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Changing Perceptions of Loss: The Influence of Generation Effects and Message Framing

Kaylee Brown

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Changing Perceptions of Loss: The Influence of Generation Effects and Message Framing

Abstract
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Natalie Dove

Second Advisor
Dr. Carol Freedman-Doan

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CHANGING PERCEPTIONS OF LOSS: THE INFLUENCE OF GENERATION EFFECTS AND MESSAGE FRAMING

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Supervising Instructor, Dr. Natalie Dove

Honors Advisor, Dr. Natalie Dove

Department Head, Dr. Carol Freedman-Doan

Honors Director, Dr. Rebecca Sipe
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Abstract

This study is a three-part survey that examines how loss can be experienced differently based on one’s generation and the way a message about loss is framed. More specifically, participants of all ages read a mock article that framed loss experiences positively or negatively, and then participants answered questions regarding their own loss experiences. It was hypothesized that, due to generational variance, older vs. younger individuals may deal with loss quite differently and, as such, may react to the positively and negatively framed loss articles as a function of their ages. As hypothesized, significant relationships among article type and age group were found with regard to participants’ coping habits. Younger individuals (ages 18-34) reported more positive coping behaviors after viewing the negatively framed article, but middle aged individuals (ages 35-51) reported more positive coping behaviors after viewing the positively framed article. Overall the oldest population (ages 52-75) reported the most positive coping. The results of this study have tangible clinical implications because professionals may impact clients’ perceptions of loss positively based upon the framing of their messages, which ultimately may have an impact on that client’s grief journey and their overall view of professional services.
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As the stigma around mental health decreases, more Americans are seeking mental health treatment. In a 2004 telephone survey consisting of 1,000 randomly selected Americans between the ages of 18-64, the American Psychological Association (APA) found that “more than nine out of 10--91 percent--said they would likely consult or recommend a mental health professional if they or a family member were experiencing a problem” (Chamberlin, 2004). The question remains of what is considered a “problem” that may lead someone to seek professional services. One experience that may result in an individual seeking treatment is an experience of loss or grief. The word “grief” may have different meanings among different groups of people. A loss can truly mean any life changes, from simply changing a behavior pattern to devastating losses of loved ones. This prompts social science researchers to study and develop ways for clinicians to effectively help facilitate change to the wide range of lived experiences that may appear in their work.

The understanding of loss and grief has changed dramatically, shifting from an individual and psychological process via Freud’s work in the early 1900s after the loss of his daughter to a more social construct-based understanding. This helps us see that grief is an ongoing reorientation that occurs in two spheres which cannot be separated: “the internal sphere of emotions, beliefs and cognitions and the external sphere of roles and behaviors” (Versalle & McDowell, 2005, p. 54). This distinction has propelled new research that utilizes a variety of empirically-based treatments to help increase functioning after a loss and to restore individuals to optimal functioning. There is an understanding amongst those in this field that unresolved grief can linger and negatively impact individuals. For example, it can...
allow them to become distanced from other people and the world, which only hinders them from integrating the loss into their lives and being able to move forward.

Discussions regarding whether grief is different from depression have led some professionals to argue for a Diagnostic and Statistical Manual of Mental Disorder (DSM) diagnosis for grief and loss to be added. Supporters of this change cite that “inclusion of complicated grief into a diagnostic taxonomy will encourage research to develop effective treatments” (Harwood, 2005, p. 283), along with noting the differences in grief responses in comparison to DSM diagnosis already included, such as PTSD or adjustment disorder. The issue with moving forward with this is two-fold: 1) loss is a natural part of life, and 2) how we experience loss is intertwined with our culture and our identities.

Within the conditions for further study section of the DSM-5, there is a discussion about Persistent Complex Bereavement Disorder (American Psychiatric Association, 2013, p. 789-792). This disorder is directly related to death as a form of loss, which is not the only type of loss that can impact an individual. Importantly, the DSM does differentiate between loss experienced by adults and children differently. Although more research needs to be done on this topic, it is important that the American Psychiatric Association is noticing “grief responses may manifest in culturally specific ways” (APA, 2013, p. 791) and that they may be age dependent.

As mentioned earlier, other aspects of one’s identity may influence whether loss is accompanied by grief. The issue of varying facets of identity in therapy is one of the primary motives behind the current research study. As a behavioral psychologist might point out, although grief is a universal experience found in all human and non-human cultures (Klass, 2013, p. 5), much of our reaction to a loss has to do with “past experiences of loss and age”
(Bevan & Thompson, 2003, p. 183). Just as individuals cannot separate their past experiences and learned responses to grief in their culture, we cannot separate the pieces of our identity which impact our socialization process, even as clinicians.

A number of different identity facets have the potential to influence the experience and perceptions of loss. Research has focused heavily on the prioritization of the social divisions of class, race and gender at the expense of other characteristics such as age, disability and sexual identity (Bevan & Thompson, 2003, p. 180). As such, the current study examined the potential effect of age on experiences with loss. Prior research has found that, when treating loss victims, ageism primarily hurts very young children, who could not be studied for this particular project, and older adults. This is due to society viewing these groups as “in need of protection, more dependent, and less able to make choices and decisions” (Bevan & Thompson, 2003, p. 181). This may make them more likely to receive differential treatment from not only their support systems, but from professionals as well.

Other popular theoretical orientations may also help shed some light on how and why people in different age groups may experience loss differently. Erik Erikson is most famous for his work on stages of psychosocial development, from infancy to death. Several books have explored what Erikson considered the “developmental crisis” for each stage of life, which, when combined with another crisis in the form of a loss, can account for some of the difficulties each age group may experience. One issue with Erikson’s stages is the wide range of ages that each stage, and the ensuing crisis, includes. In 2000, Arnett, a developmental psychologist, coined a new term that split one of Erikson’s stages to include “emerging adulthood,” which specifically covered ages 18 to 25. This division is partially due to brain development, which is not complete in the prefrontal cortex until about age 25, and also
because our society has pushed back what was considered “early adulthood” in Erikson’s time back in the 1980s (Manosetvitz, 1985). These changes in adolescent dependence and a societal push on extended education that has moved back marriage and childrearing may account for some of these generational changes. One consequence of this is that adolescent dependence and reliance on older generations may make it harder for younger generations to know how to cope with loss, as they may have been insulated for longer periods of time than young adults would have been several decades ago. There is also research that demonstrates a positivity effect amongst older adults when it comes to how messages are framed and that younger adults “exhibited greater negative reactivity to loss-framed health messages” (Mikels, Shuster, Thai, Smith-Ray, Waugh, Roth, Keilly, & Stine-Morrow, 2016). These ideas will be tested within the current research.

