

**Preparing for the Inevitable: Investigating the Role of Anticipatory Grief and Psychological  
Flexibility on Mental Well-Being**

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### Abstract

Anticipatory grief (AG) arises when individuals process emotions before an expected loss, often due to terminal illness or decline. Various factors influence AG, including coping strategies and psychological flexibility (PF), which is the ability to stay present and adapt behaviour to align one's behaviours with personal values. PF may help mitigate AG by reducing experiential avoidance (EA), the tendency to suppress distressing thoughts. Research examining the impact of AG on psychological well-being after a loss is mixed. Thus, the primary goal of this study was to examine the impact of AG and bereavement on the well-being of individuals who experienced either sudden or anticipated loss of a loved one within the past 24 months. A total of 195 participants completed a questionnaire package to assess variables associated with bereavement, anxiety, depression, coping, and PF. Results indicated that individuals who experienced an anticipated loss reported lower anxiety and higher overall PF than those with sudden loss. AG, bereavement, and EA were correlated with depression and anxiety. Interestingly, PF and coping were not positively correlated. Regression analyses indicated that bereavement, not AG, significantly predicted anxiety and depression. Aspects of PF and EA accounted for significant variance in models predicting anxiety. Qualitative responses describing relationship to the deceased provided further support that AG exacerbates depression and anxiety. Overall, the findings highlight the need to understand the distinction between bereavement and AG, emphasizing AG's unique emotional impact on anxiety in those facing an expected loss.

*Keywords:* anticipatory grief, bereavement, psychological flexibility, coping, psychological well-being

## **Preparing for the Inevitable: Investigating the Role of Anticipatory Grief and Psychological Flexibility on Mental Well-Being**

As of 2022, cancer and cardiovascular disease were the most prevalent causes of death in Canada, claiming more lives than any other health condition (Statistics Canada, 2024). Despite improved prognoses and medical advancements in recent years, individuals diagnosed with terminal illnesses and other progressive conditions face, sometimes for the first time, their own mortality. Every individual will ultimately face their own death (Carr, 2012), and most will experience the profound emotional impact of losing a loved one at some point in their lives (Lekalakala-Mokgele, 2018). This universal experience often gives rise to feelings of bereavement, grief, and mourning – terms that are frequently used interchangeably (Dubose, 1997). Despite their interconnectedness, each term reflects a distinct aspect of the human response to loss (Dubose 1997; Lekalakala-Mokgele, 2018). Bereavement refers to the state of having lost a loved one (Lekalakala-Mokgele, 2018; Shear, 2012), grief encompasses the emotional and psychological reactions to that loss (Shear, 2012), and mourning involves the outward expressions of grief, often shaped by cultural and social norms (Dubose, 1997). Understanding the differences between these concepts is important as they reveal the multifaceted nature of human loss (Shear, 2012). These responses to the loss of a loved one show that although death is universal, our ways of coping with the loss of others are deeply personal and influenced by a variety of contexts (Dubose, 1997; Shear, 2012).

### **Death and Loss**

The grieving experience is a complex emotional process that typically arises in response to the loss of someone or something significant (Lekalakala-Mokgele, 2018; McCarroll & Yan, 2024). The experience of grief often manifests because of the death of a loved one (e.g., friends,

children, partners, parents), and it can evoke emotional responses that vary greatly from person to person (Lekalakala-Mokgele, 2018; McCarroll & Yan, 2024; Shear, 2012). Grief is uniquely experienced by individuals (Lekalakala-Mokgele, 2018) and can encompass a range of feelings including: sadness, anxiety, anger, confusion, and even relief, depending on the nature of the relationship and the circumstances of the loss (McCarroll & Yan, 2024).

Emotions associated with grief and loss transcend age, as individuals of all stages of life cope with loss in unique and deeply personal ways. University students are notably vulnerable; Lipp and O'Brien (2022) estimated that between 40 and 70% of university students experience the very first meaningful death of a close friend or relative while they are enrolled in school. This statistic is concerning, as a lack of experience with grieving paired with the stress of university can significantly impact student's well being. The grief process is not only limited to death but can reflect the many different attachments and connections that people form throughout their lives (McCarroll & Yan, 2024). Similar to the differences in experiences of loss, timelines for grieving can also be unique (Lekalakala-Mokgele, 2018). Understanding and supporting the diverse ways individuals navigate grief is essential across all ages. However, it is especially important to consider that many university students may have limited experience with bereavement, which can make coping with loss particularly challenging. Acknowledging this can help promote emotional resilience and support their overall well-being during this formative stage of life.

### **Anticipatory Grief**

Although grief often follows the death of a loved one, it is not always confined to the period immediately after the loss (McCarroll & Yan, 2024; Shore et al., 2016; Theut et al., 1991). In many cases, particularly in relation to a death-related cause, such as a terminal illness (e.g.,

cancer), individuals may experience grief in anticipation of a future loss, which is known as anticipatory grief (AG; Shore et al., 2016; Theut et al., 1991). This term was first coined by Erich Lindemann (1944), who, after World War II, observed that the families of soldiers often experienced all stages of grief before the soldiers' deaths. In some instances, this grief led to the complete rejection of soldiers who returned home alive (Clayton et al., 1973; Lindemann, 1944). AG occurs when individuals foresee an impending loss, often due to terminal illness or long-term decline, and begin to emotionally process the loss while their loved one is still physically present (McCarroll & Yan, 2024; Nielsen et al., 2016; Trembl et al., 2021). This phenomenon involves a total psychological rearrangement of one's life in response to an impending loss that involves actions of mourning, coping, and planning (Li et al., 2023).

Additionally, AG can evoke a heightened range of emotional reactions in a person. It can result in changes in identity or altered roles (Shore et al., 2016). AG can be experienced by both the individual suffering from the terminal illness and those around them, including family, friends, and those providing care to the individual (Li et al., 2023; Shore et al., 2016). When an individual receives a terminal diagnosis, their close social connections sometimes transition to a more focused grieving process that allows them to move beyond speculation and feelings of anxiety about the illness (Powers, 1977). The diagnosis allows individuals to acknowledge their emotions and may allow AG to become a constructive part of their emotional journey, potentially enabling them to prepare for the inevitable loss and finding a sense of acceptance (Powers, 1977; Shore et al., 2016).

Compared to a sudden loss, AG allows individuals to prepare emotionally, complete unfinished business, say goodbyes, and adjust socially, possibly leading to less severe bereavement reactions after death (Pérez-González et al., 2023). According to Gilliland and

Fleming (1998), AG can help mitigate some acute grief responses after death. It is important to recognize that grief often arises not just from death but also from the changes experienced during a terminal illness, including declines in physical and mental abilities (Chapman & Pepler, 1998). This makes it challenging to distinguish between mourning due to the effects of the illness and the impending loss of life, as these losses occur concurrently.

Hayslip and colleagues (2015) pointed out that an often-overlooked factor in grief is the cause of death. When compared to individuals who have lost a loved one suddenly, having time to grieve prior to the loss can impact individuals' well-being after they have experienced a significant loss. Additionally, the psychological wellbeing of an individual experiencing AG can be influenced by many other factors: The time since the person was diagnosed (Davis et al., 2017), gender (Chapman & Pepler, 1998; Gilliland & Flemming, 1998; Hayslip et al., 2015), social support (Pérez-González et al., 2023), and coping style (Rogalla, 2020) all have positive and negative influences on the grieving process.

### *Negative Effects of Anticipatory Grief*

Studies have shown that the phenomenon of AG can have a negative impact on the psychological well-being of individuals well before the death of a loved one (Hayslip et al., 2015; Schmidt et al., 2022). Kalter and colleagues (2003) found that many children experience more detriments to their well-being when dealing with the anticipated death of a parent as opposed to a sudden, unexpected death. AG is associated with more severe symptoms of depression and anxiety, as well as lower satisfaction with life (Schmidt et al., 2022). Negative emotions that result from AG can lead to significant suffering after a loss (Widera & Block, 2012), leading to poor bereavement outcomes such as prolonged grief (Nielsen et al., 2016). Additionally, it was also found that higher levels of AG in the loved ones of terminally ill

individuals were linked to a greater likelihood of depression and anxiety symptoms (Meichsner & Wilz, 2018; Treml et al., 2021).

Furthermore, Gilliland and Flemming (1998) reported that increased AG was associated with high intensities of anger and loss of emotional control. Moreover, Chapman and Pepler (1998) found that those who struggled with their feelings prior to experiencing AG felt increased hostility. They also found that individuals who lacked hope during the AG process were more likely to feel socially isolated. Further, individuals experiencing AG may detach themselves from the experience and their loved one as a protective mechanism to avoid the hardship of grief (Zilberfein, 1999). Thus, AG correlates strongly with feelings of loneliness and sadness (Reynolds & Botha, 2006), suggesting a negative impact on mental well being.

### ***Positive Effects of Anticipatory Grief***

Although AG rarely makes the loss of an individual any easier, Shore and associates (2016) stated that the experience can be somewhat beneficial in helping the individuals who are preparing to lose their loved one. It can provide a sense of closure, and help individuals develop coping skills for the inevitable reality of death (Hines-Smith, 2005; Powers, 1977). In this way, AG helps individuals feel more in control of the situation (Zilberfein, 1999) and helps to frame the anticipated death as not only a painful experience but as a vital part of preparing for loss. Ultimately, the most desirable outcome after an individual has undergone the grief process is the acceptance of a loss or a return to their state of “normalcy” as before the individuals experienced the death (Rogalla, 2020). In a positive light, AG can serve as an adaptive mechanism, helping families and friends cope better with the death of a loved one, allowing them to adjust prior to the loss (Hines-Smith, 2005).

Some literature demonstrates that AG is a healthy coping mechanism (Powers, 1977), and that being well-prepared for both death and caregiving is associated with lower levels of psychological distress (Pérez-González et al., 2023). With respect to psychological wellness, AG can help strengthen family bonds through shared hardships. Moreover, the anticipation of an impending death allows individuals time to emotionally prepare for the upcoming loss (Kacel et al., 2011). When those who lost loved ones due to terminal illness were compared with individuals who suffered a sudden loss, Feigelman and associates (2023) reported that those shocked by death (e.g., death via suicide) showed greater mental health concerns and problems with grieving; individuals who anticipated the death had less pronounced mental health problems and engaged in more meaning-making after the death occurred. Moreover, Rogalla (2020) stated that certain individuals report a growing sense of self after experiencing or anticipating a tragic experience, which can be generalised into processes of AG. These findings highlight the potential of AG to mitigate psychological distress and nurture personal growth and resilience in the face of profound loss.

### **Factors that Affect AG**

#### ***Coping***

Coping, defined as the ongoing cognitive and behavioural efforts individuals employ to manage perceived internal or external demands that exceed their resources (Crunk et al., 2021), can play a mediating role in the bereavement process. Similar to the death experience, coping with respect to the loss of a loved one is unique to the individual. According to Stroebe and colleagues (2006), individual differences in coping strategies may shape the overall bereavement trajectory, potentially alleviating distress caused by grief. After the death of a loved one occurs, the coping style changes to focus on adapting to challenges they face in the present (Crunk et al.,

2021). In terms of AG, proactive coping helps individuals prepare for the upcoming loss, enabling them to reach out for the support they need (Rogalla, 2020). Individuals who actively use proactive coping strategies, such as viewing the loss they are anticipating as a challenge rather than a threat, tend to show more growth than those who perceive the impending death more negatively. Proactive coping also involves seeking social support, which is linked to greater personal growth during AG.

### ***Social Support***

Individuals with vast social support networks tend to cope better with the overall AG experience (Lipp & O'Brien, 2022; Pérez-González et al., 2023), and studies have indicated that lower levels of social support are associated with poorer coping strategies during bereavement (Amano et al., 2022; Lipp & O'Brien, 2022). By actively seeking help from other people or resources, individuals can navigate their emotions more effectively, leading to personal growth during a challenging time (Rogalla, 2020). Heijningen et al. (2024) recognized that although social support plays a beneficial role in the grieving process, grief itself is a complex experience that can complicate relationships. This complexity can lead to diminished maintenance of connections, as individuals grapple with feelings of increased anxiety and depression over potential loss or rejection and a longing for reassurance.

