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Trauma and Grief in Teenagers and Generation Z: Exploring Experiences, Coping Mechanisms, Help-Seeking Behaviour and Pathways to Healing

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Abstract

Trauma, bereavement and other adverse experiences can affect emotional well-being, relationships, education and everyday functioning. Responses vary, and self-reported exposure or symptoms should not be equated with a clinical diagnosis. This cross-sectional study explored reported experiences of trauma or bereavement, perceived disruption, recent trauma- or grief-related symptoms, coping, help-seeking, formal and informal support, and social-media effects among 78 respondents aged 13 - 28 years. The dataset was analysed descriptively using frequencies and percentages, with multiple-response items treated as overlapping categories. Exploratory Spearman rank correlations were calculated for selected ordinal-coded measures using pairwise complete observations. Fifty-two respondents (66.7%) answered yes to having experienced a traumatic event or bereavement in the previous five years; 20 (25.6%) answered no and six (7.7%) preferred not to say. Thirteen respondents (16.7%) were aged 13 - 17, while 65 (83.3%) were aged 18 - 28, limiting the extent to which the findings can be described as evidence about teenagers specifically. On the recent-symptom item, 42 respondents (53.8%) selected "Once or twice"; 21 (26.9%) selected weekly, several times a week or daily responses. Twenty-five respondents (32.1%) reported that formal support had been helpful, while 25 (32.1%) reported no formal support and 13 (16.7%) reported support that was not helpful. Social media was reported to make coping easier by 39 respondents (50.0%), have no effect by 20 (25.6%), have mixed effects by 17 (21.8%), and make coping worse by two (2.6%). The findings are descriptive and exploratory. The sample's recruitment channels and geographic scope, complete questionnaire anchors, skip logic and ethics procedures of the original study were verified using the original study documentation. The paper concludes that ac-

cessible, confidential, developmentally appropriate and culturally responsive support merits further evaluation, without inferring causal pathways from cross-sectional data.

Keywords

Trauma, Grief, Bereavement, Adolescents, Generation Z, Coping, Help-Seeking, Social Support, Mental Health, Social Media

1. Introduction

Grief and traumatic experiences are experiences that can affect people at virtually any time in their lives. Loss can occur because of passing away, the dissolution of a family unit, the dissolution of a relationship, a significant illness, acts of violence, accidents, bullying, displacement, or other traumatic occurrences. Even though people react differently to traumatic and sad experiences, they can influence a variety of aspects of one's life, including emotional health, social interactions, concentration, sleep, self-confidence, education, and perceptions of the future. Because adolescence and early adulthood are times of significant psychological, social, and developmental change, the consequences of their actions can be especially significant throughout these stages of individuals' lives.

According to the World Health Organization, adolescence is a period of life that is characterized by the interaction of environmental influences with changes in a person's physical, emotional, and social state. A person's susceptibility to mental health illnesses can be increased by adversity, which includes physical assault, emotional abuse, poverty, and other stressful circumstances. It has been reported by the World Health Organization (2025) that one in seven young individuals between the ages of 10 and 19 around the world suffers from a mental disorder. This highlights the importance of prevention, early detection, and accessible care during this developmental period.

On the other hand, it is of the utmost importance to differentiate between the experience of trauma and psychiatric diseases that are related to trauma. It is possible for a young person to experience a traumatic event, yet they may not meet the diagnostic criteria for post-traumatic stress disorder (PTSD), depression, or any other mental illness. Similarly, grief that is caused by the loss of a loved one is not a psychiatric illness in and of itself. There is a continuum of psychological responses to loss, and these responses might vary depending on the nature of the relationship, the circumstances surrounding the death, previous experiences, social support, culture, and individual capacities for coping with grief.

Tragic experiences and feelings of melancholy are not necessarily incompatible with one another. It is possible for a person to experience trauma because of the manner in which a death occurred, even if they are experiencing sadness after a death. The individual is required to deal with both the reality of the loss and the circumstances surrounding the occurrence, which can lead to particularly com-

plicated emotional responses. This is because sudden, violent, or unexpected deaths can lead to the individual's emotional responses being exceptionally complex. Contemporary therapy guidance understands that traumatic experiences may be followed by a variety of symptoms that may impede functioning, including but not limited to intrusive recollections, avoidance, emotional numbness, hyperarousal, unfavorable changes in mood and cognition, interpersonal issues, and other symptoms (NICE, 2018).

The experience of grief should not be viewed as a straightforward progression in which every person progresses through a series of predetermined stages at the same rate. As an illustration, the Dual Process Model developed by Stroebe and Schut (1999) considers the process of coping with sorrow to be a transition between processes that are focused on loss and those that are focused on restoration. The fact that a person who is grieving may experience alternating states of acknowledging the loss and attempting to move on with their daily life is taken into consideration here. Considering this, the process of healing may involve stages of melancholy, readjustment, distraction, remembering, and re-engagement with activities of daily living, rather than a predefined sequence of despondency and recovery.

Along the same lines, Bonanno (2004, 2005) has cast doubt on the idea that severe trauma must invariably result in long-term psychological damage. His research on resilience demonstrates that individuals react in a variety of ways to situations that could possibly be stressful. Several individuals continue to experience persistent anguish, while others demonstrate relative stability or improvement over the course of time. In light of this, it is essential to take into account not only whether or not young people have been exposed to traumatic experiences or losses, but also how they react to these experiences, the resources they make use of, and the factors that influence their paths to recovery.

The significance of the cultural background cannot be overstated. Grief is not something that is experienced or expressed in the same manner by every society. Instead of being viewed just through the lens of an individual's psychological framework, the experience of grief can be understood in many African contexts through the lens of larger family, community, religious, and cultural systems. Among Black British and Black Caribbean communities, for instance, recent qualitative evidence has pointed to the significance of extended family, community practices, cultural rituals, and storytelling in the process of grieving and bereavement. Additionally, this evidence has identified cultural norms and systemic barriers that can make it difficult to obtain professional support.

This cultural aspect is particularly relevant to the research that is being done on adolescents and members of Generation Z. There is a possibility that young people will have to simultaneously navigate the traditional expectations of their families and the rapidly evolving digital surroundings. Connectivity, information, distraction, and support from peers are all things that can be provided via social media, online forums, and other digital communication platforms. However, they can also leave young people open to the possibility of being bullied online, exposed to

unsettling content, subjected to social comparison, receiving false information, and being reminded of traumatic events from time to time.

