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Self-Reported Prior Awareness, Willingness to Use Griefbots and Ethical Concerns Among Spanish Adults: An Exploratory Cross-Sectional Study with Quantitative and Qualitative Components

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Abstract

Background and objectives: Griefbots simulate conversations with deceased people using their digital traces. Understanding attitudes towards this technology and the concerns it raises is necessary before considering applications in care. We examined self-reported prior awareness, willingness to use griefbots, perceived usefulness and ethical concerns in a sample of Spanish adults. **Methods:** This exploratory cross-sectional study included 119 participants aged 18–65 years: 76 women (63.9%) and 43 men (36.1%). Study-specific items and the eHealth Literacy Scale (eHEALS) were administered online. Analyses comprised descriptive statistics, 35 Spearman correlations, four Mann–Whitney U tests, one Wilcoxon signed-rank test and inductive categorisation of open-ended responses. The 40 inferential tests were adjusted jointly using the Benjamini–Hochberg procedure. **Results:** Self-reported prior awareness was low (M = 1.45; SD = 0.69; range 1–3). Willingness to use griefbots was low in both therapeutic (M = 2.34; SD = 1.22) and personal contexts (M = 2.07; SD = 1.17; ranges 1–5). Eighty-two participants (68.9%) disagreed with using a griefbot during bereavement. The median concern about misuse was 5 out of 5. No inferential test remained statistically significant after adjustment. Open-ended responses raised concerns about consent and digital identity, authenticity and dependence, and conditions of access and commercialisation. **Conclusions:** In this convenience sample, willingness to use griefbots was low. The concerns expressed can inform further acceptability research. These findings do not establish therapeutic effectiveness, safety or the effects of actual system use. Interpretation should take account of sample selection, study-specific measures and presentation of a definition before the prior-awareness question.

Keywords: griefbots; bereavement; acceptability; artificial intelligence; digital mental health; eHealth literacy; ethics

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Academic Editor: Hsiang-Ning Luk

Received: 13 October 2026
Revised: 15 November 2026
Accepted: 17 November 2026
Published: 21 November 2026

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1. Introduction

Artificial intelligence is increasingly being incorporated into healthcare and mental health services [1]. Griefbots are a specific application: conversational systems that use a deceased person's digital materials to generate a representation with which other people

can interact. Their development raises questions about consent, privacy and psychological effects, particularly when use during bereavement is proposed [2,3]. Understanding acceptability is a preliminary step towards assessing applications in care, but stated willingness to use these systems does not demonstrate clinical usefulness.

Bereavement involves adapting to the absence of the deceased person and reorganising everyday life [4]. Therapeutic letter writing and other symbolic practices may facilitate emotional expression and continuing bonds [5]. Griefbots introduce an apparently reciprocal conversation generated in real time. Their effects therefore cannot be inferred from those of letters, rituals or digital memories. The possibility of maintaining a connection may coexist with concerns about authenticity, dependence and interference with adaptation to loss [3,6].

Unlike static digital memorials, these systems generate new content from messages, recordings and other materials [7]. The vulnerability associated with bereavement requires the consideration of consequences for well-being [8], including the possibility of attributing statements to the deceased that they never made or using third-party data without authorisation [9]. Commercial availability does not constitute evidence of effectiveness in bereavement care.

Available empirical research primarily concerns perceptions and intentions to use these systems. Lu et al. interviewed 25 adults in China and described expectations of comfort alongside psychological and ethical concerns [7]. Jiménez-Alonso and Brescó de Luna observed ambivalence in interviews with three bereaved people [10]. In a sample of 294 participants, Fan and Cheng related deathbot acceptance to perceived emotional benefits, barriers and ethical attitudes [11]. Fu et al. studied 129 bereaved relatives of patients with cancer and examined factors associated with adoption intentions [12]. These studies do not establish the health effects of actually using a griefbot.

eHealth literacy may be relevant to interpreting product claims, assessing limitations and examining privacy conditions [13,14]. The eHEALS assesses perceived skills in finding, evaluating and applying digital health information [15]; its scores are not a direct test of competence in evaluating artificial intelligence. Existing evidence supports studying awareness, willingness to use and ethical concerns together, without assuming that one dimension determines the others.