Lastly, with regard to generational changes in dealing with loss, one of the newest developments is the strides in technology and social media presence. In the 21st century, younger generations have an entirely new way to express themselves via websites, such as Facebook, Instagram, and Twitter. Neimeyer, Harris, Winokur, and Thornton (2011) express that these forms of Internet resources “provide opportunities for grievers to describe personal stories, express thoughts and emotions, create memorials, and occasionally conduct rituals in a supportive environment” (p. 368). Although it seems there are positives for this new form of expression that can be utilized for any type of loss, there are also drawbacks that may come in the form of being unable to express their emotions in traditional in-person contexts. In addition, these forms of expression may influence the ways in which younger individuals respond to messages about grief and loss. Along these lines, some studies have found that “older adults may be more skilled at finding meaning in their losses than are
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younger adults” (McCoyd & Walter, 2016, p. 269). This may be due to the fact that as we age, our chances of experiencing a loss increases, affording older adults’ perspective and wisdom that younger individuals likely do not have. Finding meaning and increased resilience are two of the biggest predictors of a positive outcome and less complicated grief due to the reconstruction of one’s identity (McCoyd & Walter, 2016, p. 160).

In sum, we have seen that healthy coping mechanisms are dependent upon each individual person and the various facets of their identity. However, when individuals formulate reactions to and attitudes about a loss, how do they do so? Is their reaction more emotional, cognitive, or behavioral? Past research has shown that attitudes are composed of three separate components, affect, behavior, and cognition (Rosenberg & Hovland, 1960). All three of these components are an important part of the grieving process. Affect relates directly to emotions and sympathetic nervous system responses, such as feelings of guilt, anger or sadness in grief. Behavior is more overt, observable, and concrete, such as crying, turning to negative health-related actions such as consuming alcohol, or talking to others about the loss. Behaviors are heavily influenced by one’s environment and culture. Cognition is more complex and harder to identify as it is perceptual and related to beliefs. For example, one might imagine a cognitive response to grief would be starting to think of the self as a separate entity from a partner who has died. In the current research, all three aspects of one’s response to loss were examined.

Why is it important to determine how individuals process and react to loss? Developing specific targeted treatments for those who experience distress associated loss is extremely important. There are similarities between experiences of grief and loss and experiences of trauma, such as “an acute sense of vulnerability and subsequent
hypervigilance" (McCoyd & Walter, 2016, p. 7). On the other hand, there are things that make the grieving process unique. For example, major losses are made up of many smaller, secondary losses (such as economic support) which may complicate the process. Western culture has tried to create stages of grief and make the process seem linear in nature. Famously, Kubler-Ross created a model called “The Five Stages of Grief” (1970) in which she provided a framework for how one goes through the grief journey. This model has received criticism due to the fact that professionals find that individuals “may fluctuate among the various stages and “acceptance” comes gradually (most often), not in one delineated event” (McCoyd & Walter, 2016, p. 13). Newer research which supports this notion, has founded and researched treatments such as CGT, which shows that it is better to view grief as a “natural and adaptive process” (Wetherell, 2012, p. 160). But, as noted previously, in developing these targeted forms of treatment, it is necessary to take those identities and each individual’s developmental age into account to find what might work best to help people grow after experiencing a loss.

More specifically, as clinicians, what is said to clients and, more importantly, how it is said can impact clients during a possibly difficult transition in their private lives. Clinicians can focus on either the growth or the more negative aspects of loss, or both, but to date, research has not fully delineated which of these approaches is more beneficial, and for whom. Consequently, this study looks to see what impact message framing has on individuals’ perceptions of their own recent loss experience.

Message framing occurs each and every day in our conversations; Fairhurst (2011) argues that “perhaps the most important in the discussion of framing is the role that emotions and values play in our message behavior” (p. 13). Clinicians are taught to remove their own
personal biases and values from therapy to focus on the client, but do these values and beliefs about loss seep out in the ways in which clinicians frame messages about loss when speaking with clients? There is a power dynamic that often arises in therapy, which may make clinical messages even more powerful and credible to clients (Fairhurst, 2011, p. 13). To investigate whether positively or negatively framed message have an impact on those who have experienced loss, this study had participants read a short mock article about grief and loss in a general sense that framed the experience of loss either positively (loss is primarily a growth agent) or negatively (loss can lead to severe psychological distress).

Past research has investigated the impact of message framing across other domains. The investigation of message framing in terms of loss/gain or negativity/positivity stems from work done by Kahneman and Tversky on prospect theory. Although this theory was predominantly used and created for the discipline of economics, it has many psychological implications. Prospect theory, first created in 1979 and further developed by Kahneman and Tversky, assumes that losses and gains are valued differently. The theory goes on to suggests that individuals make decisions and interpret risk based on whether or not they perceive it as a loss or a gain. Because grief and loss is inherently aversive and risky to many individuals, the current study investigated whether differently framed messages would alter individuals’ perceptions of their own personal grief and losses.

Discussing loss, however, whether positively or negatively framed, is not something individuals experience often. In fact, part of what makes grief research and therapy challenging is our reluctance to discuss death. Bevan and Thomspson (2003) discuss that “Western societies do not generally acknowledge the enormity or the consequences of death” (p. 180). This may be due to the idea that “changes that make things worse (losses) loom
larger than improvements or gains” (Kahneman & Tversky, 2000, p. 165). Initially, it will be challenging for clients to discuss death, loss, and bereavement in therapy. Any ‘potential gains’ that clients may realize from such an open discussion will be obscured by the emotional pain such discussions engender. And, many clients will seek to avoid further loss at all costs. This aversion to more loss may make individuals more likely to respond favorably to positively framed messages about loss (e.g., avoidance of recognition of pain of loss) or lead them to unhealthy coping habits to avoid more loss.

Prospect theory and message framing has been applied to other domains in psychology. For example, Rivers, Salovey, Pizarro, Pizarro, and Schnedier (2005) looked at the impact of Pap test utilization on women when framing messages as gain/loss. This study found that “individuals are more likely to engage in a behavior with a risky outcome, such as a behavior that detects the presence of an illness, when considering the costs of not performing the behavior” (Rivers et al, 2005, p. 75). These results can be thought of in terms of who might be willing to go to therapy after a loss and what impact reading or hearing framed messages might have on that. In the Pap test study, the implications of their results showed what might be best in terms of providing education and public health campaigns to the public; in the current study, the parallel to this is the investigation of what might be best in terms of providing therapy to those who have experienced a loss.

