions about personal loss experience (Gilroy, Carroll, and Murra, 2002).

Due to this lack of understanding, assessment for loss as a specific cluster of symptoms, or as an underlying cause of client distress is absent in the participants. Reliance on standard intake forms, with generic or non-specific loss-related questions is assumed to be sufficient, even in the absence of specific questions to test of the presence of loss in clients or by defining loss to clients who are not already aware of the impact of loss.

Counselor Confidence was low or unrealistically high for most of the participants when considering their initial and ongoing ability to assess, identify, and treat loss. Lack of confidence not only drives avoidance and minimizing of the presence of loss, but also potentially impacts a client as counselor uncertainty is sensed. The literature supports the need for well-placed confidence to support client improvement (Harrawood, Doughty, & Wilde, 2001; Ober, Granello, & Wheaton, 2012). Those with higher confidence levels also suggest, consistent with (Gilroy, Carroll, & Murra, 2002), that an unrealistic over reliance on personal theoretical choice may deny proper treatment of loss based on current research. (dual process). This reliance and bootstrapping of theory to fit preference is seen in study by Conye and Ryan (2007) where counselors chose to draw from a range of theory, rather than rely on the loss-specific theory found in contemporary research findings

This study has established that there is a phenomenon to investigate pertaining to new counselors and their capacity to work with non-death loss. The next step would be to expand this study to better establish its existence through further qualitative study such as grounded theory. Future study would benefit from purposive sampling of non-CACREP schools and a wider geographic area to increase the validity of the findings. In a grounded theory, it would be

possible to isolate variables which could lead to the construction of a test instrument for further future sampling.

From this it will be possible to establish the principles underlying counseling for loss. Within the literature, it is evident that no true theory of loss treatment is established, beyond methods of attending to loss. Out of further study, evidence may be found to substantiate the prevalence of loss in client experiences, and the need for loss specific training. Adding a quantitative study to sample the frequency and scope of the identified phenomenon of new counselor deficiencies in training, leading to low confidence and assessment difficulties is the logical step in future remediation of counselor loss training. This would close the loop from phenomenon to theory to application.

Summary

New counselors face many challenges when first entering the field out of their formal graduate training. While it would be unrealistic to expect any program to cover all aspects of counseling and potential client issues, it would seem reasonable that new counselors are prepared for the most common issues they will face. This study has demonstrated the possibility that non-death loss as defined in the study is among those most common client issues. It has further demonstrated that, consistent with the literature dealing with loss work in general, that new counselors feel under-prepared and lack informed confidence to approach the topic. Moreover, it demonstrates a lack of theoretically supported framing by new counselors on the topic and treatment of non-death loss. While the literature supports training as mitigation and defense against such deficiencies, it is clear that such training is not readily available. It is hoped that with exposure to the existence of client issues as seen through the lens of loss etiology, the profession might move swiftly to readdress this training deficit.

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APPENDIX A
OLD DOMINION UNIVERSITY
APPLICATION FOR EXEMPT RESEARCH

Note: For research projects regulated by or supported by the Federal Government, submit 1 hardcopy of this application and 1 electronic copy to the Institutional Review Board. Otherwise, submit to your college human subjects committee.

Responsible Project Investigator (RPI)		
The RPI must be a member of ODU faculty or staff who will serve as the project supervisor and be held accountable for all aspects of the project. Students cannot be listed as RPIs.		
First Name: Nina	**Middle Initial:** W.	**Last Name:** Brown
Telephone: 757.683.3245	**Fax Number:** 757.683.5756	**E-mail:** nbrown@odu.edu
Office Address: Old Dominion University, 5115 Hampton Blvd, 218 Education Building, Rm 250 - 6		
City: Norfolk	**State: Virginia**	**Zip: 23529**
Department: Counseling & Human Services	**College:** Darden College of Education	
Complete Title of Research Project: New Counselors' Experiences in Working with Non-death Loss: A Qualitative Case Study		**Code Name (One word):** Loss

Investigators		
Individuals who are directly responsible for any of the following: the project's design, implementation, consent process, data collection, and data analysis. If more investigators exist than lines provided, please attach a separate list.		
First Name: Charles	**Middle Initial:** P	**Last Name:** Carrington
Telephone: 757 759-5674	**Fax Number:** 757.683.5756	**Email:** ccarr051@odu.edu
Office Address: 5115 Hampton Boulevard, Education Building 250-2		
City: Virginia Beach	**State: Virginia**	**Zip: 23529**
Affiliation: __Faculty X Graduate Student __ Undergraduate Student __Staff __Other_____		
First Name:	**Middle Initial:**	**Last Name:**
Telephone:	**Fax Number:**	**Email:**
Office Address:		
City:	**State:**	**Zip:**
Affiliation: __Faculty __Graduate Student __ Undergraduate Student __Staff __Other_____		
List additional investigators on attachment and check here: __		

Type of Research
1. This study is being conduced as part of (check all that apply):

_	Faculty Research	_	Non-Thesis Graduate Student Research
X	Doctoral Dissertation	_	Honors or Individual Problems Project
_	Masters Thesis	_	Other_____

Funding

2. Is this research project externally funded or contracted for by an agency or institution which is independent of the university? Remember, if the project receives ANY federal support, then the project CANNOT be reviewed by a College Committee and MUST be reviewed by the University's Institutional Review Board (IRB).

___Yes **(If yes, indicate the granting or contracting agency and provide identifying information.)**
 X No

Agency Name:
Mailing Address:
Point of Contact:
Telephone:

Research Dates

3a. Date you wish to start research (MM/DD/YY)   01 / 01 / 2016
3b. Date you wish to end research (MM/DD/YY)   01 / 01 / 2017

NOTE: Exempt projects do not have expiration dates and do not require submission of a Progress Report after 1 year.

Human Subjects Review

4. Has this project been reviewed by any other committee (university, governmental, private sector) for the protection of human research participants?
    ___Yes
 X No

4a. If yes, is ODU conducting the primary review?
    __Yes
    __No (If no go to 4b)

4b. Who is conducting the primary review?

5. Attach a description of the following items:

<u>X</u> Description of the Proposed Study
<u>X</u> Research Protocol
<u>X</u> References
<u>X</u> Any Letters, Flyers, Questionnaires, etc. which will be distributed to the study subjects or other study participants
___If the research is part of a research proposal submitted for federal, state or external funding, submit a copy of the   FULL proposal

Note: The description should be in sufficient detail to allow the Human Subjects Review Committee to determine if the study can be classified as EXEMPT under Federal Regulations 45CFR46.101(b).

Exemption Categories

6.   Identify which of the 6 federal exemption categories below applies to your research proposal and explain

why the proposed research meets the category. Federal law 45 CFR 46.101(b) identifies the following EXEMPT categories. Check all that apply and provide comments.

SPECIAL NOTE: The exemptions at 45 CFR 46.101(b) do not apply to research involving prisoners, fetuses, pregnant women, or human in vitro fertilization. The exemption at 45 CFR 46.101(b)(2), for research involving survey or interview procedures or observation of public behavior, does not apply to research with children, except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.

____(6.1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.
Comments:

____(6.2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; AND (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.
Comments:

____(6.3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if:

(i) The human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.
Comments:

X   (6.4) Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.
Comments:
This qualitative study will collect recalled experiences of counseling residents using semi-structured interviews following the Qualitative Case Study Tradition. The purpose of the study it to understand how new counselors interpret and interact with clients who have presentation of symptoms related to non-death losses. Each participant will be assigned an ID #, and that all other materials, e.g. transcriptions, will use that ID #. The master list with names and ID# will be retained in the RPI's office in a locked cabinet and will be destroyed after the study is complete. The identities of all participants will be maintained as confidential, with all demographic, interview data, and field notes de-identified. The original interview transcripts, informed consent documents, and supporting documents will remain in a locked file cabinet in the RPI 's office until the study is complete. All recordings of the interviews will be destroyed once transcriptions have been made, with all identifying information redacted. Only the de-identified data will be used for the audit trail or analysis.

____ (6.5) Does not apply to the university setting; do not use it

____(6.6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.
Comments:

Human Subjects Training

7.   All investigators (including graduate students enrolled in Thesis and Dissertation projects involving human subjects) must document completion of the CITI Human Subject Protection course.
(Attach a copy of all CITI Human Subject Protection completion certificates.)
Date RPI completed Human Subject Protection training: **Carrington Completed CITI on 03/20/2015**

PLEASE NOTE:

You may begin research when the College Committee or Institutional Review Board gives notice of its approval.

You MUST inform the College Committee or Institutional Review Board of ANY changes in method or procedure that may conceivably alter the exempt status of the project.

Responsible Project Investigator (Must be original signature)

Date

APPENDIX B

INFORMED CONSENT DOCUMENT

OLD DOMINION UNIVERSITY

PROJECT TITLE:
New Counselors Working with Non-Death Loss

INTRODUCTION
The purpose of this form is to give you information that may affect your decision whether to say
YES or NO to participation in this research, and to record the consent of those who say YES.

RESEARCHERS
The researcher for this project is Charles Carrington, M.A. is a doctoral student in Education,
Counseling at Old Dominion University, Darden College of Education, Department of
Counseling and Human Services. Dr. Nina Brown, PhD is the responsible project investigator
supervising this study.

DESCRIPTION OF RESEARCH STUDY
There is a significant body of research on death related loss in counseling. However, few studies
have been conducted which describe the experiences of new counselors when working with
clients suffering from non-death loss. None of them have explained the how counselors frame
and approach loss events, or how encountering those events for the first time post-graduation
have impacted or informed the new counselor. This study is designed to gather information on
what new counselors lived experiences have been.

If you decide to participate, you will join a study involving research of on your beliefs and
attitudes towards loss in general and the factors you feel help you work with clients. If you say
YES, then your participation will include one individual face to face interview with the
researcher. The interview will last approximately 30 minutes, and will be recorded. You will be
part of a small group of up to ten individual participants.

EXCLUSIONARY CRITERIA
To participate, you must have graduated from a CACREP (Council for Accreditation of
Counseling and Related Educational Programs) approved master's program in counseling, and be
registered with the Virginia Board of Counseling as a Resident in Counseling. You must also be
actively working with clients in a professional setting in the Hampton Roads region of Virginia
for at least 3 months. You should have completed a brief screening survey to establish your
qualifications by electronic means, provided to you by the researcher.

RISKS AND BENEFITS
RISKS: There are no identified risks in this study. A potential risk may include a negative
feeling or awareness regarding your particular level of efficacy with the topic. As with any

research, there is some possibility that you may be subject to risks that have not yet been identified.

BENEFITS: The main benefit to you for participating in this study is an understanding that your participation may ultimately lead to improvements in understanding the need for training, support, or additional supervision in counselor education in the area of loss treatment. Others may benefit by knowing that their opinion and experiences are valued and important to the study counselor education for the future.