The overall aim was to describe these perceptions in a sample of Spanish adults and explore their associations with personal and contextual characteristics. The specific objectives were to: (1) describe self-reported prior awareness; (2) examine willingness to use griefbots in different contexts and perceived usefulness; (3) explore associations of awareness, willingness and concerns with age, educational attainment, device use, recent losses and eHealth literacy, and conduct selected exploratory comparisons by sex; and (4) characterise concerns expressed in open-ended responses and integrate them descriptively with quantitative findings. The study documents these perceptions in a Spanish context; it was not designed to represent the entire population or evaluate a clinical intervention.

2. Materials and Methods

2.1. Design

An exploratory cross-sectional survey included closed-ended and open-ended questions administered in the same form. The quantitative component described perceptions and examined associations; the qualitative component identified concerns in written responses. The components were integrated through a joint display, without attributing individual-level relationships between themes and scores. No griefbot intervention was administered, and no follow-up was undertaken. The study was not preregistered.

2.2. Participants and Eligibility

We analysed 119 questionnaires from Spanish adults aged 18–65 years (M = 31.6; SD = 13.5). The inclusion criteria were age between 18 and 65 years and use of technological devices for at least one hour per week. The study documentation specified the exclusion of people with a psychiatric diagnosis or difficulty understanding written information. Psychiatric diagnosis was assessed by self-report, asking whether a healthcare professional had communicated a current diagnosis of a mental disorder, with the options "yes", "no" and "prefer not to answer".

The form received 119 submitted questionnaires. No records were excluded for age, psychiatric diagnosis or any other eligibility criterion, and all 119 questionnaires were included in the analysis. Although the analytical export does not retain the psychiatric screening variable, the original response records in Google Forms (Google LLC, Mountain View, CA, USA) were checked and all 119 participants selected "no". No a priori sample-size calculation was performed; the final sample comprised the completed questionnaires obtained through non-probability recruitment.

2.3. Recruitment and Procedure

Recruitment took place from 27 May to 10 June 2025 through social media and snowball sampling. The questionnaire was administered using Google Forms and was estimated to take five minutes to complete. Closed-ended questions were mandatory, and the three open-ended questions were optional. Submissions were limited to one per signed-in Google account, with email address collection disabled. Account email addresses were not recorded with survey responses or made available to the research team.

This setting restricts submissions from the same account but does not guarantee that different accounts correspond to different people.

The export contained 119 submitted questionnaires without participants' names or email addresses. The numbers of people who opened or started the form without submitting it were not recorded, so a completion rate could not be calculated. Participation was voluntary and unpaid. Participants were informed of the study objectives, and voluntary completion was taken as implied informed consent. The form provided investigator contact details but did not include bereavement-support resources. Ethics information is provided in the declarations.

2.4. Measures and Variables

The study-specific questionnaire recorded sex, age, educational attainment, daily mobile-device use and significant family losses in the previous three years. The loss question listed parents, children, siblings, aunts and uncles, cousins and grandparents. The number of deaths was recorded without assessing grief severity, functional impact or possible prolonged grief disorder.

Before the prior-awareness question, participants were shown the following Spanish description: "Los griefbots son chatbots (ChatGPT) basados en la huella digital del difunto, que ofrecen a los dolientes la posibilidad de 'hablar' con sus seres queridos después de su muerte". In English, this describes griefbots as chatbots (ChatGPT) based on the deceased person's digital footprint that offer bereaved people the possibility of "talking" to their loved ones after death. The description also preceded the willingness and ethical-concern items. Its wording is retained to document the administered procedure; the reference to ChatGPT is not a technical definition applicable to all griefbots.

