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Grieving Experiences of Undergraduate College Students

by

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Honors Thesis

Submitted to:

Psychology Department
University of Richmond
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Abstract

The purpose of this study was to compare the well-being of bereaved versus non-bereaved undergraduate students. Additionally, they were asked to report how many losses they have experienced, the characteristics of the most difficult loss, and their experiences with grief. Lastly, data on use of and access to support sources was collected as well as their perceived helpfulness. Results showed that bereaved undergraduates (i.e., those who indicated experiencing at least one significant loss) reported lower well-being than non-bereaved individuals. Further, 4% of participants met the criteria to receive a diagnosis of Prolonged Grief Disorder, 32.4% reported experiencing the separation distress “at least daily and after 6 months have elapsed since the loss,” and 29.3% indicated “a significant reduction in social, occupational, or other important areas of functioning.” Finally, the most commonly used sources of support were friends and family, who were also rated as being the most helpful. These data suggest the need for high-quality and accessible resources for grieving and bereaved students as they navigate this difficult period of their lives.

Grieving Experiences of Undergraduate College Students

Among the many stressors that college students may be confronted with at any given point during their academic career, an all-too common one is *bereavement*. Bereavement has been defined as “the objective situation of having lost someone significant” (Stroebe et al., 2001). Shockingly, as many as 30% of undergraduate college students may be in their first year of bereavement, and as many as 50% in their first two years of bereavement (Balk et al., 2010). Related to, but distinct from, bereavement is *grief*, which is known as “a primarily emotional (affective) reaction to the loss of a loved one through death (Stroebe et al., 2001). The experience of grief can be a distressing and tumultuous time in one’s life and may result in “diverse psychological (cognitive, socio-behavioral) and physical (physiology-somatic) manifestations” (Stroebe et al., 2001). Some of the most common emotions reported in response to loss are sadness, loneliness, and anger (Balk, 1997). Furthermore, grieving individuals are at a higher risk for depression, anxiety, insomnia, suicide, and other psychiatric disorders (Stroebe et al., 2001).

Despite the prevalence of grief and bereavement in many undergraduates’ lives, this area of research remains relatively understudied in emerging adult populations, as the literature focuses mainly on spousal bereavement. A 2007 study that examined longitudinal grief and bereavement studies conducted between 1993-2006 found that nearly all the research was done on spousal bereavement (Stroebe et al.). For example, of the 16 longitudinal studies that were completed, all but two examined populations of spouses or partners. It can be reasonably expected that the same symptoms and outcomes observed in spousal populations may also apply to undergraduate populations, though there may also be important nuances between the two populations as they are in distinctly different stages of life. This obvious gap in the literature

should receive immediate attention given the high percentage of undergraduate students in particular who may be bereaved at any given time.

Undergraduate college students are the chosen population of this study because the transition to higher education is already a stressor that may increase the risk of psychopathology. College itself involves profound changes not only to the structure of a student's daily life, but also a major shift in the expectations and standards that they are called on to adhere to. Regardless of educational status, though, the period of life known as emerging adulthood, or young adulthood, is a sensitive period in one's life and there is inherent potential for the development of psychopathology (Cicchetti & Rogosch, 2002). In emerging adulthood, the individual is no longer perceived as a child but is also not yet a recognized adult. There are major changes in social roles and contexts, identity, cognitive and neurobiological development, and more, that these individuals must grapple with in a few short years (Schulenberg, Sameroff & Cicchetti, 2004). This area of limbo can create space for uncertainty and insecurity that, when combined with shifting responsibilities or expectations, can result in psychopathology. This study may have particular relevance in our current age as the COVID-19 pandemic has caused monumental loss across the globe, and students have found themselves experiencing single or multiple losses (Bistricean & Shea, 2021).

Grief and its Consequences

Grief can manifest in a variety of ways. A 2001 study identified four different facets of grief: affective, behavioral, cognitive, and physiological/somatic (Stroebe et al.). In terms of affect, grief can be exhibited through feelings of "depression, despair and dejection, anxiety, guilt, anger and hostility, anhedonia, and loneliness" (Stroebe et al., 2001). Given that students are adjusting to life away from home, new adult responsibilities, the development of social

connections, and academics, it is a cause for concern when bereavement occurs as individuals who may already be predisposed to psychiatric disorders may also experience feelings of intense sadness, loneliness, anger, suicidal ideation, general distress, and social dysfunction (Balk 1997; Stroebe et al., 2007). Behaviorally, those that are grieving report “agitation, fatigue, crying, and social withdrawal” (Stroebe et al., 2001). These changes in emotion and behavior have potential consequences for the individual’s ability to maintain relationships, fulfill their daily tasks, and take proper care of themselves. What’s more, when looking at a college sample, consequences of grief extended to conditions such as “enduring depression, academic failure, social isolation, chronic sleep disturbances, severe and ongoing somatic complaints, increased vulnerability to disease and eating disorders” (Balk et al., 1998). Further, grief can be expressed cognitively through “preoccupation with thoughts of the deceased, lowered self-esteem, self-reproach, helplessness and hopelessness, a sense of unreality, and problems with memory and concentration (Stroebe et al., 2001). Related to cognitive function, sleep, for example, is crucial to maintain healthy functioning; however, in bereaved people, insomnia is consistently reported in significantly higher numbers when compared to non-bereaved people (Hardison et al., 2005). Lastly, grief can also present itself in physiological and somatic ways through a “loss of appetite, sleep disturbances, energy loss and exhaustion, somatic complaints, physical complaints similar to those the deceased had endured, changes in drug intake, and susceptibility to illness and disease” (Stroebe et al. 2001).

In addition to these facets of grief are serious implications for the mental and physical health of the bereaved. The same 2001 study found that when experiencing bereavement, an individual is at an “elevated [risk] of depression, anxiety, and other psychiatric disorders, somatic complaints and infections, and a variety of other physical illnesses” (Stroebe et al.).

Further, bereaved people are at a greater risk of mortality and suicide and report higher consultation rates with doctors as well as increased rates of hospitalization and medication use when compared to non-bereaved populations (Stroebe et al., 2001; 2007). In fact, even when controlling for confounds such as major depressive disorder and post-traumatic stress disorder, complicated grief (often used interchangeably with prolonged grief disorder) is associated with a significantly higher risk for suicidality (Latham & Prigerson, 2004). By addressing grief and bereavement, and fostering the development of positive coping strategies, there is an opportunity to not only alleviate pressure on the healthcare system, but also instill strength in a grieving individual.