In summary, there are many factors that impact how one perceives a loss. First, characteristics of the loss itself can influence how that loss is perceived. For example, was it a tangible loss or something intangible? Was it a sudden loss or was there some forewarning that it would occur? Second, characteristics of the individual experiencing the loss can influence how that loss is perceived. For example, what is the developmental level of the
person experiencing the loss? What is his/her cultural background? Current research has begun to look at these different questions to help those experiencing a loss as well as for “practitioners who strive to assist clients in their growth” (McCoyd & Walter, 2016, p. 1).

This particular research study looks to further research regarding age differences and message framing when it comes to dealing with loss so interventions can be better targeted as a function of age and there can be better clinical outcomes for those experiencing loss. More specifically, the current study will investigate age/generations (young, middle aged, older adults) and message framing (positive, negative) and how they influence perceptions of loss in an individual’s life. It is hypothesized that, overall, the participants of this study will report more favorable, healthy coping responses after reading the positively framed article. It is also hypothesized that the older age group will report the most favorable coping strategies and the most positive viewpoint of their loss.

Methods

Participants

This research study was conducted with undergraduate students and faculty or staff members at Eastern Michigan University, a public university located in Ypsilanti, Michigan. The only requirement to participate was that participants were over 18 years of age and gave informed consent (Appendix A). The ages ranged from 18 to 75 years of age (N= 33 who did not give their age). Participants (N= 239) were 70.2% faculty/staff (N= 167) and 29.4% students (N=70); two participants did not designate whether they were faculty/staff or students. The overall average age was 39.9 years of age. Other demographics asked included the generation (according to the chart located in Appendix B) to which participants belonged, as well as sex and ethnicity. With regard to sex, 23.6% (N=56) self-identified as male, and
75.9% (N= 180) self-identified as female. Three individuals did not respond to the sex question. In terms of overall ethnicity, 195 participants identified as White/Caucasian (83.7%), 11 as Black/African American (4.7%), 7 as Hispanic/Latino (3.0%), 6 as Jewish (2.6%), 4 as Asian (1.7%). 3 as Middle Eastern (1.3%) and 9 did not give an answer. With regard to generation, 2 (0.87%) participants identified with The Silent Generation (1923-1944), 62 (27%) identified with being a Baby Boomer (1945-1964), 70 (30.4%) identified with Generation X (1961-1979), 64 (27.8%) identified with Generation Y/Millennial (1980-1995) and 32 (13.9%) identified with Generation Z (1996-2010).

**Students**

With looking at just the student population (N= 70), ages ranged from 18-48 years of age with (N= 7 who did not report an age). Gender was reported: 72.8% (N= 51) Female and 22.9% (N= 16) Male (N= 2 who did not respond). Student ethnicity was reported as follows: (1.4% (N= 1) Asian, 11.4% (N= 8) Black/African American, 2.9% (N= 2) Hispanic/Latino, 2.9% (N= 2) Middle Eastern, 77.1% (N= 54) White, and N= 2 who did not answer this question. Students reported their class standing as follows: 19 freshman (27.1%), 13 sophomore (18.6%), 8 junior (11.4%), 20 senior (28.6%) and 10 were 5th year and beyond (14.3%). With the generation demographic, 4.3% (N= 3) Generation X, 22.9% (N= 16) Generation Y, 44.3% (N= 31) Generation Z, 22.9% (N= 16) Millennial and N= 3 who did not respond or identity with any generation.

**Faculty/Staff**

With looking at the faculty/staff population, ages ranged from 25-75 years of age with (N= 23 who did not report an age). Gender was reported: 72.5% (N= 121) Female and 22.8% (N= 38) Male (N= 2 who did not respond to this question). Faculty/staff ethnicity was
reported as follows: 1.2% (N= 2) American Indian, 1.8% (N=3) Asian, 1.2% (N= 2) Black/African American, 3% (N= 6) Hispanic/Latino, 3% (N= 6) Jewish, 0.6% (N= 1) Middle Eastern, 80.1% (N= 135) White and N= 7 who did not answer this question. With the generation demographic, 37.7% (N= 63) Generation X, 12.6% (N= 21) Generation Y, 35.9% (N= 60) Baby Boomer, 1.2% (N= 2) The Silent Generation, 4.8% (N= 8) Millennial and N= 7 who did not respond or identify with any generation.

Measures and Materials

This survey included three measures. These measures were self-created for this study’s purposes. The measures were created online using Google Forms (Appendix B-F). The demographic questionnaire including questions about age, generation identity, ethnic identity, status at the university and sex. All demographic questions were open-ended to allow participants to self-report. The next measure was 15 Likert Style questions (1= strongly agree to 5= strongly disagree) about the mock article including general reactions and thoughts to see if it had an impact on participants and two open-ended questions. Several questions had to be reverse scored (#2, #12, and #14). The sum of scores for this measure ranged from 24 to 73. High scores mean that participants did not agree with the article they read, while low scores mean they viewed it positively and agreed. The final measure was 100 Likert style questions (1= strongly agree to 5= strongly disagree) about perceptions of a loss they personally experienced. This measure was intend to access participant coping habits and views of coping. Participants specified what type of loss they experienced that they would reflect upon. Table 1 shows which questions went with which subtype and which items were reverse scored. Scores ranged from 223 to 329, with higher scores correlating to more positive coping habits and perceptions of personal loss/coping ability.
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<table>
<thead>
<tr>
<th>Subtypes</th>
<th>Corresponding Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affect</td>
<td>2.9R, 14, 15, 16R, 17R, 28, 39, 40, 48R, 49R, 50, 51R, 72, 84, 93R</td>
</tr>
<tr>
<td>Behavior</td>
<td>1.4, 8R, 19R, 53R, 54, 57, 58, 67R, 74, 75R, 81, 82, 97, 98R</td>
</tr>
<tr>
<td>Health Behavior</td>
<td>8R, 57, 58</td>
</tr>
</tbody>
</table>

Table 1. Subtypes for Coping Score, inventory items used and corresponding dimensions ("R" denotes reverse-scored items).

There was another unattached survey for contact information for participants to be entered to win an Amazon gift card for their participation, an incentive for taking the survey. These Google accounts were created for the survey alone to ensure confidentiality and contact information was housed in a separate form to ensure no identifiable information would be connected to a participant’s answers in the survey.

