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Coping Style Use Predicts Posttraumatic Stress and Complicated Grief Symptom Severity Among College Students Reporting a Traumatic Loss

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Problem-focused coping, and active and avoidant emotional coping were examined as correlates of grief and posttraumatic stress disorder (PTSD) severity among 123 college students reporting the unexpected death of an immediate family member, romantic partner, or very close friend. The authors administered to participants, via the Internet, 5 survey instruments that measured demographic characteristics, traumatic event exposure (Stressful Life Events Screening Questionnaire; L. Goodman, C. Corcoran, K. Turner, N. Yuan, & B. L. Green, 1998), complicated grief (CG) severity (Inventory of Complicated Grief—Revised—Short Form; A. E. Latham & H. G. Prigerson, 2004; H. G. Prigerson & S. C. Jacobs, 2001), PTSD severity (PTSD Checklist; F. W. Weathers, B. T. Litz, D. S. Herman, J. A. Huska, & T. M. Keane, 1993), and coping style use (Brief COPE; C. S. Carver, 1997). Results demonstrated that CG and PTSD severity were both significantly positively correlated with problem-focused, and active and avoidant emotional coping styles. The authors used path analysis to control for time since the loss and trauma frequency and found that only avoidant emotional coping remained significant in predicting CG and PTSD severity. Results are discussed in terms of their clinical implications for treating individuals with traumatic losses.

Keywords: posttraumatic stress disorder, coping behavior, complicated grief, bereavement

There has been a recent focus in the mental health literature on grief and bereavement after traumatic events. Studies have examined complicated grief (CG), a maladaptive symptom pattern secondary to a major loss that lasts beyond the normal grieving time (Prigerson, Frank, et al., 1995). However, the relation between CG, coping skill use, and posttraumatic stress disorder (PTSD)—including examination in young adult college students—has not been explored fully.

Trauma Exposure

Approximately 50–60% of the general population has experienced a high-magnitude, potentially traumatic event (e.g., serious accident, natural disaster, or witnessing a trauma) (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Similarly, 67% of young adult college students have been estimated to experience comparable traumatic events (Bernat, Ronfeldt, Calhoun, & Arias, 1998). Data from the early 1990s suggest that 30% of the general population (5% on an annual basis) has experienced a traumatic loss (i.e., a specific traumatic event type involving the unexpected death of a loved one) (Norris, 1992). Eighteen percent of college students reported a prior traumatic loss (Bernat et al., 1998), and is the focus of the present study.

CG

After a significant death, a common response is grief (or bereavement), which tends to resolve within several months to 1 year for most people, averaging approximately 6 months (Prigerson, Frank, et al., 1995). Over time people suffering from normal, or uncomplicated, grief are able to adjust and return to daily functioning (Prigerson, Frank, et al., 1995; Prigerson, Vanderwerker, & Maciejewski, in press). After a "traumatic" loss, for some people, the grief response can involve a lack of acceptance of the death, with the survivor undergoing a chronic state of mourning often referred to as CG (Prigerson et al., 1997; Prigerson, Frank, et al., 1995). One risk factor for CG includes the lack of emotional support sometimes associated with traumatic events (Stewart, 1999), which may particularly impact populations such as college students who may be geographically distant from their usual support systems.

CG is not listed as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition; *DSM–IV*; American Psychiatric Association, 1994), but nonetheless it is associated with substantial mental and physical health impairment (Prigerson et al., 1997). Of importance, research groups have independently identified symptom sets for CG (e.g., Horowitz et al., 1997; Prigerson et al., 1999), and these investigations have resulted in similar sets of core CG symptoms (Prigerson, Frank, et al., 1995). A consensus paper approved by these experts based on recent field testing yielded a face valid CG symptom set including yearning for the deceased, trouble accepting death, mistrust of

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others, bitterness over the death, difficulty moving forward with life, emotional numbness, feelings of emptiness, feeling one's future is meaningless, and agitation; the symptoms must be present for at least 6 months and produce functional impairment (Prigerson, Frank, et al., 1995). Empirical research has demonstrated that CG is statistically independent from depression and anxiety, including PTSD (Gray, Prigerson, & Litz, 2004; Prigerson et al., in press).