COSTS AND PAYMENTS
The researchers want your decision about participating in this study to be absolutely voluntary. Yet they recognize that your participation may pose inconvenience. The researchers are unable to give you any payment for participating in this study.

NEW INFORMATION
If the researchers find new information during this study that would reasonably change your decision about participating, then they will inform you.

CONFIDENTIALITY
All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations and publications, but the researcher will not identify you.

WITHDRAWAL PRIVILEGE
It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study -- at any time.

COMPENSATION FOR ILLNESS AND INJURY
If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of harm, costs, or injury arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Charles Carrington at (757) 759-5674 or ccarr051@odu.edu, or Dr. Jeffrey Marshall, Chair of the Darden College of Education Human Subjects Review Committee, Old Dominion University, at jrmarsha@odu.edu who will be glad to review the matter with you.

VOLUNTARY CONSENT
By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them:

Charles Carrington, (757) 759-5674, ccarr051@odu.edu

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should contact Dr. Tim Grothaus, Chair of the Darden College of Education Human Subjects Review Committee, Old Dominion University, at tgrothau@odu.edu or the responsible project investigator, Dr. Nina Brown, PhD, Professor and Eminent Scholar, Counseling and Human Services, Old Dominion University at nbrown@odu.edu .

And importantly, by signing below, you are telling the researcher YES, that you agree to participate in this study.

Participant's Printed Name & Signature	**Date**

INVESTIGATOR'S STATEMENT

I certify that I have explained to this participant the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the participant's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Charles Carrington, M.A.	**Date**

APPENDIX C

PARTICIPANT RECRUITMENT EMAIL

Greetings,

My name is Chuck Carrington and I am a doctoral candidate in Counselor Education and Supervision at Old Dominion University. I would like to invite you to participate in my dissertation research exploring how counselors in residence experienced working with non-death loss at the beginning. This study has been approved by the institutional review board at Old Dominion University and is under the supervision of my dissertation chair and responsible project investigator, Dr. Nina Brown, Professor of Counseling.

The purpose of this study is to explore the lived experience of new counselors when working with clients who have non-death loss and grief issues. Residents in counseling (pre-licensed counseling graduates) who graduated from a CACREP accredited university are invited to participate. Survey responses will be confidential and will remain anonymous.

If you agree to participate you will complete two steps:
First, fill out the online survey by clicking the link at the end of this email. You will be asked basic demographic questions, and then some questions about your counseling experiences. The total time to complete the survey is less than 10 minutes. At the end, you will be asked for your email address to connect you to the second stage.
Second, I will review your qualification from the initial survey, and if qualified, will ask you to complete a 20-minute interview, by phone or in person, to tell me about your own experience working how may have had loss issues.

Prior to beginning the survey, please read the attached informed. You will be asked at the beginning of the study to acknowledge that you have read and understood the informed consent before being allowed to continue the survey.

To begin, click the link or copy and paste into your browser.

https://www.surveymonkey.com/r/FD9T6KM

Please forward this email to any friends or associates who are residents in counseling who might be willing to participate in my dissertation study.

Please respond to ccarr051@odu.edu to if you have any questions.

Thank you in advance for your help!

Chuck Carrington

Dr. Nina Brown (nbrown@odu.edu)

APPENDIX D

PARTICIPANT DEMOGRAPHIC SURVEY

Instructions, please select the item that applies to you.

1. Gender: Male, Female
2. Age: 20-29, 30-39, 40-49, 50-59, 60-69, 70+
3. Level of Education:
    - Master Degree in Counseling-CACREP
    - Master Degree in Counseling-non-CACREP
    - Education Specialist
    - PhD
4. Year Graduated from your Masters in Counseling, _____
5. How long have you been in Residency?
    - 0-3 months,
    - 3-6 months,
    - 7-9 month,
    - 10-12 months,
    - 13-18 months,
    - 19-24 months,
    - more than two years.
6. How many direct hours have you completed to date? _____
7. Residency site(s) (Pick all that apply):
    - Private agency
    - Non-profit (government)
    - Non-profit (private)
    - Church or religious organization
    - University or College counseling center
    - Other_____
8. What population do you treat primarily? (pick all that apply):
    - Adults
    - Adolescents
    - Children
    - Couples
    - Families
9. What issues, concerns, and diagnosis do you typically treat? Pick all that apply
    - Dually diagnosed
    - Drug and Alcohol
    - Community Mental Health-
    - Anxiety
    - Depression

- Grief & Loss
- Personality Disorders
- LGBT
- Marriage
- Communication
- Other _____

10. How many different supervisors have you had since graduation: (enter number) _____

11. Have you completed any additional training since you graduated? y/n

12. Have you had specific training in loss and/or grief? y/n

13. Have you treated clients with loss issues since you began your residency? y/n

APPENDIX E

PARTICIPANT BELIEFS AND ATTITUDES SURVEY

Instructions: One the scale provided below, indicate the answer that best reflects how the following statements reflect you.

1= not at all, 2= somewhat agree, 3=neutral, 4=agree, 5=strongly agree

Short Title	Question	Response
Theory	I have a working knowledge of grief theory.	1 2 3 4 5
Competent	I know how to work with clients who are suffering from a loss.	1 2 3 4 5
Trained	I have been trained in loss and grief work.	1 2 3 4 5
Assess	It is my job as the counselor to assess for loss, even if it is not reported.	1 2 3 4 5
Prevalent	I find that Loss is present in most client issues.	1 2 3 4 5
Client Stated	Clients usually tell me when they have a loss that is a problem for them.	1 2 3 4 5
Grief=Loss	Loss is indicated by grief.	1 2 3 4 5
Hidden	People can be unaware of the impact of loss on their lives or the presenting issue.	1 2 3 4 5
5 Stages	The 5 stages of grief (Kubler-Ross) model is the standard method of processing grief with clients.	1 2 3 4 5
Grief=Death	Grief is primarily only present with death.	1 2 3 4 5
Visible	I know loss when I see it in clients.	1 2 3 4 5
Pers Exper	I have had significant experience with loss in my own life.	1 2 3 4 5

APPENDIX F

INTERVIEW PROTOCOL

The purpose of this study is to examine the experiences of new counselors when working with clients suffering from non-death loss. Specifically, I will be seeking to understand how counselors frame and approach loss events, or how encountering those events for the first time post-graduation have impacted or informed the new counselor. This study is designed to gather information on what new counselor's lived experiences have been. The research questions guiding this study are: "To what extent are new counselors aware of the presence and impact of non-death loss in resolving client issues?", "To what extent do new counselors feel confident that they can identify client's non-death losses and work with these?" and "How does working with non-death loss directly, or indirectly, affect a new counselor?"

I will begin data collection by explaining the purpose for the study to the interviewee, thank them for participating, and begin with the questions listed below:

1. Tell me about the first time when you became aware of a client's issue of loss or grief?
   a. Probe: Did the client tell you they suffered a loss voluntarily?
   b. Probe: If not, what presenting factors did you identify as an indication that there was an issue of loss?
2. What was that like for you?
3. What kind of interventions did you do with that client?
4. How much experience have you had in helping clients through loss?
5. How prepared did you feel at the time to deal with the client's loss, and the surrounding factors, or issues of loss?
6. Tell me about how you felt when working with issues of loss when you first completed your training.
7. What has anything changed for you, or how you practice, when working with loss issues since that first time your encountered issue of loss in a client.

APPENDIX G

PARTICIPANT MEMBER CHECKING EMAIL

Dear [Participant],

Thank you for completing the interview for my study on new counselor's experience with non-death loss. Attached to this email is a transcript of your interview. This is a verbatim transcript. I invite you to read through the transcript for accuracy and reflection of your intended meaning. If anything does not accurately represent your intended meaning or remembrance, please feel free to inform me. I will make the changes you request to best reflect your story and meaning. Please reference the line number for any changes you wish me to make.

Thank you for taking the time to complete the survey and interview. Your responses will help me to report on the lived experiences of new counselors when entering the field and addressing non-death loss for the first time.

Thank you,

Chuck Carrington

ccarr051@odu.edu

APPENDIX H

CONSENSUS CODING

Consensus Coding: Two coders independently identified primary codes to 170 units of coding yielded 93.5% agreement when compared. A consensus meeting was held to achieve 100% agreement on the proper final code before being placed into the case display. The units of coding are displayed below by participant identification number and by line number corresponding to the transcription. Coder one and coder two initial reported codes are displayed. Revised codes from the consensus meeting are indicated in bold type.

ID#	Line	Coder 1	Coder 2	Consensus	Unit of Coding
P1	8	1.1.1	1.1.1	1.1.1	*Hum (pause), it was, um, (pause), I guess in my master's internship, um, ah, one of my clients was coming in because her dad had, um, died of, um, oh gosh, now I can't think of the name of it. It's been in the media lately…ALS.*
P1	**12**	**1.2.3**	**1.2.1**	**1.2.3**	*Yes, he had died of ALS, um and it had been a couple of years but she hadn't really dealt with in until she got to campus and people were kind of talking about their relationships with their dads.*
P1	14	1.2.3	1.2.3	1.2.3	*Um, and I think that was the first time that I became, that it was kinda like the main focus of counseling…*
P1	24	1.2.1	1.2.1	1.2.1	*It was very point blank. IT was like, she was like, "this is why I'm here."*
P1	29	3.2.2	3.2.2	3.2.2	*I didn't know what to do. Um, honestly, um, one, I didn't know what to do because, um, it wasn't, it was a loss that occurred a couple of years ago, and two because I just didn't have much training.*
P1	**32**	**3.1.1**	**3.1.2**	**3.1.1**	*I think I had attended one, um, we had one person who was, um, we called him the grief guy, who came in and did a talk for us.*
P1	34	2.2.1	2.2.1	2.2.1	*But um, in terms of just dealing with loss and grief, I guess, scared is what I remember.*
P1	40	4.1.1	4.1.1	4.1.1	*Um, (sighs) very much from an interpersonal, like humanistic perspective. Um, we just kind of, um, any interventions I used were like were, I would say, very basic. We would just, we just processed. Um, yeah, we just processed from what was going on for her.*