Prior awareness was measured with one item and three response options: 1 = had never heard of griefbots; 2 = had heard something about them; and 3 = knew what they were.

Because the question followed a description, the variable is interpreted as self-reported prior awareness rather than an objective assessment of knowledge.

Four separate items assessed willingness to use a griefbot personally, during bereavement, to maintain a "relationship" with the deceased person and in a therapeutic context. Two items assessed perceived usefulness during bereavement and for maintaining such a "relationship". Two further items assessed ethical doubts and concern about inappropriate use. These eight items used five-point agreement responses: 1 = strongly disagree; 2 = somewhat disagree; 3 = undecided; 4 = somewhat agree; and 5 = strongly agree. No composite scores were calculated for these items.

In the analyses, "willingness to use during bereavement" refers to the grieving-process item, "ethical concern" to the ethical-doubts item, and "concern about misuse" to the closed-ended inappropriate-use item. Three separate open-ended questions explored ethical concerns, possible misuse and views on unrestricted commercialisation. No formal pretesting or psychometric validation of the study-specific items is documented. The complete administered questionnaire is provided separately as Supplementary File S1.

eHealth literacy was assessed using the eight-item eHEALS [15], whose Spanish version was validated among university students [16]. Responses are scored from 1 to 5 and summed to give a total between 8 and 40; higher scores indicate greater self-reported eHealth literacy. The previous validation does not establish identical properties across this sample's age range. Internal consistency was estimated in the present study.

2.5. Quantitative Analysis

Frequencies, percentages, means and standard deviations were calculated, together with medians and quartiles for the principal ordinal items. The 119 analytical records contained complete closed-ended responses. No values were imputed. Blank open-ended responses were excluded only from their respective qualitative analyses.

Thirty-five Spearman correlations were calculated between seven perception variables and five participant characteristics. Age, educational attainment, daily device use and recent losses were analysed as ordered categories, as shown in Table 1; eHEALS was analysed as a total score. Age was grouped into equal-width bands (18–29, 30–41, 42–53 and 54–65 years) to facilitate interpretation. Daily device use was grouped into three-hour bands, with an open-ended highest category. Categories were interpreted ordinally, without assuming equal distances between them. Perceived-usefulness variables were described but were not included in the correlation matrix.

Four Mann–Whitney U tests compared prior awareness, willingness to use griefbots therapeutically and personally, and ethical concern by sex. These outcomes were selected because the literature review led us to formulate exploratory hypotheses about possible differences by sex in awareness, willingness across personal and therapeutic contexts, and ethical concern. Effect sizes are expressed as $r = |Z|/\sqrt{N}$. A Wilcoxon signed-rank test compared therapeutic and personal willingness scores within participants.

Approximate 95% confidence intervals were calculated for all 35 Spearman correlations using Fisher's z transformation from unrounded correlation coefficients. These intervals are nominal and were not adjusted for multiplicity.

The 35 correlations, four comparisons by sex and one paired comparison were treated as a single exploratory family of 40 tests. The Benjamini–Hochberg procedure was used to control the false discovery rate at 5%. The p values in Table 2 are two-sided and unadjusted. The original analyses were performed using IBM SPSS Statistics, version 29 (IBM Corp., Armonk, NY, USA) [17].

Table 1. Participant characteristics.

Characteristic	*n*	%
Sex		
Men	43	36.1
Women	76	63.9
Age in years		
18–29	80	67.2
30–41	12	10.1
42–53	7	5.9
54–65	20	16.8
Educational attainment		
Upper secondary education or intermediate vocational training	13	10.9
Higher vocational training	7	5.9
Undergraduate or university degree	55	46.2
Postgraduate studies	42	35.3
Doctorate	2	1.7
Daily mobile-device use in hours		
0–2	17	14.3
3–5	64	53.8
6–8	35	29.4
>8	3	2.5
Significant losses in the previous three years		
0	52	43.7
1	40	33.6
2	18	15.1
≥3	9	7.6

Note. $n = 119$. Losses refer to self-reported family deaths, not grief severity. Compulsory secondary education (E.S.O.) was offered as a response option but was not selected by any participant ($n = 0$).