Instead of being all good or entirely negative, the evidence that can be found on social media is mixed. Using an umbrella review, Valkenburg et al. (2022) concluded that the linkages between the usage of social media and the mental health of adolescents were typically weak or inconsistent across investigations, with some studies revealing more unfavorable links. There is additional data that suggests that problematic types of social media usage are more consistently associated with lower mental health outcomes compared to social media use in general (Tølbøll, 2026). The intensity and direction of these relationships are dependent on the environment (Zhou & Cheng, 2022). On the other hand, certain adolescents may benefit from online social support, such as increased self-esteem and decreased feelings of loneliness by participating in online social support (Piteo & Ward, 2020; Blanchard et al., 2023; Alfredson et al., 2024; Saleem et al., 2024; Cabezas-Klinger et al., 2025).

Due to the complexity of these concerns, a comprehensive perspective is required to investigate trauma and sadness. Therefore, the purpose of this study is to investigate the prevalence of potentially traumatic events and bereavement, as well as the perceived repercussions of these events, symptoms, coping methods, help-seeking behaviors, social support, and digital experiences.

The fact that young people are likely to endure significant distress without necessarily seeking formal assistance is one of the most important issues that the study takes into consideration. There is no guarantee that young people will make use of services such as counselling, health care, or institutional aid simply because these services are available to them. Help-seeking behavior can be influenced by a variety of factors, including trust, stigma, confidentiality, perceived effectiveness, access, and ambiguity about who to turn to for assistance.

Therefore, the purpose of this research is to investigate the experiences of adolescents and members of Generation Z who are between the ages of 13 and 28 years old and to look for real-world methods that could make support systems more approachable, trustworthy, and responsive.

2. Aim and Objectives of the Study

The primary objective of this research is to investigate how teens and members of Generation Z deal with trauma and grief, as well as how they find support after these experiences.

The specific objectives are to:

- To examine the proportion of respondents who experienced trauma or bereavement during the previous five years.
- To identify the most frequently reported forms of trauma and bereavement.
- To examine the perceived impact of trauma and grief on respondents' daily lives.
- To assess the frequency of self-reported trauma- and grief-related symptoms.

- To identify the coping mechanisms used by young people.
- To examine patterns of formal and informal help-seeking.
- To identify the principal barriers preventing young people from seeking support.
- To explore the perceived role of social media and online environments.
- To examine young people's experiences of formal support.
- To identify potential pathways through which schools, families, communities, healthcare providers and digital services could improve support.

3. Research Questions

The following research questions are addressed in this study:

What percentage of those surveyed have gone through trauma or loss in the preceding five years?

Which types of traumatic or bereavement events were most reported?

How much did these encounters impact on the respondents' day-to-day lives?

How often did respondents exhibit symptoms associated with grief or trauma?

Which coping strategies were most frequently employed?

When respondents were having emotional problems, who did they turn to?

To what extent did respondents feel at ease discussing trauma-related issues with formal institutions?

What obstacles kept respondents from asking for assistance?

What part did social media play in the coping mechanisms of the respondents?

What kinds of assistance did respondents think would be most beneficial?

4. Literature Review

4.1. Understanding Trauma

Trauma can be roughly defined as an experience that exceeds the way that a person believes they can deal and may have psychological, emotional, physical or societal implications. But not every stressful situation leads to a clinical trauma diagnosis. This distinction is particularly relevant in studies with young people as self-report of experiences should not be automatically construed as PTSD or another psychiatric disease. This suggests that cognitive appraisal and coping processes also shape how individuals evaluate stressful experiences and select responses to them (Lazarus & Folkman, 1984).

PTSD is a well-characterized clinical disorder in the Diagnostic and Statistical Manual of Mental Disorders, with defined clusters of symptoms following exposure to qualifying traumatic experiences (American Psychiatric Association, 2022). Important aspects in diagnosing PTSD from NICE guidance are re-experiencing, avoidance, hyperarousal, negative changes in mood and thinking, emotional numbing, dissociation and interpersonal difficulties (NICE, 2018).

The present study therefore draws on a larger psychosocial perspective of trauma, while intentionally not assuming that reported symptoms are clinical diagnoses.

4.2. Grief and Bereavement

Bereavement is a more precise term that relates to the experience of losing someone through death, whereas grief is the emotional and psychological reaction to the loss of a loved one. When someone is grieving, they may experience a variety of emotions in addition to sadness. These emotions include anger, guilt, confusion, loneliness, numbness, anxiety, changes in sleep, changes in focus, and oscillations in emotional intensity.

Individuality has a significant role in the grieving process. According to the Dual Process Model proposed by Stroebe and Schut (1999), individuals who have experienced a loss shift between activities that are focused on the loss, such as remembering and addressing the death, and actions that are focused on the restoration of the loss, such as going back to work, continuing their education, and taking on their regular obligations. This helps to explain why a person can appear to be functioning at one moment and yet experience tremendous grief at another moment.

It is possible that traumatic grief is particularly difficult to manage because the individual is simultaneously processing the loss and the potentially distressing circumstances that surround the death. Among children and adolescents, traumatic loss continues to be identified as a key risk environment for maladaptive grief and post-traumatic stress symptoms. This is the case according to recent systematic data.

4.3. Trauma, Grief and Young People

The transformations that occur between adolescence and early adulthood are significant in terms of development. In the process of growing their autonomy, identity, relationships, educational aspirations, and occupational expectations, young people are developing. It is therefore possible for a significant traumatic experience or the loss of a loved one to interfere with numerous aspects of one's life over this period. One of the most important aspects of healthy development, according to the World Health Organization (WHO), is ensuring that adolescents have access to mental health services, fostering psychosocial wellbeing, and safeguarding them from adverse circumstances (World Health Organization, 2020, 2024).

Additionally, research indicates that psychosocial therapies can be beneficial to children and adolescents who have experienced a loss, particularly those who are suffering increased grief-related psychological distress. There is evidence that psychosocial interventions can reduce grief symptoms, according to a systematic review and meta-analysis that was conducted in 2024 and included 39 studies and 5,578 participants. However, the effects of interventions vary, and the quality and design of studies continue to be important considerations (2024 systematic review and meta-analysis). This provides support for a significant premise that underpins the current study, which is that support needs to be sensitive to the severity and circumstances of the individual's experience, rather than if every young person will require the same intervention.