Research Design

This was 3 X 2 between-groups design. Prior to conducting the study, IRB approval was secured. All subjects received an informed consent form (Appendix A). The main independent variable was article type with two levels - positively framed loss or the negatively framed loss. The other independent variable was age group with two levels, student or faculty/staff (education level). Although participants were recruited by status at the university (faculty/staff or student) to get to a variety of ages; due to an overlap and the literature, the data was analyzed by age. The age groups were created using the mean age ($M=39.9$) and then the standard deviation ($SD=16$) to create the less than mean range and the more than mean range. The age ranges were broken down into three groups: 18-34 years (younger), 35-51 years (middle-aged), and 52-75 years (older).
The operational definition of a loss, for the purpose of this study, was anything that was removed and/or changed the participant's life in about the last 12 months or something that had a large impact on them. Examples were given for what type of loss could be reflected on for the survey questions. These examples are common losses for these age groups and included death, divorce, and job loss. There were several dependent variables being measured besides overall reaction to both sets of questions, including emotional responses to loss, coping habits, support system, treatment, etc. Subtypes were created utilizing the tripartite model (Rosenberg & Hovland, 1960) of affect, behavior and cognition as well as attempting to look at participant views of professional treatment and support.

Procedure

Recruitment for this survey occurred mainly through online methods, particularly email (Appendix F). A brief description of the study was emailed out to faculty/staff using a comprehensive emailing list of all faculty, part-time lecturers, and full-time lecturers through The Faculty Development Center at Eastern Michigan University. Due to numbers of each of these groups, one survey was sent out to faculty and the other survey was sent to lecturers to eliminate bias. For students, the survey was on an online system through the Psychology department where students can receive extra credit to participate (SONA), and it was also sent in a blog post via Blogger (www.blogger.com) which was then distrusted over other outlets of Social Media. Students self-selected into which survey they would like to take after logging into the SONA system, however; they could not participate in both surveys. Students were not aware of the differences between each survey as there was just a symbol in front of each title to differentiate to try and reduce bias. This led to one survey having more responses than another (N= 127 for negative-framed and N= 112 for positive-framed). Participants read
through the informed consent and either provided consent to move forward or not (100% gave permission).

After completing the informed consent, participants first completed a 6-item demographic questionnaire. The next part of the survey allowed them to read one of two articles which were about 500 words a piece. The mock article was intended to have an impact on participant’s moods and perceptions. One of the articles mock article was positively framed and described possible gains from experience a loss. The other mock article was negatively framed and described possible long-term psychological distress from a loss. These surveys were created with general notions about loss in mind and some very basic empirical evidence (Appendix C). One article describes positive views on loss and the second describes negative views on loss. Participants answered a 15-item questionnaire assessing their reactions to the article and what assumptions it made about loss. The next part of the survey had participants were asked to briefly describe a loss they experienced in the last 12 months. Subjects then completed a 100-item questionnaire asking them to describe how the loss has affected them. This was followed by two open ended questions asking subjects to describe things that have helped them to cope with loss and obstacles/challenges to “moving forward.” The final five questions asked the subjects to judge ‘how far (they) feel (they) have progressed in (their) grief journey’. The end included a debrief session with contact information to different resources if they experienced any negative emotions after completion. The survey took about 30 minutes to complete.

**Results**

The main hypothesis for this study was that the oldest age group (52-75 years of age) would have the lowest coping scores, meaning they had the most positive coping and also the
most positive perceptions about their loss. The second hypothesis was that participants would respond better to the positively framed article. The questions about type of loss experience were coded to the top 8 categories listed by participants in terms of frequency. These categories were: death, job loss, divorce, breakup, politics, relationships (i.e. any changes, friendships, and relocation), pets, and health. There was also an “other” category for ones that did not fit the others listed.

With regards to grief journey, the last question on the coping measure, answers were coded to numbers that corresponded with multiple choice answer. For this question 1= have barely begun my grief journey, 2= have made a little progress in my grief journey, 3= have made moderate progress in my grief journey, 4= have made significant progress in my grief journey, and 5= have made great progress in my grief journey. An average was created for each age group with the youngest age group having $M= 3.75$, the middle aged group $M= 4.11$ and the oldest age group having $M= 3.88$. When looking at this in regards to just article type, the means were very similar, $M= 3.90$ for positive and $M= 3.94$.

The types of loss were examined by age group with Group 1, (18-34 years of age; N= 66), Group 2, (35-51 years of age; N= 53) and Group 3, (52-75 years of age; N= 46). A total N= 165 participants responded to this question. For the youngest age group: 3% (N= 2) for three categories (politics, pet and other), 1.5% (N= 1) divorce, 12.1% (N= 8) for three categories (breakup, relationships and health), 7.6% (N= 5) job loss, 45.5% (N= 30) for death. For the middle age group: 1.9% (N= 1) for three categories (politics, pet and other), 3.8% (N= 2) divorce and relationships, 7.5% (N= 4) breakup, 5.7% (N= 3) health, 13.2% (N= 7) job loss and 60.4% (N= 32) for death. Finally, the oldest age group had 2.2% (N= 1)
for three categories (politics, divorce, and pet), 6.5% (N= 3) for health and other, 19.6% (N= 9) for job loss, 56.5% (N= 26) for death, and 0 participants reported breakup (See Figure 3).

A sum of scores for the overall coping measure and the affective, behavioral and cognitive subscales was also computed. The sum of scores calculated are a representation of coping and perception of loss. The average sum of scores for the total measure was $M = 277.59$ for younger adults, 270.32 for middle-aged adults and $M = 269.31$ for older adults. In regards to the articles, the average sum of scores representing favourability was calculated. The average sum of scores by article type was $M = 43.46$ for the positively framed article and $M = 44.12$ for the negatively framed article.

A series of analyses of variance (ANOVA) was performed on the overall coping score, and the affective, behavioral and cognitive subscales as a function of article type and age group. These were done utilized a two-way ANOVA. When comparing the overall coping sum as a function of the article type, there seemed to be no significant difference ($F(1, 195) = 0.541, p = .463$). When comparing the overall coping score as a function of age group alone, there was a significant relationship ($F(2, 195) = 4.335, p = 0.014$). There was a significant two-way interaction between age group and article type on the sum of all coping measures ($F(2, 195) = 3.357, p = 0.037$). The younger participants responded most favorably to the negatively framed article ($M = 274.810 (-), M = 280.658 (+)$). The middle-aged group responded most favorably to the positively framed article ($M = 264.767 (+), M = 275.531 (-)$). There was no significant difference in how the oldest age group responded to the articles ($M = 269.781 (-), M = 268.741 (+)$).