All of this is not to say that feeling grief is unhealthy. There is a line, albeit fine, between healthy grieving and complicated or prolonged grieving. These symptoms associated with grief are not pleasant, but they are normal and appropriate given the circumstance. Healthy grief is characterized by a person's willingness to confront their new reality, the negative emotions that arise from the loss, and the trauma that may be related to the loss (Kurian, 2014).

Acknowledging all of these components of healthy grieving is difficult in a healthy individual, and it may be even more challenging for someone who hitherto struggled with aspects of their life not related to the loss. In their new reality, research has shown that the bereaved individual is often the most successful in taming their grief when they honor the feelings associated with the loss, as well as seek out a new sense of purpose and meaning in their own lives without the deceased (Kurian, 2014). This might suggest that certain coping behaviors are more effective in overcoming grief than others. It is important to learn more about this issue as research on grief and the potential for it to develop into a distinct psychiatric disorder, Prolonged Grief Disorder (PGD) (also called complicated grief), is relatively new and has only been explored rigorously in

the last two decades (Jordan & Litz, 2014). While a healthy grieving individual will feel better over time, in prolonged grief, the individual's symptoms and bereavement difficulties tend to get increasingly more distressing and impairing as time goes on (Jordan & Litz, 2014).

Grief, Emotion Regulation, and Coping

As with any stressful life event, the use of emotion regulation is of the utmost importance in decreasing negative symptoms and achieving a more stable condition. Generally, people utilize a variety of emotion regulation strategies to realize their goals, and we see that some strategies are used more than others and are more effective than others depending on the context.

Coping in the context of grief is defined as “processes, strategies, or styles...of managing (reducing, mastering, tolerating) the situation in which bereavement places the individual” (Stroebe et al., 2001). A 2021 systematic review of coping strategies used by a general population of bereaved individuals found that the most relevant strategies were avoidance, cognitive reappraisal, and positive repetitive thought (Eisma & Stroebe). Relevant in this sense refers to the frequency with which the strategy was used, not necessarily how beneficial it was in reducing negative emotions. Several studies on coping in general have identified a set of coping skills that splits into two branches: adaptive and maladaptive. In a 1997 study by Balk, some of the most common and more adaptive coping strategies reported by bereaved students were “remembering good things about the deceased, engaging in religious practices, crying, keeping busy, and talking about the death.” The results suggest that these techniques may be beneficial for the bereaved as nearly half the sample (43.6%) considered talking about the death as very helpful when it pertained to a family member, and 40.2% reported it as very helpful when it was about the death of a friend (Balk, 1997). Further, prior research has found that social sharing following an emotional event, not just bereavement, can “buffer the destabilizing effects that

[the] emotional event” can have on an individual (Rimé, 2011). Thus, having these important sources of social support are instrumental to a student’s recovery from grief.

Contrastingly, examples of maladaptive strategies reported by undergraduates included not thinking about the death, working on their grief alone, and not engaging in any coping practices (Balk, 1997). Predictably, these ineffective strategies mirror the opposite of the more adaptive coping mechanisms, supporting the idea that social support is instrumental in the recovery of a bereaved individual. Interestingly, the practice of keeping belongings of the deceased and working on grief by oneself were reported as both “distressing and helpful,” suggesting the complex nature of how to process grief (Balk, 1997). The avoidant nature of most of these strategies is alarming because past research on avoidant coping suggests that it is associated with depression and anxiety (Carnahan et al., 2022; Bistricky et al., 2019). Further, avoidant coping strategies are also characterized by a sense of expressive suppression. This strategy is maladaptive as it only worsens the negative emotion and is even linked to poorer levels of well-being (Haga et al., 2009).

What these two branches of coping can tell us is that some of the most effective strategies fall under two domains known as “problem-focused coping (seeking information and support, taking action, and identifying alternatives) [and] emotion-focused coping (affective regulation, emotional discharge, and resigned acceptance),” while a third strategy of avoidance is less effective (Balk et al., 1998). Being able to regain a feeling of control through seeking out information or social support combined with the ability to freely express the negative emotions they feel, without the fear of judgement, seem to be the most successful means of coping for undergraduate students experiencing grief.

Supporting Bereaved Students

What is unique about the grieving process is that it is often difficult to support someone if you have not experienced it yourself. This makes providing adequate support to students especially complex. Given what the research has suggested, universities would benefit from implementing grief-specific resources to bereaved students in order to facilitate their problem-focused and emotion-focused coping skills. Not only that, but peers should be able to access resources that can educate them on how to better support their friends. In the context of college, we would expect to observe differences in the access, use, and perceived helpfulness of different sources of support. There are many different sources of support that students typically turn to in university, though they vary in how helpful the students perceive them to be. For example, a 2021 study found that the two most utilized sources of support were from family and friends (Glickman). In fact, 76% of participants reported utilizing a family member for support, though only 55% of them reported that support as being “very helpful.” Additionally, 80% of participants reported using friends for support, but only 59% labeled that support as “very helpful.” Interestingly, the most helpful resource (62%), was a religious leader, though only a mere 16% reported using that resource for support. This suggests a need for a variety of resources as well as significant role that family and friends can play in the recovery from bereavement.

Though their peers may want to help, often times they do not know how to. A 1990 study on undergraduate grief states that their peers “possess ‘substantial awareness of the various factors of the grief process’ and seem sensitive to the needs of grieving peers” (Vickio et al.). Despite that though, these peers do not “possess the skills to act on their awareness of others’ grief” (Vickio et al., 1990). Grief and bereavement are not topics that their peers are equipped to deal with. As stated previously, the bereaved often report social withdrawal (Stroebe et al.,

2001). It is possible that when they retreat into themselves, their peers, while able to sympathize with their grieving friend, may not have the proper skills or knowledge to feel confident in approaching the topic. This has the potential to dissolve friendships and further alienate the bereaved individual from their social connections. As stated by Balk et al., “these reactions occur paradoxically within the larger developmental context of desiring to achieve relationships more intimate and mature than attained in early or middle adolescence” (1997). Naturally, in the transition to college, students are making efforts to create social connections to achieve a sense of belonging and the grieving process can act as a barrier to this aspect of college life. These relationships with peers are especially important as universities do not always provide options to support their students.