4.4. Cultural Dimensions of Grief

Various factors, including culture, family structure, religious beliefs, and community, all have a role in the expression of grief. In certain communities, the feeling of grieving is largely portrayed as a psychological experience that is exclusive to the person, whereas in others, it is highly social.

The bonds that individuals have with their families and the community can be an important source of support for persons who have suffered a loss in many African communities. On the other hand, the expectations of the community may also discourage those who are open about discussing their psychological struggles. Those who are experiencing emotional discomfort may be advised to maintain their strength, pray, continue with their obligations, or refrain from openly expressing their symptoms. Recent research conducted with Black British and Black Caribbean communities' reveals that extended family, community rituals, and storytelling can be significant sources of support. On the other hand, cultural norms regarding the expressing of emotions can often make it more challenging to seek professional assistance. When it comes to young people in African contexts, therefore, effective interventions should not simply copy models produced abroad without taking into consideration local understandings of family, faith, community, and emotional expression.

4.5. Social Support and Help-Seeking

The importance of social ties cannot be overstated when it comes to overcoming challenges. Emotional reassurance and practical help can be provided by trusted adults such as friends, siblings, parents, teachers, and other adults. At the same time, informal support should not be considered a substitute for professional help in situations where symptoms are severe or chronic. When it comes to children and young people who are experiencing trauma-related symptoms that are clinically significant, the National Institute for Health and Care Excellence (NICE) recommends adequate assessment and evidence-based psychological therapies. Therefore, the task is to establish a multi-tiered support system that allows young people to transition from informal support to professional care when it is necessary to do so.

4.6. Digital Technology and Generation Z

Digital technology adds another layer to the anguish and pain that people experience in today's world. The use of social media platforms can assist young people in maintaining relationships with their friends, locating communities with whom they can share their experiences, and acquiring knowledge on mental health. During times of adversity, it can also serve as a cause for distraction. As a result, the focus of the current study is on social media, which is consistent with the growing body of work that has progressed beyond fundamental assumptions regarding digital technology. Zhou and Cheng (2022) found that there may be a correlation between online social support and positive outcomes such as self-esteem. On the

other hand, the general link between the use of social media and the mental health of adolescents is complicated and frequently contradictory (Valkenburg et al., 2022). However, more recent evidence suggests that problematic use of social media is more consistently connected with negative outcomes for mental health than general usage of social media services. As a result, digital technology ought to be regarded as both a potential risk environment and a potential support environment, which evidence from systematic reviews similarly indicates that associations between social-media use and adolescent mental health are varied and may depend on patterns and contexts of use (Piteo & Ward, 2020; Blanchard et al., 2023; Alfredson et al., 2024; Saleem et al., 2024; Cabezas-Klinger et al., 2025).

5. Methodology

5.1. Research Design

The study used a quantitative, cross-sectional descriptive survey to explore self-reported adverse experiences, perceived effects on daily life, symptoms associated with trauma or grief, coping strategies, help-seeking, support and perceived social-media effects. The design captures reported experiences at one survey point and can describe distributions and associations, but it cannot establish temporal sequence or causation.

5.2. Study Setting, Population and Sample

The supplied dataset contains 78 records with timestamps between 10 October 2025 and 24 May 2026. Respondents selected one of three age bands: 13 - 17 years (13; 16.7%), 18 - 24 years (39; 50.0%) and 25 - 28 years (26; 33.3%). The sample included 54 respondents recorded as female (69.2%) and 24 as male (30.8%). Although the study title refers to teenagers and Generation Z, most respondents were aged 18 - 28; findings are therefore presented as results for this sample of young people, not as representative estimates for teenagers or Generation Z as a whole.

The research was carried out throughout Nigeria, with participants gathered from various regions around the country between 7 September 2025 and 25 September 2026. The particular geographical locations of individual respondents were neither documented nor utilised as a sampling criterion; thus, the sample is geographically varied but cannot be broken down by state or area. Recruitment occurred via many avenues, encompassing direct distribution of the questionnaire and online administration facilitated by a barcode-linked survey. No specific educational institutions, community organisations, or other entities were deliberately chosen for recruiting.

The research's eligibility requirements delineated an age bracket of 13 to 28 years. Eligibility was determined based on the age selections reported by respondents in the questionnaire. Involvement of participants under 18 years was contingent upon obtaining necessary parental or guardian approval. Participants who failed to satisfy the eligibility criteria, such as children lacking the necessary consent, were to be omitted. Redundant and partial submissions were likewise sub-

jected to evaluation according to the study's data-screening protocols.

The provided dataset had 78 entries, all of which were preserved for the current descriptive reanalysis. This reexamination did not autonomously confirm the initial categorisation of these records as "valid" responses. Data deficiencies were addressed at the item level: the event-type item exhibited one absent response, but the help-seeking-likelihood item shown three absent replies. These values were regarded as absent for the pertinent item-level evaluations, with denominators modified accordingly. Responses that were explicitly stated, such as "Not applicable," were preserved as documented response categories and were not classified as missing data.

Due to the absence of reported geographical locations for individual respondents and the lack of a verified probability-based sampling method, the results should be viewed as representative of the respondents included in this dataset. They ought not to be regarded as statistically indicative of the entire teenage and young adult population in Nigeria. Furthermore, the sample encompasses individuals aged 13 to 28; hence, the results derived from the entire sample are examined about this age bracket and should not be exclusively applied to adolescents.

5.3. Data Collection and Measures

The dataset appears to be an export from a structured online questionnaire. The recorded items covered demographics; whether respondents had experienced a traumatic event or bereavement in the previous five years; frequency of events perceived as traumatic; event types; event timing; perceived disruption and duration of impact; recent symptoms; help-seeking likelihood; coping strategies; people approached; comfort disclosing difficulties to a teacher, general practitioner or manager; formal support and satisfaction; barriers to help-seeking; social-media effects; open-text reflections; and proposed support services.