It should be noted that other terms for CG include "traumatic grief" (a term previously preferred by experts), "abnormal grief," "pathological grief," "atypical grief," and "pathological mourning" (Prigerson, Frank, et al., 1995). These terms are sometimes used interchangeably and refer to the same clinical phenomenon. However, bereavement, included in *DSM–IV*, is statistically independent from CG (Prigerson et al., 1997).

PTSD

CG is not the only syndrome that can result from traumatic loss. Other disorders, such as PTSD, can occur with CG (Barry, Kasl, & Prigerson, 2001; Prigerson, Frank, et al., 1995). PTSD prevalence in the general population is estimated at 8% (Kessler et al., 1995), and roughly similar rates are found in college students (Bernat et al., 1998). PTSD involves symptoms of reexperiencing the traumatic event (Criterion B), avoidance and emotional numbing (Criterion C), hyperarousal in response to a trauma (Criterion D); symptoms are present for at least 1 month (Criterion E) and cause functional impairment (Criterion F). Some symptom overlap is apparent between CG and PTSD but this overlap is not substantial (Prigerson, Frank, et al., 1995).

Coping

Efficient and adaptive coping skills could buffer PTSD reactions among those experiencing a traumatic loss, since training patients in the use of effective coping skills is part of treatment for PTSD (Foa, Davidson, & Frances, 1999). Coping may also be a mediating variable between traumatic loss and CG, as studies have demonstrated that people who experience a traumatic loss have a greater risk of developing both complicated grief and PTSD (Stewart, 1999).

Most coping responses are considered to broadly encompass problem- or emotion-focused coping (Carver & Scheier, 1994; Folkman & Lazarus, 1985). Problem-focused coping is generally viewed as an adaptive mode of coping that involves actively planning or engaging in a specific behavior to overcome the problem causing distress (Folkman & Lazarus, 1985). Emotion-focused coping involves attempts to regulate one's emotions, and can be considered active or avoidant (Holahan & Moos, 1987). Active emotional coping, such as venting one's emotional distress or cognitively reframing a stressor's impact, is typically viewed as an adaptive emotion-regulation strategy (Folkman & Lazarus, 1985). Avoidant emotional coping is viewed as maladaptive, for example, using denial or self-distraction to avoid the source of distress (without engaging in problem-focused behavior) (Holahan & Moos, 1987). Although avoidant coping may help individuals manage their day-to-day activities soon after a crisis, reliance on this coping style over time can lead to mental health problems (Holahan & Moos, 1987); similarly, problem-focused coping in the absence of active emotional coping may be problematic. Little is known about the association between specific coping responses and traumatic loss, or between coping and CG and PTSD. However, studies have found that emotion-focused coping, especially an avoidant strategy, is generally related to worse overall mental health outcomes (Coyne & Racioppo, 2000).

Aims

Despite previous work done on CG and PTSD, their relations with coping style use have received little attention. The goal of this study was to examine how coping style use was associated with CG and PTSD severity following a traumatic loss among college students. We were interested in college students because of the scarcity of research on CG with young adults and the relatively high prevalence of trauma in this population (Bernat et al., 1998). We hypothesized that avoidant emotional coping would be related to greater severity of CG and PTSD, given previous research on the maladaptive nature of this coping strategy (Holahan & Moos, 1987), including this strategy's association with CG and PTSD outcomes (Stewart, 1999). We hypothesized that problem-focused and active emotional coping, as adaptive strategies (Holahan & Moos, 1987), would be related to decreased CG and PTSD severity. We attempted to account for potential confounding correlates by statistically controlling for trauma frequency and time since the loss.

Method

Participants

One hundred twenty-three students (91 women, 31 men, 1 gender not indicated), enrolled in college courses (mostly psychology) at a midwestern U.S. state university, served as participants. Participants were recruited from the university's multidepartmental research pool (N = 543 students in Fall 2005, and N = 467 students in Spring 2006).

Participant age ranged from 18 to 45 (M = 21.18, SD = 4.87). Educational level completed ranged from 11 to 16 years, with an average of 13.33 (equivalent to 1 year of college; SD = 1.50). Annual personal income was quite variable, averaging $13,097 ($SD$ = 25,330). The majority of participants worked part-time (n = 70, 57%) or were unemployed (n = 44, 36%). Most participants reported race as Caucasian (n = 117, 95%), and ethnicity was largely non-Hispanic (n = 107, 87%) or unknown (n = 16, 13%). Relationship status for the majority of the sample was single (n = 103, 85%).