Table 2. Exploratory Spearman associations.

Perception Variable	Related Characteristic	ρ	95% CI	*p*
Self-reported prior awareness	Age group	−0.174	[−0.343, 0.006]	0.059
Self-reported prior awareness	Daily mobile-device use	0.055	[−0.127, 0.232]	0.556
Self-reported prior awareness	eHealth literacy	0.005	[−0.176, 0.184]	0.960
Self-reported prior awareness	Educational attainment	0.117	[−0.065, 0.29]	0.207
Self-reported prior awareness	Recent significant losses	−0.191	[−0.359, −0.011]	0.038
Concern about misuse	Age group	−0.164	[−0.334, 0.016]	0.075
Concern about misuse	Daily mobile-device use	−0.056	[−0.234, 0.125]	0.543
Concern about misuse	eHealth literacy	0.246	[0.069, 0.408]	0.007
Concern about misuse	Educational attainment	0.163	[−0.017, 0.333]	0.076

Table 2. *Cont.*

Perception Variable	Related Characteristic	ρ	95% CI	*p*
Concern about misuse	Recent significant losses	−0.262	[−0.422, −0.086]	0.004
Ethical concern	Age group	−0.245	[−0.407, −0.068]	0.007
Ethical concern	Daily mobile-device use	−0.040	[−0.218, 0.141]	0.667
Ethical concern	eHealth literacy	0.178	[−0.002, 0.347]	0.052
Ethical concern	Educational attainment	0.257	[0.081, 0.418]	0.005
Ethical concern	Recent significant losses	−0.158	[−0.328, 0.023]	0.087
Willingness to maintain a "relationship" with the deceased	Age group	0.020	[−0.161, 0.199]	0.829
Willingness to maintain a "relationship" with the deceased	Daily mobile-device use	0.127	[−0.055, 0.3]	0.170
Willingness to maintain a "relationship" with the deceased	eHealth literacy	−0.059	[−0.236, 0.122]	0.524
Willingness to maintain a "relationship" with the deceased	Educational attainment	−0.113	[−0.287, 0.068]	0.221
Willingness to maintain a "relationship" with the deceased	Recent significant losses	−0.013	[−0.193, 0.167]	0.889
Willingness to use during bereavement	Age group	0.090	[−0.093, 0.267]	0.330
Willingness to use during bereavement	Daily mobile-device use	0.060	[−0.121, 0.238]	0.514
Willingness to use during bereavement	eHealth literacy	0.052	[−0.129, 0.23]	0.574
Willingness to use during bereavement	Educational attainment	−0.073	[−0.25, 0.108]	0.427
Willingness to use during bereavement	Recent significant losses	0.127	[−0.054, 0.3]	0.169
Willingness to use personally	Age group	−0.006	[−0.186, 0.174]	0.948
Willingness to use personally	Daily mobile-device use	0.125	[−0.056, 0.299]	0.174
Willingness to use personally	eHealth literacy	0.109	[−0.073, 0.283]	0.240
Willingness to use personally	Educational attainment	−0.089	[−0.264, 0.093]	0.338
Willingness to use personally	Recent significant losses	0.009	[−0.171, 0.189]	0.923
Willingness to use therapeutically	Age group	−0.071	[−0.248, 0.11]	0.442
Willingness to use therapeutically	Daily mobile-device use	−0.001	[−0.18, 0.18]	0.996
Willingness to use therapeutically	eHealth literacy	0.015	[−0.166, 0.194]	0.875

Table 2. *Cont.*

Perception Variable	Related Characteristic	ρ	95% CI	*p*
Willingness to use therapeutically	Educational attainment	−0.035	[−0.213, 0.146]	0.707
Willingness to use therapeutically	Recent significant losses	0.072	[−0.109, 0.249]	0.437

Note. $N = 119$ for every association. ρ = Spearman's correlation coefficient; CI = confidence interval. Approximate 95% CIs were calculated using Fisher's z transformation from unrounded correlation coefficients. Confidence intervals and two-sided p values are unadjusted for multiplicity. Age, educational attainment, device use and losses were analysed as ordered categories; eHEALS was analysed as a total score. No test remained statistically significant after joint Benjamini–Hochberg adjustment across 40 tests.