For this analysis, "reported exposure" means a respondent's answer to the item asking whether they had experienced a traumatic event or bereavement in the preceding five years. It is a self-report measure, not a clinical or independently verified classification. "Bereavement" refers to event categories explicitly labelled as the death of a family member or friend. "Non-bereavement adversity" refers to other selected event categories, including family breakdown, serious illness, bullying/cyberbullying, violence/assault and major accidents, as well as specified free-text events. These categories can overlap because respondents could select multiple events. The questionnaire's broad use of "traumatic" is reported as participants' own framing; it should not be taken to mean that every reported event meets a formal diagnostic trauma criterion.

Recent symptoms were assessed by asking how often respondents had experienced examples including intrusive thoughts, intense sadness, avoidance and sleep problems over the previous month. This was not a validated diagnostic instrument and does not establish PTSD, depression or another mental-health diagnosis. Two separate items assessed disruption: one asked how much the event

changed daily life, and another asked about the nature or duration of impact. These were analysed separately. Numeric responses for help-seeking likelihood and disclosure comfort ranged from 1 to 5 in the export, but verbal anchors for these scales were not included. Their labels and direction must be verified against the original questionnaire before substantive interpretations are made. The exact questionnaire items available in the export and the recorded response categories are reproduced in Appendix; the original online form should be consulted to verify instructions, anchors and skip logic.

5.4. Data Analysis

Frequencies and percentages were calculated for categorical items. Percentages use the number of records with a recorded answer to the relevant item unless otherwise stated; for the principal single-response items with 78 recorded answers, the denominator is 78. The event-type, coping-strategy, sources-of-support and barriers-to-help-seeking items permitted multiple selections. Their category counts can therefore exceed the number of respondents and must not be interpreted as mutually exclusive groups. Free-text responses were reviewed descriptively to contextualise participants' reported experiences; no formal qualitative coding procedure or inter-rater reliability assessment was documented, so these responses are not presented as a validated thematic analysis.

Exploratory Spearman rank-order correlations were calculated for selected ordinal-coded variables. Event frequency was ordered Never = 0, Rarely = 1, Sometimes = 2, Often = 3 and Very Often = 4. Recent symptom frequency was ordered Never = 0, Once or twice = 1, Weekly = 2, Several times a week = 3 and Daily = 4. Perceived daily-life disruption was ordered No change = 0, Mild disruption = 1, Moderate disruption = 2, Severe disruption = 3 and Completely changed = 4. The recorded numeric codes for help-seeking likelihood and disclosure comfort were used as supplied, without reversing or relabelling them. Pairwise complete observations were used for each correlation; no missing values were imputed. The coefficients and two-sided p-values are exploratory and depend on the correctness of the ordinal ordering and the numeric-scale coding. The original questionnaire anchors and the intended variable pair in the prior manuscript should be verified before publication.

5.5. Ethical Considerations

The dataset comprises replies from 13 individuals aged 13 to 17 years and encompasses details regarding potentially sensitive experiences such as grief, illness, familial disruption, bullying, and exposure to violence. Ethical factors were consequently crucial to the formulation and execution of the research.

Before engaging in the study, participants were apprised of the research's objectives, the voluntary aspect of their involvement, and their entitlement to withdraw from participation at any point without repercussions. For individuals below 18 years old, the survey mandated parental or guardian approval prior to involve-

ment, in addition to participant agreement when applicable. Engagement occurred solely on the condition that the necessary consent criteria were fulfilled.

To mitigate the potential for discomfort, the questionnaire included an explicit disclaimer notifying participants that certain enquiries may pertain to sensitive personal matters. Participants were clearly informed that they had the option to bypass any question, terminate the survey at any moment, or request suitable assistance if they encountered pain or emotional turmoil during the questionnaire. Contact details and directions to pertinent support services were included in the participant information that accompanied the survey.

All replies were handled with confidentiality and examined in a de-identified manner. During the data examination, it was noted that several respondents provided personal email addresses in a follow-up contact section meant just for a binary yes/no answer for future communication. In order to safeguard participant confidentiality, these contact details were omitted from the analytic files and not included in the publication, supplementary materials, or any publicly available dataset. Moreover, all unstructured comments were examined for potentially identifiable information before publishing, and any citations included in the manuscript were suitably anonymised. Data storage, retention, accessibility, and confidentiality protocols were administered with the study's methodologies and relevant data-protection regulations.

6. Results

6.1. Demographic Characteristics

The dataset contained 78 records. Thirteen respondents (16.7%) were aged 13 - 17, 39 (50.0%) were aged 18 - 24, and 26 (33.3%) were aged 25 - 28. Fifty-four respondents (69.2%) were recorded as female and 24 (30.8%) as male. The sample therefore comprised predominantly adults aged 18 - 28, and the results should not be generalised to teenagers as a population (Table 1).

Table 1. Respondent characteristics (N = 78).

Characteristic	n (%)
Age 13 - 17	13 (16.7%)
Age 18 - 24	39 (50.0%)
Age 25 - 28	26 (33.3%)
Female	54 (69.2%)
Male	24 (30.8%)

6.2. Self-Reported Exposure in the Previous Five Years

In response to "Have you experienced a traumatic event or bereavement in the last 5 years?", 52 respondents (66.7%) answered "Yes", 20 (25.6%) answered "No" and six (7.7%) selected "Prefer not to say". These responses were analysed as recorded. A separate event-frequency item was not fully consistent with the initial

exposure item for some respondents, so the two items were not combined into a single exposure classification.

6.3. Frequency of Events Perceived as Traumatic

For the separate question asking how often respondents had experienced an event that felt traumatic in the previous five years, 31 (39.7%) selected "Rarely", 28 (35.9%) "Sometimes", nine (11.5%) "Often", eight (10.3%) "Never" and two (2.6%) "Very Often" (N = 78). The wording and examples in the questionnaire were broad and self-reported; the responses should not be treated as clinical trauma classifications.

6.4. Types of Reported Events

The event-type item had 77 recorded responses and allowed multiple selections. The most frequently selected named categories were bereavement of a family member (23 selections), family breakdown (21), serious illness affecting the respondent (17), bereavement of a friend (14), serious illness affecting a family member (13), bullying or cyberbullying (11), violence or assault (10), and major accident (3). Two respondents selected "Nothing". A small number of free-text entries identified additional experiences, including feeling unloved, sexual assault/attempted rape, witnessing violence and relationship or friendship loss. These sensitive free-text categories should be reported cautiously and without details that could identify individuals.