The most commonly available resources for bereaved individuals, student or otherwise, are structured clinical interventions, meaning counseling and possibly medication, but this Eurocentric approach to grief support may not be of use to BIPOC individuals, even though it is generally successful with White individuals (Bistricean & Shea, 2021; Moore et al., 2022). Because of this, it would be beneficial to examine a more multicultural approach in grief counseling or support, especially in a university context. Additionally, while some universities may provide a range of options to support their students (various policies, group therapy, and organization chapters), students are often unaware of these resources. A 2015 study reported that a quarter of their sample did not know there were psychological counseling resources available to them and 52.1% encountered one or more barriers in accessing those services (Cox et al.). Access to these resources may foster a greater sense of perceived support and offer the student a stronger sense of community. This is especially important as prior research found that having a psychological sense of community, specifically in college, was associated with perceived support

by friends and family (McNally et al., 2021). Removing barriers and increasing the level of transparency between administration and students would be instrumental in not only supporting students' mental health, but also allowing them to flourish academically in spite of great loss.

The Present Study

The present study seeks to examine the grieving experiences of undergraduate college students through a variety of measures. As explored above, it is known that well-being is impacted by grief and bereavement. Thus, I hypothesize that bereaved students will have statistically significantly lower levels of well-being when compared to non-bereaved students. What's more, coping strategies influence levels of well-being with research showing that generally more adaptive coping such as emotion and problem-focused decreases negative emotion while maladaptive strategies like avoidant coping increase negative emotion. As such, I hypothesize that students reporting adaptive coping will have statistically significantly higher levels of well-being than students who report using maladaptive coping. Lastly, social support type and accessibility are paramount to facilitating a healing journey for students. I hypothesize that those who report using family members and friends will have the highest levels of well-being, and that generally those who had access to resources will have higher levels of well-being than those who did not or those who simply did not use the resource.

Method

Participants

This survey was conducted online using Qualtrics survey software and distributed to undergraduate college student participants via Prolific (<https://www.prolific.co/>) and the Introduction to Psychological Science (PSYC 100) participant pool at the University of Richmond via SONA (<https://richmond.sona-systems.com/>). In order to identify participants who

met the primary criterion of “bereaved,” the study was conducted in two parts. In Part 1 (prescreening), participants answered questions about their demographics and current mental/physical health, as well as whether or not they had lost a significant person in their life due to death. Part 2 (main survey) was completed by participants who indicated in Part 1 that they had experienced the death of a significant person in their life. In Part 2, participants completed a loss inventory about this significant person and measures of grief-related symptoms, coping strategies, and social support systems used. Note that, given the two differing platforms used to recruit participants and their requirement affordances, Prolific participants (Sample A) saw two different surveys advertised (two sets of recruitment materials, two consent forms, and two survey instruments). Only those who “qualified” based on the prescreening were then able to see (and contacted via Prolific with an invitation to participate in) the main survey. In contrast, UR PSYC 100 participants (Sample B) only saw one survey that was simply longer for those who met the primary criterion of “bereaved.”

The study participants were undergraduate college students, particularly those who had experienced bereavement. Assuming a small-to-moderate effect size of $r = .25$ it was calculated that a sample of $N = 120$ was required for an adequately powered study ($\alpha = .05$, power = .80). Therefore, the goal was to collect data from $N = 150$ participants for the main survey (i.e., concentrating specifically on those who had experienced the death of a significant person in their life), assuming that some data would need to be excluded for insufficient attention. To meet this goal, it was necessary to initially recruit many more participants in the prescreening survey. Previous work has suggested that the 1-year prevalence rate of bereavement for college students is approximately 30% (Balk et al., 2010), so the initial aim was to recruit 450 participants (400 via Prolific, 50 via PSYC 100). All participants were asked to attest that they were 18 years of

age or older at the time of the survey. On Prolific, the option to participate in the study was limited to only those individuals who listed their nationality and residence as the United States, were fluent in English, and indicated that they were currently a student. Given that participation was voluntary and that the minimum incentives offered (\$10.00/hour or one unit of research participation credit) were modest in size for a study of this effort-level, it was determined that no factors were present that should have made research with these populations ethically unacceptable or suggest coercion or undue influence on the part of the research team.

Full Sample

A total of $N = 467$ participants (64.2% females, 30.8% males) were recruited to participate in the study. Participants' ages ranged from 18 to 59 years old ($M = 23.70$, $SD = 6.52$). Participants primarily identified as White (64.2%), but also included those who identified as Black (5.6%), Asian (12.6%), Latinx (6.2%), and Bi/multiracial (8.6%). Participants also reported sexual identity as heterosexual only (65.5%) or LGBPQA (33.4%).¹

Bereaved Sample

After filtering out those who did not report a loss and those who did not report being an undergraduate student, we were left with a sample of $N = 225$ participants (66.2% females, 28.4% males). The participants' ages ranged from 18 to 53 years old ($M = 23.5$, $SD = 6.76$). Participants, again, primarily identified as White (67.1%), but also included those who identified as Black (5.8%), Asian (8.9%), Latinx (7.6%), and Bi/multiracial (8.4%). Participants also reported sexual identity as heterosexual only (64.4%) or LGBPQA (34.7%).

Measures

Well-being

¹ LGBPQA = lesbian, gay, bisexual, pansexual, queer/questioning, and/or asexual. Note that other racial and sexual identity categories were available for participants to self-report but have been condensed for reporting purposes.

Twenty-two items were adapted from Grossi et al.'s (2006) Psychological General Well-Being Index (PGWBI) to assess psychological well-being in the full sample: (a) anxiety (5 items including "How often have you felt relaxed and at ease?"); (b) depression (3 items including "How often have you felt depressed?"); (c) positive well-being (4 items including "How often have you felt you were in good spirits?"); (d) self-control (3 items including "How often did you feel in control of your behavior and emotions?"); (e) general health (3 items including "How often did you feel healthy enough to carry out the things you like to do or had to do?"); and (f) vitality (4 items including "How often did you feel energetic and active?"). Participants responded to questions reflecting on the past week using a 6-point Likert scale, ranging from 1 (*None of the time*) to 6 (*All of the time*). The means, standard deviations, and alphas are as follows: anxiety: $M = 3.49$, $SD = 1.33$, $\alpha = .91$; depression: $M = 4.24$, $SD = 1.38$, $\alpha = .92$; positive well-being: $M = 3.41$, $SD = 1.22$, $\alpha = .91$; self-control: $M = 4.02$, $SD = 1.29$, $\alpha = .81$; general health: $M = 4.45$, $SD = 1.27$, $\alpha = .67$; vitality: $M = 3.33$, $SD = 1.27$, $\alpha = .82$. Appropriate items were reverse scored (12 items). Scores were then averaged to create a combined well-being score ($M = 3.64$, $SD = 1.29$, $\alpha = .94$), in which higher numbers indicated higher levels of well-being.