2.6. Qualitative Analysis and Integration

Inductive content categorisation was undertaken. The first author read the responses and initially grouped recurring content. The unit of analysis was each participant's response to each question. The authors reviewed the coding and reached consensus on three non-exclusive categories: consent, privacy and digital identity; grief, well-being, authenticity and human connection; and access controls and commercialisation. A response could receive more than one category. Frequencies were calculated separately for each question, using its non-empty responses as the denominator. No formal inter-coder agreement statistic was calculated. Participant quotations were translated from Spanish into English by the authors.

Positions on unrestricted sale were reported separately from the thematic categories: objections or reservations, an unclear position, and support. This classification is distinct from assignment to the "access controls and commercialisation" theme. The components were integrated in a joint display of quantitative findings, related qualitative content and the interpretations supported. Individual-level associations between thematic membership and scores were not examined.

3. Results

3.1. Sample Characteristics

The sample included 119 participants: 76 women (63.9%) and 43 men (36.1%). Eighty were aged 18–29 years (67.2%) and 99 had university, postgraduate or doctoral qualifications (83.2%). Sixty-seven reported at least one significant family loss in the previous three years (56.3%). The mean eHEALS score was 26.47 (SD = 7.77), with Cronbach's α = 0.916 across the 119 complete records.

3.2. Prior Awareness and Willingness to Use

Self-reported prior awareness was low (M = 1.45; SD = 0.69; median = 1; Q1–Q3 = 1–2). Mean willingness to use griefbots therapeutically was 2.34 (SD = 1.22), compared with 2.07 (SD = 1.17) for personal use; both medians were 2, with Q1–Q3 = 1–3. For use during bereavement, the mean was 1.93 (SD = 1.10), the median was 2 and Q1–Q3 = 1–3. Eighty-two participants disagreed or strongly disagreed with this use (82/119; 68.9%). Willingness to use a griefbot to maintain a "relationship" with the deceased person was lower (M = 1.39; SD = 0.77; median = 1; Q1–Q3 = 1–1).

Therapeutic willingness exceeded personal willingness in 44 participants, was lower in 22 and was equal in 53. The Wilcoxon test yielded $Z = -2.544$ and unadjusted $p = 0.011$. This difference did not remain statistically significant after joint adjustment for multiple testing and is not interpreted as a confirmed preference for therapeutic use.

3.3. Perceived Usefulness and Ethical Concerns

Perceived usefulness during bereavement was low (M = 2.35; SD = 1.17; median = 2; Q1–Q3 = 1–3), as was usefulness for maintaining a "relationship" with the deceased person (M = 1.78; SD = 1.05; median = 1; Q1–Q3 = 1–3). The median ethical concern was 4 (Q1–Q3 = 3–5), and the median concern about misuse was 5 (Q1–Q3 = 4–5). Table 3 summarises the descriptive statistics.

Table 3. Descriptive statistics for the measures.

Variable	M	SD
Self-reported prior awareness	1.45	0.69
Willingness to use therapeutically	2.34	1.22
Willingness to use personally	2.07	1.17
Willingness to use during bereavement	1.93	1.10
Willingness to maintain a "relationship" with the deceased	1.39	0.77
Ethical concern	3.90	1.20
Concern about misuse	4.35	1.02
Perceived usefulness during bereavement	2.35	1.17
Perceived usefulness for maintaining a "relationship"	1.78	1.05
eHealth literacy (eHEALS)	26.47	7.77

Note. $N = 119$. M = mean; SD = standard deviation. Prior awareness: 1–3. Willingness, usefulness and concerns: 1–5. eHEALS: 8–40. Higher scores indicate a higher level of the specified variable.