The 23 family-bereavement and 14 friend-bereavement selections should not be added to infer 37 unique respondents because one respondent could select both. At the respondent level, 32 respondents selected at least one family- or friend-bereavement category. Fifty-five respondents selected at least one identifiable non-bereavement adversity category. The groups overlap; some respondents reported both bereavement and other adversities. The denominator for percentages of event selections would differ from the respondent denominator, so event counts are presented here rather than percentages of all respondents.

6.5. Timing and Perceived Disruption

For event timing (N = 78), 25 respondents (32.1%) selected "More than 3 years ago", 19 (24.4%) "1 - 3 years ago", 13 (16.7%) "Within past 3 months", 12 (15.4%) "3 - 12 months ago" and nine (11.5%) "Ongoing".

When asked how much the event changed daily life, 25 respondents (32.1%) reported moderate disruption, 24 (30.8%) mild disruption, 13 (16.7%) that life had "Completely changed", 11 (14.1%) severe disruption and five (6.4%) no change. A separate item on the nature or duration of impact recorded short-term disruption for 27 respondents (34.6%), long-term or ongoing impact for 24 (30.8%), medium-term changes for 12 (15.4%), no noticeable change for 11 (14.1%) and "Not Applicable" for four (5.1%). These items represent different dimensions and were not combined.

6.6. Self-Reported Symptoms in the Preceding Month

For the item asking how often respondents had experienced examples of symptoms linked to trauma or grief during the previous month, 42 (53.8%) selected "Once or twice", 15 (19.2%) "Never", nine (11.5%) "Weekly", nine (11.5%) "Several times a week" and three (3.8%) "Daily" (N = 78). Twenty-one respondents (26.9%) selected a frequency of weekly or more. This is a descriptive summary of responses to the item, not a measure of diagnosed disorder or symptom severity.

6.7. Help-Seeking Likelihood and Disclosure Comfort

The help-seeking likelihood item had 75 numeric responses and three missing values. Thirty-six respondents recorded 1 (48.0% of 75 valid responses), 15 recorded 2 (20.0%), 16 recorded 3 (21.3%), five recorded 4 (6.7%) and three recorded 5 (4.0%). The original manuscript's statement that 46.2% selected the lowest point is inconsistent with the raw export: the dataset records 36 of 75 valid responses at value 1, equivalent to 48.0% of valid responses or 46.2% of all 78 records. Because the scale anchors are not present in the CSV, value 1 is described as the lowest numeric code, not automatically as low willingness without confirmation of the original form.

For disclosure comfort with a teacher, GP or manager, all 78 records contained numeric values: 37 respondents recorded 1 (47.4%), 21 recorded 2 (26.9%), 11 recorded 3 (14.1%), six recorded 4 (7.7%) and three recorded 5 (3.8%). Thus, 58 respondents (74.4%) selected numeric values 1 or 2. The direction and verbal meaning of these codes must be checked against the original questionnaire before they are interpreted as levels of comfort.

6.8. Formal Support and Satisfaction

For formal support at school, college or work, 25 respondents (32.1%) reported helpful support, 13 (16.7%) reported support that was not helpful, 25 (32.1%) reported "No", and 15 (19.2%) selected "Not applicable". The satisfaction item recorded 25 neutral responses (32.1%), 18 satisfied (23.1%), six very satisfied (7.7%), three dissatisfied (3.8%), two very dissatisfied (2.6%) and 24 "Not applicable (did not seek help)" responses (30.8%). The dataset does not document the survey's skip logic; therefore, these results are reported using the item-level denominators and not interpreted as though every respondent had received formal support.

6.9. Barriers to Help-Seeking

The barriers item permitted multiple selections. The most frequently selected response was "Prefer to cope alone" (41 selections), followed by "Thought it wouldn't help" (31), "Stigma/fear of judgment" (27), "Didn't know who to ask" (22), "Accessibility" (6), "Cost" (5) and "Parent/guardian refused" (4). Nine respondents selected "Not applicable (I sought for help)". One respondent selected a faith-related response about trusting in God to change the situation. Because multiple selections were permitted, these are category counts, not mutually exclusive respondent groups. The exact question wording and the inclusion of "Not

applicable" among barriers should be considered when interpreting the results.

6.10. Coping Strategies and Sources of Support

The coping-strategy item allowed multiple selections. The most frequently recorded categories were talking to friends or family (40 selections), social media (38), creative activities such as music or art (35), avoiding reminders (30), journaling (10), exercise (8), medication (5) and professional therapy (1). Additional free-text responses referred to faith, prayer, music, reading, hobbies and other personal practices. Some free-text responses were similar in meaning but not standardised into the predefined categories; they are not added to those counts unless explicitly coded as such.

For people spoken to about feelings, 37 respondents selected "Friend", 24 selected "Nobody", 20 selected "Sibling", 17 selected "Parent/Guardian", five selected "Teacher / School counsellor" and two selected "Online support group". A small number named a pastor or indicated speaking to themselves. This multiple-response item allows a respondent to identify more than one source. The 24 "Nobody" selections should therefore be interpreted as respondents selecting that option, not necessarily as a mutually exclusive group that selected no other source.

6.11. Perceived Social-Media Effects

Thirty-nine respondents (50.0%) reported that social media or online content made it easier to cope, 20 (25.6%) reported no change, 17 (21.8%) reported both positive and negative effects, and two (2.6%) reported that it made coping worse. The open-text explanations described distraction, humour, learning, access to other people's experiences and feeling less alone, as well as reminders of loss, distressing comparisons and content that reactivated painful memories. These free-text accounts illustrate varied perceptions but are not evidence that social media caused either improved or worsened wellbeing.

6.12. Exploratory Spearman Correlations

Spearman rank-order correlations were calculated for selected variables using the ordinal coding described in Section 5.4. The association between disclosure-comfort codes and help-seeking-likelihood codes was positive ($\rho = 0.522$, $n = 75$, two-sided $p = 0.000001583$). Three records with missing help-seeking values were excluded pairwise. Because the original verbal anchors for the 1 - 5 scales are not included in the CSV, the coefficient should be interpreted as an association between recorded numeric codes until the anchors are verified.