Loss of a Significant Person

Participants responded to two questions in order to determine if they met criteria to complete the main survey. The two questions were "Have you experienced the loss of a significant person (or people) in your life due to death?" and "Has this loss (or these losses) affected you during your undergraduate program (even if the loss occurred prior to your undergraduate enrollment)?" to which the participant answered *yes*, *no*, or *prefer not to answer*. Those who answered *yes* to the first question were permitted to complete the main survey.

Loss Inventory

Five items were adapted from Varga's (2016) study on Graduate Student Grief Experiences in order to take stock of the nature of the participants' losses. Participants responded to "Have you experienced multiple losses due to death? If so, how many?" (*No, only a single loss, Yes, 1-3, Yes, 4-6, Yes, 7-9, Yes, 10 or more*); If participants reported more than one loss, they were asked to answer the remaining questions pertaining to the loss they felt was the most difficult to experience: "How long ago did the loss occur?" (*0-6 months, 7-12 months, 13-24 months, 25-36 months, More than 36 months*); "What was the relationship to you of the person you lost?" (*Parent, Grandparent, Friend, Sibling, Cousin, Other (please specify)*); "What was the cause of death?" (*Illness, Accident, Murder, Suicide, Unsure, Other (please specify)*); and "Was the loss expected or unexpected?" (*Expected (forthcoming, death was anticipated), Unexpected (sudden, death was not anticipated)*).

Experiences with Grief and Bereavement

Because grief is such a complex condition with multiple facets and ways of presenting, it is necessary to examine it using a variety of scales and measures. Four key variables were examined including holistic grieving, separation distress, grief symptoms, and Prolonged Grief Disorder diagnosis criteria.

Six items were used to assess Balk's (2011) six dimensions of holistic grieving which include: (a) emotionally; (b) physically; (c) cognitively; (d) behaviorally; (e) world assumption; and (f) interpersonally (adapted by Vargas, 2016). Participants responded to questions on a 5-point Likert scale with higher numbers suggesting higher levels of being affected by their grief, ranging from 1 (*Not at all affected*) to 5 (*Significantly affected*). A single question was asked for each facet of holistic grieving with the stem "Please indicate how this loss affected you *during*

your undergraduate program” (emotionally: $M = 3.24$, $SD = 1.31$; physically: $M = 2.27$, $SD = 1.34$; cognitively: $M = 2.65$, $SD = 1.38$; behaviorally: $M = 2.42$, $SD = 1.33$; world assumption: $M = 2.36$, $SD = 1.26$; interpersonally: $M = 2.48$, $SD = 1.33$). Scores were averaged together to create a combined holistic score ($M = 2.57$, $SD = 1.09$, $\alpha = .91$).

Additionally, thirteen items were adapted from Prigerson et al.’s. (2009) proposed criteria for Prolonged Grief Disorder (PGD) in order to assess whether participants met criteria for PGD: (a) separation distress (2 items); (b) duration (1 item); (c) emotional, cognitive, and behavioral symptoms (9 items; $\alpha = 0.91$); and (d) impairment (1 item). Participants responded to questions on separation distress using a 5-point Likert scale with higher scores indicating higher levels of distress, ranging from 1 (*Not at all*) to 5 (*Several times a day*). The two separation distress items were averaged together to create a mean variable ($M = 2.32$, $SD = 0.96$). Participants responded to the question on duration by answering *yes* or *no* to “Have you experienced either of these symptoms at least daily and after 6 months have elapsed since the loss.” The emotional, cognitive, and behavioral symptoms were measured using two scales. Two questions are measured using a 5-point Likert scale with higher scores indicating high levels of grief, ranging from 1 (*not at all*) to 5 (*several times a day*). The remaining seven are scored on another 5-point Likert scale with higher scores again suggesting higher levels of grief, ranging from 1 (*not at all*) to 5 (*overwhelmingly*). The symptom variables were also averaged together ($M = 2.04$, $SD = 0.90$, $\alpha = .91$). Impairment was assessed with the question “Have you experienced a significant reduction in social, occupational, or other important areas of functioning (e.g., domestic responsibilities)?” (*yes, no*).

In order to receive a diagnosis of PGD, participants had to meet the diagnostic criteria as outlined by Prigerson et al. (2009). Criteria include items such as event criterion (the respondent

has experienced bereavement) and duration criterion (the symptoms of separation distress must be elevated at least 6 months after the loss).

Social Support Systems

Eleven items were adapted from Glickman (2021) and Varga (2016) that asked about the use of various support systems by the bereaved participants. Participants reported if they used a support system, if they did not use a support system, or if the support system was unavailable or very difficult to access. Additionally, participants were asked to rate how helpful they perceived a used support system to have been. This was done on a 5-point Likert scale with higher values representing a greater sense of helpfulness, ranging from 1 (*Not at all helpful*) to 5 (*Extremely helpful*).

Coping Strategies

Twenty-six items were adapted from Carver's (1997) Brief COPE to assess the various coping strategies that bereaved individuals may use. Participants responded to these statements using a 4-point Likert scale, ranging from 1 (*I haven't been doing this at all*) to 4 (*I've been doing this a lot*), where higher numbers indicate more frequent use of the coping mechanism. Of the multiple subscales included in this measure, the three most relevant that were selected for analysis included avoidant coping, emotion-focused coping, and problem-focused coping. Avoidant coping included questions such as "I've been saying to myself 'this isn't real;'" emotion-focused coping included questions such as "I've been getting emotional support from others;" and problem-focused coping included questions such as "I've been taking action to try to make the situation better." Each subscale was averaged to create three distinct scores for

avoidant, emotion, and problem respectively ($M = 1.89, SD = 0.55, \alpha = .70; M = 2.07, SD = 0.45, \alpha = .69; M = 2.09, SD = 0.65, \alpha = .28$)².