Emotional challenges experienced during AG and post-loss grief can significantly impact social support systems (Heijningen et al., 2024). By maintaining strong relationships and seeking support, individuals can better navigate the intricate emotions associated with grief. Rogalla (2020) suggested that social support and proactive coping work together in a synergistic relationship, in which their combination leads to a more positive outlook and greater motivation

to move forward in life. This relationship between social support and proactive coping creates a buffer against the stress of AG, helping individuals manage their feelings and foster resilience.

### **Psychological Flexibility**

Psychological flexibility (PF) is the ability to fully engage with the present moment and adjust behaviour based on personal values and goals (Murrell et al., 2018; Proctor et al., 2023). PF involves being aware of what is happening both inside and around an individual, which helps facilitate decisions about whether to stick with certain actions or change them. PF is a skill that allows people to focus on their current situation and prioritize thoughts and feelings that matter to them (Martin & Pakenham, 2022). PF can be enhanced through Acceptance and Commitment Therapy (ACT), a variant of Cognitive Behavioural Therapy (CBT; Martin & Pakenham, 2022; Watt et al., 2023), that helps build resilience and teaches people how to prevent negative thoughts and feelings from dominating their lives (Proctor et al., 2023). By increasing self-awareness and addressing their trauma, individuals can avoid letting their adverse situations (e.g., diagnoses) define their core values. Incorporating PF into daily life can improve coping with trauma and help maintain a focus on the present and on individual values (Proctor et al., 2023).

PF is described by using three main pillars: (a) “open,” which includes acceptance and cognitive defusion; (b) “aware,” which focuses on being present and adopting a perspective-taking view of oneself; and (c) “engaged,” which involves identifying values and living in accordance with them (Proctor et al., 2023). Other important aspects are self as context, the awareness of oneself as an observer of thoughts, feelings, and experiences; values, which are chosen concepts across various life domains that provide meaning and guide a fulfilling life; and

committed action, the development of consistent choices and behaviours aligned with those chosen values (Fonseca et al., 2020).

With respect to PF, the purpose of ACT is not to eliminate negative thoughts but to help individuals manage all of their emotions, both positive and negative. ACT emphasizes the acceptance of things that are outside of an individual's control and helps to target meaning by connecting situations to personal values (Martin & Pakenham, 2022). Through ACT, individuals learn that they can have ongoing negative thoughts yet still engage with both positive and negative feelings in a way that allows them to live according to their core values (Proctor et al., 2023).

As denoted by Watt and associates (2023), the ACT model involves six interconnected processes aimed at increasing PF: (a) acceptance – allowing space for difficult thoughts and emotions rather than avoiding them; (b) defusion – distancing oneself from unhelpful thoughts to decrease their impact; (c) present moment awareness – staying open to the present without excessive focus on past or future worries; (d) self-as-context – adopting a flexible view of self rather than rigid beliefs about identity; (e) values – identifying qualities and behaviours that bring meaning to life, rather than conforming to external expectations; and (f) committed action – taking purposeful actions aligned with values instead of remaining inactive or acting impulsively.

In a systematic review, Watt and colleagues (2023) noted that several studies found that higher acceptance (a component of ACT) was associated with statistically significant improvements in PF, AG, depression, and anxiety. As individual factors, ACT is shown to help improve anxiety and depression symptoms and greater acceptance was significantly associated with reduced AG. Among bereaved university students, their systematic review found that higher

levels of acceptance and alignment with personal values were significantly linked to better adjustment to loss.

Understanding the underlying processes of ACT that help to influence effective outcomes is important for encouraging PF (Murrell et al., 2018). The existing literature reveals notable gaps regarding the relationship between PF and AG; however, a study by Davis and colleagues (2017) found that ACT has demonstrated efficacy in helping people cope with many of life's challenges. Davis et al. examined AG, acceptance, anxiety, and depression in patients from two palliative care units in Australia. Their regression analysis revealed that acceptance significantly reduces AG among patients in palliative care, suggesting that individuals more accepting of their situation experience less emotional distress related to pre-loss grief, accounting for a significant increase in variance beyond what was explained by depression and anxiety. This suggests that acceptance-based interventions (such as ACT) could be effective in alleviating AG. Findings such as these highlight the importance of fostering acceptance and PF in palliative care to support emotional well-being during end-of-life experiences. Significant gaps in the literature on PF and AG pose questions about how ACT and PF could be applied not only to palliative care patients, but also to their caregivers and loved ones, given AG's impact on psychological well-being (Chapman & Pepler, 1998; Grimby et al., 2015; Semenescu et al., 2022).

### **Experiential Avoidance**

A key factor contributing to psychopathology is the reluctance to engage with unwanted inner experiences, such as distressing thoughts or feelings (Watt et al., 2023). This reluctance often manifests as efforts to change, avoid, or eliminate these experiences, a process termed experiential avoidance (EA; Davis et al., 2017), which is a facet of psychological inflexibility

(Murrell et al., 2018). In contrast to acceptance, EA tends to increase the frequency of these unwanted private events, ultimately resulting in more psychological distress (Davis et al., 2017).

EA can be adaptive in the grieving process over the short-term. Murrell et al. (2018) reported that in short-term scenarios, EA can be compared to pragmatic coping, a strategy that is associated heavily with resilience. It may support functioning by helping to process the painful information surrounding the loss and restoring the ability to return to a sense of normalcy when the individual is ready (Stone et al., 2024). When used as a long-term strategy however, using EA can hinder and prolong grief (Murrell et al., 2018; Stone et al., 2024). In these situations, pragmatic coping still exists, however, the use of it as a long-term coping mechanism is associated with undesirable outcomes, including rigidity, narcissism, and poor health (Murrell et al., 2018). Along with the negative characteristics associated with long-term EA, Stone et al. (2024), further stated that longer-term avoidance is thought to impede acceptance of the loss, counteracting the effect that PF and ACT may have with respect to feelings of grief.

### **Purpose of the Current Study**

AG is an understudied phenomenon that affects over 25% of caregivers faced with the impending death of a loved one (Kustanti et al., 2024). As denoted in the literature, AG does not only affect caregivers but can impact many different social connections (Li et al., 2023; Shore et al., 2016). Given the high prevalence of AG, the primary aim of this study was to examine the experiences of AG in individuals who experienced the recent (< 24 months) death of someone significant in their lives due to a terminal illness (e.g., cancer, neurodegenerative diseases, organ failure). This study assessed how these experiences of AG and bereavement impacted overall psychological well-being. Although there is significant research on the effects of mindfulness and well-being on post-loss grief, research focused on the relationship between PF, AG, and

well-being remains overlooked. Considering this, I addressed the gaps in the literature concerning PF and its relationship with AG. To do this, I explored the role of PF in shaping feelings of AG and examined whether it strengthens or weakens the relationship between AG and psychological well-being.

The following research questions were investigated:

1. Is AG associated with psychological wellness (e.g., lower levels of anxiety and depression)? It was hypothesized that people who have had high levels of AG would have lower levels of depression and anxiety.
2. Is bereavement associated with psychological wellness (e.g., lower levels of anxiety and depression)? It was hypothesized that people who have high levels of bereavement would have higher levels of depression and anxiety.
3. Does having high PF affect psychological well-being during bereavement? It was hypothesized that individuals with higher levels of PF would have lower levels of depression and anxiety symptoms after the loss of a loved one.
4. Do individuals with better coping mechanisms have higher levels of PF? It was hypothesized that individuals who have high levels of adaptive coping following the loss of a loved one would have higher levels of overall PF.
5. Does EA affect psychological wellbeing after a loss? It was hypothesized that individuals with low levels of EA would have lower depression and anxiety levels following the loss of a loved one.
6. Does PF and adaptive coping predict lower psychological distress? After controlling for demographic variables and the effects of AG and bereavement, it was

hypothesized that PF, and adaptive coping would predict lower depression and anxiety symptoms.

## **Method**

### **Participants**

In total, 362 participants completed at least some questions in the questionnaire package. After data conditioning, a total of 195 participants were included in the analyses ( $M_{\text{age}} = 29.15$ ;  $SD = 13.17$ ). Individuals who identified as any gender were recruited for this study, however, more individuals who identified as female (65.0%) participated, with fewer male-identifying individuals (33.88%) and other gender identities (1.11%). Participants who had experienced a death in the past 24 months were recruited from UNB through SONA, the general public via social media, and through Prolific. In total, 103 (52.8%) UNB students participated in the study, a total of 32 (16.4%) participants from the general public filled out the survey, and a total of 60 (30.7%) participants were obtained from Prolific.

### **Measures**

#### ***Demographic Questionnaire***

A demographic questionnaire was developed for this study (see Appendix A). In addition to basic demographic information such as age and gender, questions were developed that required participants to focus on the death of a sole loved one and consider how the loss affected their wellbeing. In addition, the demographic questionnaire included questions about their loved one who has passed, including information about the cause of their loved ones' death, the loved one's age at the time of death, the length of time they were sick for prior to their death, the loved ones' relationship to the participant, and degree of caregiving that participants provided to their loved one before their death. Questions about the psychological and physical symptoms of grief

experienced prior to their passing were also included.

### ***Anticipatory Grief Scale***

The Anticipatory Grief Scale (AGS) was originally implemented to document AG in caregiving spouses of patients with dementia (Theut et al., 1991; see Appendix B). The AGS consists of 27 items that measures an individual's level of AG scored on 5-point Likert scale, ranging from “*strongly disagree*” to “*strongly agree*”. Items appear in both positive and negative directions in order to minimize response sets. Theut et al. (1991) demonstrated good internal reliability with a Cronbach's  $\alpha$  of .84. In this study, high internal consistency was also observed, with a Cronbach's  $\alpha$  of .87. For the purposes of this study, the verbs in the AGS questionnaire were modified to past tense rather than present tense, and dementia-specific keywords were changed to encompass all terminal illnesses.

### ***Bereavement Experience Questionnaire***

The Bereavement Experience Questionnaire (BEQ-24; Guarnaccia & Hayslip, 1998; see Appendix C) measures emotions and common reactions felt during the bereavement process. The BEQ-24 has three subscales that assess existential loss/emotional needs (e.g., “Felt life has no meaning”), anger or blame or guilt (e.g., “Felt guilty about some things I said or did after the death”), and preoccupying thoughts of the deceased person (e.g., “Felt the deceased was/is guiding me”). This measure has 24 items that are rated on a Likert-type scale that ranges from 0 (*never*) to 4 (*almost always*), with higher scores indicating more grief and bereavement experience. In this study, the mean total score was used for correlation analyses, and the subscale scores were used in the regressions. Guarnaccia and Hayslip (1998) reported high internal consistency for the BEQ-24 total score (Cronbach's  $\alpha = .90$ ), with good reliability for the subscales: BEQ-24: G ( $\alpha = .83$ ), BEQ-24: EL ( $\alpha = .86$ ), BEQ-24: G ( $\alpha = .83$ ), and BEQ-24: PD

( $\alpha = .81$ ). These findings closely align with the results of my study, in which the BEQ-24 total score achieved a Cronbach's  $\alpha$  of .94, while the EL, G, and PD subscales had Cronbach's  $\alpha$  values of .89, .90, and .85, respectively.