P1	47	1.2.3	1.2.3	1.2.3	*I guess, you know it comes up with, especially on a college campus with relationship losses.*
P1	49	1.1.3	1.1.3	1.1.3	*Um, losing friends, um, romantic relationships ending, um, even loosing pets. Uh, (sighs), I guess I hadn't considered this as much as a loss, but even, um, having something major even impact someone's future, I guess like the loss of a dream, however you want to say it.*
P1	58	1.1.3	1.1.3	1.1.3	Okay. But you didn't identify then as primarily as loss at the time? Is that what you are saying? P1. Yeah. Not at the time I didn't.
P1	65	4.1.1	4.1.1	4.1.1	*I mean I, in some respects I did. I had my basic skills, um I felt really, I felt grounded in those.*
P1	67	3.2.3	3.2.3	3.2.3	*But in terms of just methods for, or techniques for addressing grief and loss, I didn't feel prepared in that respect.*
P1	76	2.1.1	2.1.1	2.1.1	*, I think in some respects, my own experience with loss has helped. It did, it helped in that it definitely helped, well, I'd say it helped and hindered my empathy.*
P1	79	2.1.1	2.1.1	2.1.1	*to some extent I can understand what you're going through, having experienced loss myself.*
P1	**82**	**3.1.4**	**2.1.4**	**2.1.4**	*because I was wondering if maybe I put some of my own beliefs about loss on the client, in terms of how they should deal with it.*
P1	90	3.2.1	3.2.1	3.2.1	*, In some respects, I think it depends on the type of loss. Because I'm still working with college students. So, in some respects, um, if it's the loss of relationship, if it's the loss of the sense of future, um, I feel very prepared. Um, in that respect.*
P1	94	1.1.1	1.1.1	1.1.1	*But I still struggle with, with grief, in terms of like if it is the loss of a person, um, and, I guess death is what I struggle with.*
P1	94	3.2.2	3.2.2	3.2.2	*But I still struggle with, with grief, in terms of like if it is the loss of a person, um, and, I guess death is what I struggle with.*
P1	100	3.2.3	3.2.3	3.2.3	*Yeah, so I think it depends on the type of loss. But when it's the loss of a person, I don't feel as prepared in that.*

P1	122	1.1.2	1.1.2	1.1.2	*I almost see it as a sense, I'm trying to define it without using the word loss, but, almost like losing a sense of the future?*
P1	125	1.2.2	1.2.2	1.2.2	*I think that's been a common theme when I've dealt, when I have dealt with client's, um, who've lost something, is that this idea that some aspect of their future, um, was gone.*
P1	**130**	**1.1.2**	**1.1.3**	**1.1.3**	*Uh huh. It doesn't always have to be tangible. Yeah.*
P1	134	1.3.2	1.3.2	1.3.2	*So, with the age group [college] that I am working with, I would say at least half of the time*
P1	140	1.2.2	1.2.2	1.2.2	*I assess for it. We've got a brief intake form, um, where we ask if there have been any losses. And I generally frame that in a general standpoint, "that could be death, that could be a relationship ending," or something along those lines.*
P2	8	1.1.2	1.1.2	1.1.2	*Well I would say that it could be a multitude of things. It could be losing a job, a dream, um, it could be, you know, losing your home, it could be anything that really impacts you. It doesn't have to be death itself.*
P2	14	1.1.1	1.1.1	1.1.1	*Well, it was probably about a year and a half ago. A client came to me and she had lost her father as a young girl. I think she was about 11 when she lost her father, and she's currently about 52, right now. And, she still struggles with grief from losing her father at such a young age.*
P2	22	1.2.3	1.2.3	1.2.3	*It came out as we were talking.*

P2	27	1.2.3	1.2.3	1.2.3	*You know, I think we were just trying to process her, she feels, she has abandonment issues. She came in and it was a relational issue with her husband, and the more we dug into what was going on with her, we found that she really is just afraid of losing her husband. She's clingy, she's very jealous, all of these things. And we were able to connect it to her feelings that, well, it was a death, but she felt abandoned by her father. Granted she was only 10 or 11 when he passed away, so she felt like he abandoned her and she felt very angry. And so, we just realized through processing what was going on with her was that it's connected, you know, to her loss as a child.*
P2	**44**	**2.1.3**	**2.2.2**	**2.1.3**	*Well, not necessarily, not personally, no.*
P2	52	4.1.1	4.1.1	4.1.1	*You know, I just remember we just did a lot of talk therapy, trying to, in, a, I was just trying to help her make connections.*
P2	67	4.1.1	4.1.1	4.1.1	*Hum. Well, she was telling the story, and then I would use talk therapy along the way to try to help her make those connections. But again, but I guess more talk therapy. Um she's just a very difficult client. Very resistant. She always came in with her agenda. She would always basically, I kind of had the impression that she didn't necessarily want to improve. She was kind of, she was getting some sort of benefit from being, you know, in the position she was in, she kind of appeared to a, to complain, but almost appeared to enjoy her misery. If that makes any sense.*
P2	**79**	**2.1.2**	**3.2.2**	**2.1.2**	*Not a lot. Not a lot at all. I, yeah, it's not something that I welcome, I don't necessarily like working with loss. (laughs). Um, but I would. I just don't seem to have a whole lot of clients that have had losses.*
P2	81	1.3.3	1.3.3	1.3.3	*Um, but I would. I just don't seem to have a whole lot of clients that have had losses. Or at least that they have not come into therapy, you know, to talk about.*
P2	88	3.1.2	3.1.2	3.1.2	say I felt *un*-prepared (heavily emphasized "un") *because I have done some research on grief, because it tends to be one of those*

					subjects that as a counselor, I don't look forward to working with it."
P2	90	2.1.2	2.1.2	2.1.2	*I do not look forward to working with. So I, you know, went ahead and tried to read about how you would go about helping a person who's struggling with this.*
P2	95	2.1.2	2.1.2	2.1.2	*if someone gives me as an option, "hey do you want this grief and loss client?"*
P2	97	3.2.2	3.2.2	3.2.2	*I'm going to say no. But if they end up on my schedule, and I have no choice, then, I do the best I can and, you know, that's kind of my plan. You know, do the best you can.*
P2	102	2.1.2	2.1.2	2.1.2	*No. but I think that my fear (emphasized fear) of losing others in my life impacts me not wanting to deal with loss. Because it reminds me that I'm going to have loss in my life.*
P2	111	2.2.1	2.2.1	2.2.1	*Uh, knowing that I have to deal with my own issues. Knowing that that is an area of weakness in me. Knowing that it makes me really nervous.*
P2	119	2.1.1	2.1.1	2.1.1	*So, yeah, I try to avoid it because I don't like to think about that unless I die first, I will have to deal with losing my mom.*
P2	126	1.3.3	1.3.3	1.3.3	*I'd say, out of the clients that I have been seeing, that probably 25% to 30% of the time.*
P2	130	1.2.3	1.2.3	1.2.3	*When I see it. You know. Typically, it comes out when during my initial interview with the client.*
P2	132	1.2.2	1.2.2	1.2.2	*Because I have a form, and I ask a ton of questions about them and their lives, and their families.*
P2	134	4.1.1	4.1.1	4.1.1	*And then as therapy progresses, you can start to see how things are tied.*
P3	8	1.1.3	1.1.3	1.1.3	*what I really think of typically is the loss of a family member. And the second one, that was death related, and the second one was somebody had lost their child to the CPS system, and to foster care.*
P3	26	1.1.2	1.1.2	1.1.2	So as a resident, that would leave this one person who, um, who was typically upset that her son had been taken away. And, she wanted to get him back, and that, and she was in my substance abuse group, and when she lost that case, she did not come back, so

					one could only make the presumption that she had relapse because of that. And, unfortunately is was crack cocaine.
P3	36	1.2.3	1.2.3	1.2.3	*She came as a mandated person, trying to make herself look better for the court, that she wen t through substance abuse. So we got to know her, doing check-ins and, um, you know, "what's going on with you?" That was the main focus for her.*
P3	46	2.2.1	2.2.1	2.2.1	*Well, I still feel sad about not having her in our group anymore, because she was there, maybe 8 weeks or so. And knowing of her substance abuse problems, you really want the best for them. And the fact that you know that this absolutely crushed her, um, I still feel sad, and I hope to see her come back and try again. You never get to see them, or say goodbye, or anything, you just know that they are out there and they are not okay*
P3	58	2.2.1	2.2.1	2.2.1	*Yeah. I feel sad for her.*
P3	61	4.1.2	4.1.2	4.1.2	*Well, like in the group session, or what really comes to mind, is advocating, because I worked directly with my supervisor.*
P3	63	1.2.3	1.2.3	1.2.3	*And she was the one that would work directly with Child Protective Services, trying to get them on board with her recovery.*
P3	74	3.2.3	3.2.3	3.2.3	*It was a big one. I don't know if I had that much preparation in dealing with grief and loss in particular.*
P3	76	4.1.1	4.1.1	4.1.1	*just holding that space for her, I felt very competent in that, and letting her talk about her feelings and her wants, and her desires.*
P3	82	4.1.1	4.1.1	4.1.1	So, I guess, it was that called, *indirectly dealing with it.*
P3	97	1.2.2	1.2.2	1.2.2	*I think during intake, people report having lost somebody, more so than they do I my groups. So, maybe it will come it, like I said, it's come up once so far.*
P3	104	1.2.2	1.2.2	1.2.2	Actually, it is a written question on the protocol sheet.
P3	109	1.2.2	1.2.2	1.2.2	*That's true. And there's another similar question, first is there any significant loss, and the next is if there is any significant*

					trauma. And a lot of times you will have to go back and fill it in if you find something later. But they will say no to trauma as well.
P3	116	1.2.4	1.2.4	1.2.4	R1.　So how do you know if someone has an issue of loss if they don't tell you? *I guess that I don't.*
P3	124	2.1.1	2.1.1	2.1.1	*In this particular case, I couldn't relate it back to my loss. But I could relate it to my imagined loss of my son if I were in her shoes. So more of an empathic feeling.*
P3	129	2.1.1	2.1.1	2.1.1	*Yes, and when I imagine that, I imagine it being very hard and very sad and I would tell her what a great job she was doing to stay in there, and be there for her son, and to try to get him back. Because I think I be the insane asylum.*
P3	142	3.2.2	3.2.2	3.2.2	*No…(pause), not any more than when I had my first client (prior to residency), I'm still kinda winging it.*
P3	143	4.1.1	4.1.1	4.1.1	*I'm still kinda winging it. But I just try to rely on that person centered holding the space and letting them have their moment.*
P3	148	4.2.2	4.2.2	4.2.2	R1.　So since that first one, has anything changed for you in how you practice now, or frame working with loss? P3.　*No.*
P3	155	1.1.3	1.1.3	1.1.3	The only thing I can think of is like divorce, or with a child in foster care.
P4	8	1.1.2	1.1.2	1.1.2	*I've mainly seen loss, um, I'm trying got think back, loss of a partner, a breakup, in that sense. I haven't worked with anyone with loss of a limb, or anything like that, even though I would consider that a huge loss.*
P4	13	2.1.1	2.1.1	2.1.1	*Because of my dad. He only had one leg, so. Um, I think, I haven't had any*
P4	15	1.1.2	1.1.2	1.1.2	*I can't remember any off the top of my head if I've had people who've had experience,* like, *loss due to a natural disaster,* cuz *I would consider that a part of loss, the home, or anything like that. Um, I have had people who have had a loss of job. Um, which I think, that would go with identity.*
P4	30	1.1.2	1.1.2	1.1.2	*my client's that had a loss of freedom in the sense that they got in trouble with the law. And were required to go to counseling.*