ANOVA tests were also conducted to investigate the tripartite model subtypes, including affect, behavior and cognition sums of scores compared against both independent
variables (article type and age group). Unreliable measures (5 questions) were moved from
analysis through conducting a scale reliability analysis. When scale reliabilities were below
0.7 items were omitted until reliabilities reached the 0.7 level. No significant relationship was
found in regards to affect or overall behavior differing by age group or article type. With
cognition, a relationship was found in regards to both age group and article type (F(2, 195) =
2.693, \( p = 0.070 \)). The younger participants responded most favorably to the negatively
framed article (\( M = 79.429 \) (-), \( M = 83.000 \) (+)). The middle-aged group responded most
favorably to the positively framed article (\( M = 79.167 \) (+), \( M = 82.438 \) (-)). There was no
significant difference in how the oldest age group responded to the articles (\( M = 80.844 \) (-),
\( M = 81.000 \) (+)). While looking at just health related behaviors, a marginally significant
interaction was found (F(2, 189) = 2.310, \( p = .102 \)) between age group and article type. As
consistent with other tests, the younger participants responded most favorably to the
negatively framed article (\( M = 8.452 \) (-), \( M = 9.514 \) (+)). The middle-aged group responded
most favorably to the positively framed article (\( M = 9.163 \) (+), \( M = 10.008 \) (-)). There was no
significant difference in how the oldest age group responded to the articles (\( M = 9.333 \) (-), \( M =
8.913 \) (+)).

Questions regarding willingness to seek professional treatment as a coping
mechanism was also analyzed. There was a significant effect (F(1, 192) = 3.003, \( p = 0.052 \))
in regards to willingness to try treatment, and overall positive associations with treatment, for
participants that read the positively framed article (See Figure 2). This did not interact with
gender or age. Some other tests were conducted, both t-tests and ANOVA, in regards to other
independent variables that were not the focus of this study, such as gender. No significant
relationship was found between gender identity and any of the measures.
Discussion

The purpose of the current study was to go beyond previous research to investigate two different potential influences on coping with a loss: age and message framing. The results supported the hypothesis that both age and message framing influenced coping strategies. More specifically, younger individuals responded with more proactive coping strategies to the negatively framed article, but middle-aged individuals responded with more proactive coping strategies to the positively framed article. There may be multiple reasons for this. As is evidenced by our data, the types of loss one experiences when young often vary quite dramatically from the types of loss experienced by middle aged or older individuals (see Figure 3).

Younger individuals did experience death, but also had more of their losses related to relationships (friendships) and breakups. Interestingly, health was one of the most common types of loss for those 18-34 years of age. We speculate that younger individuals may deal with more mental health issues, and by older age, health may be an issue, but not a severe type of loss to those older individuals, perhaps because it is more expected. Older individuals may consider other things to be a deeper loss. Although death was the most common experience by all age groups, it was lowest for younger individuals.

These distributions of types of loss are important because, for most Western society, the words "loss" and "grief" are immediately associated with death. In the current sample, death as the type of loss increased to 60.4% in the middle age group. This could be due to having more death occur as a function of life experience; people in this age bracket could be more often losing more than one specific type of person through death, including: parents, spouses, siblings, friends, children. On the other hand, younger individuals may deal with
death less or at the lower end of the spectrum, around 18, and may be shielded from it as the literature suggested. Middle aged individuals may be in a situation where optimism in the form of a positively framed article gives them hope and a motivation for the future because their losses are more likely to be death related. However, "the exploration of grief from a broader perspective opens up doors for the exploration of clients' life experiences as they have been shaped by loss in its many forms" (Neimeyer et al., 2011, p. 413) including nondeath, nonfinite and intangible losses. This study left the term loss up to interpretation and a broad variety of experiences were reflected upon by participants. In future studies, asking participants to reflect upon a specific type of loss (such as death) may yield both more generalizable and more specific results.

Notably, there was no impact of the article type on older individuals at all. We speculate that this could be because, by the time individuals are older, they have discovered methods of coping that "work" for them and are less persuaded by outside sources regarding how to think about and deal with loss and grief. This also was pointed out in the literature that mentioned that as we age, more loss has occurred and therefore it may not be as likely to turn into complicated grief. On the other hand, it is possible that what Bevan and Thompson (2003) called "bereavement overload" (p. 182) in older adults is possible due to probable cumulative losses in their lives.

When only considering the types of articles, the pattern that emerged from the results of the analysis was that younger people responded with more positive coping to the negatively framed article. It is curious and counterintuitive that the negatively framed article would identity more with a particular age group than the positively framed article. In explaining why this result was found, it would be important to consider more literature
related to the upcoming generation. It could be that part of the reason this is the case is due to the fact that with further brain development and maturity, individuals can find and identity more with the idea that positivity can be found from humanity's darkest moments or our greatest losses. Younger individuals may have only seen loss framed in a negative way via their primary caregivers, the media, and other strong influences.

While looking at the tripartite model of attitude structure and decomposing our created measures into three broad categories - affect, behavior and cognition - minimal significant differences were found by age or article type. More specifically, while no impact of article type or age was found on the affective measure of coping, some significant differences were found with regard to behavior and cognition. When looking directly at items within the coping measure that related to health, we found a significant effect of both the articles and age group. It seems that overall, the youngest age group had the best coping habits related to health behaviors, whereas the middle aged group who read the negatively framed article had the worst. This may be due to inability to engage in some of the negative coping behaviors, but also could be explained by a new age focus on health amongst younger individuals. In addition, younger individuals may compare themselves to peers and not think that their behavior is abnormal in comparison.

These results have implications for the human experience. This study explored one aspect of identity, age, and combined it with the effects of message framing. The results of this study suggested that people have strong beliefs and behaviors when it comes to coping that are not easily changed by reading a short article within a survey. This has implications for therapy and the ability to make significant changes to how one grieves, either positivity or
negatively, as well as on social psychology and that our previous socialization processes and culture have created very concrete reactions to loss, even by 18 years of age.

A limitation of this study, with respect to the tripartite model of attitude (Rosenberg & Hovland), is that these coping subtypes were created after the fact for the purpose of data analysis. Different questions were placed into the coping subtypes that they appeared to correlate with most readily. In future research, it would make sense to use either established measures or consider these different coping aspects from the beginning. A factor analysis would be an important feature that could be utilized if time allowed to find more information about the measures and their intercorrelations. Another limitation of this study was the lack of randomization in grouping by article type which in future studies should occur to ensure the most accurate analysis of the effect of our intervention.

As stated above, there was a significant interaction among age group and article type found for the cognitively related coping measures. Research done regarding message framing, in the literature cited in this paper and elsewhere, shows that message framing most readily influences our cognitions, thought processes, and overall belief system. Since message framing, one of the main components of this study, is a cognitive process and most of the questions asked of participants were about their perceptions of their loss and their beliefs about loss, that is where the greatest effect was found.