### ***Patient Health Questionnaire-9***

The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001; see Appendix D) is a tool that was originally designed to facilitate criteria-based diagnoses of depression and other mental disorders frequently seen in primary care settings. The PHQ-9 is a nine-item symptom checklist, including items such as, "Little interest or pleasure in doing things". Participants rate their subjective experiences over the past two weeks on a scale from 0 (*not at all*) to 3 (*nearly every day*). Kroenke et al.'s (2001) outline that the scores are categorized based on severity of depression, with scores from 0–4 being the least severe, indicating none to minimal severity, and higher scores classified as moderate to severe depression. Particularly, scores of 1–4 indicate minimal depression, scores of 5–9 indicate mild depression, scores of 10–14 indicate moderate depression, scores of 15–19 indicate moderately severe depression, and scores of 20–27 indicate severe depression. For the purposes of this research, the mean PHQ-9 scores were used in statistical analyses. The PHQ-9 is widely used in research and yields strong internal reliability, with a Cronbach's  $\alpha$  of .89 (Kroenke et al., 2001). Similar consistency was found in the present study, with a Cronbach's  $\alpha$  value = .88.

### ***Generalized Anxiety Disorder-7***

First introduced by Spitzer and colleagues (2006), the Generalized Anxiety Disorder-7 (GAD-7; see Appendix E) is a seven-item scale that measures symptoms of generalized anxiety disorder among individuals. Responses are rated on a Likert scale with responses ranging from 0 (*not at all*) to 3 (*nearly every day*). A higher total score indicates a greater level of anxiety and

can be interpreted regarding its severity, which ranges from minimal to severe. Specifically, scores are categorized as follows: 0–4 for minimal anxiety, 5–9 for mild anxiety, 10–14 for moderate anxiety, and 15–21 for severe anxiety. For the purposes of this research, the mean PHQ-9 scores were used in statistical analyses. Spitzer and associates (2006) found the internal consistency of the GAD-7 to be excellent, with a Cronbach's  $\alpha$  value = .92, which aligned with the high internal consistency in the current study (Cronbach's  $\alpha$  = .90).

### ***Acceptance and Action Questionnaire-II***

The Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011; see Appendix F) is the most widely used measure of EA and psychological inflexibility. This scale consists of 10 items that assess negative evaluations of feelings, avoidance of thoughts and feelings, the ability to distinguish thoughts from what they represent, and behavioural adjustment in the presence of challenging thoughts or feelings. Participants rate the extent to which items are true for them on a seven-point scale ranging from 1 (*never true*) to 7 (*always true*). The AAQ-II has been found to demonstrate strong internal consistency, with a Cronbach's  $\alpha$  value of .88 (Bond et al., 2011), which is consistent with the reliability in the current study ( $\alpha$  = .84).

### ***Coping Assessment for Bereavement and Loss Experiences***

The Coping Assessment for Bereavement and Loss Experiences (CABLE; see Appendix G) is a 28-item scale developed by Crunk and colleagues (2021) to identify the ways people who are grieving cope after the death of a loved one. Participants use a 5-point verbal frequency scale to show how often they used each strategy over a two-week period, ranging from 0 (*never*) to 4 (*daily*). The subscales include Help Seeking (e.g., "I read self-help books about the grieving process or coping with grief"), Positive Outlook (e.g., "I reminded myself of my strengths"), Spiritual Support (e.g., "I turned to my spirituality in order to experience hopefulness or peace"),

Continuing Bonds (e.g., “I talked to my loved one in my mind or out loud”), Compassionate Outreach (e.g., “I cared for and nurtured others”), and Social Support (e.g., “I identified supportive individuals to turn to when I am experiencing feelings of grief”). In this study, the total CABLE score was determined by calculating the mean of the six subscales. Crunk et al. (2021) reported high internal reliability for the total score, with a Cronbach’s  $\alpha$  of .95, and acceptable internal consistency for the subscales, with Cronbach’s  $\alpha$  values ranging from .65 to .87. For purposes of this study, total CABLE scores were used for the correlation analyses, and subscales were used for the regressions. These findings are similar to the values presented in the current study, with CABLE total score yielding a Cronbach’s  $\alpha$  value of .90 and its subscales yielding moderate to strong internal reliability, with Cronbach’s  $\alpha$  values ranging from .75 to .89.

### ***The Comprehensive Assessment of Acceptance and Commitment Therapy Processes***

The Comprehensive Assessment of Acceptance and Commitment Therapy Processes (CompACT; Francis et al., 2016; see Appendix H) is a 23-item questionnaire that assesses an individual's PF using a 7-point scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). It features three related but distinct subscales: Openness to Experience (e.g., “Thoughts are just thoughts—they don’t control what I do”), Behavioral Awareness (e.g., “I rush through meaningful activities without being attentive to them”), and Valued Action (e.g., “I can identify what matters to me in life and pursue it”). Francis and colleagues (2016) found that the inter-item correlation was .34, representing an acceptable internal consistency. Each of the individual subscales exhibited high levels of internal consistency. Openness to Experience and Valued Action had a Cronbach’s  $\alpha$  value of .90, and Behavioural Awareness had a Cronbach’s  $\alpha$  value of .87. Additionally, the internal consistency remained strong with a Cronbach’s  $\alpha$  value for the total CompACT score being .91. These values align with those observed in the present study, with

total score yielding a Cronbach's  $\alpha$  value of .90, and CompACT: Openness to Experience, CompACT: Behavioural Awareness and CompACT: Valued Action, yielding Cronbach's  $\alpha$  values of .81, .84, and .88, respectively.

### **Procedure**

Research Ethics Board approval from the University of New Brunswick was obtained (REB# 188-2024, see Appendix I). Participants were recruited using social media platforms such as Facebook and Instagram. SONA, a psychology study platform available to University of New Brunswick's undergraduate students, was also used to recruit participants. In addition, to increase the generalizability of the current findings, Prolific, an online participant recruitment tool was used to recruit participants who were not currently attending university. The study was promoted on grief support groups on Facebook, along with a brief description of the study (see Appendix J), and those interested could follow the provided link, leading them to a questionnaire package on Qualtrics ([www.qualtrics.com](http://www.qualtrics.com)).

Prior to starting the questionnaire package, participants were presented with a link to the informed consent form (see Appendix K). Once they read the form and provided consent, they completed the demographic questionnaire. After the initial demographics questions were filled out, the six or seven questionnaires were presented to participants in a randomized order, depending on whether the death was sudden or anticipated. Those who reported sudden deaths did not complete the AGS. Upon completion of the study, participants were directed to an end of survey question where they can either choose to be entered in a draw for a 20\$ Amazon gift card or obtain 0.5 of a bonus point (see Appendix L). Once completed, participants will be redirected to a debriefing form (see Appendix M), where they were provided with a list of North American

grief and mental health resources to contact if the questionnaires imposed any distress on them, or who they could contact if they wanted to receive the results of the study upon completion.

### **Results**

Prior to data analysis, data conditioning was conducted to ensure that data were screened for missing values, out of range values, and outliers. Those who did not respond to at least 80% of questions in the questionnaire package were excluded from the study. All participants whose questionnaire completion time was lower than 300 seconds were removed. ReCAPTCHA scores were examined to exclude questionnaire completion by bots. Additionally, if participants did not respond to 80% of items on a specific scale, but completed the other measures, their responses were excluded only from analyses that involved that scale. To control for outliers in the CABLE data, Windsorizing was applied, which involved replacing each outlier with the next highest value in the sample. Specifically, five scores were Windsorized for the CABLE: Help Seeking, and four scores were Windsorized for the CABLE: Compassionate Outlook. After data conditioning, data from a total of 195 participants were included in the analyses.

After data conditioning, the assumptions underlying statistical tests were assessed. Specifically, I assessed the normality, linearity, and homogeneity of variance. Because multiple variables were entered into my regression models, I assessed for multi-collinearity and found that all variance inflation factors were less than 5, indicating the correlations between the variables would not affect the statistical analyses. All inferential analyses were conducted at  $p < .05$ , and when appropriate, Cohen's  $d$  criteria were used to assess effect sizes (small = 0.2, medium = 0.5, large = 0.8).

**Table 1***Frequency of Demographic Variables Based on Death Type (Anticipated versus Sudden)*

Characteristic	Anticipated death		Sudden death		Total	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Gender of participant						
Women	85	66.92	42	67.74	127	65.0
Men	46	34.58	20	32.26	66	33.88
Another identity	2	1.50	—	—	2	1.11
Cause of death						
Cancer	55	41.35	—	—	55	28.2
Alzheimer's/Other dementias	27	20.30	—	—	27	13.8
Degenerative disease	10	7.51	—	—	10	5.10
Autoimmune condition	6	4.51	—	—	6	3.10
Organ failure	26	19.55	—	—	26	13.3
Psychological disorder	9	6.77	—	—	9	4.60
Sudden death	—	—	47	75.81	47	24.1
Other	—	—	15	24.19	15	7.7
Relationship to the deceased						
Parent	18	13.53	5	8.06	23	11.79
Cohabiting spouse/partner	6	4.51	—	—	6	3.07
Non-cohabiting spouse/partner	3	2.26	2	3.23	5	2.56
Child	0	—	1	1.61	1	0.51
Sibling	2	1.50	4	6.45	6	3.08
Grandparent	66	49.62	14	22.58	80	47.02
Another family member	23	11.79	14	22.58	37	18.97
Friend	11	8.27	18	29.03	29	14.87
Other	4	3.01	4	6.45	8	4.10
Peripheral or close relationship						
Peripheral	51	61.44	32	38.55	83	46.9
Close	30	31.91	64	68.09	94	53.11
Gender of deceased						
Female	54	69.23	24	30.77	78	40.0
Male	37	31.89	79	68.10	116	59.49
Another identity	—	—	1	0.961	1	0.51
Caregiver?						
Yes	30	78.94	8	21.05	38	19.49
No	54	34.39	103	65.61	157	80.51
Duration of illness before passing						
Not applicable	6	9.68	56	90.32	62	33.16
Less than 1 year	37	94.87	2	5.13	39	20.86
Between 1 – 5 years	60	95.24	3	4.76	63	33.69
More than 5 years	22	95.65	1	4.34	23	12.30

*Note.* Dashes inserted to represent lack of data.

### **Descriptive Statistics**

In total, 133 (68.21%) participants reported an anticipated loss, and a total of 62 (31.79%) individuals reported a sudden loss. Based on the reported relationship status, the effects of relationship type (close vs. peripheral) on bereavement, AG, and psychological variables was examined. Overall, a total of 94 (53.1%) participants reported having a close relationship with their loved one (e.g., parent, child, spouse, best friend) and a total of 83 (46.9%) participants reported a peripheral relationship (e.g., cousin, aunt, friend, colleague; see Table 1). Descriptive and inferential statistics were used to examine differences between these groups on the primary variables. (see Table 2). Overall, individuals who experienced an anticipated death reported lower scores on AAQ-II, GAD-7, BEQ-24 total and subscale scores, and CompACT total, CompACT: Openness to Experience, and CompACT: Behavioural Awareness. Interestingly, except for CABLE: Continuing bonds, there were no differences in CABLE total or subscale scores. This can be seen in Table 2, the effect sizes ranged from 0.62 to 1.25, indicating moderate to large effect sizes.

### **Types of Loss**

The effect of relationship status was also examined. Interestingly, except for BEQ-24: Preoccupation with Death,  $t(173) = 2.45, p = .012$ , and CABLE: Continuing Bonds,  $t(173) = 9.03, p = .003$ , variables did not differ according to relationship type.