P4	37	1.2.3	1.2.3	1.2.3	*The resistance, um, spoke to me. Because they definitely felt, "I don't want to be here", I don't understand why I have to be here.*
P4	42	1.2.3	1.2.3	1.2.3	Yes. Or when I would say, *"well, you have a choice to be here." And they would say, "no I don't."*
P4	49	2.1.1	2.1.1	2.1.1	*I think it helped me empathize with them. It helped me kind of take away the judgment and give that positive regard.*
P4	60	4.1.2	4.1.2	4.1.2	I think in that situation, I *used mainly helping them recognize what they can control, and what they do still have power over.*
P4	67	3.2.2	3.2.2	3.2.2	*I feel like that issue, yes, had it been heavier, I don't think like I would have been.*
P4	72	3.2.2	3.2.2	3.2.2	For instance, someone who lost a limb, or who maybe a natural disaster like, those are a lot harder to rationalize, so, I feel like that would be more difficult,
P4	75	2.1.2	2.1.2	2.1.2	and I don't think, at least at the beginning I had, I might have had that "oh-Shit" going through my head. If that makes sense, when they said it.
P4	83	2.1.1	2.1.1	2.1.1	I think, *I don't know if it sensitized me, but it definitely goes back to helping me empathize, also to helping me realize that I, what am I trying to say,*
P4	87	2.1.3	2.1.3	2.1.3	*), it was a reality check for me, I guess. Um, in the sense that, like I said earlier, what's the big deal, and then having my own experiences with loss tells me, "oh, okay, that's what it is like."*
P4	95	1.1.1	1.1.1	1.1.1	*Most of them were death ones,* well, not all of them were death related.
P4	96	1.1.2	1.1.2	1.1.2	My internship, well, in my practicum *I worked youth offenders, that, you know, had family members in jail, so they didn't have that family, um, they also got in trouble with the law. So they had a loss I that sense.*
P4	100	1.1.2	1.1.3	1.1.2	Um, but then in my internship I worked with elderly. Um, and *they experienced a whole bunch of different loss.*

P4	113	1.2.1	1.2.1	1.2.1	I would say the majority. Um, I don't want to say everything could be a loss, but I'd say the majority.
P4	117	1.2.3	1.2.3	1.2.3	*I wait until it becomes visible to me.*
P4	121	1.2.3	1.2.3	1.2.3	*). I don't know how I know. Um, it's just if they are, they feel*
P4	123	1.2.3	1.2.3	1.2.3	*I guess if they feel like something's missing. Like if it's a person, a place, control, freedom, you know. Something's not there.*
P4	127	1.2.3	1.2.4	1.2.4	*Yeah. I guess I don't pry into it, because I fear some of that might be me, throwing my stuff, my interpretation, so that's why I wait for it.* I
P4	138	3.2.1	2.1.4	2.1.4	*I did in the sense that I wanted to work with, I really enjoyed working with the elderly. So, I wanted to work, and I was looking for jobs working with them, but I didn't find one. And, I think working with that population, that's kind of a given.*
P4	144	3.2.1	3.2.1	3.2.1	, I felt pretty prepared because I had already worked with it.
P4	147	3.2.1	3.2.1	3.2.1	R1. So you felt like your training was enough. P4. Yup.
P4	152	4.1.1	4.1.1	4.1.1	*I don't know if I feel like I've been trained on stages, or anything like that, but I feel like what I am good at, and the one thing I've learned is to let people express it their way. And what they're going through.*
P4	161	4.1.1	4.1.1	4.1.1	Yes. And be supportive in that sense, and not label to different things, levels, or boxes or whatever you want to call it.
P5	7	1.1.2	1.1.2	1.1.2	*Loss is a simple word. It's when a person has something of value, and no longer has it, or it has been taken away. And, there are psychological ramifications for that person.*
P5	15	1.1.2	1.1.2	1.1.2	*How about, especially early on, my first work was as a school counselor, um, a student who was denied entrance into an institute of his or her choice.*
P5	26	1.2.3	1.2.3	1.2.3	R1. Did you frame it as a loss in your own mind at that time? P5. *Yes.*
P5	29	2.1.3	2.1.3	2.1.3	*I think it's something that is part of the basic human experience. And so, watching a client go through it, I could put myself in the*

					client's shoes very readily, very easily. And so, um, it some, and always take a little bit of bracketing to keep the counselor's loss out of it. The counselor's experience of loss out of it, and stay focused on what the client is experiencing with this particular situation in this particular context, and how the client is experiencing specifically.
P5	40	2.1.1	2.1.1	2.1.1	R1. It also sounds like you're saying that your own losses sensitized you to being able to recognize and deal with the student's loss. P5. *Yes.*
P5	44	4.1.2	4.1.2	4.1.2	*so there's some really quick empathy, and some sitting with the client about what he or she is experiencing.* And then, in a *solution-focused way,*
P5	53	3.1.4	3.1.4	3.1.4	*I don't remember any specific training about grief and loss in my master's program.* Um, the *preparedness came from the comprehensive nature of my program though, in the way it emphasized basic counseling skills to attend, provide empathy,*
P5	64	3.1.4	3.1.4	3.1.4	*not beyond the training in my master's program, that was not specific about grief and loss, but, um, was comprehensive*
P5	66	4.1.1	4.1.1	4.1.1	*I felt that I learned the skills I needed to attend to someone who was experiencing a loss.*
P5	71	1.3.1	1.3.1	1.3.1	*I would expect to see it in everybody. It's just I see it as part of the basic human experience. We go through certain losses every single day. And, um, it doesn't have to be a traumatic loss to affect a client, to affect the person, um, so traumatic loss, not in all of them, but everyday loss? In all ten.*
P5	79	1.2.4	1.2.4	1.2.4	*I like to think that if a loss is affecting a client, I will recognize it.* Um, but *I don't have a specific go to question that I ask clients to see if they are being affected by any kind of loss right now.*
P5	85	1.2.3	1.2.3	1.2.3	*It more intuitive.*
P5	90	4.2.2	4.2.2	4.2.2	I think what's changed most dramatically is that I've had the opportunity to work with different populations.

P5	101	4.2.3	4.2.3	4.2.3	*so the way that I approach them with their losses is different. And I have had to change the cultural lens through which I view my clients in how they are experiencing their particular losses.*
P6	7	1.1.2	1.1.2	1.1.2	*from my experience so far, it's, we can encounter loss when we talk about relationships, when we talk about a job, you know, all of these things that actually affect you, or could affect you in the same sense of what we understand as grief and loss.*
P6	19	1.2.3	1.2.3	1.2.3	*. I had a client that came in, and didn't really understand that they had lost, that they were actually going through grief and loss, but in all reality they were.* *They came in with a different issue, of course, um, they were stressed, they had all the symptom, anxiety, depression, insomnia, um, but they were blaming it on something else. They were unable to understand it. They thought everything was fine. I asked them if they had lost something recently, in the interim, and they said, "yeah, but it was like months ago". I said, be more specific. "Well, it was like 8 months ago, I lost my job, I loved my job. But I found another job." So the question was, so do you like the job you're doing right now? And, the response was, "not as much as the job that I lost."*
P6	32	1.2.3	1.2.3	1.2.3	*Then we went into it a little bit. So can we talk about your last job. "well, I really don't want to talk about it because it still hurts." Um, so that right there, just sitting back and letting them talk, is, was a big indication that what they came in initially was not really what was the ground or issue.*
P6	43	2.2.3	2.2.3	2.2.3	*I, it did. I think the impact it had on me was a positive impact in that it was challenging. Ah, I couldn't wait to just, you know, begin working with this individual, with this client, um, based on the little bit of information that I had. But I was ready to give so much. Offer so much. But it did have a very positive turn out.*

P6	50	4.1.1	4.1.1	4.1.1	*one of the first things I had to do was identify, or actually, kind of, I didn't want to identify it, I assisted them in identifying it, because I wanted it to come from them more than from me.*
P6	62	3.2.1	3.2.1	3.2.1	Well, as far as preparedness, um, I don't want to say that I was overconfident. Because I knew that there was a lot more information out there, not too much experience dealing with grief and loss, or loss
P6	66	3.1.2	3.1.2	3.1.2	*I went and did extra reading, you know, education. I educated myself so I could actually assist them, and better help them.*
P6	76	1.3.1	1.3.1	1.3.1	*Oh! I'll just use a number; I'd say 8 out of 10.*
P6	86	1.2.2	1.2.2	1.2.2	*Well, and that' a matter of the initial meeting, during the diagnostic interview, or initial encounter.*
P6	90	1.2.2	1.2.2	1.2.2	R1. Okay, so you have a specific set of questions to test for it. P6. Yes.
P6	95	2.1.3	2.1.3	2.1.3	*I would definitely answer yes.*
P6	99	1.2.3	1.2.3	1.2.3	*Again, now I feel more confident. I can actually identify it a little sooner, so the line of questioning, during out meetings are less, because now I know what I am looking for. Versus in the past I was actually learning so I was, I don't want to say fishing, but it was searching for more information just to make sure, to ensure for myself that it was a loss.*
P6	108	4.1.4	4.1.4	4.1.4	*That is, I'm going to say no,*
P6	117	4.1.4	4.1.4	4.1.4	*I have many theories that I individualize depending on the person.*
P7	8	1.1.2	1.1.2	1.1.2	*I have many theories that I individualize depending on the person.*
P7	13	1.1.2	1.1.2	1.1.2	*Yes, it was actually one of my very first clients that I had the opportunity to work with, a, ah, successful fellow who was and executive, ah, who lost his job due to the termination of a contract with the government.*
P7	19	1.2.3	1.2.3	1.2.3	*No, he basically came with saying, "I don't know what to do."*
P7	24	1.2.3	1.2.3	1.2.3	*As he related his narratives, probably by the end of the first session. It started to sounds*