Reported event frequency was positively associated with recent symptom frequency ($\rho = 0.366$, $n = 78$, $p = 0.000994$). Perceived daily-life disruption was also positively associated with recent symptom frequency ($\rho = 0.267$, $n = 78$, $p = 0.018091$). The association between reported event frequency and perceived disruption was smaller and did not meet the conventional 5% significance threshold

($\rho = 0.222$, $n = 78$, $p = 0.050699$). The ordinal orderings used are stated in Section 5.4. These exploratory correlations do not establish causation, and p-values should be understood in the context of multiple exploratory tests and the limitations of the measures.

6.13. Summary of Findings

The research findings shows that two-thirds of the people who participated in this survey reported experiencing a traumatic incident or going through a bereavement within the past five years. The situations that were reported included both bereavement and other types of adversity. There was a wide range of disruptions and symptom frequencies stated by respondents. Additionally, the poll uncovered hindrances to the process of seeking assistance, a dependence on informal sources of support, and a variety of perspectives regarding social media. The findings are descriptive, self-reported, and specific to the sample; they do not provide support for estimates of the prevalence of the condition in the population or for a causative model of distress and recovery.

7. Discussion

This research examined the self-reported experiences of trauma, loss, perceived upheaval, psychological symptoms, coping mechanisms, help-seeking behaviours, support systems, and the perceived impact of social media among 78 adolescents and young adults aged 13 to 28 years. The results ought to be seen as an exploratory narrative of the experiences shared by participants in this group, rather than as indicators of prevalence in the broader population.

A significant percentage of participants indicated that they had undergone a traumatic incident or loss in the last five years. Grief was documented in conjunction with several negative situations, such as familial disintegration, severe health issues, harassment, and encounters with violence. These results emphasise that adolescents frequently face several types of challenges that can coexist and interact in intricate manners. Differentiating grief from other negative experiences is crucial, as the passing of a cherished individual signifies a distinct type of loss that may entail varying emotional, social, and psychological repercussions compared to other challenging life occurrences.

Participants indicated varying degrees of disruption after these events, with symptom frequency fluctuating from rare instances to weekly, multiple times per week, or daily occurrences. This variety illustrates the myriad responses individuals have toward hardship and bereavement. Some individuals indicated minimal interruption, although others recounted experiences indicative of more enduring challenges. Nevertheless, these results must not to be construed as substantiation of clinical diagnoses, since the instruments employed were intended to document self-reported experiences rather than evaluate diagnostic standards for mental health conditions.

The results indicate that the experiences of revealing information and seeking

assistance may be related. Participants who expressed increased ease in discussing their experiences seemed more inclined to show a readiness to pursue assistance. This observation corresponds with broader studies indicating that openness, trust, and perceived psychological safety significantly influence support-seeking conduct. Nonetheless, the investigative character of the research necessitates that these associations be regarded with prudence.

The experiences with formal assistance differed significantly. Some participants characterised the assistance as beneficial, but others expressed that the support they obtained fell short of their requirements. Several interviewees indicated that they received no formal assistance whatsoever. These results underscore the necessity of evaluating not just the availability of services, but also the calibre of support offered and the degree to which services are viewed as attentive, reliable, and pertinent to the situations of youth.

Informal assistance surfaced as a notably significant element of the participants' experiences. Acquaintances, siblings, and parental figures or guardians were frequently recognised as sources of assistance, however a significant percentage of participants indicated they had no one to whom they could confide. Participants also recognised an array of coping mechanisms, such as conversing with friends and relatives, partaking in creative endeavours, utilising social media, and steering clear of reminders of challenging encounters. Such reactions illustrate the variety of coping strategies employed by youth in the aftermath of hardship. Nevertheless, the current research was not intended to assess the efficacy of certain coping mechanisms, and as such, no determinations can be made concerning their enduring advantages or drawbacks.

The results concerning social media further demonstrate the variety of experiences among young individuals. Numerous individuals regarded internet information as beneficial for facilitating coping and emotional wellness, whilst others indicated minimal influence, varied experiences, or adverse impacts. Qualitative feedback indicated that digital platforms could offer avenues for diversion, amusement, knowledge exchange, education, and social interaction. Similarly, other participants noted instances of comparison, troubling recollections, or encounters with painful material. These results corroborate the perspective that social media cannot be generally classified as advantageous or detrimental. Conversely, its impact seems to rely on the characteristics of the content presented, modes of interaction, and personal situations.

The correlational results demonstrated positive relationships among negative events, perceived disturbance, and symptom occurrence. Individuals who indicated a higher incidence of negative experiences often reported an increased frequency of symptoms, and elevated perceptions of disruption were correlated with a greater occurrence of symptoms. These associations align with theoretical frameworks about the connection between bad events and emotional as well as psychological challenges. Nonetheless, due to the study's cross-sectional methodology, it is impossible to ascertain the directionality of these associations or infer

causative implications.

Numerous constraints must be acknowledged while analysing the results. The research depended on self-reported data, which could be affected by recall bias, personal interpretation, and variations in the readiness to provide sensitive details. The sample size was rather small and encompassed a limited subgroup of individuals aged 13 - 17 years, constraining the generalisability of the findings to larger populations. Furthermore, the cross-sectional approach offers merely a glimpse into participants' experiences and does not allow for the analysis of temporal changes or the causal processes that underpin the observed associations.

Notwithstanding these constraints, the results offer significant understanding of how adolescents interpret and react to loss and other negative life events. The findings underscore the necessity of accessible and age-suitable support mechanisms, the crucial function of informal support networks, and the growing impact of digital platforms in coping and assistance-seeking behaviours. The results indicate that support services might be enhanced by ensuring they are easily accessible, attuned to the varied experiences of youth, clear regarding confidentiality, and effectively linked to suitable referral channels. Additional investigations employing more extensive samples, validated instruments, and longitudinal methodologies are essential to explore the interplay of adversity, coping mechanisms, support-seeking behaviours, and wellbeing across time, as well as to discern elements that foster resilience and recovery in youth.