Results

Characteristics of Bereavement and Loss

Within the bereaved sample, 27.6% reported experiencing only a single loss, while a majority 56.4% reported experiencing 1-3 losses, 12.0% reported 4-6 losses, 2.2% reported 7-9 losses, and 1.8% reported 10 losses or more. In the same sample, focusing on the loss that was the most difficult to experience, 17.8% reported the loss occurring 0-6 months ago, 14.2% reported 7-12 months ago, 13.3% reported 13-24 months ago, 12.0% reported 25-36 months ago, with a plurality of 40.9% reporting more than 36 months ago.³ In terms of their relationship to the deceased, 11.6% reported a parent relationship, a majority 54.7% reported a grandparent, 13.8% reported a friend, 1.8% reported a sibling, 3.6% reported a cousin, and 14.7% reported Other. A majority 67.6% reported cause of death being illness, 8.4% reported accident, 2.2% reported a murder, 9.3% reported suicide, 6.3% reported being unsure about the cause of death, and 6.2% reported Other. A majority 62.2% reported the death being unexpected and 37.8% reported the death being expected.

Characteristics of Grieving

Descriptive statistics for well-being and relevant grieving variables are reported in Table 1. To summarize, as expected, greater grieving symptoms, separation distress, and holistic effects were each significantly negatively correlated with lower levels of well-being ($r_s \geq -.28, p_s < .0001$). Additionally, 4% of participants met the criteria to receive a diagnosis of Prolonged Grief Disorder, 32.4% reported experiencing the separation distress “at least daily and after 6

² Note: The original Brief COPE included twenty-eight items. Two items were removed to attain IRB approval.

³ Note that data is missing from 4 participants, so the total percentage only adds up to 98.2%.

months have elapsed since the loss,” and 29.3% indicated “a significant reduction in social, occupational, or other important areas of functioning.”

Table 1

Descriptive Statistics and Correlations for Continuous Grieving-Related Variables

	Well-being	Grieving symptoms	Separation distress	Holistic effects
Well-being	3.58 (0.86)			
Grieving symptoms	-.46**	2.04 (0.90)		
Separation distress	-.35**	.73**	2.32 (0.96)	
Holistic effects	-.28**	.73**	.69**	2.57 (1.09)

Note. Means and standard deviations (in parentheses) appear in bold along the diagonal. Correlations between variables appear below the diagonal. ** $p < .001$

To evaluate whether well-being differed among bereaved and non-bereaved individuals, I conducted an independent samples t test using the full sample. Bereaved undergraduates (i.e., those who indicated experiencing at least one significant loss) reported lower well-being ($M = 3.59$, $SD = 0.86$) than non-bereaved individuals ($M = 3.79$, $SD = 0.90$), a statistically significant difference of -0.20 , 95% CI $[-0.37, -0.03]$, $t(453) = -2.29$, $p = .02$. See Figure 1.

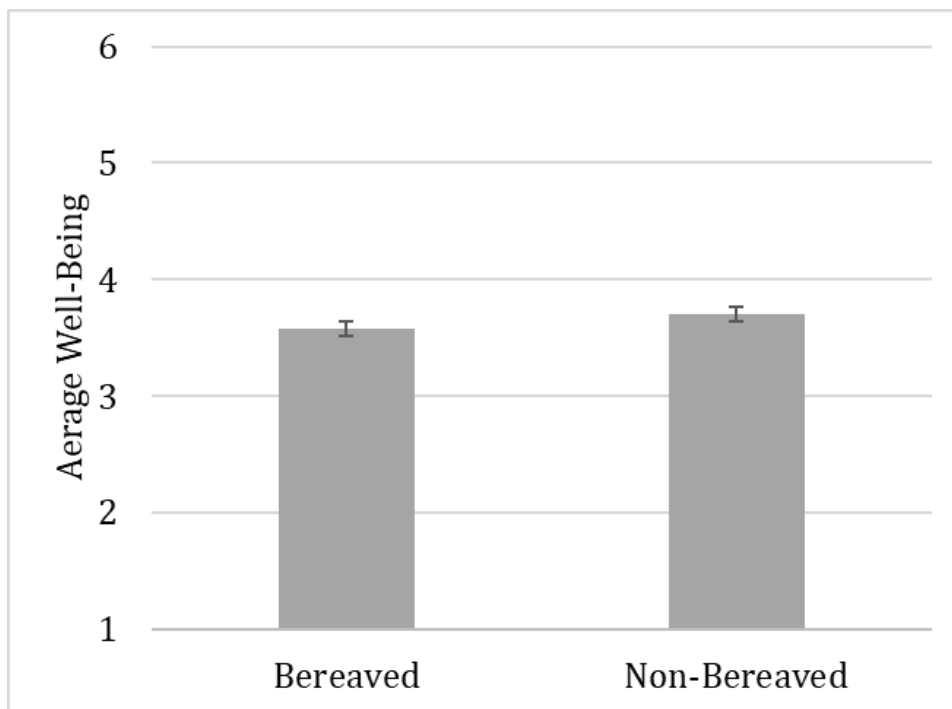


Figure 1. Sample means for well-being for both bereaved and non-bereaved undergraduates. Error bars represent 95% confidence intervals.

Types of Support Accessed and Perceived Helpfulness

The most frequently used resource that participants reported turning to for support were both family members (80.9%) and friends (70.2%). The least frequently used resource reported by participants were grief support groups on-campus (2.2%) as well as off-campus (3.1%). Participants were most likely to report being unable to access grief support groups on-campus (13.3%) and other mentors on-campus (10.2%). The most helpful resources reported by participants were family ($M = 3.72$, $SD = 1.00$) and friends ($M = 3.61$, $SD = 1.03$), with 25.3% and 22.8%, respectively, reporting family and friends to be “extremely helpful.” The least helpful resources reported by participants were grief support groups-off campus ($M = 2.29$, $SD = 0.95$) and doctors/general practitioners ($M = 2.70$, $SD = 0.75$). See Table 2.