					awfully like what I had learned and studied regarding loss and grief and, uh, some grief issues.
P7	34	2.1.1	2.1.1	2.1.1	*ah, there was certainly a certain amount of empathy, because, having retired from the military, I had experienced a lot of that myself. Uh, so I was able to. I could kind of see where he was coming from.*
P7	**44**	**2.1.3**	**2.1.1**	**2.1.1**	*Uh, I think it gave me insight because, it led me in a direction, other than to say, adjustment or, ah, uncertainty, to where I could actually see grieving process going on with this guy.*
P7	50	4.1.3	4.1.3	4.1.3	*The first thing I did was I reached for my Kubbler-Ross. Un, and tried to gain some articulation for the sorts of insights that I was getting out of just working with the client.*
P7	53	4.1.3	4.1.3	4.1.3	*and a lot of it was just coming to terms with just the existential fact of the loss. And its implications, and almost working through the stages of the Kubbler-Ross grief cycle.*
P7	58	4.1.3	4.1.3	4.1.3	*Q10.* Is that the theory that feel is best to use to approach loss? P7. *When it's appropriate, yes. I can imagine circumstances where it wouldn't be. But it seems to be just the trick for this one.*
P7	66	4.1.3	4.1.3	4.1.3	*I just stuck with that one theory[Kubler-Ross] because it seemed to fit so well.*
P7	72	3.1.4	3.1.4	3.1.4	*for loss, for this kind of loss specifically, probably underprepared.*
P7	72	3.2.2	3.2.2	3.2.2	*for loss, for this kind of loss specifically, probably underprepared.*
P7	75	3.1.4	3.1.4	3.1.4	*Other than, I had a really good foundation in scholarly study.*
P7	75	3.1.4	3.1.4	3.1.4	*Other than, I had a really good foundation in scholarly study.*
P7	82	3.1.4	3.1.4	3.1.4	*I don't think there was a specific training in that. If memory serves.*
P7	86	1.3.3	1.3.3	1.3.3	*To one degree or another, probably at least a third.*
P7	91	1.2.4	1.2.4	1.2.4	Um, no I don't assess specifically.
P7	92	1.2.3	1.2.3	1.2.3	Uh, *I remain aware*, uh, given instances where I have encountered it.

P7	104	2.1.1	2.1.1	2.1.1	Q 9 Going back to a previous statement you made, it sounds like your own losses in life gave you insight, or sensitized you towards you being able to perceive loss in your clients, is that correct? P7. *Yes, I would say that that is correct.*
P7	110	2.2.3	2.2.3	2.2.3	*Oh, definitely positive. Yeah.*
P7	116	4.2.2	4.2.2	4.2.2	*I would say that once I am able to identify it, or once it seems to come up in the therapeutic relationship, I, that becomes my focus. That becomes the focus of therapy.*
P7	120	4.2.2	4.2.2	4.2.2	*Um. No, that has pretty much stayed constant, yeah.*
P7	**123**	**Not coded**	**4.1.3**	**4.1.3**	Q12 Okay, so Kubbler-Ross or some sort of stage or existential sort of thing, when you see it. P7. Right.
P8	10	1.1.2	1.1.2	1.1.2	*I would say that loss can take a number of forms. It doesn't always have to deal with grief, like, I couldn't tell from the survey if you are getting at loss in terms as in handling a death, but there are other kinds of loss as well. I think it's really about first and foremost actually, understanding a client's inner world, and the loss the they are experiencing.*
P8	49	1.1.2	1.1.2	1.1.2	So, a common way that I experienced working with loss was when these students has been them not getting into the programs.
P8	57	4.1.2	4.1.2	4.1.2	Typically, I never followed a loss or grief model. I did understand stages, but that wasn't something that I have typically focused on. I usually let my theoretical perspective guide me.
P8	60	4.1.2	4.1.2	4.1.2	my primary theoretical model was integrative approach. I used MMT, and with MMT, an integrative approach you ground it in your primary approach. Which for me was solution focused.
P8	64	4.1.5	4.1.5	4.1.5	Since I was working in the school system which is primarily present-future oriented.
P8	85	4.1.5	4.1.5	4.1.5	So my goal, coming from that approach, was to actually follow my theoretical orientation of MMT, which is grounded in solution-focused. And I'd use [?] theories. And so, [inaudible] intended to pull from

					strategies like person centered, um, and really trying to focus on building the relationship, and using relationship to help work with them. And then, I start moving on to the solution focused,
P8	100	4.1.5	4.1.5	4.1.5	And then a lot of times coming from a person centered approach
P8	112	1.2.3	1.2.3	1.2.3	Um, it of course depends on the unique needs of each client.
P8	125	1.2.3	1.2.3	1.2.3	Part of it's being able to recognize the emotions that the client is saying and explaining and showing non-verbally and verbally in the session. To see if there is some kind of indication that they might be experiencing some loss. I think the other half of it is common sense. And, if the client comes to you with a presenting concern that is often associated with loss, just having a common sense to not assume their experiencing it, but to know enough to just probe to see if they're experiencing it.
P8	135	1.2.3	1.2.3	1.2.3	So you never know if it's actually loss or not without fully listening to the client and just making yourself available.
P8	138	4.1.1	4.1.1	4.1.1	Giving them opportunities to share with you their experience
P8	150	2.1.4	2.1.4	2.1.4	I remember the hardest part was not letting my own business get in the way. Um, for me, when they expressed some type of loss, for example, like a death in the family, um, if you think about that kind of a loss, um, it didn't really phase me too much.
P8	155	1.1.1	1.1.1	1.1.1	It was pretty easy to focus on the client and be present in the session. However, I've had deaths in my family, but none were really extremely close to me. So I didn't feel it, there wasn't much personal business there.
P8	**158**	**2.1.1**	**2.3.3**	**2.1.1**	But, the hard part was, um, when they expressed some type of loss, um, like um, for one I remember when I was at that age, I was super focused on a particular sport. And when I didn't do well in and didn't meet my expectations, I experienced loss. And I've worked with students that didn't do well, or didn't make it to State, and things like that. So when those forms of loss came up, for

					example, I've worked with plenty of students with parents who are divorcing. Thought my parents never divorced, at that point, I kind of just wished they had, when I was in my master's program.
P8	158	2.1.4	2.1.4	2.1.4	But, the hard part was, um, when they expressed some type of loss, um, like um, for one I remember when I was at that age, I was super focused on a particular sport. And when I didn't do well in and didn't meet my expectations, I experienced loss. And I've worked with students that didn't do well, or didn't make it to State, and things like that. So when those forms of loss came up, for example, I've worked with plenty of students with parents who are divorcing. Thought my parents never divorced, at that point, I kind of just wished they had, when I was in my master's program.
P8	168	2.1.4	2.1.4	2.1.4	So, the thing I'm really cognizant of was checking my issues at the door. And when a client brought something up that got hold of me, that I felt a personal piece, to kind of just think about it almost as a switch. Okay, that's there. Turn it off, and refocus, stay present with the client in the session.
P8	182	1.3.2	1.3.2	1.3.2	I'd say maybe about half the time.
P8	184	1.3.3	1.3.3	1.3.3	I'd say maybe about half the time.
P8	193	1.2.4	1.2.4	1.2.4	But I didn't always, or wasn't always able to see that. Sometimes it was more closer to helping them discover the purpose and meaning that helps to drive them.
P8	198	4.1.2	4.1.2	4.1.2	when I worked with college kids that I still worked from the MMT approach where solution-focused approach was my primary theory that I was grounded in. but, I still used the theoretical approach properly in trying to identify their firing modality, and needs based off of basic ID. But most often I ended up gravitating toward what were the issues that were brought up in the session. It seemed as though, existential approach, um, always somewhere in the humanistic area, but typically in the existential approach ended up being the most prevalent approach I used concurrently with solution-focused.

P8	211	3.2.3	3.2.3	3.2.3	I don't feel I was prepared to deal with very much of anything.
P8	**216**	**3.2.3**	**3.2.3**	**3.2.3**	I had a lot _self-doubt_ Because it was still so new. And, you know, having only had um, a 600-hour internship, and 100-hour practicum, and having only half of those hours at most being direct hours with clients, it's hard to have a lot of self-confidence at that point. At least it was for me.
P8	223	3.1.4	3.1.4	3.1.4	No, not really. The closest we got was under diagnosis and assessment course where we got case scenarios, and then had to identify diagnosis and work up treatments. So some people in the class had diagnostic criteria that they identified as loss. Typically, could have been associated with major depressive disorder and bereavement, but um, no specific training. But we got a piece of it here and there. Just depending on what happened, just variables within the program. But no specific curriculum.
P8	238	4.2.3	4.2.3	4.2.3	I think what I would change the most if I knew that I would be working with clients specifically for loss, is that I would supplement my theoretical approach with additional education in treatment strategies in working with individuals with loss.
P8	242	1.2.4	1.2.4	1.2.4	And, actually, thinking about it, you know, considering I never even thought of it as a fact but yeah, half the students I worked with at the middle school setting were probably dealing with some type of loss. Or experiencing some type of loss in one form or another.
P8	247	3.2.3	3.2.3	3.2.3	I think it would behoove me to actually do some more research, independent self-research, um, just to better educate myself on knowing more than just the stages of loss. And knowing how to actually help clients through that experience with models of therapy built for that. And I think that would be a really useful supplement to what I currently do.
P8	258	1.1.1	1.1.1	1.1.1	And, I remember just the other day, a supervisee brought into a session, that for

					the first time, they had a death of someone at the school that they worked at. And, they were working with students and faculty coming in to talk to them.
P8	262	3.2.3	3.2.3	3.2.3	And, I remember just the other day, a supervisee brought into a session, that for the first time, they had a death of someone at the school that they worked at. And, they were working with students and faculty coming in to talk to them.
P8	265	4.1.5	4.1.5	4.1.5	And, they were working with students and faculty coming in to talk to them. So we did our normal things in supervision, and help peers [?] the knowledge of the group, and basically I also take a solution focused approach in group supervision as well.
P8	**270**	**3.2.3**	**3.2.3**	**3.2.3**	But anyway, the thing that was really apparent to me, speaking of the purpose of your study, and I realize these were still students who are in their master's program, but I don't feel that they were prepared for that initial experience, many of them.
P8	274	3.1.4	3.1.4	3.1.4	It seemed like they came to me and they were very shocked. It kind of felt like a deer caught in the headlights the first time they had a client come to them that was crying and couldn't be consoled. The first thing that they wanted to do was to try and make the client feel better.