Instruments

Five instruments were administered in a fixed order (due to logistical constraints of the Web survey) and took approximately 30 min to complete.

Demographics survey. This survey inquired about gender, age, educational level, employment, relationship status, annual income, race, and ethnicity.

Stressful Life Events Screening Questionnaire—Modified (SLESQ; Goodman, Corcoran, Turner, Yuan, & Green, 1998). The SLESQ is a self-report measure querying past exposure to 13 *DSM–IV* PTSD Criterion A traumatic events (i.e., involving seri-

ous injury or death, or the threat thereof) using behaviorally specific questions. Test–retest reliability is adequate, with a median kappa coefficient of .73. Convergent validity was established with an extensive trauma interview, with a mean kappa of .64 and good discrimination between Criterion A and non-Criterion A events (Goodman et al., 1998). We modified the measure's scaling by querying event frequency (*never*, *once*, *twice*, *three times*, *four times*, *five times*, or *more than five times*) rather than presence–absence. Since the SLESQ has only a general item on loss (it does not specify a "sudden" nature), we revised Item 4 to add the unexpected focus element of Item 17 taken from the Life Stressor Checklist—Revised (Wolfe, Kimerling, Brown, & Chrestman, 1997): "Has an immediate family member, romantic partner or *very close* friend died suddenly or unexpectedly (for example, sudden heart attack, murder or suicide)?" Items were summed for a total score of trauma frequency (sample $\alpha = .59$, which is expected since trauma exposures do not reflect a unitary construct). It is noteworthy that the *more than five times* response option was rarely endorsed. Participants were instructed to complete the subsequent measures based on how they were affected by their most recent unexpected loss.

Inventory of Complicated Grief—Revised—Short Form (ICG–R; Prigerson & Jacobs, 2001). The ICG–R is a 37-item evaluation of complicated (as opposed to normal) grief responses over the previous month. Test–retest reliability of .80 is adequate, and the measure has excellent internal consistency ($\alpha \geq .95$). The ICG–R has sensitivity and specificity of .93 for identifying or ruling out CG (based on an interviewer-administered CG measure; Prigerson & Jacobs, 2001). We used a 17-item short-form of the ICG–R based only on items applied to the CG consensus criteria, and obtained correct classification of 93% and excellent interrater agreement ($\kappa = 1.0$) (Latham & Prigerson, 2004; Prigerson et al., 1999). These items mirror the content of the consensus criteria (described above) and query symptom frequency or intensity (e.g., inquiring about the frequency of yearning for the deceased, intensity of loneliness since the deceased departed, etc.). The total, summed score was obtained, with higher scores indicating greater CG severity (sample $\alpha = .94$).

Brief COPE (Carver, 1997). The Brief COPE is a 28-item measure of coping style use derived from the longer COPE inventory (Carver, Scheier, & Weintraub, 1989). The Brief COPE uses a 4-point Likert scale (*I haven't been doing this at all* to *I've been doing this a lot*), querying a variety of different coping methods (e.g., praying or meditating, receiving emotional support from others, criticizing oneself, etc.). It includes 14 subscales of two items each. Subscale coefficient alphas range from .50 to .90, with nine $\geq .65$ (Carver, 1997). Based on conceptual and empirical literature describing the three coping strategies summarized above (Carver & Scheier, 1994; Folkman & Lazarus, 1985; Holahan & Moos, 1987), we rationally grouped the 14 subscales into these three coping categories by summing items accordingly (with higher scores indicating greater intensity of use of the coping strategy). The three coping strategies and their associated subscales were problem-focused coping (active coping, planning, instrumental support, and religion scales; $\alpha = .80$ for our sample); active emotional coping (venting, positive reframing, humor, acceptance, and emotional support scales; $\alpha = .81$); and avoidant emotional coping (self-distraction, denial, behavioral disengagement, self-blame, and substance use scales; $\alpha = .88$).

The PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993). The PCL is a 17-item Likert-scaled self-report measure of past-month PTSD symptom severity, mapping well onto *DSM–IV* Criteria B, C, and D (e.g., unpleasant dreams about the trauma, avoiding discussing the trauma, and exaggerated startle response). The PCL has excellent internal consistency ($\alpha = .94$) and test–retest reliability of .88 in college students (Ruggiero, Del Ben, Scotti, & Rabalais, 2003). Studies have found that the PCL has adequate sensitivity in detecting PTSD (82%–94%), specificity (83%–86%), and overall PTSD diagnostic efficiency (83%–90%) (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Weathers et al., 1993). For this study, the PCL score was a summed total; higher scores indicated greater PTSD severity (current sample $\alpha = .95$).