3.4. Exploratory Associations and Comparisons

None of the 40 inferential tests remained statistically significant after Benjamini–Hochberg adjustment at the 5% level; the minimum adjusted p value was 0.071. Nominal associations included lower concern about misuse with more recent losses ($\rho = -0.262$; $p = 0.004$), greater ethical concern with higher educational attainment ($\rho = 0.257$; $p = 0.005$), lower ethical concern in older age categories ($\rho = -0.245$; $p = 0.007$), and greater concern about misuse with higher eHEALS scores ($\rho = 0.246$; $p = 0.007$). The association between recent losses and prior awareness was $\rho = -0.191$ ($p = 0.038$). These exploratory results do not establish confirmed associations.

The mean ranks for prior awareness were 62.35 in men and 58.67 in women (U = 1533; r = 0.06; unadjusted $p = 0.503$). The corresponding ranks were 57.59 and 61.36 for therapeutic willingness (U = 1530.5; r = 0.05; $p = 0.550$), and 55.86 and 62.34 for personal willingness (U = 1456; r = 0.10; $p = 0.300$). The mean ranks for ethical concern were 67.91 in men and 55.53 in women, with corresponding medians of 5 and 4 (U = 1294; r = 0.18; $p = 0.048$).

No comparison remained statistically significant after adjustment.

3.5. Open-Ended Responses

There were 69 non-empty responses concerning ethical issues (58.0% of the sample), 76 concerning potential misuse (63.9%) and 75 concerning unrestricted commercialisation (63.0%). These results describe respondents to each question and cannot be attributed to all 119 participants. Thematic frequencies are presented in Table 4.

Table 4. Thematic-category frequencies by question.

Open-Ended Question	Non-Empty Responses	Consent, Privacy and Digital Identity	Grief, Well-Being, Authenticity and Human Connection	Access Controls and Commercialisation
Ethical concerns	69	15	49	9
Potential misuse	76	10	54	27
Unrestricted commercialisation	75	0	26	40

Note. Categories are non-exclusive and counts do not represent different individuals across questions. For commercialisation, the 66 thematic assignments do not account for all 75 responses, even before overlaps are considered; the available counts therefore leave at least nine responses without an assigned theme. Positions on sale are reported separately from thematic classification.

3.5.1. Consent, Privacy and Digital Identity

Participants questioned permission to use the deceased person's materials and recreate their image or personality. One referred to "the deceased person's inability to provide consent for the use of their image" (P068; woman; 18–29 years; no significant losses in the previous three years). A further response described possible misuse: "manipulate people emotionally, exploit their pain for commercial purposes, or recreate someone's personality without permission, violating their privacy and dignity" (P084; man; 30–41 years; three or more recent significant losses).

3.5.2. Grief, Well-Being, Authenticity and Human Connection

Responses raised concerns about replacing the deceased person, dependence and authenticity. One participant described using a griefbot "as a replacement for the deceased person, potentially forming a dangerous bond" (P013; woman; 18–29 years; three or more recent significant losses). Another mentioned "a risk of 'addiction' to this type of method and the development of dependence" (P049; man; 18–29 years; one recent significant loss). Authenticity was also questioned: "They do not seem real to me; they are AI, so I am not interested" (P039; woman; 54–65 years; one recent significant loss). These are anticipated concerns, not effects observed after griefbot use.

3.5.3. Access Controls and Commercialisation

Of the 75 participants who answered this question, 69 expressed objections or reservations about unrestricted sale (92.0%), two did not express a clear position (2.7%) and four expressed support (5.3%). Nine mentioned specialist oversight or use by qualified professionals (12.0% of the 75 responses). This last count may overlap with the preceding positions and does not constitute a fourth opinion category.