APPENDIX I

FINAL BETWEEN CASE DISPLAY

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1. IDENTIFICATION OF LOSS IN CLIENTS

1.0 When prompted to define non-death loss, participants defined:
1.1.1= Framed in terms of death or described client issue in death-related terms
1.1.2= Framed in non-death terms, or described client issue in non-death terms
1.1.3= Did not have a description or unable to frame non-death loss

Participant	Line #	Code	Unit of Coding
P1	8	1.1.1	*Hum (pause), it was, um, (pause), I guess in my master's internship, um, ah, one of my clients was coming in because her dad had, um, died of, um, oh gosh, now I can't think of the name of it. It's been in the media lately…ALS.*
P1	94	1.1.1	*But I still struggle with, with grief, in terms of like if it is the loss of a person, um, and, I guess death is what I struggle with.*
P2	14	1.1.1	*Well, it was probably about a year and a half ago. A client came to me and she had lost her father as a young girl. I think she was about 11 when she lost her father, and she's currently about 52, right now. And, she still struggles with grief from losing her father at such a young age.*
P4	95	1.1.1	*Most of them were death ones,* well, not all of them were death related.
P8	155	1.1.1	It was pretty easy to focus on the client and be present in the session. However, I've had deaths in my family, but none were really extremely close to me. So I didn't feel it, there wasn't much personal business there.
P8	258	1.1.1	And, I remember just the other day, a supervisee brought into a session, that for the first time, they had a death of someone at the school that they worked at. And, they were working with students and faculty coming in to talk to them.
P1	122	1.1.2	*I almost see it as a sense, I'm trying to define it without using the word loss, but, almost like losing a sense of the future?*
P2	8	1.1.2	*Well I would say that it could be a multitude of things. It could be losing a job, a dream, um, it could be, you know, losing your home, it could be anything that really impacts you. It doesn't have to be death itself.*
P3	26	1.1.2	So as a resident, that would leave this one person who, um, who was typically upset that her son had been taken away. And, she

			wanted to get him back, and that, and she was in my substance abuse group, and when she lost that case, she did not come back, so one could only make the presumption that she had relapse because of that. And, unfortunately is was crack cocaine.
P4	8	1.1.2	*I've mainly seen loss, um, I'm trying got think back, loss of a partner, a breakup, in that sense. I haven't worked with anyone with loss of a limb, or anything like that, even though I would consider that a huge loss.*
P4	15	1.1.2	*I can't remember any off the top of my head if I've had people who've had experience,* like, *loss due to a natural disaster,* cuz *I would consider that a part of loss, the home, or anything like that. Um, I have had people who have had a loss of job. Um, which I think, that would go with identity.*
P4	30	1.1.2	*my client's that had a loss of freedom in the sense that they got in trouble with the law. And were required to go to counseling.*
P4	96	1.1.2	My internship, well, in my practicum *I worked youth offenders, that, you know, had family members in jail, so they didn't have that family, um, they also got in trouble with the law. So they had a loss I that sense.*
P4	100	1.1.2	Um, but then in my internship I worked with elderly. Um, and *they experienced a whole bunch of different loss.*
P5	7	1.1.2	*Loss is a simple word. It's when a person has something of value, and no longer has it, or it has been taken away. And, there are psychological ramifications for that person.*
P5	15	1.1.2	*How about, especially early on, my first work was as a school counselor, um, a student who was denied entrance into an institute of his or her choice.*
P6	7	1.1.2	*from my experience so far, it's, we can encounter loss when we talk about relationships, when we talk about a job, you know, all of these things that actually affect you, or could affect you in the same sense of what we understand as grief and loss.*
P7	8	1.1.2	*I have many theories that I individualize depending on the person.*
P7	13	1.1.2	*Yes, it was actually one of my very first clients that I had the opportunity to work with, a, ah, successful fellow who was and executive, ah, who lost his job due to the termination of a contract with the government.*

P8	10	1.1.2	*I would say that loss can take a number of forms. It doesn't always have to deal with grief, like, I couldn't tell from the survey if you are getting at loss in terms as in handling a death, but there are other kinds of loss as well. I think it's really about first and foremost actually, understanding a client's inner world, and the loss the they are experiencing.*
P8	49	1.1.2	So, a common way that I experienced working with loss was when these students has been them not getting into the programs.
P1	49	1.1.3	*Um, losing friends, um, romantic relationships ending, um, even loosing pets. Uh, (sighs), I guess I hadn't considered this as much as a loss, but even, um, having something major even impact someone's future, I guess like the loss of a dream, however you want to say it.*
P1	58	1.1.3	Okay. But you didn't identify then as primarily as loss at the time? Is that what you are saying? P1. Yeah. Not at the time I didn't.
P1	130	1.1.3	*Uh huh. It doesn't always have to be tangible. Yeah.*
P3	8	1.1.3	*what I really think of typically is the loss of a family member. And the second one, that was death related, and the second one was somebody had lost their child to the CPS system, and to foster care.*
P3	155	1.1.3	The only thing I can think of is like divorce, or with a child in foster care.

1.2 When asked about how participants assessed for loss in a client, participants reported: 1.2.1= Relied on client to disclose or identify loss as the issue. 1.2.2= Relied on an assessment form or tool for client self-disclosure or to prompt loss awareness and disclosure. 1.2.3= Identifies it from the context of therapy (e.g. knows it when the see it) 1.2.4= Does not actively assess for loss. Framed in terms of death or described client issue in death-related				
Participant	Line #	Code	*Unit of Coding*
P1	24	1.2.1	*It was very point blank. IT was like, she was like, "this is why I'm here."*
P4	113	1.2.1	I would say the majority. Um, I don't want to say everything could be a loss, but I'd say the majority.
P1	125	1.2.2	*I think that's been a common theme when I've dealt, when I have dealt with client's, um, who've lost something, is that this idea that some aspect of their future, um, was gone.*

P1	140	1.2.2	*I assess for it. We've got a brief intake form, um, where we ask if there have been any losses. And I generally frame that in a general standpoint, "that could be death, that could be a relationship ending," or something along those lines.*
P2	132	1.2.2	*Because I have a form, and I ask a ton of questions about them and their lives, and their families.*
P3	97	1.2.2	*I think during intake, people report having lost somebody, more so than they do I my groups. So, maybe it will come it, like I said, it's come up once so far.*
P3	104	1.2.2	Actually, it is a written question on the protocol sheet.
P3	109	1.2.2	*That's true. And there's another similar question, first is there any significant loss, and the next is if there is any significant trauma. And a lot of times you will have to go back and fill it in if you find something later. But they will say no to trauma as well.*
P6	86	1.2.2	*Well, and that' a matter of the initial meeting, during the diagnostic interview, or initial encounter.*
P6	90	1.2.2	R1. Okay, so you have a specific set of questions to test for it. P6. Yes.
P1	12	1.2.3	*Yes, he had died of ALS, um and it had been a couple of years but she hadn't really dealt with in until she got to campus and people were kind of talking about their relationships with their dads.*
P1	14	1.2.3	*Um, and I think that was the first time that I became, that it was kinda like the main focus of counseling…*
P1	47	1.2.3	*I guess, you know it comes up with, especially on a college campus with relationship losses.*
P2	22	1.2.3	*It came out as we were talking.*
P2	27	1.2.3	*You know, I think we were just trying to process her, she feels, she has abandonment issues. She came in and it was a relational issue with her husband, and the more we dug into what was going on with her, we found that she really is just afraid of losing her husband. She's clingy, she's very jealous, all of these things. And we were able to connect it to her feelings that, well, it was a death, but she felt abandoned by her father. Granted she was only 10 or 11 when he passed away, so she felt like he abandoned her and she felt very angry. And so, we just realized through processing what was going on with her was that it's connected, you know, to her loss as a child.*
P2	130	1.2.3	*When I see it. You know. Typically, it comes out when during my initial interview with the client.*
P3	36	1.2.3	*She came as a mandated person, trying to make herself look better for the court, that she wen t through substance abuse. So we got to*

			know her, doing check-ins and, um, you know, "what's going on with you?" That was the main focus for her.
P3	63	1.2.3	*And she was the one that would work directly with Child Protective Services, trying to get them on board with her recovery.*
P4	37	1.2.3	*The resistance, um, spoke to me. Because they definitely felt, "I don't want to be here", I don't understand why I have to be here.*
P4	42	1.2.3	Yes. Or when I would say, *"well, you have a choice to be here." And they would say, "no I don't."*
P4	117	1.2.3	*I wait until it becomes visible to me.*
P4	121	1.2.3	*). I don't know how I know. Um, it's just if they are, they feel*
P4	123	1.2.3	*I guess if they feel like something's missing. Like if it's a person, a place, control, freedom, you know. Something's not there.*
P5	26	1.2.3	R1. Did you frame it as a loss in your own mind at that time? P5. *Yes.*
P5	85	1.2.3	*It more intuitive.*
P6	19	1.2.3	*. I had a client that came in, and didn't really understand that they had lost, that they were actually going through grief and loss, but in all reality they were.* *They came in with a different issue, of course, um, they were stressed, they had all the symptom, anxiety, depression, insomnia, um, but they were blaming it on something else. They were unable to understand it. They thought everything was fine. I asked them if they had lost something recently, in the interim, and they said, "yeah, but it was like months ago". I said, be more specific. "Well, it was like 8 months ago, I lost my job, I loved my job. But I found another job." So the question was, so do you like the job you're doing right now? And, the response was, "not as much as the job that I lost."*
P6	32	1.2.3	*Then we went into it a little bit. So can we talk about your last job. "well, I really don't want to talk about it because it still hurts." Um, so that right there, just sitting back and letting them talk, is, was a big indication that what they came in initially was not really what was the ground or issue.*
P6	99	1.2.3	*Again, now I feel more confident. I can actually identify it a little sooner, so the line of questioning, during out meetings are less, because now I know what I am looking for. Versus in the past I was actually learning so I was, I don't want to say fishing, but it was searching for more information just to make sure, to ensure for myself that it was a loss.*
P7	19	1.2.3	*No, he basically came with saying, "I don't know what to do."*

P7	24	1.2.3	*As he related his narratives, probably by the end of the first session. It started to sounds awfully like what I had learned and studied regarding loss and grief and, uh, some grief issues.*
P7	92	1.2.3	Uh*, I remain aware*, uh, given instances where I have encountered it.
P8	112	1.2.3	Um, it of course depends on the unique needs of each client.
P8	125	1.2.3	Part of it's being able to recognize the emotions that the client is saying and explaining and showing non-verbally and verbally in the session. To see if there is some kind of indication that they might be experiencing some loss. I think the other half of it is common sense. And, if the client comes to you with a presenting concern that is often associated with loss, just having a common sense to not assume their experiencing it, but to know enough to just probe to see if they're experiencing it.
P8	135	1.2.3	So you never know if it's actually loss or not without fully listening to the client and just making yourself available.
P3	116	1.2.4	R1. So how do you know if someone has an issue of loss if they don't tell you? *I guess that I don't.*
P4	127	1.2.4	*Yeah. I guess I don't pry into it, because I fear some of that might be me, throwing my stuff, my interpretation, so that's why I wait for it.* I
P5	79	1.2.4	*I like to think that if a loss is affecting a client, I will recognize it.* Um, but *I don't have a specific go to question that I ask clients to see if they are being affected by any kind of loss right now.*
P7	91	1.2.4	Um, no I don't assess specifically.
P8	193	1.2.4	But I didn't always, or wasn't always able to see that. Sometimes it was more closer to helping them discover the purpose and meaning that helps to drive them.
P8	242	1.2.4	And, actually, thinking about it, you know, considering I never even thought of it as a fact but yeah, half the students I worked with at the middle school setting were probably dealing with some type of loss. Or experiencing some type of loss in one form or another.