**Table 2***Descriptive Statistics and Group Differences for Anticipated vs. Sudden Death Groups*

Scale/Variable	Anticipated death		Sudden death		T( <i>p</i> )	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Age of participant	29.42	12.62	28.60	12.62	0.40(.343)	0.06
<b>Age of deceased</b>	<b>69.55</b>	<b>19.26</b>	<b>51.24</b>	<b>27.21</b>	<b>5.23(.001)</b>	<b>0.82</b>
AGS	3.01	0.53	-	-	-	-
<b>AAQ-II</b>	<b>3.32</b>	<b>0.92</b>	<b>3.84</b>	<b>1.01</b>	<b>3.03 (.001)</b>	<b>0.95</b>
PHQ-9	2.06	0.68	2.24	0.60	1.60 (.056)	0.66
<b>GAD-7</b>	<b>2.18</b>	<b>0.70</b>	<b>2.53</b>	<b>0.84</b>	<b>2.70 (.004)</b>	<b>0.74</b>
<b>BEQ-24 total score</b>	<b>2.03</b>	<b>0.75</b>	<b>2.40</b>	<b>0.84</b>	<b>2.78 (.003)</b>	<b>0.77</b>
<b>Existential loss</b>	<b>2.13</b>	<b>0.81</b>	<b>2.58</b>	<b>0.86</b>	<b>3.10 (.001)</b>	<b>0.83</b>
<b>Preoccupation with death</b>	<b>2.18</b>	<b>0.86</b>	<b>2.46</b>	<b>0.98</b>	<b>1.81 (.036)</b>	<b>0.89</b>
Guilt	1.85	0.81	2.06	0.94	2.22 (.014)	0.85
CABLE total score	2.48	0.63	2.64	0.59	1.49 (.069)	0.62
Compassionate Outlook	3.52	0.88	3.58	0.70	0.49 (.314)	0.84
Social Support	2.94	0.72	3.06	0.61	0.99 (.162)	0.69
Help Seeking	1.65	0.78	1.82	0.81	1.29 (.100)	0.79
Spiritual Support	2.15	1.24	2.28	1.28	0.60 (.273)	1.25
<b>Continuing Bonds</b>	<b>2.64</b>	<b>0.87</b>	<b>3.07</b>	<b>0.82</b>	<b>2.88 (.002)</b>	0.86
Positive Outlook	2.99	0.86	3.00	0.86	0.03 (.487)	0.86
<b>CompACT total score</b>	<b>4.41</b>	<b>0.84</b>	<b>4.00</b>	<b>0.71</b>	<b>-2.92 (.002)</b>	<b>0.80</b>
<b>Openness to Experience</b>	<b>3.84</b>	<b>1.04</b>	<b>3.30</b>	<b>0.92</b>	<b>-3.00 (.002)</b>	<b>1.01</b>
<b>Behavioural Awareness</b>	<b>3.95</b>	<b>1.31</b>	<b>3.27</b>	<b>1.06</b>	<b>-3.12 (.001)</b>	<b>1.24</b>
Valued Action	5.40	0.97	5.27	0.98	-0.74 (.231)	0.97

*Note.* AGS = Anticipatory Grief Scale; AAQ-II = Acceptance and Action Questionnaire-ii; PHQ-9: Patient Health Questionnaire-9; GAD-7: Generalized Anxiety Disorder-7; BEQ-24 = Bereavement Experience Questionnaire-24. Significant differences are **bolded**.

### Evaluating the Research Hypotheses

H1 stated that there would be a statistically significant negative correlation between AG and psychological wellness (PHQ-9, GAD-7). To test this hypothesis, a one-tailed Pearson product moment-correlation correlation analysis was conducted to examine the association between AG, PHQ-9, and GAD-7. A statistically significant moderate positive correlation between AGS scores and PHQ-9 scores was observed,  $r(122) = .380, p < .001$ , suggesting that higher levels of AG were associated with more symptoms of depression. Similarly, a statistically significant moderate positive correlation was found between AGS scores and GAD-7 scores,  $r(121) = .434, p < .001$ , indicating that individuals with higher AG also experienced more symptoms of anxiety.

H2 stated that higher scores on the BEQ-24 would be associated with higher levels of depression and anxiety. To test this hypothesis, Pearson's correlations were calculated, using BEQ-24 subscales and total score (see Table 3). There were statistically significant moderate positive correlations between AG, depression, and anxiety and BEQ-24 subscales and total scores (see Table 3), which demonstrate relationships between bereavement and psychological wellness associated with both anticipated and sudden losses.

**Table 3**

*Pearson Product Moment Correlation Coefficients (r) Between BEQ-24, AGS, PHQ-9, GAD-7*

Variable	BEQ-24 subscales			BEQ-24 Total
	Existential Loss	Guilt	Preoccupation with Death	
Anticipatory Grief: AGS	.582**	.530**	.647**	.635**
Depression: PHQ-9	.541**	.470**	.324**	.498**
Anxiety: GAD-7	.561**	.441**	.393**	.518**

*Note.* BEQ-24 = Bereavement Experience Questionnaire-24; AGS = Anticipatory Grief Scale; PHQ-9: Patient Health Questionnaire-9; GAD-7: Generalized Anxiety Disorder-7. \*\* $p < .001$ .

H3 stated that lower PF would be associated with lower psychological wellness (e.g., higher scores on PHQ and GAD). Correlations to evaluate H3 were calculated to determine the

associations between the three subscales of the BEQ-24 subscales, BEQ-24 total score, the three subscales of the CompACT, and the CompACT total score. Overall, results indicated statistically significant inverse correlations between the subscales of the BEQ-24 and the subscales of the CompACT (see Table 4). Results suggested that having higher scores on the BEQ-24, PHQ-9 and GAD-7 was inversely associated with levels of PF.

**Table 4**

*Pearson Product Moment Correlation Coefficients (r) Between CompACT, BEQ-24, PHQ-9, GAD-7*

Variable	CompACT Subscales			CompACT Total
	Openness to Experience	Behavioural Awareness	Valued Action	
BEQ-24 Subscales				
Existential Loss	-.419**	-.378**	-.323**	-.489**
Guilt	-.422**	-.376**	-.369**	-.505**
Preoccupation with Death	-.350**	-.327**	-.262**	-.407**
BEQ-24 Total Score	-.440**	-.398**	-.356**	-.518**
AGS	-.538**	-.441**	-.302**	-.558**
Depression: PHQ-9	-.403**	-.405**	-.306**	-.476**
Anxiety: GAD-7	-.416**	-.415**	-.221**	-.452**

*Note.* BEQ-24 = Bereavement Experience Questionnaire-24; AGS = Anticipatory Grief Scale; PHQ-9: Patient Health Questionnaire-9; GAD-7: Generalized Anxiety Disorder-7; CompACT = Comprehensive Assessment of Acceptance and Commitment Therapy Processes. \*\* $p < .001$ .

H4 stated that higher levels of adaptive coping would be positively correlated with higher levels of PF. Correlations were calculated to examine the associations between the six subscales of CABLE and the three subscales of the CompACT, along with their total scores (see Table 5). Interestingly, the correlations between CABLE total score and the CompACT total score and CompACT subscale scores were not statistically significant, suggesting that higher levels of adaptive coping were not associated with greater PF. When examining the relationships between CABLE subscales and CompACT total and subscale scores subscales, four correlations were significant. A weak negative correlation emerged between CompACT: Valued Action and CABLE: Help Seeking,  $r(186) = -.19, p = .006$ , and CABLE: Continuing Bonds,  $r(186) = -.19, p = .006$ .

The Help-Seeking subscale measured the use of external resources, such as professional support and tools, to cope with grief. The Continuing Bonds subscale reflected efforts to maintain a connection with the deceased through reflection, meaningful activities, and keepsakes. In contrast, the Compassionate Outreach subscale captured coping through expressions of love, care, and kindness toward others. Although H4 was not supported, the findings suggest that variations in PF are negatively aligned with behaviours involving continuing bonds. In particular, the acting in line with values (Valued Action subscale) was positively associated with compassionate coping and negatively associated with help seeking.

**Table 5**

*Pearson Product Moment Correlation Coefficients (r) Between CompACT and CABLE scores*

Variable	CompACT Subscales			CompACT Total
	Openness to Experience	Behavioural Awareness	Valued Action	
<b>CABLE Subscales</b>				
Help Seeking	-.165	-.117	<b>-.190**</b>	<b>-.222***</b>
Spiritual Support	-.093	.096	.029	-.005
Positive Outlook	.012	.151	.170	.125
Continuing Bonds	-.145	-.168	-.113	<b>-.189**</b>
Social Support	-.160	-.057	.095	-.063
Compassionate Outreach	.015	.121	<b>.179**</b>	.125
CABLE total score	-.148	-.015	-.012	-.099

*Note.* CompACT = Comprehensive Assessment of Acceptance and Commitment Therapy Processes; CABLE = Coping Assessment for Bereavement and Loss Experiences. \*\*  $p < .01$ , \*\*\*  $p < .001$ .

Although they were not part of the original hypotheses, correlations between BEQ-24 subscales, AGS total score and CABLE subscales were analyzed (see Table 6). This was particularly relevant as the CABLE was designed to assess coping with bereavement, and I wanted to assess whether these measures demonstrated relationships that were statistically significant. The results yielded significant positive correlations with most of the respective subscales of BEQ-24 and AGS, particularly with Help Seeking and Continuing Bonds, suggesting that these coping strategies are indeed closely linked to grief-related emotions.

**Table 6***Pearson Product Moment Correlation Coefficients (r) Between CABLE and BEQ-24 scores*

Variable	BEQ-24 subscales			BEQ-24 Total	AGS Total
	EL	G	PD		
CABLE Subscales					
Help Seeking	.411***	.387***	.359***	.427***	.242**
Spiritual Support	.163*	.162*	.112	.165	-.152*
Positive Outlook	.083	.043	.153	.095	-.009
Continuing Bonds	.413***	.342***	.642***	.489***	.409***
Social Support	.251***	.186**	.299***	.214***	.261***
Compassionate Outreach	.036	.010	.127*	.153*	.059
CABLE total score	.383**	.329**	.454**	.419**	.219**

*Note.* CABLE = Coping Assessment for Bereavement and Loss Experiences; BEQ-24 = Bereavement Experience Questionnaire; EL = Existential Loss; G = Guilt; PD = Preoccupation with Death. \*\*  $p < .01$ , \*\*\*  $p < .001$ .

H5 stated that lower EA (AAQ-II) following the loss of a loved one would be positively correlated with depression (PHQ-9) and anxiety (GAD-7). Correlations to evaluate H5 were calculated to examine the associations between the AAQ-II, AGS, PHQ-9, GAD-7, and the BEQ-24 total and subscale scores (see Table 7). Overall, results indicated statistically significant moderate correlations between subscales of the BEQ-24. Thus, the hypothesis was supported; having lower EA was associated with lower overall grief, bereavement, anxiety and depression.

**Table 7***Pearson Product Moment Correlation Coefficients (r) Between AAQ-II, BEQ-24, AGS, PHQ-9, GAD-7*

Variable	AAQ-II Scores
BEQ-24 Total Score	.493**
Existential Loss	.504**
Guilt	.473**
Preoccupation with Death	.310**
AGS	.475**
Depression: PHQ-9	.445**
Anxiety: GAD-7	.524**

*Note.* AAQ-II= Acceptance and Action Questionnaire-ii; BEQ-24 = Bereavement Experience Questionnaire-24; AGS = Anticipatory Grief Scale; PHQ-9: Patient Health Questionnaire-9; GAD-7: Generalized Anxiety Disorder-7; Processes. \*\* $p < .001$ .

Finally, H6 stated that PF and coping would predict depression and anxiety after controlling for demographics and the effects of AG and bereavement. To examine whether PF

and adaptive coping were associated with lower psychological distress (PHQ-9, GAD-7) in individuals who have experienced a loss, four hierarchical linear regressions were conducted. The first two regression analyses included all participants (anticipatory and sudden losses) and predicted PHQ-9 and GAD-7 scores. In these regressions, demographic variables including age of participant, age of deceased, and gender of the participant were entered in Block 1, bereavement (BEQ-24 subscale scores) was entered in Block 2, and EA (AAQ-II), CompACT subscales, and CABLE subscales were entered in Block 3. In the second set of regressions, the effects of AG were included as a predictor of PHQ-9 and GAD-7 scores and thus, only participants who experienced an anticipated loss were included. Cause of death was not statistically significant in the regressions, therefore was not included with the demographics in Block 1.