Table 2

Types of Support Accessed and Perceived Helpfulness

Support Type	Percentages Reported			For “Used,” How Helpful?
	Used	Did Not Use	Could Not Access	<i>M (SD)</i>
Family members	80.9	12.9	6.2	3.72 (1.00)
Friends	70.2	23.6	6.2	3.61 (1.03)
Professor	9.3	82.2	8.4	2.90 (1.04)
Academic advisor	8.0	84.0	8.0	2.83 (1.10)
Other mentor on-campus	4.9	84.9	10.2	3.45 (1.04)
Licensed mental health professional on-campus	11.6	79.1	9.3	3.19 (1.39)
Licensed mental health professional off-campus	26.2	66.2	7.6	3.46 (1.12)
Grief support group on-campus	2.2	84.0	13.3	3.20 (1.64)
Grief support group off-campus	3.1	90.2	6.7	2.29 (0.95)
Doctor/general practitioner	13.3	83.1	3.6	2.70 (0.75)
Religious/spiritual community	16.9	77.8	5.3	3.34 (1.10)

Note. Perceived helpfulness of the support type was only asked of those who reported using it. Scale for perceived helpfulness: 1 = *not at all helpful*, 5 = *extremely helpful*.

Which Coping Strategies Are Most Strongly Associated with Healthy Functioning?

I next examined the relationship between coping strategies and two indicators of healthy functioning: well-being and grieving symptoms. Descriptive statistics are reported in Table 3. To

summarize, as expected, greater avoidant coping was significantly correlated with lower well-being ($r = -.36, p < .0001$) and more intense grieving symptoms ($r = .53, p < .0001$).

Unexpectedly, greater emotion-focused and problem-focused coping were not statistically significantly correlated with well-being ($|rs| \leq .09, p > .05$), though greater use of emotion-focused coping was associated with more intense grieving symptoms ($r = .24, p < .0001$).

Table 3

Descriptive Statistics and Correlations for Healthy Functioning and Coping Strategies

	Well-being/ Grieving symptoms	Avoidant coping	Emotion- focused coping	Problem- focused coping
Well-being/ Grieving symptoms	3.58 (0.86)	.53**	.24**	.12
Avoidant coping	-.36**	1.89 (0.55)	.35**	.22*
Emotion-focused coping	-.03	.35**	2.07 (0.45)	.67*
Problem-focused coping	.09	.22**	.67**	2.09 (0.65)

Note. Means and standard deviations (in parentheses) appear in bold along the diagonal. Correlations between well-being and coping variables appear below the diagonal. Correlations between grieving symptoms and coping variables appear above the diagonal. ** $p < .01$.

Which Support Types Are Most Strongly Associated with Healthy Functioning?

To evaluate the relationship between the use of a support type and healthy functioning, well-being scores were subjected to a one-way analysis of variance with one between-subjects variable having three levels of access (I used this support, I did not use this support, this support was not available to me or was very difficult to access). To summarize, there were six

statistically significant omnibus F tests that will be reported in the order of most strongly associated with healthy functioning to least. In each case, a Bonferroni correction for multiple comparisons was used to examine the pairwise differences. Only statistically significant effects are reported below. For more comprehensive results, see Table 4.

First there was statistically significant relationship between level of access to family members and well-being, $F(2,222) = 6.73, p = .001, \eta^2 = .06$. Participants who used family members for support reported higher levels of well-being ($M = 3.67, SD = 0.86$), than those who were unable to access it ($M = 2.24, SD = 0.76$), a statistically significant difference of -0.73 , 95% CI [0.17., 1.29].

There was a statistically significant relationship between level of access to a licensed mental health professional off-campus and well-being, $F(2,222) = 5.29, p = .006, \eta^2 = .05$. Participants who used this resource reported lower levels of well-being ($M = 3.28, SD = 0.81$) when compared to those who did not use the resource ($M = 3.70, SD = 0.83$), a statistically significant difference of -0.42 , 95% CI [-0.73, -0.11].

There was also a statistically significant relationship between level of access to a doctor/general practitioner and well-being, $F(2,222) = 3.95, p = .021, \eta^2 = .34$. Participants who used this resource had lower well-being ($M = 3.18, SD = 0.16$) when compared to those who did not use it ($M = 3.65, SD = 0.82$), a statistically significant difference of -0.45 , 95% CI [-0.85, -0.05].

There was a statistically significant relationship between level of access to a grief group both on and off campus and well-being, $F(2,221) = 3.38, p = .036, \eta^2 = .03$; $F(2,222) = 3.79, p = .024, \eta^2 = .033$. Participants who reported using an on-campus group had higher levels of well-being ($M = 4.37, SD = 0.38$) when compared to those who were unable to access it ($M = 3.34, SD$

= 0.16), a statistically significant difference of 1.03, 95% CI [0.04, 2.02]. Additionally, participants who did not use off-campus groups had higher levels of well-being ($M = 3.61$, $SD = 0.06$) when compared to those who were unable to access it ($M = 3.03$, $SD = 0.22$), a statistically significant difference of 0.58, 95% CI [0.03, 1.12].

There was a statistically significant relationship between level of access to an academic advisor and well-being, $F(2,222) = 3.30$, $p = .039$, $\eta^2 = .029$. Participants who reported using an academic advisor for support had lower levels of well-being ($M = 3.12$, $SD = 1.03$) when compared to those who were unable to access one ($M = 3.81$, $SD = 0.76$), a statistically significant difference of -0.69, 95% CI [-1.37, -0.004]. Further results can be found in Table 4.

Table 4

Results for One-Way Between-Subjects ANOVAs Evaluating the Relationship between the Use of a Support Type and Well-Being

Support Type	Estimated Marginal Means			<i>F</i> statistic
	Used	Did Not Use	Could Not Access	
Family members	3.67 ^a	3.30 ^{a, b}	2.95 ^b	6.73*
Friends	3.60 ^a	3.61 ^a	3.21 ^a	1.34
Professor	3.28 ^a	3.57 ^{a, b}	3.93 ^b	2.93*
Academic advisor	3.12 ^a	3.60 ^{a, b}	3.81 ^b	3.30*
Other mentor on-campus	3.37 ^a	3.62 ^a	3.36 ^a	1.22
Licensed mental health professional on-campus	3.41 ^a	3.63 ^a	3.33 ^a	1.78
Licensed mental health professional off-campus	3.23 ^a	3.70 ^b	3.55 ^{a, b}	5.29*

Grief support group on-campus	4.37 ^a	3.60 ^{a, b}	3.34 ^b	3.38 [*]
Grief support group off-campus	3.92 ^{a, b}	3.61 ^a	3.03 ^b	3.79 [*]
Doctor/general practitioner	3.20 ^a	3.65 ^b	3.35 ^{a, b}	3.95 [*]
Religious/spiritual community	3.70 ^a	3.56 ^a	3.44 ^a	0.56

Note. Means sharing a subscript are not statistically significantly different from each other based on a Bonferroni-corrected $\alpha = .05$. *F* statistic is the omnibus test of the relationship of access to support with well-being. * $p < .05$.