1.3 When asked about the prevalence of loss in client issues, clients reported in terms of numbers, percentage, etc:
1.3.1= High (e.g., "most, 60% or higher, majority, etc)
1.3.2= Medium (e.g., 40-59%, "about half")
1.3.3= Low (e.g., less than 40%, "about a third, etc.)

Participant	Line #	Code	*Unit of Coding*
P5	71	1.3.1	*, I would expect to see it in everybody. It's just I see it as part of the basic human experience. We go through certain losses every single*

			day. And, um, it doesn't have to be a traumatic loss to affect a client, to affect the person, um, so traumatic loss, not in all of them, but everyday loss? In all ten.
P6	76	1.3.1	*Oh! I'll just use a number; I'd say 8 out of 10.*
P1	134	1.3.2	*So, with the age group [college] that I am working with, I would say at least half of the time*
P8	182	1.3.2	*, I'd say maybe about half the time.*
P2	81	1.3.3	*Um, but I would. I just don't seem to have a whole lot of clients that have had losses. Or at least that they have not come into therapy, you know, to talk about.*
P2	126	1.3.3	*I'd say, out of the clients that I have been seeing, that probably 25% to 30% of the time.*
P7	86	1.3.3	*To one degree or another, probably at least a third.*
P8	184	1.3.3	*, I'd say maybe about half the time.*

2. Subjective Experience in Working with Loss

2.1 When asked to describe the participant's first experience with non-death loss regarding impact on the participant, participants responded with:
2.1.1= Provided empathy
2.1.2= Caused or created avoidance
2.1.3= No affective impact reported or non-responsive
2.1.4= Recognition or description of counter transference

Participant	Line #	Code	*Unit of Coding*
P1	76	2.1.1	*, I think in some respects, my own experience with loss has helped. It did, it helped in that it definitely helped, well, I'd say it helped and hindered my empathy.*
P1	79	2.1.1	*to some extent I can understand what you're going through, having experienced loss myself.*
P2	119	2.1.1	*So, yeah, I try to avoid it because I don't like to think about that unless I die first, I will have to deal with losing my mom.*
P3	124	2.1.1	*In this particular case, I couldn't relate it back to my loss. But I could relate it to my imagined loss of my son if I were in her shoes. So more of an empathic feeling.*
P3	129	2.1.1	*Yes, and when I imagine that, I imagine it being very hard and very sad and I would tell her what a great job she was doing to*

			stay in there, and be there for her son, and to try to get him back. Because I think I be the insane asylum.
P4	13	2.1.1	*Because of my dad. He only had one leg, so. Um, I think, I haven't had any*
P4	49	2.1.1	*I think it helped me empathize with them. It helped me kind of take away the judgment and give that positive regard.*
P4	83	2.1.1	I think, *I don't know if it sensitized me, but it definitely goes back to helping me empathize, also to helping me realize that I, what am I trying to say,*
P5	40	2.1.1	R1. It also sounds like you're saying that your own losses sensitized you to being able to recognize and deal with the student's loss. P5. *Yes.*
P7	34	2.1.1	*ah, there was certainly a certain amount of empathy, because, having retired from the military, I had experienced a lot of that myself. Uh, so I was able to. I could kind of see where he was coming from.*
P7	44	2.1.1	*Uh, I think it gave me insight because, it led me in a direction, other than to say, adjustment or, ah, uncertainty, to where I could actually see grieving process going on with this guy.*
P7	104	2.1.1	Q 9 Going back to a previous statements you made, it sounds like your own losses in life gave you insight, or sensitized you towards you being able to perceive loss in your clients, is that correct? P7. *Yes, I would say that that is correct.*
P8	158	2.1.1	But, the hard part was, um, when they expressed some type of loss, um, like um, for one I remember when I was at that age, I was super focused on a particular sport. And when I didn't do well in and didn't meet my expectations, I experienced loss. And I've worked with students that didn't do well, or didn't make it to State, and things like that. So when those forms of loss came up, for example, I've worked with plenty of students with parents who are divorcing. Thought my parents never divorced, at that point, I kind of just wished they had, when I was in my master's program.
P2	79	2.1.2	*Not a lot. Not a lot at all. I, yeah, it's not something that I welcome, I don't necessarily like working with loss. (laughs). Um, but I would. I just don't seem to have a whole lot of clients that have had losses.*
P2	90	2.1.2	*I do not look forward to working with. So I, you know, went ahead and tried to read about how you would go about helping a person who's struggling with this.*

P2	95	2.1.2	*if someone gives me as an option, "hey do you want this grief and loss client?"*
P2	102	2.1.2	*No. but I think that my fear (emphasized fear) of losing others in my life impacts me not wanting to deal with loss. Because it reminds me that I'm going to have loss in my life.*
P4	75	2.1.2	and I don't think, at least at the beginning I had, I might have had that "oh-Shit" going through my head. If that makes sense, when they said it.
P2	44	2.1.3	*Well, not necessarily, not personally, no.*
P4	87	2.1.3	*), it was a reality check for me, I guess. Um, in the sense that, like I said earlier, what's the big deal, and then having my own experiences with loss tells me, "oh, okay, that's what it is like."*
P5	29	2.1.3	*I think it's something that is part of the basic human experience. And so, watching a client go through it, I could put myself in the client's shoes very readily, very easily. And so, um, it some, and always take a little bit of bracketing to keep the counselor's loss out of it. The counselor's experience of loss out of it, and stay focused on what the client is experiencing with this particular situation in this particular context, and how the client is experiencing specifically.*
P6	95	2.1.3	*I would definitely answer yes.*
P1	82	2.1.4	*because I was wondering if maybe I put some of my own beliefs about loss on the client, in terms of how they should deal with it.*
P4	138	2.1.4	*I did in the sense that I wanted to work with, I really enjoyed working with the elderly. So, I wanted to work, and I was looking for jobs working with them, but I didn't find one. And, I think working with that population, that's kind of a given.*
P8	150	2.1.4	I remember the hardest part was not letting my own business get in the way. Um, for me, when they expressed some type of loss, for example, like a death in the family, um, if you think about that kind of a loss, um, it didn't really phase me too much.
P8	168	2.1.4	So, the thing I'm really cognizant of was checking my issues at the door. And when a client brought something up that got hold of me, that I felt a personal piece, to kind of just think about it almost as a switch. Okay, that's there. Turn it off, and refocus, stay present with the client in the session.
P8	158	2.1.4	But, the hard part was, um, when they expressed some type of loss, um, like um, for one I remember when I was at that age, I was super focused on a particular sport. And when I didn't do well in and didn't meet my expectations, I experienced loss. And I've worked with students that didn't do well, or didn't make it to

			State, and things like that. So when those forms of loss came up, for example, I've worked with plenty of students with parents who are divorcing. Thought my parents never divorced, at that point, I kind of just wished they had, when I was in my master's program.

2.2 Impact of the Client's loss event upon the counselor.
2.2.1= Negative impact(s) reported
2.2.2= Neutral or no impact(s) reported
2.2.3= Positive impact(s) reported

Participant	Line #	Code	Unit of Coding
P1	34	2.2.1	*But um, in terms of just dealing with loss and grief, I guess, scared is what I remember.*
P2	111	2.2.1	*Uh, knowing that I have to deal with my own issues. Knowing that that is an area of weakness in me. Knowing that it makes me really nervous.*
P3	46	2.2.1	*Well, I still feel sad about not having her in our group anymore, because she was there, maybe 8 weeks or so. And knowing of her substance abuse problems, you really want the best for them. And the fact that you know that this absolutely crushed her, um, I still feel sad, and I hope to see her come back and try again. You never get to see them, or say goodbye, or anything, you just know that they are out there and they are not okay*
P3	58	2.2.1	*Yeah. I feel sad for her.*
P6	43	2.2.3	*I, it did. I think the impact it had on me was a positive impact in that it was challenging. Ah, I couldn't wait to just, you know, begin working with this individual, with this client, um, based on the little bit of information that I had. But I was ready to give so much. Offer so much. But it did have a very positive turn out.*
P7	110	2.2.3	*Oh, definitely positive. Yeah.*

3.1 When asked if the participant had program specific, or post-masters training in loss or grief, the participants reported:
3.1.1= Program had loss specific loss training, or some inclusion of loss training within a class
3.1.2= Participant reported some level of self-training through research or independent study
3.1.3= Participant attended some form of post-master's training with others, e.g. workshops, etc.
3.1.4= Participant had no specific loss training

Participant	Line #	Code	Unit of Coding

P1	32	3.1.1	*I think I had attended one, um, we had one person who was, um, we called him the grief guy, who came in and did a talk for us.*
P2	88	3.1.2	say I felt *un*-prepared (heavily emphasized "un") *because I have done some research on grief, because it tends to be one of those subjects that as a counselor, I don't look forward to working with it."*
P6	66	3.1.2	*I went and did extra reading, you know, education. I educated myself so I could actually assist them, and better help them.*
P5	53	3.1.4	*I don't remember any specific training about grief and loss in my master's program.* Um, the *preparedness came from the comprehensive nature of my program though, in the way it emphasized basic counseling skills to attend, provide empathy,*
P5	64	3.1.4	*not beyond the training in my master's program, that was not specific about grief and loss, but, um, was comprehensive*
P7	72	3.1.4	*for loss, for this kind of loss specifically, probably underprepared.*
P7	75	3.1.4	*Other than, I had a really good foundation in scholarly study.*
P7	75	3.1.4	*Other than, I had a really good foundation in scholarly study.*
P7	82	3.1.4	*I don't think there was a specific training in that. If memory serves.*
P8	223	3.1.4	No, not really. The closest we got was under diagnosis and assessment course where we got case scenarios, and then had to identify diagnosis and work up treatments. So some people in the class had diagnostic criteria that they identified as loss. Typically, could have been associated with major depressive disorder and bereavement, but um, no specific training. But we got a piece of it here and there. Just depending on what happened, just variables within the program. But no specific curriculum.
P8	274	3.1.4	It seemed like they came to me and they were very shocked. It kind of felt like a deer caught in the headlights the first time they had a client come to them that was crying and couldn't be consoled. The first thing that they wanted to do was to try and make the client feel better.