Model 1 predicting total PHQ-9 scores was statistically significant,  $F(14, 32) = 6.194, p < .001$ , and accounted for 39.6% of the total variability. In Block 1, demographic variables were not statistically significant,  $F\Delta(3, 143) = 1.89, p = .14$ . Block 2 was statistically significant,  $F\Delta(1, 142) = 46.43, p < .001$ , and accounted for 23.7% of variability, with BEQ-24: Existential Loss contributing to the model. Block 3 did not account for significant variability,  $F\Delta(10, 130) = 1.81, p = .07$ . Thus, after controlling for the BEQ-24 subscales, PF and coping did not provide additional explanatory value for PHQ-9 scores after controlling for other variables.

Model 2 predicting total GAD-7 was statistically significant,  $F(14, 132) = 7.687, p < .001$ , and accounted for 44.9% of the variability. Block 1 was statistically significant,  $F\Delta(3, 143) = 7.71, p < .001, R^2\Delta = .140$ , with gender of participant and age of the deceased contributing to the model. Block 2 was also statistically significant,  $F\Delta(1, 142) = 36.972, p < .001$ , and accounted for 17.8% of the variability; BEQ-24: Existential Loss contributed significantly to the model

predicting GAD-7. Block 3 was also statistically significant,  $F(10, 132) = 3.147, p = .001, R^2\Delta = .131$ . In Block 3, EA, and CompACT: Valued Action contributing to the model. The results demonstrate that gender of the participant (being women), age of the deceased, decreased EA, and increased CompACT: Valued Action predicted increased anxiety symptoms.

**Table 8**

*Regression Coefficients of the Final Prediction Model for Depression and Anxiety (All Participants)*

Variable	Depression (PHQ-9)					Anxiety (GAD-7)				
	<i>B</i>	<i>SE B</i>	$\beta$	<i>t</i>	<i>p</i>	<i>B</i>	<i>SE B</i>	$\beta$	<i>t</i>	<i>p</i>
Step 1										
Age	0.00	0.00	.04	0.51	.613	-0.01	0.01	-.13	-1.55	.124
Age of deceased	-0.00	0.00	-.10	-1.17	.244	-0.01	0.00	<b>-.02</b>	<b>-2.37</b>	<b>.019</b>
Gender of participant	0.11	0.06	.17	1.88	.063	0.20	0.07	<b>.24</b>	<b>2.89</b>	<b>.005</b>
Step 2										
<b>BEQ-24: EL</b>	<b>0.39</b>	<b>0.09</b>	<b>.50</b>	<b>4.42</b>	<b>&lt;.001</b>	<b>0.53</b>	<b>0.10</b>	<b>.58</b>	<b>5.24</b>	<b>&lt;.001</b>
BEQ-24: G	0.17	0.09	.22	1.92	.057	-0.05	0.10	-.06	-0.49	.627
BEQ-24:PWD	-0.14	0.07	-.19	-1.96	.052	-0.04	0.08	-.04	-0.46	.644
Step 3										
CABLE: HS	-0.04	0.079	-.04	-0.48	.634	-0.07	0.09	-.07	-0.74	.462
CABLE: SP	-0.02	0.037	.09	-0.57	.571	-0.03	0.04	-.05	-0.69	.492
CABLE: PO	0.07	0.065	-.14	1.02	.310	0.01	0.07	.01	0.01	.922
CABLE: CB	-0.10	0.078	-.08	-1.30	.201	0.05	0.09	.06	0.56	.576
CABLE: CO	-0.06	0.065	.17	-0.90	.369	-0.02	0.07	-.03	-0.31	.760
CABLE: SS	0.16	0.087	-.02	1.79	.077	-0.06	0.10	-.05	-0.60	.552
CompACT: OE	-0.01	0.064	-.15	-0.22	.823	0.01	0.07	.12	1.33	.187
CompACT: BA	-0.08	0.050	-.11	-1.60	.114	-0.07	0.06	-.10	-1.18	.239
CompACT: VA	-0.07	0.060	.11	-1.25	.215	<b>0.15</b>	<b>0.10</b>	<b>.02</b>	<b>2.26</b>	<b>.025</b>
AAQ-II	0.07	0.065	.11	1.02	.308	<b>0.31</b>	<b>0.07</b>	<b>.44</b>	<b>4.34</b>	<b>&lt;.001</b>

*Note.* PHQ-9 = Patient Health Questionnaire-9; GAD-7 = Generalized Anxiety Disorder-7; BEQ-24 = Bereavement Experience Questionnaire-24; EL = Existential Loss; G = Guilt; PWD = Preoccupation with Death; CABLE = Coping Assessment for Bereavement and Loss Experiences; HS = Help Seeking; SP = Spiritual Support; CB = Continuing Bonds; CO = Compassionate Outreach; SS = Social Support. CompACT = Comprehensive Assessment of Acceptance and Commitment Therapy Processes; OE = Openness to Experience; BA = Behavioural Awareness; VA = Valued Action AAQ-II = Acceptance and Action Questionnaire-II. Significant results are **bolded**.

The second set of regressions also predicted symptoms of depression and anxiety but, to examine the effects of AG, both bereavement and AG were included in Block 2. The overall model predicting total PHQ-9 scores was also statistically significant,  $F(15, 15) = 4.428 p < .001$ , and accounted for 47.0% of variability in PHQ-9 scores (see Table 9). Block 1

demographic variables was not statistically significant  $F(3, 87) = .713$ . Block 2 was statistically significant,  $F\Delta(2, 85) = 19.486, p < .001$ , and accounted for 30.7% of the variability, with BEQ-24: EL contributing significantly to the model. Block 3 was also statistically significant,  $F\Delta(10, 75) = 1.964, p < .001$ , accounting for 13.9% of the variability, with CABLE: Spiritual Support contributing significantly to the model. Thus, an increased sense of existential loss and lower levels of spiritual support were associated with higher levels of depression.

Overall, the model predicting total GAD-7 was statistically significant,  $F(15, 75) = 3.09, p < .001$ , and accounted for 38.2% of the variability in GAD-7 scores. Block 1 demographic variables were statistically significant,  $F\Delta(3, 87) = 3.808, p < .013$ , and accounted for 11.6% of the variability, with gender of the participant contributing to the model. Block 2 was also statistically significant,  $F(2, 85) = 6.593, p = .002, R^2\Delta = .119$ , with BEQ-24: Existential Loss contributing to the model. Block 3 was not statistically significant,  $F(10, 73) = .06$ , and therefore the contributions of individual variables was not evaluated. Thus, increased anxiety was associated with gender (being female) and existential loss.

Although not included in the final analyses, participants were given the option to describe their relationship to the individual they lost. After examining the responses, the relationships were coded as either peripheral (non-immediate family members, friends, colleagues, etc.) or intimate (immediate family - parents, siblings, children, best friends, grandparents who played a primary caregiving role, etc.). Although there were few quantitative differences between these groups, qualitative responses illustrated the universality of the bereavement experience, regardless of whether the loss was sudden or anticipated, or whether relationships to the deceased were immediate or peripheral.

**Table 9***Regression Coefficients of the Final Prediction Model for Depression (Anticipated Death Participants)*

Variable	Depression (PHQ-9)					Anxiety (GAD-7)				
	<i>B</i>	<i>SE B</i>	$\beta$	<i>t</i>	<i>p</i>	<i>B</i>	<i>SE B</i>	$\beta$	<i>t</i>	<i>p</i>
Step 1										
Age	0.07	0.07	.10	0.93	.358	0.10	0.07	.14	1.34	.183
Age of deceased	-0.01	0.00	-.10	-0.89	.374	-0.01	0.01	-.15	-1.47	.145
Gender of participant	-0.00	0.00	-.05	-0.43	.667	<b>-0.01</b>	<b>0.00</b>	<b>-.27</b>	<b>-2.67</b>	<b>.009</b>
Step 2										
<b>BEQ-24: EL</b>	<b>0.39</b>	<b>0.12</b>	<b>.46</b>	<b>3.19</b>	<b>.002</b>	<b>0.37</b>	<b>0.14</b>	<b>.41</b>	<b>2.58</b>	<b>.012</b>
BEQ-24: G	0.24	0.10	.30	2.33	.022	-0.01	0.12	-.01	-0.07	.944
BEQ-24:PWD	-0.19	0.10	-.24	-1.82	.072	-0.05	0.12	-.06	-.38	.702
AGS	0.16	0.15	.13	1.05	.298	0.06	0.18	.05	.36	.719
Step 3										
CABLE: HS	0.07	0.01	.11	0.79	.433	0.14	0.10	.19	1.33	.187
CABLE: SP	<b>-0.13</b>	<b>0.06</b>	<b>-.25</b>	<b>-2.12</b>	<b>.038</b>	-0.11	0.07	-.19	-1.46	.148
CABLE: PO	-0.04	0.08	-.06	-0.50	.621	0.01	0.09	.02	0.13	.894
CABLE: CB	-0.13	0.11	-.17	-1.18	.241	-0.08	0.13	-.09	-0.58	.563
CABLE: CO	0.02	0.05	.04	0.38	.708	0.01	0.06	.03	0.23	.819
CABLE: SS	0.13	0.09	.18	1.41	.164	0.01	0.10	.01	0.10	.925
CompACT: OE	-0.05	0.10	-.63	-0.45	.656	-0.09	0.12	-.12	-0.80	.424
CompACT: BA	-0.12	0.08	-.16	-1.39	.169	0.11	0.10	.15	1.19	.237
CompACT: VA	0.12	0.11	.14	1.11	.271	0.01	0.13	.01	0.05	.962
AAQ-II	0.11	0.09	.17	1.32	.190	0.36	0.10	.52	3.64	<.001

*Note.* BEQ-24 = Bereavement Experience Questionnaire; EL = Existential Loss; G = Guilt; PWD = Preoccupation with Death; AGS = Anticipatory Grief Scale; CABLE = Coping Assessment for Bereavement and Loss Experiences. HS = Help Seeking; SP = Spiritual Support; CB = Continuing Bonds; CO = Compassionate Outreach; SS = Social Support. CompACT = Comprehensive Assessment of Acceptance and Commitment Therapy Processes. OE = Openness to Experience; BA = Behavioural Awareness; VA = Valued Action AAQ-II = Acceptance and Action Questionnaire-II. Significant results are **bolded**.

### Discussion

The purpose of this study was to examine the impact of AG on bereavement experiences and psychological well-being in individuals who experienced death in the past 24 months. Additionally, I explored if PF and coping strategies mitigated the effects of AG. Overall, in the current study (see Table 2), compared to those who experienced a sudden loss, participants who experienced an anticipated death reported higher PF, lower EA, as well as lower anxiety and depression levels. Furthermore, no significant differences were observed across coping subscales for sudden versus anticipated losses, except for continuing bonds, in which the participants who reported an anticipated loss had lower coping scores. These results align with those of Feigelman and colleagues (2023) who reported that those who lost someone suddenly showed greater mental health concerns and problems with grieving, whereas individuals who anticipated a death had less pronounced mental health problems. Six hypotheses were tested to explore the relationships between AG, PF, coping, and psychological well-being, with the aim of understanding how these factors interact and influence anxiety, depression, and overall bereavement experiences in individuals who have experienced a loss of someone meaningful in their lives.

Given the uncertainty in the literature surrounding the potential benefits of AG (Hines-Smith, 2005; Pérez-González et al., 2023; Powers, 1977; Rogalla, 2020), H1 predicted that there would be a negative correlation between AG and levels of psychological distress. Contrary to my hypothesis, the findings revealed moderate *positive* correlations between increased AG and severity of symptoms of both depression and anxiety. Further, given that the correlation between AG and anxiety was stronger than the correlation between AG and depression, these results suggest that AG may be more closely linked to anxiety-related distress than depressive

symptoms, aligning with the findings of Davis and colleagues (2017). Overall, these results propose that individuals experiencing AG may be at greater risk of experiencing symptoms of depression and anxiety than individuals who experience a sudden loss, which supports research suggesting that AG can exacerbate psychological distress in the lead-up to a loved one's death (Gilliland & Flemming, 1998; Hayslip et al., 2015; Kalter et al., 2002-2003; Tekdemir et al., 2024).