To evaluate the relationship between the use of a support type and grieving symptoms, grieving symptom scores were subjected to a one-way analysis of variance with one between-subjects variable having three levels of access (I used this support, I did not use this support, this support was not available to me or was very difficult to access). To summarize, all but one of the eleven omnibus *F* tests were statistically significant. For brevity's sake, only the same six resources as above will be reported below, in order of most associated with grieving symptoms to least. In each case, a Bonferroni correction for multiple comparisons was used to examine the pairwise differences.

There was a statistically significant relationship between level of access to family members and grieving symptoms, $F(2,222) = 13.4, p < .001, \eta^2 = .11$. Participants who reported using family members as support had lower levels of grieving symptoms ($M = 1.96, SD = 0.06$) when compared to those who reported that family members were difficult to access or unavailable to them ($M = 3.18, SD = 0.23$), a statistically significant difference of -1.22, 95% CI [-1.80, -0.65]. Also, those who did not use this resource had lower levels of grieving symptoms ($M = 2.03, SD = 0.16$) than those who were unable to ($M = 3.18, SD = 0.23$), a statistically significant difference of -1.16, 95% CI [-1.83, -0.49].

There was a significant relationship between level of access to an academic advisor and grieving symptoms, $F(2,222) = 5.15, p = .01, \eta^2 = .04$. Participants who reported using an academic advisor had higher levels of grieving symptoms ($M = 2.66, SD = 1.07$), when compared to those who did not ($M = 1.97, SD = 0.87$), a statistically significant difference of 0.69, 95% CI [0.16, 1.21].

There was a statistically significant relationship between levels of access to a licensed mental health professional off-campus and grieving symptoms, $F(2,222) = 8.72, p < .001, \eta^2 = .07$. Participants who reported using this resource had higher levels of grieving symptoms ($M = 2.27, SD = 0.89$) when compared to those who did not use this resource ($M = 1.91, SD = 0.83$), a statistically significant difference of 0.36, 95% CI [0.04, 0.69]. Further, those who reported not using had lower levels of grieving symptoms ($M = 1.91, SD = 0.83$) when compared to those who were unable to ($M = 2.46, SD = 1.27$), a statistically significant difference of -0.56, 95% CI [-0.69, -0.04].

Additionally, there was a statistically significant relationship between levels of access to a doctor/general practitioner and grieving symptoms, $F(2,222) = 21.1, p < .001, \eta^2 = .16$. Participants who reported using this resource had higher levels of grieving symptoms ($M = 2.75, SD = 0.93$) when compared to those who did not use this resource ($M = 1.88, SD = 0.79$), a statistically significant difference of 0.87, 95% CI [0.48, 1.26]. Further, those who reported not using had lower levels of grieving symptoms ($M = 1.88, SD = 0.79$), when compared to those who were unable to ($M = 3.11, SD = 1.21$), a statistically significant difference of -1.23, 95% CI [-1.94, -0.51].

Lastly, there was a statistically significant relationship between level of access to a grief group off campus and grieving symptoms, $F(2,222) = 12.0, p < .001, \eta^2 = .03$. Participants who

did not use off-campus groups had lower levels of grieving symptoms ($M = 1.96$, $SD = 0.83$) when compared to those who were unable to access it ($M = 3.07$, $SD = 1.25$), a statistically significant difference of -1.12 , 95% CI $[-1.11, 0.49]$. Further results can be found in Table 5.

Table 5

Results for One-Way Between-Subjects ANOVAs Evaluating the Relationship between the Use of a Support Type and Symptoms of Prolonged Grief Disorder

Support Type	Estimated Marginal Means			<i>F</i> <i>statistic</i>
	Used	Did Not Use	Could Not Access	
Family members	1.96 ^a	2.03 ^a	3.18 ^b	13.4 [*]
Friends	2.09 ^a	1.74 ^b	2.64 ^a	6.55 [*]
Professor	2.66 ^a	1.97 ^b	2.06 ^{a, b}	5.79 [*]
Academic advisor	2.66 ^b	1.97 ^a	2.16 ^{a, b}	5.15 [*]
Other mentor on-campus	2.08 ^{a, b}	1.98 ^a	2.58 ^b	4.78 [*]
Licensed mental health professional on-campus	2.59 ^a	1.92 ^b	2.41 ^a	8.72 [*]
Licensed mental health professional off-campus	2.27 ^a	1.91 ^b	2.47 ^a	5.69 [*]
Grief support group on-campus	2.71 ^a	1.99 ^a	2.32 ^a	3.26
Grief support group off-campus	2.27 ^{a, b}	1.96 ^a	3.07 ^b	12.04 [*]
Doctor/general practitioner	2.75 ^a	1.88 ^b	3.11 ^a	21.1 [*]
Religious/spiritual community	1.90 ^a	2.01 ^a	2.96 ^b	7.27 [*]

Note. Means sharing a subscript are not statistically significantly different from each other based on a Bonferroni-corrected $\alpha = .05$. *F* statistic is the omnibus test of the relationship of access to support with symptoms. * $p < .05$.

Discussion

The purpose of this study was to examine the grieving experiences of undergraduate college students and better understand the ways in which they cope. Participants completed a battery of measures that evaluated the characteristics of grieving, types of support accessed and their perceived helpfulness, coping strategies, and degree of healthy functioning. To summarize, approximately half of the sample reported at least one loss. Of those, the most common total number of losses was 1-3. The most common characteristics of their most significant loss were that the relationship was with a grandparent, the manner of death was illness, the loss occurred 36+ months ago, and the loss was unexpected. Those in the bereaved sample had statistically significantly lower levels of well-being when compared to the non-bereaved sample. As expected, more intense grieving symptoms were significantly correlated with lower levels of well-being. Additionally, there was a significant negative correlation between avoidant coping and both well-being and grieving symptoms. Unexpectedly, there was not a significant correlation between emotion-focused coping or problem-focused coping and well-being. Though, there was a significant positive correlation between emotion-focused coping and grieving symptoms. Furthermore, the most used sources of support were friends and family, who were also rated as being the most helpful. Lastly, ability to access resources and whether or not they were used was found to be correlated with intensity of grieving symptoms.