Procedure

A prescreening questionnaire on the electronic system included an item aimed at eliminating participants who had experienced a previous loss (either sudden or expected). The question wording was from the original SLESQ Item 4, without reference to a sudden or expected nature of the loss. After electronic sign-up for study participation, students ($n = 228$) were directed to a Web-based consent form stating that the study dealt with stressful events, coping, and emotional functioning. Those consenting to participate were administered the five Web-based surveys.

Of the 228 individuals who had experienced a loss and consented to participate in the study, 126 reported an unexpected loss and thus were retained since a PTSD Criterion A event involving loss requires that it is unexpected. Out of those 126 participants, 3 completed no more than a few items before terminating the survey and were removed from analyses, leaving an effective sample size of 123 participants. The most recent traumatic loss was reported to occur in the past 2 years for 66 participants (54%), and over the past 5 years for a cumulative total of 95 participants (77%).

Results

Preliminary Analyses

Across the five instruments that 123 participants completed, some item-level data were missing (not more than 10% of items was missing by a given participant). Looking specifically at the symptom survey measures (ICG–R, Brief COPE, and PCL), we found that items were missing at random; participants with missing data were not substantially different from those without missing data on other variables; Little's missing completely at random test, $\chi^2(1{,}339, N = 123) = 1{,}401.38$, $p > .05$. Using SPSS Missing Value Analysis 14.0, we estimated missing item data on the ICG–R, Brief COPE, and PCL using the expectation maximization algorithm, a maximum-likelihood method of missing data estimation that is more accurate than case deletion or mean substitution (Schafer & Graham, 2002).

Correlational Analyses

Correlations between coping styles and the ICG–R. The ICG–R total score was significantly related to problem-focused

coping, $r = .52$, $p < .001$. Additionally, the ICG–R was significantly related to active emotional coping, $r = .42$, $p < .001$. The most substantial relationship was with avoidant emotional coping, $r = .72$, $p < .001$ (see Table 1); this correlation was significantly higher than the other two correlations (t tests for correlations ps $<$ .01).

Correlations between coping styles and the PCL. The PCL total score was significantly correlated with problem-focused coping, $r = .48$, $p < .001$. Additionally, the PCL was significantly related to active emotional coping, $r = .43$, $p < .001$, and was most strongly associated with avoidant emotional coping, $r = .81$, $p < .001$ (see Table 1), with a significantly higher correlation for avoidant coping, ps $< .01$.

Path Analysis

We estimated a maximum likelihood path analysis using Mplus Version 4.2 software (Muthén & Muthén, 1998–2006) to model the relationship between two trauma-related covariates, coping styles, CG, and PTSD severity. Covariates included years since the most recent traumatic loss and logarithmically transformed trauma frequency (trauma frequency was logarithmically transformed because of substantial skewness of 2.7). Coping styles included avoidant emotional coping and a composite of problem-focused and active emotional coping, since the latter two variables were substantially intercorrelated ($r = .74$; see Table 1). Dependent variables were the ICG–R and the PCL. In order to account for the significant relationships between avoidance and active emotional/problem-focused coping ($r = .56$), as well as between the ICG–R and PCL ($r = .70$), the variables' residual error variances within each pair were specified to correlate (further supported empirically by modification indices). See Figure 1 for the hypothesized model, including sample parameter estimates.

The hypothesized path model corresponded closely to the sample's covariance matrices, $\chi^2(4, N = 123) = 13.22$, $p = .01$. Based on goodness of fit indices that are most accurate with small samples, the comparative fit index (.97) and standardized root-mean-square residual (.04) indicated a very close fit (CFI $> .95$ and SRMR $< .08$ represent an excellent fit; Hu & Bentler, 1998). After accounting for the two covariates, and shared variation between the coping styles and between CG and PTSD severity, avoidant coping (but not active/problem-focused coping) was significantly associated with CG and PTSD severity ($\beta = .65$ and .78, respectively).