To further examine the effects of grief, H2 focused on associations between different aspects of bereavement and psychological distress. A correlational analysis supported this hypothesis, with moderate to strong correlations between depression and anxiety and BEQ-24 subscales, ranging from,  $r = .324$  to  $r = .561$ . Interestingly, the Existential Loss subscale was most strongly correlated with both depression,  $r = .541, p < .001$ , and anxiety,  $r = .561, p < .001$ , indicating that higher EL may be linked to greater psychological distress. Similar results were observed by Tsaga et al. (2024), who reported correlations between existential loss with emotional reactions,  $r = .586, p < .001$ , further implying that a disrupted sense of meaning and purpose during grief contributes to heightened emotional distress.

To examine the potential protective role of PF, H3 predicted that higher levels of PF would result in higher psychological wellness after the loss of a loved one. The results of the correlational analyses indicated that individuals who reported high levels of psychological distress (based on scores from GAD-7 and PHQ-9) had lower scores on the CompACT subscale and total scores. These findings further support the hypothesis that higher PF is associated with lower levels of anxiety and depression, aligning with the findings of Martin and Pakenham's (2022), who reported negative correlations between CompACT scores and psychological distress.

Based on the literature and theoretical models, I expected that PF and coping measures would be strongly and positively correlated (Tindle et al., 2022). Therefore, H4 predicted that higher coping scores (using the CABLE subscales and total scores) would be positively correlated with PF scores (using the CompACT subscales and total scores), but this hypothesis was not supported, as correlational analyses revealed only a few weak correlations. A potential explanation for this is emphasized by Murrell et al.'s (2018), in which they suggested that although PF is heavily correlated with coping in other settings, due to the emotionally intense and complex experience of bereavement, individuals may rely on coping strategies that are more immediate or instinctive, such as avoidance. While EA can be adaptive in the short-term by facilitating resilience in the grieving process, helping individuals process painful emotions and return to normalcy when ready (Murrell et al., 2018; Stone et al., 2024), its use as a long-term strategy can hinder and prolong grief, negatively impacting healthy aspects of coping, such as acceptance (Murrell et al., 2018; Stone et al., 2024). Additionally, because the CABLE was designed for individuals experiencing bereavement, its weak correlations with relevant subscales of the BEQ-24, such as Spiritual Support and Positive Outlook (see Table 6), raises concerns about its full validity in capturing all emotional aspects of grief. Thus, further testing is needed to ensure the validity of this scale.

Furthermore, H5 predicted that individuals with lower levels of EA would have lower depression and anxiety levels following the loss of a loved one. Upon correlational analyses, strong positive correlations were observed between EA and psychological distress. These results align with Murrell and colleagues (2018) who reported that individuals who had higher levels of EA experienced more difficulty with psychological distress during the bereavement experience.

Finally, H6 predicted that after controlling for demographic variables and the effects of AG and bereavement, high levels of PF and adaptive coping would result in lower depression and anxiety. The regression analyses revealed that bereavement, specifically existential loss, significantly predicted both depression (PHQ-9) and anxiety (GAD-7) symptoms, even after controlling for demographic variables. PF and adaptive coping strategies, such as valued action, were significant predictors of lower psychological distress, particularly in models predicting depression. Among participants who reported an anticipated loss, bereavement remained a strong predictor of depression and anxiety, but additional predictors from PF and coping did not significantly improve the model. With respect to depression, the findings that PF and coping strategies, which likely involve acceptance, are important in reducing psychological distress. This aligns with Davis and associates (2017) conclusions, in which they found that acceptance (a key component of ACT) was effective in reducing AG among patients in palliative care. This highlights the role of acceptance in mitigating emotional distress related to AG and further emphasizes the role that AG can play with respect to the actively dying individual themselves (potentially beneficial) or their surrounding relationships that they will leave behind (potentially detrimental).

Although AG was not a significant predictor of depression (PHQ-9), it was a significant predictor of anxiety (GAD-7), suggesting that the emotional and psychological processes captured by the AGS, such as worry, fear of impending loss, and heightened distress, are more closely associated with anxiety symptoms than symptoms of depression. As noted by Burke and associates (2015), individuals who exhibit anxiety symptoms, such as excessive worry and apprehension, may be more directly influenced by AG. Depression may be more strongly linked to the broader experience of bereavement itself (see Assareh et al., 2015). These results highlight

the importance of understanding the distinction between bereavement and AG, while focusing on the specific emotional dynamics of AG when addressing anxiety in individuals facing an expected loss.

### **The Role of Relationship Strength**

The qualitative descriptions of participants' relationship to the deceased in the demographics emphasized the profound impact of bereavement regardless of the relationship type. Individuals reported feelings of loneliness and sadness whether the relationship was intimate or peripheral – which suggested a potential negative impact on psychological wellbeing, similar to what Reynolds and Botha (2006) found in their study. The nature of these relationships shaped participants' experiences of loss in distinct ways. With respect to intimate relationships, one individual described their grandmother as “A mother to me. We were extremely close, and I lived with her most of my life. She never missed a birthday, holiday, sporting event, or achievement.” Others reflected on the long-term impact of a parent's loss, even when distance/time had altered their relationship. “My dad was a strong, quiet man who [...] gave my sister and I a wonderful childhood... I didn't really get to see him grow old and took his age for granted much of the time.”

Individuals who reported that their loss was to a peripheral relationship also shared significant emotional experiences after the loss of their loved one. Responses illustrated how colleagues and friends became deeply embedded in participants' lives, shaping their work and personal growth: “He was my creative partner and great friend. All of my work was tied together with him.” Others described friendships that evolved into profound bonds: “We started as colleagues and then became close friends. She was the first adult friend in my life that I lost to cancer, and it was because she did not get timely diagnostic care that she died, which was

heartbreaking.”. Despite not being in close contact daily, the loss experienced by these individuals still carried immense weight, further supporting research conducted by Widera and Block (2012) who emphasized the notion that even when mentally preparing to lose someone due to a terminal condition such as cancer, AG can still lead to significant suffering after a loss has occurred.

Additionally, some participants encountered complex losses, such as the cognitive decline of a loved one. The complex transition from normal function to dementia was highlighted by participants; “She always had a heart of gold... but she began forgetting little things or having trouble finishing sentences. She was diagnosed with Alzheimer’s shortly after.”. These experiences emphasize the notion of how losing someone, whether peripheral or intimate, is not always a single event but sometimes a series of events. This can further extend periods of AG and provides support for the notion that it may also complicate and exacerbate the psychological response to the loss of a person (Nielsen et al., 2016; Reynolds & Botha, 2006; Widera & Block, 2012; Zilberfein, 1999)

### **Limitations of the Current Study**

There are limitations to the present study that are worth noting. Prior to data collection, I anticipated that it may be difficult to accumulate a large sample size of undergraduate students who had lost a loved one in the past two years. To mitigate this, I expanded recruitment through promotion on Facebook and Instagram and also through Prolific. However, after data conditioning, the final sample size remained smaller than expected. A priori power analyses specified that a minimum of 92 participants was required for hypothesis testing, my goal was to collect a minimum of 200 participants to account for equal male and female representation. Upon completion of data collection, there were a total of 362 participants that consisted of UNB

undergraduate students, Prolific participants, and the general population; however, after data cleaning, a total of 195 participants (54.01%) had experienced the death of someone in the past two years and fit the criteria to be included in the current analyses. Many participants who answered “no” to the initial question about losing someone in the past 24 months were likely from SONA, where undergraduates received bonus points for participation. These respondents were redirected to the end of the survey, resulting in a smaller-than-anticipated final sample size, though statistical power remained adequate.

Another limitation of the current study was the uneven gender distribution. Although providing a more equal distribution than other studies, there was a higher proportion of women participants compared to men and other genders. Specifically, 65% ( $n = 127$ ) of the sample identified as women, while men accounted for only 33.88% ( $n = 66$ ), and only 1.11% ( $n = 2$ ) of the sample identified as another gender. As a result, men and individuals who identify as another gender who have experienced grief are underrepresented, which may limit the generalizability of the findings to their respective populations.

Given that the sample for this study consisted of younger adults ( $M_{age} = 29.15$ ;  $SD = 13.17$ ), it is also important to acknowledge that their limited personal experience with loss may have affected the relevance and applicability of the findings to those who are older and/or have experienced more substantial grief over a longer period. Their perceptions of grief may differ from individuals with more experience, potentially influencing their understanding and emotional responses. This difference in experience could impact the extent to which AG and PF are correlated, as those with previous loss may have developed more adaptive coping mechanisms or a more nuanced understanding of grief.

Finally, this study was conducted entirely online, which provided a diverse participant pool but also introduced challenges. Sampling bias may have occurred due to limited internet access, social media engagement, or participants avoiding the study to prevent emotional discomfort. Additionally, some participants failed to complete over 80% of the survey and were removed, reducing the final sample size. It is likely that individuals with higher PF may have been more willing to engage in the study, this may have resulted in an unbalanced representation, potentially affecting the generalizability of the findings.

### **Future Research**

To address some of the limitations of the current study, future researchers could replicate the current results with a larger sample size that includes a more equal representation of genders. Although the online format of this study allowed for a broader age and geographic range of participants, it also led to the inclusion of many individuals outside of the target population, resulting in a significant reduction of participants eligible for analysis. Additionally, adding a question to the questionnaire regarding how other family members or friends have handled similar losses could provide valuable insight. For example, if a participant is undergoing AG and anticipating the loss of their father, understanding how the mother copes during this time might influence the participant's own grief process and reveal potential dynamics that may either support or complicate the individual's emotional experience, especially in cases where family members might adopt different coping strategies.

The findings of this study highlight the significant impact of recent loss on psychological wellness, particularly in relation to anxiety. Although coping style did not emerge as a strong predictor in regression models, aspects of PF did, suggesting that PF may play a critical role in mitigating distress during bereavement. Future research should explore targeted interventions

aimed at enhancing PF in individuals experiencing AG or bereavement. Additionally, future research could explore how palliative care units foster PF through psychosocial support and grief counseling. Examining their impact on PF may reveal strategies to enhance bereavement care and reduce anxiety and depression in grieving individuals.

Although the current results indicated that AG was associated with heightened anxiety in individuals who experienced a loss, it could still be very beneficial to the dying individual. As Fegg and colleagues (2010) denoted, terminally ill patients living in palliative care settings may embrace the feelings of grief and have a priority shift – focusing more on close relationships and spirituality as their condition progresses. Additionally, compared to healthy individuals, terminally ill patients may reshape their sense of meaning, placing greater emphasis on emotional and relational fulfillment rather than external experiences (Fegg et al., 2010). Future research should explore these differing effects, particularly within the context of Medical Assistance in Dying (MAID). Moreover, although the age of the deceased did not appear to play a major role in psychological outcomes, future studies could examine whether other contextual factors such as the quality of the relationship with the deceased, the circumstances of the loss, or the availability of social support moderate the impact of PF on mental health.

Finally, to mitigate sampling bias, future research could aim to include a more diverse sample, with a focus on specific aspects of bereavement. This could involve intentionally recruiting individuals at different stages of grief, including those with varying degrees of experience in coping with loss, and ensuring a balance of participants with both low and high PF. Additionally, using different recruitment strategies, such as targeting support groups or healthcare professionals, could help reach individuals who might otherwise avoid participating.

Understanding this bias would be essential in interpreting the results and refining future studies on bereavement, AG and PF.

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**Appendix A****Demographics Questionnaire**

What is your age?

- \_\_\_\_\_

Are you a student at the University of New Brunswick

- Yes
- No

**[IF AGE <19 YEARS AND UNB STUDENT = NO, GO TO THE END OF QUESTIONNAIRE PACKAGE]**

Have you experienced the death of someone you knew in the past 24 months?