One participant opposed sale without prior assessment: "I do not think it should be sold to anyone without first assessing the person and the situation" (P007; woman; 18–29 years; one recent significant loss). Another suggested that "the tool should be used exclusively for therapeutic purposes" (P046; woman; 18–29 years; no recent significant losses). A participant objected to commercial exploitation: "It is dangerous because people are vulnerable during grief, and their pain should not be turned into a business" (P050; woman; 42–53 years; one recent significant loss). Another compared unrestricted sale to "selling medicines with serious side effects to anyone" (P027; man; 18–29 years; two recent significant losses).

3.6. Descriptive Integration

Table 5 presents findings from both components together. Convergence is descriptive: open-ended responses characterise concerns present in the sample, but do not establish which reasons determined each participant's scores.

Table 5. Joint display of quantitative and qualitative findings.

Quantitative Finding	Related Qualitative Content	Supported Interpretation
Median willingness to use during bereavement = 2/5; 82/119 express disagreement.	Concerns about authenticity, replacement of the bond and dependence.	Low willingness and expressed concerns coexist; individual-level explanatory relationships have not been established.
Median concern about misuse = 5/5.	Consent, privacy, emotional manipulation and use of materials without permission.	Identifies topics for information and user consultation; does not show that anticipated harms have occurred.
Of 75 open-ended responses, 69 express objections or reservations about unrestricted sale.	Requests for prior assessment, oversight and limits on commercial exploitation.	Describes conditions proposed by some participants; does not establish that oversight guarantees safety.

4. Discussion

4.1. Interpretation of the Main Findings

In this sample, self-reported prior awareness and willingness to use griefbots were low, whereas ethical concerns and concern about misuse were high. Open-ended responses elaborated concerns about consent, authenticity, dependence and commercialisation. Associations with personal characteristics did not remain statistically significant after joint adjustment. The study's strongest contribution is therefore descriptive, rather than the identification of predictive acceptance profiles.

Low willingness does not imply rejection of bereavement care or predict responses to a specific intervention. Participants evaluated a general description, rather than a defined system they had used. The mention of ChatGPT and presentation of a definition before the prior-awareness item may also have shaped their understanding of the technology. These conditions should be considered when interpreting the scores.

The findings complement the acceptance studies by Fan and Cheng [11] and Fu et al. [12], which examine perceived benefits, barriers and social or ethical factors. Differences in samples and instruments prevent direct comparison of acceptance levels. Our study also did not measure grief severity or evaluate the explanatory mechanisms proposed in those studies.

The qualitative concerns resemble those described by Lu et al. [7] and the ambivalence observed by Jiménez-Alonso and Brescó de Luna [10]. A wish to maintain a connection may coexist with concerns about an artificial representation. Research on continuing bonds indicates that their relationship with well-being depends on their form and context [18,19]; generative interaction should not be assumed to have the same effects as a symbolic practice.

The nominal correlation between eHEALS and concern about misuse does not show that greater literacy produces more critical attitudes. The eHEALS measures perceived skills [15], and the association did not survive adjustment. Similarly, the small sex difference

in ethical concern does not justify selecting users or making clinical recommendations by sex. Research on responses to AI may inform future questions [20], but does not itself explain this finding.

4.2. Implications for Research and Development

The findings may inform consultation with bereaved people, professionals and developers about acceptable uses, information needs and access conditions. We propose three priorities, informed by the themes and ethical literature [2,9,13,21]: establishing procedures for authorisation and control of digital materials; communicating the artificial nature of responses and evaluating their emotional effects; and examining access conditions and commercial practices. These are proposals for research and governance, not safeguards validated by this survey.

Future research should first define the application and its purpose, assess acceptability and feasibility and, where appropriate, investigate clinical outcomes using suitable comparators. Evidence concerning therapeutic writing [5] or bereavement interventions [22] cannot be transferred automatically to AI-generated conversations. Evaluations should include grief symptoms, everyday functioning and possible adverse effects over the medium and long term. A stated preference for professional oversight does not establish that such oversight prevents harm.