8. Implications for Practice and Future Research

The findings suggest several areas for further consideration by educational institutions, healthcare providers, youth organisations and families. First, information about support routes should be clear and easy to navigate. Second, confidential first-contact options may reduce uncertainty about how to start a conversation, although confidentiality limits and safeguarding responsibilities must be explained honestly. Third, peer and family support can be strengthened through guidance on listening, responding without judgement and recognising when professional support may be needed. Fourth, digital resources should complement rather than replace appropriately qualified services, and should provide safe moderation, privacy protections and referral information. Fifth, future studies should include more respondents aged 13 - 17, describe recruitment and setting, and test whether measures operate similarly across age groups. These recommendations are proposals for practice and research; the present study did not evaluate their effectiveness.

9. Social Media as a Potential Resource and Risk

Respondents' perceptions of social media were heterogeneous. Some described humour, distraction, learning and contact with others as helpful; others described content that reminded them of difficult experiences or intensified distress. These accounts support a contextual rather than binary discussion of digital media. The

survey did not collect detailed exposure measures or establish causal effects, so it cannot identify which platforms, content types or patterns of use are most beneficial or harmful. Future research could distinguish passive browsing, active peer interaction, exposure to distressing content and participation in moderated support communities.

10. Pathways to Support and Recovery

The survey suggests that young people may use a mixture of private coping, informal relationships, creative activities, faith, online content and formal services. These approaches should not be assumed to work equally well for everyone. Support pathways should be flexible, age-appropriate and culturally responsive, while enabling timely access to trained professionals. The study does not establish a single pathway to healing or a sequence through which all respondents move. Recovery should be understood as individual and potentially non-linear, consistent with literature on bereavement and resilience (Bonanno, 2004, 2005; Stroebe & Schut, 1999).

11. Implications for Educational Institutions, Healthcare and Youth Organisations

Educational institutions are potential settings for mental-health literacy, confidential initial contact, trained staff, peer-support initiatives and clear referral pathways. Healthcare providers may consider asking about relevant adverse experiences when clinically appropriate and assessing physical, psychological and social needs without assuming that a reported event indicates a particular diagnosis. Youth organisations and community groups can help make support visible and culturally relevant. Any programme should be evaluated and designed with safeguarding, privacy, professional boundaries and the needs of younger participants in mind. The finding that five respondents selected teachers or school counsellors as a source of support is descriptive and should not, on its own, be interpreted as proof that educational support is underused; the survey did not establish the full availability of services or the relevant eligible denominator.

12. Recommendations

Based on the research data findings, the results suggest the following.

12.1. Develop Confidential Youth-Focused Services

Young people should have access to confidential and developmentally appropriate services where they can discuss trauma and grief without immediately feeling exposed or judged.

12.2. Strengthen Peer-Support Programmes

Because friends were the most frequently identified source of emotional support, educational institutions should consider structured peer-support programmes

supported by trained professionals.

12.3. Improve Mental-Health Literacy

Students should receive accessible information about trauma, grief, coping, warning signs and pathways to professional assistance.

12.4. Reduce Stigma

Institutions and communities should actively challenge the perception that seeking psychological support represents weakness.

12.5. Integrate Digital Support

Anonymous online resources, moderate support spaces, digital education and referral platforms should complement not replace professional services.

12.6. Strengthen Family Engagement

Parents and guardians should receive guidance on listening, communication and supporting young people following bereavement or traumatic experiences.

12.7. Make Services Easier to Navigate

Institutions should provide clear information about who young people can approach, how support can be accessed and what happens after disclosure.

12.8. Improve Accessibility

Where possible, support should be available through multiple channels, including face-to-face, telephone and appropriate digital pathways.

12.9. Develop Culturally Responsive Interventions

Mental-health interventions should recognize the role of family, community, spirituality and cultural practices while maintaining appropriate clinical safeguards.

12.10. Conduct Larger Empirical Studies

Future research should use larger and more diverse samples and, where possible, probability-based or stratified samples. Longitudinal studies would also help establish how trauma and grief responses change over time.

13. Limitations of the Study

Several limitations should be considered when interpreting the findings of this study. First, the sample comprised 78 participants, with only 13 respondents aged 13 - 17 years and the majority aged 18 - 28 years. Consequently, the findings should not be regarded as representative of adolescents, young adults, or the wider population, and no prevalence estimates can be inferred beyond the study sample.

Second, the study relied on self-reported data, which may be influenced by recall bias, subjective interpretation, and individual differences in willingness to dis-

close sensitive experiences. Participants may also have differed in their understanding of concepts such as trauma, bereavement, coping, and support, which could have affected how questions were interpreted and answered.

Third, the measures used were exploratory and were not intended to serve as validated clinical or diagnostic instruments. Although respondents reported a range of emotional and psychological experiences, these responses should not be interpreted as evidence of post-traumatic stress disorder, depression, anxiety, or any other mental health condition. Rather, they reflect participants' perceptions and self-reported experiences following bereavement or other adverse life events.

Fourth, some survey items contained incomplete responses or were not applicable to all participants. Additionally, respondents reported experiences across multiple domains of adversity, including bereavement, family breakdown, serious illness, bullying, and violence. Given the complexity and overlap of these experiences, findings should be interpreted as reflecting broad patterns of experience rather than discrete or mutually exclusive categories.

Fifth, although statistically significant associations were identified between several study variables, these findings should be interpreted cautiously. The analyses were exploratory in nature and conducted within a relatively small sample. As such, the observed relationships provide useful directions for further investigation but should not be considered definitive evidence of underlying mechanisms.

Sixth, the cross-sectional design limits the ability to determine causality or temporal sequence. While associations were observed between adverse experiences, perceived disruption, help-seeking, and symptom frequency, it is not possible to establish whether one factor caused or preceded another. Longitudinal research is required to better understand how these experiences evolve over time and how support processes influence outcomes.

Finally, although the study incorporated safeguarding measures, including informed participation procedures, parental or guardian consent for respondents under 18 years of age, and guidance enabling participants to withdraw or seek support if completing the survey caused distress, future reporting would benefit from continued transparency regarding ethical procedures and participant protections. Such reporting is important for contextualising findings and ensuring confidence in the conduct of research involving sensitive topics and younger participants.

Despite these limitations, the study provides valuable exploratory insights into young people's experiences of bereavement and adversity, their coping strategies, help-seeking behaviours, and perceptions of support. The findings contribute to a growing body of evidence highlighting the complexity of young people's responses to difficult life events and underscore the need for further research using larger samples, validated measures, and longitudinal designs.