- Yes
- No

**[IF NO, GO TO THE END OF QUESTIONNAIRE PACKAGE]**

**When you answer these questions, consider the period before the death of your loved one. If you have lost more than one person in the past 24 months, think of the most impactful loss.**

What was the primary cause of death?

- Cancer
- Alzheimer's/Other dementias
- Degenerative conditions, such as Parkinson's Disease
- Autoimmune conditions, such as MS or ALS
- Cardiovascular disease, including unmanaged blood pressure
- Organ failure, such as kidney or liver failure
- Psychological disorders, such as major depression or eating disorders
- Sudden death, such as suicide, heart attack, accident
- Other: \_\_\_\_\_

**[IF SUDDEN, EXCLUDE FROM ANTICIPATORY GRIEF QUESTIONNAIRE]**

What was your relationship to your loved one?

- Parent
- Spouse/Partner that I live with
- Romantic partner that I don't live with
- Child
- Sibling
- Grandparent
- Another family member
- Friend
- Other: \_\_\_\_\_

What is the gender of your loved one?

- Male

- Female
- Transgender
- Non-binary
- Genderfluid
- Two-spirit
- Other: \_\_\_\_\_

Could you describe the relationship?

- \_\_\_\_\_

What was the age of the person you lost?

- \_\_\_\_\_

When were they diagnosed (year)?

- \_\_\_\_\_

Did you provide care for the individual?

- Yes
- No

**[If yes, what percentage of the care were you responsible for? Scale from 0-100.]**

How would you describe their quality of life after their diagnosis?

- Very good
- Good
- Fair
- Poor
- Very poor

How long were they ill before they passed away?

- \_\_\_\_\_ months
- \_\_\_\_\_ years

What is your gender?

- Male
- Female
- Transgender
- Non-binary
- Genderfluid
- Two-spirit
- Other: \_\_\_\_\_

What is your current marital status?

- Single
- Married
- Common-law
- Divorced
- Widowed
- Dating casually
- I have a long-term partner I do not live with

What was your marital status at the time of your loved one's death?

- Single
- Married (they were my spouse)
- Common-law

- Divorced
- Widowed
- Dating casually
- I have a long-term partner I do not live with

Are you currently employed [check all that apply]

- No
- Full-time employment
- Part-time employment
- Full-time student
- Part-time student
- Volunteer

Were you employed at the time of your loved one's death?

- Yes
- No

In the period before the death, did you experience psychological symptoms such as depression and anxiety?

- Always
- Most days
- Sometimes
- A few days
- Rarely

Did you experience any physical symptoms of grief (e.g., fatigue, insomnia, loss of appetite) before their passing?

- Always
- Most days
- Sometimes
- A few days
- Rarely

**Appendix B**

**Anticipatory Grief Scale (AGS; Theut et al., 1991)**

**When you fill out this scale, consider the period before the death of your loved one. If you have lost more than one person in the past 24 months, think of the most impactful loss.**

The following statements represent feelings and attitudes of some people connected to individuals with life threatening diagnoses.

Respond to the statements based on how you felt during the time after their diagnosis and before their death

Read each statement carefully and select the option that most closely reflects your degree of agreement or disagreement.

Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
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1. I daydreamed about how life *was* with my loved one before they died.
2. I felt close to my loved one *in the time before their death*.
3. I seemed to be more irritable *after my loved one's diagnosis*.
4. I was preoccupied with thoughts about my loved one and *their illness*.
5. I discovered new personal resources since my loved one's illness *was diagnosed*.
6. I very much missed my loved one *and the way they used to be prior to the diagnosis*.
7. I felt very much alone since the diagnosis was made.
8. I *was* able to move ahead with my life.
9. I blamed myself for *my loved one's illness*.
10. I found it hard to concentrate on my work *after the initial diagnosis was made*.
11. I had the personal resources to help me cope with my loved one's illness.
12. I *had* periods of tearfulness as I *thought* about the course of my loved one's illness.
13. I *felt* detached from my loved one *in the time before their death*.
14. I *felt* a need to talk to others *about my loved one's illness*.
15. I *felt* it was unfair that my loved one had *this diagnosis*.
16. I *found* it hard to sleep *after the diagnosis was made*.
17. I *felt* that no one *would* ever take their place in my life.
18. I avoided some people *after my loved one was diagnosed*.
19. I *felt* I had adjusted to their illness.
20. Since *my loved one* was diagnosed, I *found* it more difficult to get along with certain people.
21. I wondered what my life would be like if they had not been given *their diagnosis*.
22. I *felt* more competent *after my loved one was diagnosed with their illness*.
23. I *got* angry when I *thought* about my *my loved one's diagnosis*.
24. Since the diagnosis was made, I *didn't* feel interested in keeping up with day-to-day activities (TV, newspapers, friends).
25. I was unable to accept the fact that my loved one had *their diagnosis*.
26. *My functioning didn't change after my loved one was diagnosed*.
27. I *still* planned for the future.

### Appendix C

#### Bereavement Experience Questionnaire-24 (BEQ-24; Guarnaccia & Hayslip, 1998)

The statements below are thoughts and feelings that bereaved people sometimes have. Read each statement carefully and choose how often you have experienced this thought or feeling in the past month, including today.

Never (0)	Sometimes (1)	Often (2)	Almost always (4)
-----------	---------------	-----------	-------------------

1. Felt life has no meaning
2. Found myself searching for the one who died
3. Thought I contributed to the death
4. Yearned for the deceased person
5. Lost my religious faith
6. Lost interest in my work
7. Thought I was losing my mind
8. Lost interest in activities I previously cared about
9. Felt like I was watching myself go through the motion of living
10. Felt the deceased was/is guiding me
11. Felt a need to be emotionally close to someone
12. Felt that some person was responsible for the death
13. Felt guilty about some things I said or did after the death
14. Spent time looking at deceased's pictures, clothing, belongings
15. Felt emotionally distant from people
16. Thought that there were some very real reasons why I feel guilty
17. Felt guilt about things I did/said before the death
18. Felt angry at myself
19. Felt guilty about little, unimportant things
20. Felt angry at the deceased person
21. Was preoccupied with thought of the deceased person
22. Felt afraid to be alone
23. Could not bear to sort or part with the deceased's belongings
24. Felt unable to recall the deceased's image.

## Appendix D

## Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly half the days
Little interest or pleasure in doing things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed, or hopeless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling or staying asleep, or sleeping too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tired or having little energy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite or overeating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Appendix E**

**Generalized Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006)**

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being so restless that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid, as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Appendix F

### Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011)

Below are 10 statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate how true these statements are for you by clicking for your response. Please be open and honest in your responding.

Never true (1)	Rarely true (2)	Sometimes true (3)	Neutral (4)	Often true (5)	Usually true (6)	Always true (7)
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1. It's OK if I remember something unpleasant
2. My painful experiences and memories make it difficult for me to live a life that I would value
3. I'm afraid of my feelings.
4. I worry about not being able to control my worries and feelings.
5. My painful memories prevent me from having a fulfilling life.
6. I am in control of my life.
7. Emotions cause problems in my life.
8. It seems like most people are handling their lives better than I am.
9. Worries get in the way of my success.
10. My thoughts and feelings do not get in the way of how I want to live my life.

## Appendix G

### Coping Assessment for Bereavement and Loss Experiences (CABLE; Crunk et al., 2021)

**Below are statements of feelings of certain individuals who have lost someone and undergone the bereavement experience.** Read each statement carefully and click the circle which most closely reflects the how often in the past two weeks that you have experienced these statements.

Never (0)	Once (1)	A few times (2)	Nearly every day (3)	Daily (4)
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1. I reached out to others for comfort and companionship.
2. I identified supportive individuals to turn to when I am experiencing feelings of grief.
3. I told someone how much I love or care for them.
4. I engaged in an act of kindness toward someone.
5. I cared for or nurtured others.
6. I turned to my spirituality or religion for comfort (for example, prayer or scripture reading).
7. I attended a meeting or service related to my faith (for example, synagogue or church service).
8. I sought help from organized bereavement support groups.
9. I attended grief therapy sessions from a mental health professional.
10. I read self-help books about the grieving process or coping with grief.
11. I consulted professional resources (for example, Internet websites) to help me cope.
12. I visited websites that focus on the grieving process.
13. I reminded myself of the things I am thankful for.
14. I talked to my loved one in my mind or out loud.
15. I regularly set aside time by myself to express my grief and to remember my loved one.
16. I focused on the things I am doing to get better, rather than on how bad things are.
17. I reminded myself of my strengths.
18. I posted reminders of how to cope during difficult times in visible locations to look at when I am struggling.
19. I made notes of how well I am doing.
20. I took steps to regain my sense of hope, such as creating goals for the future.
21. I took steps toward a "new me" by coming up with some new goals or plans for my life.
22. I reviewed photos or videos of my loved one.
23. I sought comfort in a keepsake or object that reminds me of my loved one.
24. I turned to my spirituality in order to experience hopefulness or peace.
25. I set aside time to talk to God or my Higher Power about my grief.
26. I looked for companionship by exploring new friendships.
27. I turned to others for positive feedback or praise.
28. I did things or went places that once held special meaning for my loved one and me.

**Appendix H**  
**The Comprehensive Assessment of Acceptance and Commitment Therapy processes**  
**(CompACT; Francis et al., 2016)**

Please rate the following 23 statements using the scale below:

Strongly disagree	Moderately disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Moderately agree	Strongly agree
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1. I can identify the things that really matter to me in life and pursue them
2. One of my big goals is to be free from painful emotions
3. I rush through meaningful activities without being really attentive to them
4. I try to stay busy to keep thoughts or feelings from coming
5. I act in ways that are consistent with how I wish to live my life
6. I get so caught up in my thoughts that I am unable to do the things that I most want to do
7. I make choices based on what is important to me, even if it is stressful
8. I tell myself that I shouldn't have certain thoughts
9. I find it difficult to stay focused on what's happening in the present
10. I behave in line with my personal values
11. I go out of my way to avoid situations that might bring difficult thoughts, feelings, or sensations
12. Even when doing the things that matter to me, I find myself doing them without paying attention
13. I am willing to fully experience whatever thoughts, feelings and sensations come up for me, without trying to change or defend against them
14. I undertake things that are meaningful to me, even when I find it hard to do so
15. I work hard to keep out upsetting feelings
16. I do jobs or tasks automatically, without being aware of what I'm doing
17. I am able to follow my long terms plans including times when progress is slow
18. Even when something is important to me, I'll rarely do it if there is a chance it will upset me
19. It seems I am "running on automatic" without much awareness of what I'm doing
20. Thoughts are just thoughts – they don't control what I do
21. My values are really reflected in my behaviour
22. I can take thoughts and feelings as they come, without attempting to control or avoid them
23. I can keep going with something when it's important to me

## Appendix I

### REB Approval Letter

Prof. Lisa Best  
Department of Psychology  
University of New Brunswick Saint John

Professor Best:

As Chair of the University of New Brunswick (UNB) Research Ethics Board (REB), I have reviewed your ethics application for the project entitled "Preparing for the Inevitable: Investigating the Role of Anticipatory Grief and Psychological Flexibility on Mental Well-Being" which has been assigned the file number **REB 2024-188**. On the basis of the review, I consider your project to be eligible for delegated review, since any risk to participants that might exist appears not to exceed the "minimal risk" outlined in the Tri-Council Policy Statement, 2nd edition (TCPS2). I am also pleased to inform you that, in my opinion, your project is in compliance with TCPS2 and the University Policy on Research Involving Humans (UPRIH). **Accordingly, please consider this E-mail to represent official notification of REB approval of your project. This REB approval is in effect from November 18, 2024 to November 18, 2027.**

**NOTE 1:** In the "Contact Information" section on Page 2 of your Informed Consent Form (Appendix I), would you please insert the assigned REB Project number into your phrase "This project has been reviewed by the University of New Brunswick Research Ethics Board and is on file as REB 2024-188."? Then, would you please email to me (cc to <ethics@unb.ca>) a copy of that modified document for our records? There is no need to send a revised version of the whole application.