Discussion

This study found that CG and PTSD severity were both significantly positively correlated with problem-focused coping and active and avoidant emotional coping styles among students endorsing a previous traumatic loss; the largest correlations were found with avoidant emotional coping. In fact, the three coping styles demonstrated substantial intercorrelations, suggesting that there is a fair amount of overlap in the use of these coping strategies (Coyne & Racioppo, 2000). However, we did not expect to find problem-focused or active emotional coping as highly related to the outcomes. In a path model, controlling for time since the most recent loss and trauma frequency, however, we found that only avoidant emotional coping remained as a significant and substantial predictor of both CG and PTSD severity, with "large" path coefficients. In contrast, using active emotional/problem-focused coping no longer significantly predicted outcomes. Thus, despite the interrelationships between coping styles, and their substantial individual relations with CG and PTSD severity, it appears that variance in CG and PTSD severity is best accounted for by avoidant emotional coping.

Our work confirms results from prior extant research on the relationship between coping and both CG and PTSD. In particular, Stewart (1999) also found that grief is often accompanied with avoidant coping reactions. Furthermore, the author discovered that avoidant coping is one of the best predictors of PTSD (Stewart, 1999), consistent with the present study. However, our hypothesis that active emotional and problem-focused coping would be related to less distress was unsupported in our results. In fact, bivariate correlations revealed a positive relationship between using these more adaptive coping styles and distress, and path analyses found no relation with distress. Perhaps with the substantial disease burden of PTSD (Kessler, 2000) and CG (Prigerson et al., 1997), these emotional difficulties are best alleviated by professional treatment, and respond less to personal coping strategies.

Although we conclude that the high correlations between avoidant emotional coping and PTSD–CG severity indicate a strong association between avoidant coping and these forms of emotional distress, there is a potential alternative explanation.

Table 1
Correlation Matrix of Predictor and Outcome Variables

Variable	*M*	*SD*	1	2	3	4	5	6
1. Trauma frequency	5.11	5.22	—					
2. Years since loss	3.57	3.77	−.03	—				
3. Problem coping	13.49	4.37	.26*	−.14	—			
4. Active emotional coping	17.90	5.18	.37**	.16	.74**	—		
5. Avoidant emotional coping	14.83	5.31	.28*	−.25*	.56**	.50**	—	
6. ICG–R	29.84	11.56	.24*	.33**	.52**	.41**	.72**	—
7. PCL total	26.78	11.78	.31**	−.14	.48**	.43**	.81**	.70**

Note. Trauma frequency means and standard deviations are presented as normal but log-transformed in correlational analyses. ICG–R = Inventory of Complicated Grief—Revised—Short Form; PCL = PTSD checklist.
*$p < .01$. **$p < .001$.

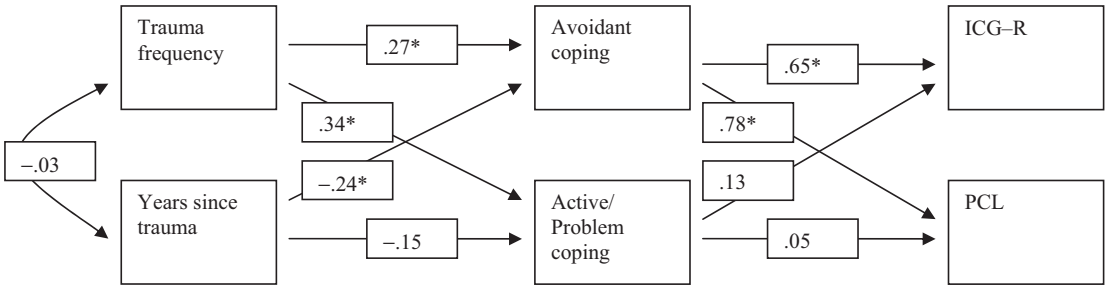

Figure 1. Hypothesized path model and standardized path coefficients. Each variable with a straight arrow pointing to it has associated residual error variance. Residual variances were set to intercorrelate for the two coping variables: the Inventory of Complicated Grief—Revised—Short Form (ICG–R) and the PTSD Checklist (PCL). * $p < .01$.