In regards to looking at any other demographic data and loss, the limitations of our study made it challenging to analyze anything in great detail. Due to convenience sampling and time restraints, our main concern was finding participants who represented a variety of ages. When considering development and what has an impact on coping, we decided to focus more on age/life experience rather than education level (student vs. faculty staff). This was
due to research and literature about psychosocial development and brain development which changes dramatically across the years in comparison to there being no legitimate theoretical reason that education level would have an impact on how a person grieves or copes with loss.

In addition, due to the study being primarily taken by white women, it is hard to generalize some of the results to all other groups. Eastern Michigan University has an undergraduate student population of approximately 23,000 and a group of faculty/staff in the thousands as well. A limitation of this study was our N of about 240 participants, lower in certain aspects due to the lack of responding on certain questions, may not be an accurate representation of the entire student or faculty population. The researchers would have liked to reach more students, and more participants in general, but time did not allow for more recruitment to occur.

We did see, however, that overall, individuals were more likely to endorse seeking treatment for grief and loss after reading the positively framed article. This finding may have implications for clinicians as they provide resources for individuals who are presenting for treatment after a significant life loss. These results can be used by clinicians at all levels who deal with anyone undergoing a significant life change or a loss to try to improve mental functioning and adjustment and limit any complicated grief issues. As stigma about mental health issues decreases, it is good to confirm that people are self-reporting that they would seek treatment for these issues instead of dealing with them on their own after reading a positively framed article. This finding confirms what the APA found in the early 2000s.

In a higher education setting such as the one in which this study was done, these results can be used by each age group to try to understand how those in different age groups and generations deal with life changes. It is important to realize that although this study has
implications for clinicians and other professionals who work directly with those who experience a significant life change, we all have the ability to convey messages that may change a person's perceptions about their loss situation. Distribution of research like this and other studies about this topic have the capability to inform the general public about how to best support one another during an inevitable human experience.

The process and expression of grief and what affects it is a challenging topic to discuss and research. This is due to Western society's culture and beliefs surrounding death and loss as well as the multidimensional aspect of the topic. In further studies it would be interesting to investigate this topic particularly looking at other often ignored areas such as disability and sexual identity as independent variables similar to how age was looked at in this study. Another study that could be done might explore more explicitly coping habits used as a function of type of loss, or more specifically, type of death.

Overall, this study's purpose was to provide information about an underrepresented topic in order to provide more support for all individuals who experience a loss. The results of this study showed that there is significant difference in how individuals within different age groups experience loss and how they perceive their coping strategies. Grief will be encountered in life by all individuals, no matter their identities. Grief and loss that is both traditional and nontraditional needs to be recognized and supported in all forms of therapy. Ideally, all who experience a loss would be supported in a way that allows them to make meaning of their loss and move forward with the ability to cope more effectively in the future.
Figure 1

Age Group and Article Type on Coping Score

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Positive Article Mean</th>
<th>Negative Article Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-34 yrs</td>
<td>280.658</td>
<td>274.81</td>
</tr>
<tr>
<td>35-51 yrs</td>
<td>275.531</td>
<td>264.767</td>
</tr>
<tr>
<td>52-75 yrs</td>
<td>268.741</td>
<td>269.781</td>
</tr>
</tbody>
</table>
Figure 2

*Willingness to Seek Out Treatment by Article Type*

![Bar chart showing willingness to seek out treatment by article type](chart.png)
Figure 3

Type of Loss by Age Group

18-34 yrs

- Politics 12.1%
- Death 3.0%
- Job Loss 3.0%
- Health 45.5%
- Pet 7.6%
- Relationship 5.7%

35-51 yrs

- Politics 12.1%
- Death 3.8%
- Job Loss 1.9%
- Health 13.2%
- Pet 7.5%
- Relationship 60.4%

52-75 yrs

- Politics 12.1%
- Death 3.8%
- Job Loss 1.9%
- Health 19.6%
- Pet 6.5%
- Relationship 56.5%

- Relationship 2.2%
- Other 4.3%
- Divorce 2.2%
- Other 0.0%
- Other 2.2%
References


CHANGING PERCEPTIONS OF LOSS


APPENDIX A

INFORMED CONSENT FORM

Changing Perceptions of Loss: The Influence of Generation Effects and Message Framing

PURPOSE OF STUDY: You are invited to participate in a research study that is a generational investigation of message framing and how it impacts perceptions of loss within one's life. The purpose of this project is to better understand how loss may impact college students differently than staff/faculty. The results of this study will help researchers understand the impact of loss and how framing it can impact clinical outcomes.

FORMAT AND LENGTH OF TIME: If you choose to participate, your participation would involve completing several short online surveys after reading a short, one page article regarding current findings in the field of psychology regarding loss. After reading the article, you will be asked to complete a few questions on your reactions to the article. The next phase is a short demographic survey that asks questions about how you identify your age, gender, ethnicity and status at the university. The final part of the survey will ask you to reflect on an experience of loss you have experienced in the last 12 months. In total, this study should take about 30-45 minutes.

EXPECTED RISKS: The risk involved in participating in this study is minimal, although it is possible that a few people may experience stronger than anticipated reactions to some of the facets of the study, such as reflecting on a recent loss. If, after participating, you find yourself experiencing strong feelings and you feel a need to talk to someone about how you feel, please contact one of the following resources: counseling and psychological services, located at snow health center, telephone no.: 734-487-1118; college of education counseling clinic, located at 135 porter building, telephone no.: 734-487-4410; the emu psychology clinic, located at 611 w. cross St., telephone no.: 734-487-4987; or the crisis call center, telephone no.: 1-800-273-8255.

PARTICIPATION WITHDRAWAL: Participation in this study is voluntary. If you do not wish to continue participating or want to withdraw from participating during the study, you may quit the survey at any time without any negative consequences whatsoever. You may quit the study by closing the browser at any time during the survey without any penalty to you.

EXPECTED BENEFITS: There are no foreseeable, direct, expected benefits to you for participating in the study besides the compensation. However, the knowledge that we obtain from your participation will help researchers understand the different ways that people deal with loss and how to best serve different populations after a loss has occurred.

COMPENSATION: Your full participation in this study will put you into a raffle to receive one of six $25 amazon gift cards. If you are a student at the university, you may also be eligible to receive participation/extra credit for your psychology class in exchange for your
participation. If you would like to be considered for extra credit in exchange for your participation, please be sure you access this study through the Sona system, selected a course to which your credit should be allocated, and your extra credit will be credited automatically.