If you require an official hardcopy letter of this approval to satisfy a funding body, please inform the UNB Research Ethics Board office <ethics@unb.ca> as soon as possible. If the funds for this research project are held until REB approval, then please inform UNB Fredericton's Office of Research Services of this approval in order to release your funds.

Please note that, in the future, if you find that you must make any changes to your protocol, those changes must be considered and approved by the REB before they are implemented. Please submit the REB Case Modification Request form, available online through the Research Ethics page of the Office of the VP (Research).

Also please note that you are obliged to advise the REB of any adverse event(s) that occur during this approval period. An adverse event includes — but is not limited to — a complaint, a change or unexpected event that alters the level of risk for the researcher or participants, or a situation that requires a substantial change in approach to a participant or participants.

Finally, Annual Reports for this project are due on the 15th of January each year, provided that this date is at least six months after the date of this project approval. Final reports are due 90 days after project completion. Form templates for both of these reports can be found on our website at <https://www.unb.ca/research/vp/ethics.html>.

Best wishes for the successful completion of your research project.

— David

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**David Coleman**

Chair • UNB Research Ethics Board  
Professor Emeritus • UNB Fredericton  
T 506 453-5189 E [dcoleman@unb.ca](mailto:dcoleman@unb.ca)

## **Appendix J**

### **Social Media Post – Sample Script**

Dr. Lisa Best and I are researchers from the University of New Brunswick in Canada. We are interested in understanding the impact of anticipatory grief (the grief process that occurs before the death of a loved one) and its effects on well-being.

We are inviting you to complete a 30-minute survey that includes questions about a loved one you have lost in the last 2 years, your mental wellbeing, coping skills, and mindfulness practices. If you are interested in participating, please use the following link to access the study: \_\_\_\_\_.

In appreciation for your participation, you will have the opportunity to enter a draw prize for one of three \$20 Amazon gift cards. Research such as this is important and will aid in our understanding of how to help ameliorate the wellbeing of individuals who struggle with feelings of grief before and after a loss.

## Appendix K

### Informed Consent Form

**Title of the study:** Preparing for the Inevitable: Investigating the Role of Anticipatory Grief and Psychological Flexibility on Mental Well-Being

**Investigator(s):** Robyn Moore, Honours Student, Department of Psychology, University of New Brunswick, [robyn.moore@unb.ca](mailto:robyn.moore@unb.ca).

**Supervisor(s):** Dr. Lisa Best, Professor, Department of Psychology, University of New Brunswick, [lbest@unb.ca](mailto:lbest@unb.ca)

**Please read the following information carefully before agreeing to participate in this research study.**

#### Purpose of the Study

The purpose of this study is to examine the experiences of anticipatory grief in individuals from varying backgrounds who have lost someone significant in their lives from terminal illness and to assess how these experiences impact their overall psychological well-being and distress. In order to address the evident gaps in the literature that pertain to psychological flexibility and anticipatory grief, we aim to explore the role of psychological flexibility in shaping feelings of anticipatory grief and to determine whether it strengthens or weakens the relationship between anticipatory grief and psychological well-being.

**This study is open to individuals older than 19 years and to University of New Brunswick students.**

#### Participation

Your participation in this study is voluntary. Should you wish to withdraw from the study at any point, you are free to do so. The study will take approximately 20 minutes to complete. Any information provided by you throughout the study will be strictly confidential. You will not provide your name or contact information. The unidentified data will be stored on an encrypted and password protected hard drive stored in a secure UNB laboratory. Any information that you provide will be only used for the purposes of this study. No individuals will be singled out or identified in this study when reporting the findings. Depending on where the findings are published, the unidentified data could be accessed by other researchers for review and quality control purposes before publication. Only the data pertaining to the specific analyses would be provided and answers to demographics questions would NOT be provided to avoid re-identification of participants. Data cannot be withdrawn once it is made publicly available.

#### Qualtrics

The study will be completed online via Qualtrics, an online survey platform. Qualtrics provides information on the confidentiality of the data here: [Privacy Statement - Qualtrics](#)

Data from Qualtrics is stored on Canadian servers in Toronto, Ontario.

### **Compensation**

Students enrolled at the University of New Brunswick will be awarded one half of a bonus point towards their final grade in the participating course. Speak with your professor if you wish to receive half a bonus point without completing the study by submitted additional course work. All other participants will be given the option to be entered in a draw for one of 3 \$20 Amazon gift cards upon completion of the study. Participants will be directed to a separate survey to enter personal information required for bonus points or to reach you if you win the gift card, which will not be linked to survey responses. You are free to skip any question(s) on the questionnaire(s). You may discontinue your participation in the study at any time without penalty.

### **Risks & Benefits**

The benefits of this study include helping us develop knowledge on the role of psychological flexibility and anticipatory grief on psychological wellness. There is no risk associated with participating in the study, although some questions ask you to reflect on a death of someone who had a terminal illness that you are connected to that occurred over the last two years, it also asks about your health, mental health, and coping experiences. Some of these questions could potentially be mildly distressing. Should you believe that you require access to mental health or grief support you can consult the resources below. This list will also be shown in the “debriefing” after you complete the survey.

### **Contact Information**

This study is being conducted by Robyn Moore ([robyn.moore@unb.ca](mailto:robyn.moore@unb.ca)) and Dr. Lisa Best (506-648-5562, [lbest@unb.ca](mailto:lbest@unb.ca)) in the Psychology Department at the University of New Brunswick, Saint John.

Note: If you wish to be notified of the results when this study is completed, please email the investigators of this study at [robyn.moore@unb.ca](mailto:robyn.moore@unb.ca) or [lbest@unb.ca](mailto:lbest@unb.ca) at your convenience.

This project has been reviewed by the Research Ethics Board of the University of New Brunswick and is on file as REB#2024-188. Participants who wish to discuss this study with someone who is not directly involved in the research can contact Dr. David Coleman, Chair of the ethics committee at (506) 453-5189, [dcoleman@unb.ca](mailto:dcoleman@unb.ca)[mailto:](mailto:dcoleman@unb.ca)

By clicking the box below, I confirm that I have read the information on the INFORMED CONSENT FORM and volunteer to participate in this study.

**Appendix L**  
**End of Survey**

**Thank you. Your response has been recorded (if individuals are immediately directed to the end of the survey).**

1. Are you a student at the University of New Brunswick, Saint John campus who wishes to receive 0.5 bonus point in an eligible course?
  - a. Yes (directed to separate survey).
  - b. No
  
2. Are you a community participant who wishes to be entered into a draw for the chance to win 1 of 3 \$20.00 Amazon gift cards?
  - a. Yes (directed to separate survey).
  - b. No

Separate survey for students:

1. Please type your first and last name to receive your bonus point (this information will not be linked to survey responses).
  - a. \_\_\_\_\_

Separate survey for community participants:

2. Please provide your email address so you can be notified if you have won the draw for 1 of 3 Amazon \$20.00 gift cards (this information will not be linked to survey responses).
  - a. \_\_\_\_\_

## Appendix M

### Debriefing Form

#### Debriefing

Thank you for taking the time to complete our survey “**Preparing for the Inevitable: Investigating the Role of Anticipatory Grief and Psychological Flexibility on Mental Well-Being**”. This study was designed to examine the role of anticipatory grief and psychological flexibility and its pillars in psychological well-being. If psychological flexibility is found to contribute to the process of anticipatory grief, then it may be a target for grief through Acceptance and Commitment Therapy (ACT); a kind of therapy that focuses on enhancing psychological flexibility. If you would like to receive a summary of the results after the study is completed, please contact us at [lbest@unb.ca](mailto:lbest@unb.ca) or [robyn.moore@unb.ca](mailto:robyn.moore@unb.ca).

If after completing the study you require mental health or grief resources, please consult the resources below. If you are in an emergency, call 911.

#### CANADA RESOURCES:

##### **Mental Health and Grief Support Resources. If you are in an emergency, dial 911**

Wellness Together Canada: <https://wellnesstogether.ca/en-CA>

Wellness Together Canada: If you are in distress, text WELLNESS to 741741

National Suicide Prevention Hotline: 1-800-273-8255

If you require referrals to services, dial 211.

Canadian Grief Alliance: <https://www.canadiangriefalliance.ca/>

Healthy Gamer: <https://www.healthygamer.gg/>

Northwest Territories Helpline: 1-800-661-0844

Northwest Territories Bereavement Helpline: 604-738-9950

Nunavut Elder Support Line: Toll-free 1-866-684-5056

Nunavut Kamatsiaqtut Help Line: 1-867-979-3333 or Toll-free at 1-800-265-3333 (24 hours).

Nunavut Residents can also call the NWT Crisis/Helpline: 1-800-661-0844

Hospice Yukon Grief Support Group: Call 867-667-7429 or visit

<https://hospiceyukon.net/en/services/grief-groups/>

Canadian Mental Health Association, Yukon Division: (867) 668-6429

Yukon Territorial Health Information Line: 8-1-1, or dial (604)-215-4700 if calling from a satellite phone.

British Columbia Crisis Intervention and Suicide Prevention Centre: Call 1-800-784-2433 (1-800-Suicide) or visit <http://crisiscentre.bc.ca>

British Columbia Bereavement Helpline: Call (604) 738-9950 or toll free 1-877-779-2223.

Alberta Mental Health Helpline: 1-877-303-2642

Alberta Health Services – Grief & Bereavement Support:

<https://www.albertahealthservices.ca/info/Page13161.aspx>

Saskatchewan Mental Health & Addiction Services Directory (Select “Find Mental Health and Addictions Services in My Community”):

<https://www.saskatchewan.ca/residents/health/accessing-health-care-services/mental-health-and-addictions-support-services>

Saskatchewan North East Outreach and Support Services:(800) 611-6349

Manitoba Suicide Prevention & Support Line: 1-877-435-7170 (1-877-HELP170)  
Ontario Mental Health Helpline: 1-866-531-2600  
Quebec Preventing Suicide: 1-866-277-3553  
Quebec Health Resources: <https://www.quebec.ca/en/health/health-issues/a-z/>  
New Brunswick Suicide Prevention CHIMO Helpline: 1-800-667-5005  
Nova Scotia Provincial Mental Health and Addictions Crisis Line: 1-888-429-8167  
Prince Edward Island Mental Health and Addictions Phone Line: **1-833-553-6983**  
Prince Edward Island - The Island Helpline: 1-800-218-2885 (toll-free)  
Newfoundland & Labrador Provincial Mental Health Crisis Line: 1-888-737-4668 or (709) 737-4668  
Newfoundland & Labrador Mental Health and Addictions Systems Navigator: 1-877-999-7589 or (709) 752-3916  
Newfoundland & Labrador CHANNEL Peer Support Warm Line: 1-855-753-2560 or (709) 753-2560

## USA RESOURCES

### **Mental Health & Grief Support Resources. If you are in an emergency, dial 911**

988 Suicide & Crisis Lifeline: Call or text 988.  
Crisis Text Line: Text HOME to 741741  
National Helpline: 1-800-662-HELP (4357)  
Disaster Distress Helpline: 1-800-985-5990  
Grief and Loss Hotline: 866-903-3787  
Healthy Gamer: <https://www.healthygamer.gg/>  
StrongHearts Native Helpline: 1-844-762-8483  
National Grad Crisis Line: 1-877-472-3457  
Su Familia: The National Hispanic Family Health Helpline: 1-866-783-2645  
Centerstone Military Services: 1-866-781-8010  
Vets4Warriors: 1-855-838-8255  
Physician Support Line: 1-888-409-0141  
National Alliance on Mental Illness NAMI Helpline: 1-800-950-6264 or text NAMI to 741-741

Appendix N

TCPS 2 Certificate of Completion