4.3. Limitations

The non-probability sampling and the sample size limit generalisability. The sample predominantly comprised young adults (67.2% aged 18–29 years) and participants with university or postgraduate qualifications (83.2%). This composition may partly reflect social-media recruitment and snowball sampling, which can introduce coverage and self-selection biases [23,24]. However, the study did not assess why individuals chose to participate, and the sample composition cannot be attributed to greater interest in griefbots or higher digital competence. These characteristics limit generalisability to older adults and people with lower educational attainment. The direction and magnitude of any resulting bias in estimates of willingness to use griefbots or ethical concerns remain unknown. Women were also overrepresented. No invitation or survey-start denominators were available, and use of multiple accounts by the same person cannot be excluded.

The study-specific items were brief, with no documented validation or pretesting. The administered description may have introduced framing effects, and prior awareness was assessed after that description. Self-reported losses do not characterise grief intensity, course or impact.

The cross-sectional design does not establish causality or temporal order. Absence of statistical significance after adjustment does not demonstrate absence of associations; the study has limited sensitivity to small effects. Categorising age and device use reduced the granularity of the recorded information. The confidence intervals are approximate and nominal, without adjustment for multiplicity, and should not be interpreted as simultaneous confidence intervals.

Open-ended questions were optional, and their results may reflect self-selection among those who answered. Consensus categorisation was not accompanied by a formal agreement measure, and incomplete coding documentation and responses without an assigned category limit reproducibility. Integration was descriptive and did not examine individual-level relationships between themes and scores.

5. Conclusions

In this sample of Spanish adults, griefbots were little known and willingness to use them was low, alongside concerns about consent, digital identity, authenticity, dependence and commercialisation. No exploratory association remained statistically significant after adjustment for multiple testing. The findings identify questions for further research on acceptability and responsible design, but do not establish clinical effects or support recommendations for patient use. Interpretation requires the consideration of limitations in sampling, measurement and documentation of the procedure.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/healthcare14234008/s1, Supplementary File S1: Study questionnaire in Spanish with an English translation.

Author Contributions: Conceptualisation, A.G.-R. and E.R.; data curation, A.G.-R.; formal analysis, A.G.-R.; funding acquisition, E.R.; investigation, A.G.-R. and E.R.; methodology, E.R.; project administration, E.R.; software, A.C.-M. and F.M.-M.; supervision, A.C.-M., F.M.-M. and E.R.; validation, E.R.; visualisation, E.R.; writing—original draft, A.G.-R. and E.R.; writing—review and editing, A.C.-M., F.M.-M. and E.R. All authors have read and agreed to the published version of the manuscript.

Funding: Fundación Universitaria San Pablo CEU (CEU Universities). The funder had no role in the study design; data collection, analysis or interpretation; manuscript preparation; or decision to submit the manuscript for publication.

Institutional Review Board Statement: The study was approved by the Ethics Committee of Universidad San Pablo-CEU, approval code 1016-25 TFM, with the approval document dated 26 May 2025, and was conducted in accordance with the Declaration of Helsinki.

Informed Consent Statement: Participants were informed of the study objectives, and participation was voluntary. Voluntary completion was taken as implied informed consent. Google account sign-in was required to limit submissions to one per account, but email address collection was disabled. No participant names or email addresses were collected in the survey response records or made available to the research team.

Data Availability Statement: Participant-level responses are not publicly available because the consent did not cover their public disclosure and open-ended responses may contain sensitive information. Requests concerning access to a minimum de-identified dataset may be directed to the corresponding author; any access is subject to the scope of consent and institutional authorisation. The administered questionnaire is supplied separately as Supplementary File S1.

Acknowledgments: ChatGPT (GPT-6.1 Sol, OpenAI) was used to assist with restructuring and drafting of the revised text. No participant-level data or new analytical results were generated using this tool. Responsibility for the content rests with the authors.

Conflicts of Interest: The authors declare no conflicts of interest.

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