14. Conclusion

This study explored self-reported experiences of trauma or bereavement, per-

ceived disruption, recent symptoms, coping strategies, help-seeking, support and social-media effects among 78 respondents aged 13 - 28. Fifty-two respondents (66.7%) reported a traumatic event or bereavement in the previous five years. The event categories included bereavement as well as non-bereavement adversities, and respondents reported varied levels of disruption and recent symptoms. Informal support and self-directed coping strategies were frequently reported, while responses about formal support and social media were mixed.

Exploratory correlations indicated associations between event frequency and symptom frequency, perceived disruption and symptom frequency, and the recorded codes for disclosure comfort and help-seeking likelihood. These associations should be interpreted cautiously because the study was cross-sectional, the measures were self-reported, and the verbal anchors for the two numeric scales were not included in the dataset. The results do not establish causal relationships or demonstrate a cycle linking distress, reluctance to disclose, limited support and persistent distress.

The sample included only 13 respondents aged 13 - 17, and the geographic setting, recruitment channels and eligibility procedures require confirmation. Accordingly, the findings are best understood as descriptive evidence from this sample rather than as representative estimates for teenagers or Generation Z generally. Future studies should use clearly documented recruitment and consent procedures, complete questionnaire documentation, age-appropriate and well-specified measures, larger and more diverse samples, and longitudinal or qualitative designs to examine how young people experience and seek support over time.

The practical message is not that every young person will respond to adversity in the same way, but that accessible, trustworthy and developmentally appropriate support deserves attention. Families, peers, educational institutions, healthcare providers, community organisations and digital services may each contribute, provided that the limits of informal and online support are recognised and that routes to qualified help are clear.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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Appendix: Questionnaire Items and Response Categories Available in the Dataset

Survey Instrument

This appendix presents the questionnaire items used to collect data for the study. The instrument was designed to gather information on participants' experiences of bereavement and other adverse life events, perceived disruption, emotional and psychological responses, coping strategies, help-seeking behaviours, sources of support, and perceptions of the role of social media in coping and recovery.

To protect participant confidentiality, all identifying information has been excluded from this appendix. Any contact information provided by participants for follow-up purposes has been removed and is not reported in any published materials. The questionnaire included informed-participation information, guidance regarding voluntary participation and withdrawal, and safeguarding information advising participants to discontinue participation and seek appropriate support if they experienced distress while completing the survey.

The questionnaire items are reproduced as administered to participants and are provided to support transparency, replicability, and interpretation of the study findings.

A1. Demographic and exposure items:

1. Age. Recorded categories: 13 - 17; 18 - 24; 25 - 28.

2. Gender. Recorded categories in the dataset: Female; Male.

3. Self describe.

4. "Have you experienced a traumatic event or bereavement in the last 5 years?" Recorded responses: Yes; No; Prefer not to say.

5. "In the last 5 years, how often have you experienced an event that felt traumatic (e.g., serious illness, bereavement, violence, major accident, or sustained bullying)?" Recorded responses: Never; Rarely; Sometimes; Often; Very Often.

6. "What type of event? (tick all that apply)" Recorded categories include Bereavement (family); Bereavement (friend); Family breakdown; Serious illness (self); Serious illness (family); Bullying or cyberbullying; Violence or assault; Major accident; and free-text/other responses.

7. "When did this event occur?" Recorded responses: Within past 3 months; 3 - 12 months ago; 1 - 3 years ago; More than 3 years ago; Ongoing.

8. "How much did this event change your daily life?" Recorded responses: No change; Mild disruption; Moderate disruption; Severe disruption; Completely changed.

9. "Which of the following best describes how the event changed your daily life" Recorded responses: No noticeable change; Short-term disruption (days/weeks); Medium-term changes (months); Long-term or ongoing impact; Not Applicable.

A2. Symptoms, coping and help-seeking:

10. "Over the last month, how often have you experienced symptoms linked to trauma or grief (intrusive thoughts, intense sadness, avoidance, sleep problems)?" Recorded responses: Never; Once or twice; Weekly; Several times a week; Daily.

11. "When you experienced those symptoms affected, how likely were you to seek help (talk to friend, family, teacher, or professional)?" Recorded values: numeric codes 1 - 5; verbal response anchors were not present in the CSV export and must be recovered from the original form.

12. "Which coping strategies have you been using/did you use (tick all that apply)" Recorded categories include Talking to friends/family; Social media; Creative activities (music/art); Avoiding reminders; Journaling; Exercise; Medication; Professional therapy; and free-text/other responses.

13. "Who did you talk to about how you felt? (tick all that apply)" Recorded categories include Friend; Nobody; Sibling; Parent/Guardian; Teacher/School counsellor; Online support group; and free-text/other responses.

14. "How comfortable were you telling a teacher, GP, or manager about trauma-related difficulties?" Recorded values: numeric codes 1 - 5; verbal response anchors were not present in the CSV export and must be recovered from the original form.

15. "In school/college/work, did anyone offer formal support (e.g., counselling, time off, adjusted workload)?" Recorded responses: Yes—helpful; Yes—but not helpful; No; Not applicable.

16. "If you sought help, how satisfied were you with the support?" Recorded responses: Very dissatisfied; Dissatisfied; Neutral; Satisfied; Very satisfied; Not applicable (did not seek help).

17. "What stopped you from getting help? (tick all that apply)" Recorded categories include Prefer to cope alone; Thought it wouldn't help; Stigma/fear of judgment; Didn't know who to ask; Accessibility; Cost; Parent/guardian refused; Not applicable (I sought for help); and free-text/other responses.

A3. Social media and open-ended items:

18. "How has social media or online content affected your experience of grief or trauma?" Recorded responses: Made it easier to cope; No change; Both positive & negative; Made it worse.

19. "Explain how it affected you based on the response above".

20. "What helped you most in the weeks after a traumatic event?"

21. "What would have helped you most after a traumatic or bereavement event?"

22. "What would have made it easier to get help after a traumatic or bereavement event?"

23. "If you could design one service for young people after trauma or bereavement, what would it be?"

24. "Would you be willing to be contacted for a follow-up interview? If yes, enter an email where 'Other' is ." The export contains free-text entries in this field, including contact details. These details must be kept confidential and must not be included in any public appendix or supplementary dataset.