CONFIDENTIALITY: Your confidentiality while participating in this research study is of the utmost importance. There will not be any way for someone to know what answers you gave. Your name and all other identifying information will not be connected with your survey responses in any way. All data will be housed on a secure server within a password protected file that is only accessible by the principal investigator and affiliated faculty sponsor. Upon completion, data will be available to both researchers involved with the study and university human subject’s research committee staff. In addition, once the data have been analyzed, the results of the study will be presented in aggregate form, and never individually.

PRESENTATION OF RESULTS: The results of the study, which will be de-identified so that no identifying information is provided, will be presented in a senior thesis, conferences (in aggregate form), and a possible resulting academic journal publication. If you are interested in the results of the study, please contact the principal investigator or the supervising professor.

CONTACT: Should you wish to speak to someone directly about the study, you may contact the principal investigator, Kaylee Brown at kbrow107@emich.edu or the supervising professor, Dr. Natalie Dove, at ndove@emich.edu. For information about your rights as a participant in research, you can contact the emu human subjects review committee at human.subjects@emich.edu or 734-487-3090.

1. CONSENT: By signing this consent form, I attest that I am at least 18 years of age, have read take out over this consent form and take out I voluntarily consent to participate in this study and follow its requirements. I additionally understand the purpose, intent, and necessity of the present study.

If you have read all of the above and would like to take part in this study, please indicate in the drop down menu below.
APPENDIX B

Demographics

1. What is your current age (in years)?

2. What generation do you identify with?

<table>
<thead>
<tr>
<th>Generation Name</th>
<th>Births Start</th>
<th>Births End</th>
<th>Youngest Age Today*</th>
<th>Oldest Age Today*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Lost Generation - The Generation of 1914</td>
<td>1890</td>
<td>1915</td>
<td>101</td>
<td>126</td>
</tr>
<tr>
<td>The Interbellum Generation</td>
<td>1901</td>
<td>1913</td>
<td>103</td>
<td>115</td>
</tr>
<tr>
<td>The Greatest Generation</td>
<td>1910</td>
<td>1925</td>
<td>91</td>
<td>106</td>
</tr>
<tr>
<td>The Silent Generation</td>
<td>1923</td>
<td>1944</td>
<td>72</td>
<td>93</td>
</tr>
<tr>
<td>Baby Boomer Generation</td>
<td>1945</td>
<td>1964</td>
<td>52</td>
<td>71</td>
</tr>
<tr>
<td>Generation X</td>
<td>1961</td>
<td>1979</td>
<td>37</td>
<td>55</td>
</tr>
<tr>
<td>Generation Z</td>
<td>1996</td>
<td>2010</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Gen Alpha</td>
<td>2011</td>
<td>2025</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

3. What is your gender identity?

4. With which ethnic background do you most identify with?

5. What of the following best reflects your current status at the university?
   - college student
   - faculty
   - staff

6. If you identify as a college student, what is your class standing?
   - freshman
   - sophomore
   - junior
   - senior
   - 5th year and beyond
APPENDIX C

Positively Framed Article

Psychologists agree that everyone experiences loss differently. Many psychologists also agree that one can experience gain and positive growth from loss experiences. There is evidence that a loss can help a person grow and change through experiencing a new reality. This is supported through research that shows that the majority of individuals who experience a loss make meaning out of the situation and gain wisdom from the experience that they could not have had without it. In one study done by Bonanno, participants’ core symptoms of grief (such as anxiety, sadness, and guilt) lifted within six months and many reported that these symptoms had helped them grow and develop in some way. Many effective therapies have been adapted to be used with individuals who have suffered a loss so that they are able to gain a new, fresher perspective on life. In addition, there is evidence that anger, sadness and fear are not always unhealthy and can actually help people find a way to cope with a loss and move forward. Research suggests that many individuals develop healthy coping habits such as gaining new support systems, increasing their levels of exercise, or taking positive life risks such as finding a new job, moving, etc. as a result of loss. Many experts have also shown a connection between the grief process and the healing process and define grief as just regaining equilibrium to move forward. Doing this can lead to positive outcomes of recovery, resolution and resilience later in life. Time is the best predictor of a positive reflection on the experience. If you have recently experienced a loss, then taking positive steps such as increasing exercise, finding a new hobby, journaling, or interacting with family and friends, may help.
Psychologists agree that everyone experiences loss differently. Many psychologists also believe that grief is a disease. These professionals, when drafting the DSM-5, or the Diagnostic and Statistical Manual of Mental Disorders, wanted to make it so those who experience bereavement or grief could be diagnosed with a mental disorder. The reasoning behind this is that many symptoms are similar with major depressive disorder or adjustment disorder, including sadness, inability to sleep or eat, withdrawal, inability to focus, and anxiety. Some professionals see the benefit of medicalizing grief so that those who experience it can get treatment in the form of medications, etc. Otherwise, grief can be quite serious and cause quite a setback in a person’s life.

Elizabeth Kübler-Ross, MD, documented five stages of grief, and there is evidence that some individuals get stuck in certain stages, such as anger or depression, and can develop prolonged or complicated grief that does not resolve. Research suggests that loss can have major negative impacts on individuals’ lives, and these can spill over into other parts of their lives, such as their work, romantic relationships, finances, etc. Many people feel like their lives are never the same after a loss. They struggle to cope and may turn to negative habits such as excessive drugs, alcohol, procrastination, etc. Sidney Zisook, a psychologist, stated that there are 4 major components of grief: separation distress, traumatic distress, guilt/remorse, and social withdrawal. Suffering from grief through these components can have long-term negative effects that require prolonged medical/psychological assistance.
APPENDIX D

Considering the article you just read, please answer the following questions.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I found this article to be interesting.
2. This article was not useful.
3. This article is a reliable source about loss.
4. This article is valid in its assumptions about loss.
5. Reading this article changed the way I view loss.
6. After reading this article, I view loss as more positive than negative.
7. There were parts of this article that matched my personal experiences with loss.
8. This article taught me something about the impact of loss.
9. I believe this article was written by someone who is an expert in the field of loss.
10. I think everyone should read this article after a loss.
11. I think this article had accurate facts about those who experience a loss.
12. I think this article was very one-sided.
13. I would be interested in reading similar articles about this topic.
14. This article should have included more factual information.
15. This article summed up loss in a nice manner.

Open-ended Questions

1. What were your general reactions to reading this article?
2. Did you find the article to be thought-provoking? Why or why not?
APPENDIX E

Think about a recent (in about the last 12 months) or significant loss you have experienced.