3.2 When prompted to consider competence, participants reported:			
3.2.1= High levels of confidence at the onset for dealing with loss or grief			
3.2.2= Low levels of confidence at the onset for dealing with loss or grief			
3.2.3= No confidence at the onset for dealing with loss or grief			
3.2.4= No response			
Participant	Line #	Code	*Unit of Coding*
P1	90	3.2.1	*, In some respects, I think it depends on the type of loss. Because I'm still working with college students. So, in some respects, um, if*

			it's the loss of relationship, if it's the loss of the sense of future, um, I feel very prepared. Um, in that respect.
P4	144	3.2.1	, I felt pretty prepared because I had already worked with it.
P4	147	3.2.1	R1. So you felt like your training was enough. P4. Yup.
P6	62	3.2.1	Well, as far as preparedness, um, I don't want to say that I was overconfident. Because I knew that there was a lot more information out there, not too much experience dealing with grief and loss, or loss
P1	29	3.2.2	*I didn't know what to do. Um, honestly, um, one, I didn't know what to do because, um, it wasn't, it was a loss that occurred a couple of years ago, and two because I just didn't have much training.*
P1	94	3.2.2	*But I still struggle with, with grief, in terms of like if it is the loss of a person, um, and, I guess death is what I struggle with.*
P2	97	3.2.2	*I'm going to say no. But if they end up on my schedule, and I have no choice, then, I do the best I can and, you know, that's kind of my plan. You know, do the best you can.*
P3	142	3.2.2	*No…(pause), not any more than when I had my first client (prior to residency), I'm still kinda winging it.*
P4	67	3.2.2	*I feel like that issue, yes, had it been heavier, I don't think like I would have been.*
P4	72	3.2.2	For instance, someone who lost a limb, or who maybe a natural disaster like, those are a lot harder to rationalize, so, I feel like that would be more difficult,
P7	72	3.2.2	*for loss, for this kind of loss specifically, probably underprepared.*
P1	67	3.2.3	*But in terms of just methods for, or techniques for addressing grief and loss, I didn't feel prepared in that respect.*
P1	100	3.2.3	*Yeah, so I think it depends on the type of loss. But when it's the loss of a person, I don't feel as prepared in that.*
P3	74	3.2.3	*It was a big one. I don't know if I had that much preparation in dealing with grief and loss in particular.*
P8	211	3.2.3	I don't feel I was prepared to deal with very much of anything.
P8	216	3.2.3	I had a lot *self-doubt* Because it was still so new. And, you know, having only had um, a 600-hour internship, and 100-hour practicum, and having only half of those hours at most being direct hours with clients, it's hard to have a lot of self-confidence at that point. At least it was for me.

P8	247	3.2.3	I think it would behoove me to actually do some more research, independent self-research, um, just to better educate myself on knowing more than just the stages of loss. And knowing how to actually help clients through that experience with models of therapy built for that. And I think that would be a really useful supplement to what I currently do.
P8	262	3.2.3	And, I remember just the other day, a supervisee brought into a session, that for the first time, they had a death of someone at the school that they worked at. And, they were working with students and faculty coming in to talk to them.
P8	270	3.2.3	But anyway, the thing that was really apparent to me, speaking of the purpose of your study, and I realize these were still students who are in their master's program, but I don't feel that they were prepared for that initial experience, many of them.

1.   Application of Theoretical Models

4.1 When asked about applied theories and intervention used when loss was perceived, participants responded with:
4.1.1= Reliance on basic skills training (e.g. attending, making space, client centered, etc.)
4.1.2= Used a general theory other than a grief-specific theory
4.1.3= Reported using a loss-specific theory
4.1.4= No theoretical framing used (other or residual response.)
4.1.5= Specific theory, other than loss-specific, as grounding theory or personal theoretical choice

Participant	Line #	Code	Unit of Coding
P1	40	4.1.1	*Um, (sighs) very much from an interpersonal, like humanistic perspective. Um, we just kind of, um, any interventions I used were like were, I would say, very basic. We would just, we just processed. Um, yeah, we just processed from what was going on for her.*
P1	65	4.1.1	*I mean I, in some respects I did. I had my basic skills, um I felt really, I felt grounded in those.*
P2	52	4.1.1	*You know, I just remember we just did a lot of talk therapy, trying to, in, a, I was just trying to help her make connections.*
P2	67	4.1.1	*Hum. Well, she was telling the story, and then I would use talk therapy along the way to try to help her make those connections. But again, but I guess more talk therapy. Um she's just a very difficult client. Very resistant. She always came in with her agenda. She would always basically, I kind of had the impression that she didn't necessarily want to improve. She was kind of, she was getting some sort of benefit from being, you know, in the position*

			she was in, she kind of appeared to a, to complain, but almost appeared to enjoy her misery. If that makes any sense.
P2	134	4.1.1	*And then as therapy progresses, you can start to see how things are tied.*
P3	76	4.1.1	*just holding that space for her, I felt very competent in that, and letting her talk about her feelings and her wants, and her desires.*
P3	82	4.1.1	So, I guess, it was that called, *indirectly dealing with it.*
P3	143	4.1.1	*I'm still kinda winging it. But I just try to rely on that person centered holding the space and letting them have their moment.*
P4	152	4.1.1	*I don't know if I feel like I've been trained on stages, or anything like that, but I feel like what I am good at, and the one thing I've learned is to let people express it their way. And what they're going through.*
P4	161	4.1.1	Yes. And be supportive in that sense, and not label to different things, levels, or boxes or whatever you want to call it.
P5	66	4.1.1	*I felt that I learned the skills I needed to attend to someone who was experiencing a loss.*
P6	50	4.1.1	*one of the first things I had to do was identify, or actually, kind of, I didn't want to identify it, I assisted them in identifying it, because I wanted it to come from them more than from me.*
P8	138	4.1.1	Giving them opportunities to share with you their experience
P3	61	4.1.2	*Well, like in the group session, or what really comes to mind, is advocating, because I worked directly with my supervisor.*
P4	60	4.1.2	I think in that situation, I *used mainly helping them recognize what they can control, and what they do still have power over.*
P5	44	4.1.2	*so there's some really quick empathy, and some sitting with the client about what he or she is experiencing.* And then, in a *solution-focused way,*
P8	57	4.1.2	Typically, I never followed a loss or grief model. I did understand stages, but that wasn't something that I have typically focused on. I usually let my theoretical perspective guide me.
P8	60	4.1.2	my primary theoretical model was integrative approach. I used MMT, and with MMT, an integrative approach you ground it in your primary approach. Which for me was solution focused.
P8	198	4.1.2	when I worked with college kids that I still worked from the MMT approach where solution-focused approach was my primary theory that I was grounded in. but, I still used the theoretical approach properly in trying to identify their firing modality, and needs based off of basic ID. But most often I ended up gravitating toward what were the issues that were brought up in the session. It seemed as

			though, existential approach, um, always somewhere in the humanistic area, but typically in the existential approach ended up being the most prevalent approach I used concurrently with solution-focused.
P7	50	4.1.3	*The first thing I did was I reached for my Kubbler-Ross. Un, and tried to gain some articulation for the sorts of insights that I was getting out of just working with the client.*
P7	53	4.1.3	*and a lot of it was just coming to terms with just the existential fact of the loss. And its implications, and almost working through the stages of the Kubbler-Ross grief cycle.*
P7	58	4.1.3	*Q10. Is that the theory that feel is best to use to approach loss?* P7. *When it's appropriate, yes. I can imagine circumstances where it wouldn't be. But it seemed to be just the trick for this one.*
P7	66	4.1.3	*I just stuck with that one theory[Kubler-Ross] because it seemed to fit so well.*
P7	123	4.1.3	Q12 Okay, so Kubbler-Ross or some sort of stage or existential sort of thing, when you see it. P7. Right.
P6	108	4.1.4	*That is, I'm going to say no,*
P6	117	4.1.4	*I have many theories that I individualize depending on the person.*
P8	64	4.1.5	Since I was working in the school system which is primarily present-future oriented.
P8	85	4.1.5	So my goal, coming from that approach, was to actually follow my theoretical orientation of MMT, which is grounded in solution-focused. And I'd use [?] theories. And so, [inaudible] intended to pull from strategies like person centered, um, and really trying to focus on building the relationship, and using relationship to help work with them. And then, I start moving on to the solution focused,
P8	100	4.1.5	And then a lot of times coming from a person centered approach
P8	265	4.1.5	And, they were working with students and faculty coming in to talk to them. So we did our normal things in supervision, and help peers [?] the knowledge of the group, and basically I also take a solution focused approach in group supervision as well.

4.2 When asked if the participant's use of theory has evolved since that first encounter, participants responded with:
4.2.1= New or revised loss approach

4.2.2= No revisions			
4.2.3= Other response/residual			
Participant	Line #	Code	*Unit of Coding*
P3	148	4.2.2	R1. So since that first one, has anything changed for you in how you practice now, or frame working with loss? P3. *No.*
P5	90	4.2.2	I think what's changed most dramatically is that I've had the opportunity to work with different populations.
P7	116	4.2.2	*I would say that once I am able to identify it, or once it seems to come up in the therapeutic relationship, I, that becomes my focus. That becomes the focus of therapy.*
P7	120	4.2.2	*Um. No, that has pretty much stayed constant, yeah.*
P5	101	4.2.3	*so the way that I approach them with their losses is different. And I have had to change the cultural lens through which I view my clients in how they are experiencing their particular losses.*
P8	238	4.2.3	I think what I would change the most if I knew that I would be working with clients specifically for loss, is that I would supplement my theoretical approach with additional education in treatment strategies in working with individuals with loss.

Vitae

Charles P. Carrington earned a Bachelor of Science in organizational leadership from Regent University in 2009, a Master of Arts in human services counseling from Regent University in 2010, and a Master of Arts in counseling from Regent University in 2012. He is certified as a Traumatologist, Compassion Fatigue Therapist, and Compassion Fatigue Educator with the Green Cross.

Mr. Carrington has served as a pastoral counselor and faith based counselor for five years. He has led therapeutic foster care programs, training foster parents and professionals. He has taught undergraduate courses in human services, and has co-taught master's level courses in mental health counseling. He has also provided supervision to master's level students during their practicum and internship experiences, and led process group training for masters and doctoral students.

Mr. Carrington has been a member of numerous organizations including the American Counselors Association, Association for Counselor Association for Counselor Education and Supervision, The International Association of Addictions and Offender Counselors, American Mental Health Counseling Association, American School Counselor Association, Virginia Counselors Association, Christian Association for Psychological Studies, Chi Sigma Iota Counseling and Academic and Professional Honor Society, and the Golden Key Honor Society. He has been recognized by Chi Sigma Iota: Omega Delta Chapter with the with the outstanding doctoral researcher award-2015, Regent University as 2010 Outstanding Graduate, Department of Human Services, and the Virginia Association of Counselor Education and Supervision, (VACES): Student Development Research Award. Currently he serves as executive director at Virginia Beach Coaching and Counseling.