While elements of the results suggest support for the previously stated hypotheses, others do not. There are three key implications of the present research; first, that there is a significant difference in well-being between bereaved and non-bereaved undergraduates; second, that the type of coping mechanism used may be influential in their grieving experience; third, that support type and accessibility matter in their association with the grieving experience.

Bereavement status was strongly linked to well-being in this study, with bereaved individuals reporting lower levels of well-being than their non-bereaved counterparts. Well-being was also significantly negatively correlated with grieving symptoms, separation distress, and holistic effects, suggesting that as grieving symptoms get worse, well-being does as well. The same can be said for separation distress and holistic effects. This finding is consistent with past research that bereavement impacts the welfare of an individual (Balk et al., 1998; Stroebe et al., 2001).

Coping strategies are also relevant to the health of a grieving individual. This area is where there was an unexpected result. Past research suggested that emotion-focused coping and problem-focused coping are more adaptive skills and have the ability to reduce negative emotion (Balk, 1997). Contrastingly, the present study found that emotion and problem-focused coping had no significant association with well-being, but rather that they were positively associated with more intense grieving symptoms. It is possible that this is because those with lower levels of well-being and more intense grieving symptoms are engaging in a wide variety of strategies to alleviate their negative emotions. Additionally, it is possible that although they are engaging in these adaptive mechanisms, they are not being supported properly in a social context which may negate the possible benefits. As expected, avoidant coping was negatively associated with well-

being and positively associated with grieving symptoms. This is in line with past research that suggested maladaptive coping strategies lead to poorer well-being (Haga et al., 2009).

The most frequently used support systems, family and friends, were also reported as being the relatively most helpful resources. This is consistent with prior findings that highlighted the role those interpersonal relationships played in recovery from grief. This suggests that for undergraduate students in particular, being able to access and engage with high-quality friendships if they are away from family is essential. Additionally, having consistent access to technology that would allow them to reach family members may be key, and could be reasonably supported by the university. Interestingly, although friends were perceived as being very helpful, results suggested that there was no significant difference in well-being between those who were able to access friends, those who did not use friends, and those who were unable to access friends. It is possible that participants are using supplemental support systems or other resources and coping strategies that are enhancing their levels of well-being.

The least frequently used support systems were grief support groups on-campus and off-campus. Those who were unable to access an off-campus grief group had significantly lower levels of well-being than those who chose not to use it. It's possible that those who did not use it simply did not need it as much and may have had other means of support to enhance their well-being. Research shows that access to care and well-being/health needs are linked, in that, those who are unable to access care are more likely to have more unmet health needs than those that are able to access care (Lasser et al., 2006). This suggests the need for greater institutional support because if students are unable to access help outside of campus, they will need to be better supported from within the campus.

Both on and off-campus grief groups were reported to be severely underutilized by participants. Past research has shown that there is chronic underutilization of campus counseling resources, with only about 10% of students expressing psychological distress ever seeking help (Marsh, 2015). It is also possible that a simple lack of awareness that these resources exist drives the high rate of underutilization of on-campus grief groups. This is supported by prior research as a 2015 study by Cox et al. found that a quarter of their sample was unaware that psychological counseling resources were available to them. Universities may need to take the lead in making these resources more widely known. What this also tells us is that there is a need for widely available, and high-quality grieving resources for bereaved students in order to foster well-being and reduce negative emotions.

Limitations and Future Directions

Certain limitations of this study could be addressed in future research. For example, this is correlational data, meaning that this study alone does not establish that grief itself is causing these changes in well-being, or that certain strategies improve well-being, simply that they are associated. Future studies could contribute to this domain by conducting high-quality longitudinal studies on the relationship between grief and well-being as well as addressing academic performance of undergraduates facing bereavement.

In addition, there is a lack of clarity in how to interpret some of the data. For example, the use of academic advisors was associated with significantly lower levels of well-being when compared to those that didn't use one or that didn't have access to one. Is this because academic advisors are poor sources of support? Or is it because students are only seeking out their support when they are in the most dire of circumstances, or some combination thereof?

Also, this study does not limit participants to losses that occurred during their undergraduate years, but to any loss that has occurred across the lifetime. Future studies could limit the period to during their undergraduate years in order to focus on a specifically pained group that are in a particularly vulnerable time in their lives. Because time elapsed since the loss plays a role in the severity of grieving symptoms, this would be an important study to run as it would allow students to examine what it is that they need most, and it would identify to schools how they can better support their students in an academic environment (Cupit et al., 2021). The study also only looked at a convenience sample. College students are a diverse population and there is merit in examining specific sub-populations within a typical college setting, for example, racial and ethnic minorities, individuals that identify as LGBTQA+, students of different socioeconomic backgrounds, etc.

Furthermore, there are a variety of characteristics of grieving that were not analyzed in this paper. Manner of death, relationship to the deceased, time elapsed since the loss, number of losses, and others can all be explored. For example, are low levels of well-being more significantly related to a death by natural causes or suicide? What type of relationship is more closely related to low levels of well-being? Would levels of well-being be higher if more time has passed since the loss? Do multiple losses lead to lower well-being than a single loss?

Lastly, the subscales in the Brief COPE could have been broken down even further to develop a more nuanced portrait of grief. The potential subscales include items such as denial, humor, emotional support, instrumental support, and venting among others. Future research may explore these individual facets in the future to get a more rounded view of grief and the ways in which students attempt to cope with unimaginable loss.

Conclusion

In conclusion, there is a need for further research on the effects of grief and bereavement on the undergraduate student population. As this study has shown, those who have experienced bereavement have statistically significantly lower levels of well-being than those who have not been bereaved. There were also a small number of participants that met criteria for Prolonged Grief Disorder, drawing attention to the impact that grief can have on an individual. Further, the most commonly used resources were family and friends, suggesting the social nature of recovery from grief. Finally, there is a marked underutilization of campus resources and the reasons for that should be explored.

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