Briefly describe what type of loss you experienced (i.e., death, divorce, job loss, etc.) then answer the following questions.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I openly told people about my loss after it occurred.
2. I have dealt with negative emotions because of my loss.
3. Sometimes I think my life is better because my loss occurred.
4. I have created new ways to cope.
5. I have been told that time makes things easier.
6. I have gained insight into myself.
7. Things were the hardest in the few days after the loss occurred.
8. I have turned to negative coping habits such as abusing drugs and alcohol.
9. I have had symptoms of depression.
10. I have sought out professional help after my loss.
11. My support system helped me through my loss.
12. My loss didn’t offer me any positive experiences.
13. People expect me to be over my loss by one year.
14. I have cried in public due to my loss.
15. I have only cried alone after my loss.
16. I have never cried due to a loss.
17. My emotions after a loss are hard to handle.
18. I have experienced many different types of loss in my lifetime.
19. I cannot grieve over a loss for long due to my other responsibilities.
20. It is wrong for people to get remarried after a loss.
21. Some losses are worse than others.
22. Those who seek professional help are weak.
23. Everyone should reach out to professionals if they are grieving.
24. I believe I deal with loss as the average American does.
25. A person should deal with loss alone.
26. A person needs a strong support system after a loss.
27. Grief after a loss is temporary.
28. I have been surprised by my feelings after a loss.
29. People have asked me not to talk about my loss.
30. People have pushed me to talk about the loss when I did not want to.
31. Experiencing a loss has had a negative impact on the rest of your life.
32. Experiencing a loss has had a positive impact on my life.
33. My family was very strict about how feelings were expressed.
34. My family allowed us to express ourselves openly.
35. I have experienced loss in many different aspects of my life.
36. I have only experienced one or two major losses in my life.
37. I find it easy to reflect on loss.
38. I find it challenging to reflect on loss.
39. I keep things to myself for the most part.
40. I like to share my thoughts and feelings with others.
41. I would be willing to join a support group after a loss.
42. Grief is a disease.
43. I would not be willing to join a support group after a loss.
44. Going to therapy is beneficial.
45. Going to therapy has no impact on the grief process.
46. I would not want others to know I went to therapy.
47. I would not mind if anyone knew that I have attended therapy.
48. I experienced anger as a result of my loss.
49. I experienced sadness as a result of my loss.
50. I experienced relief as a result of my loss.
51. I experienced guilt as a result of my loss.
52. I know how to deal with pain well.
53. I isolated myself after my loss.
54. I was more active after my loss.
55. I was distracted for a long time after my loss.
56. I was distracted for a short time after my loss.
57. I had a change in my sleeping habits.
58. I had a change in my eating habits.
59. People were surprised with how I dealt with loss.
60. It is easier for young people to deal with loss.
61. It is easier for older people to deal with loss.
62. Being strong after a loss is important.
63. Showing a weaker side after a loss shows you are human.
64. Everyone is entitled to their feelings after a loss.
65. People treated me differently when they found out.
66. I don’t want people to feel sorry for me.
67. I didn’t tell people unless they asked first.
68. My loss only stayed in the one part of my life in which it happened.
69. My loss had a negative impact on other aspects of my life.
70. My loss had a positive impact on other aspects of my life.
71. I questioned everything I knew when this happened.
72. Even after six months had passed, memories would still come up and upset me.
73. I can use this experience to help others.
74. There are things I had to change about my life to move on after the loss.
75. I avoid certain things due to the connections with the loss (i.e. food, music, smells, etc.)
76. After a year, the memories are not as vivid about the details.
77. After a year, it is easy to remember exactly what happened.
78. Certain dates on the calendar bother me.
79. I barely remember the date of when the loss occurred.
80. My priorities have changed after my loss.
81. I have made drastic changes to my life or self-due to my loss.
82. My life is pretty much the same as it was before the loss occurred.
83. My priorities were not affected by the loss.
84. I have a great feeling of self-resilience.
85. I can count on people in times of trouble.
86. I can only count on myself in times of trouble.
87. I experienced health problems due to the loss.
88. I was referred to treatment.
89. I sought out treatment for myself.
90. I am more willing to express emotions now.
91. I know that I am capable of handling more than I thought.
92. New opportunities came into my life which wouldn't have otherwise.
93. I felt like my own life had no purpose.
94. I knew I had much more of my life to live.
95. I am more likely to like change now.
96. I am less likely to like change now.
97. I started having new interests.
98. I fell into same old routines.
99. I received adequate support from my family and friends.
100. I was disappointed by how the people around me responded to my loss.

Open-Ended Questions

1. Please describe what has best helped you cope after your loss.
2. Please describe any obstacles or challenges you faced in moving forward.

Some people think of grief as a journey. When thinking of your own grief experiences as a journey, please indicate how far you feel you have progressed in your grief journey.

1. Have barely begun my grief journey.
2. Have made a little progress in my grief journey.
3. Have made moderate progress in my grief journey.
4. Have made significant progress in my grief journey.
5. Have made great progress in my grief journey.
APPENDIX F

To students:

Hello,

My name is Kaylee Brown. I am a senior at Eastern Michigan University, majoring in Psychology. For my Honors Senior Thesis and my Undergraduate Research Symposium Project; I am looking for participants to take a very short survey, with a chance to win 1 of 4 $25 Amazon gift cards. For EMU students, you may receive extra credit in a course through the SONA online research sign-up system. The survey in total should take about 30 minutes.

To participate you must be over 18 years of age and provide informed consent. This is an entirely voluntary online survey which is investigating how message framing impacts perceptions of loss across generations.

To access the short survey and/or more information about it, please click here (will insert link)!

- If you need to find the survey, it will be titled “Changing Perceptions of Loss: The Influence of Generation Effects and Message Framing”

Thank you for your time help in completing my research project. It is very much appreciated.

If you have any questions or concerns, please feel free to contact me at kbrow107@emich.edu.

To faculty,

Hello,

My name is Kaylee Brown. I am a senior at Eastern Michigan University, majoring in Psychology. For my Honors Senior Thesis and my Undergraduate Research Symposium Project; I am looking for participants to take a very short survey, with a chance to win 1 of 4 $25 Amazon gift cards. The survey in total should take about 30 minutes.

To participate you must provide informed consent. This is an entirely voluntary online survey which is investigating how message framing impacts perceptions of loss across generations.

To access the short survey and/or more information about it, please reply to this email by emailing kbrow107@emich.edu so I can send you the survey access link.

Thank you for your time help in completing my research project. It is very much appreciated.