Specifically, avoidant coping, as measured by the Brief COPE, could merely tap the same constructs as PTSD and CG. However, there are some problems with this alternate hypothesis. First, after a careful examination of items, we find that the Brief COPE does not map well onto the symptom criteria for PTSD (PCL) or CG (ICG–R); in fact only two avoidant coping items from the Brief COPE (self-distraction subscale) are relevant to PTSD or CG, similar to trauma-related behavioral avoidance. In fact, factor analytic findings for an earlier version of the ICG–R demonstrate a single underlying construct of CG (Prigerson, Maciejewski, et al., 1995), which does not seem to be characterized by avoidant coping. It is true that PTSD factor analytic work (including the PCL) supports the PTSD avoidance and numbing Criterion C as a distinct factor (in addition to reexperiencing and hyperarousal factors) (Asmundson, Stapleton, & Taylor, 2004). However, if avoidant emotional coping is redundant with PTSD, we would expect to find its strongest relationship with PTSD avoidance and numbing symptoms (Criterion C). Yet in fact avoidant coping was not more strongly correlated with PTSD Criterion C ($r = .72$) than with Criterion B or Criterion D (rs = .77, not presented in Results), and the differences between these correlations were not significant (t test for correlations, $p > .05$). Nonetheless, future research should assess whether the construct of avoidant coping may be redundant with PTSD and CG.

Previous research has demonstrated an empirical distinction between CG and PTSD (as well as other disorders), finding engagement and rumination to be unique to CG and associated with worse outcomes (Prigerson, Frank, et al., 1995). This research was based on older adults and investigated CG after the loss of a spouse. However, our results with younger adult college students demonstrate a substantial relationship between these constructs. Furthermore, unlike previous research, we found that in younger college students avoidant emotional coping—which has a strong avoidant (rather than engagement–ruminative) coping component—was particularly related to greater CG severity. This raises the question of whether loss among young adults may be associated with a different form of CG than that observed in previously studied CG populations.

In addition to the consistency between our findings and those of Stewart's (1999) study on CG and PTSD, our findings are also consistent with the broader literature demonstrating a reliable relationship between emotion-focused (in particular, avoidant) coping and psychopathology (Coyne & Racioppo, 2000). It is often presumed that this relationship is causal, with psychopathology causing avoidant coping; after all, there is little reason to employ avoidant emotional coping without a negative emotion to process (Coyne & Racioppo, 2000). Alternatively, perhaps the reliance on avoidant emotional coping can result in psychopathology, wherein the individual uses fewer active coping strategies that may be more beneficial to their mental health. However, we found large, positive relationships between active and avoidant coping—suggesting that people may use both strategies—consistent with other research (Coyne & Racioppo, 2000), and thus failing to support the latter explanation.

Limitations

Several limitations apply to this study. First, we did not inquire about the closeness of the relationship between the deceased individual and the survivor, which prevented us from controlling for this important variable in our analyses. Thus, it is possible that a participant endorsed a relatively insignificant loss (e.g., brother who the participant never met, romantic partner from a 1-week relationship) that cannot be distinguished from another participant's more serious loss (e.g., child, spouse of several years). Thus, the sample may reflect a heterogeneous group of participants with losses ranging from minor to substantial, possibly diluting the results. Future research should attempt to control for the closeness of the deceased.

A second limitation is that the results are only generalizable to college students in the Midwest, and may not be representative of the general population of individuals reporting a traumatic loss. Third, the Brief COPE, though cost-effective and adaptable, has been criticized for having limited clinical relevance (Coyne & Racioppo, 2000). Fourth, we assessed PTSD symptoms and did not include measures of general anxiety or distress, which could mediate the CG–PTSD relationship, possibly obscuring more complex relationships in our sample. Similarly, we did not use a structured interview for PTSD as the entire survey was conducted online, and we are unaware of research on the utility of administering these surveys electronically. Additionally, because we made minor modifications to the SLESQ, we cannot be sure that its psychometric properties reflect those of the original version. Finally, although we instructed participants to complete the measures based on their most recent, unexpected loss, these measures are based on a recent time-frame, and may not capture initial responses

to a traumatic loss from years ago. This time difference between the loss and symptom ratings could have resulted in less accurate recall by participants, and could be addressed in future research using longitudinal designs.

Clinical Applications

The lack of association between research on adaptive coping and mental health outcomes is puzzling (Somerfield & McCrae, 2000). Some avoidant emotional coping strategies (e.g., distraction, thought stopping) are currently used in clinical treatment for trauma-related sequelae such as CG and PTSD (Foa et al., 1999). Further study into the effect of avoidant emotional coping is necessary to determine if the relevant treatment techniques are beneficial. Additionally, despite reports that the Brief COPE has limited clinical relevance (Coyne & Racioppo, 2000), the relations between avoidant emotional coping and CG and PTSD suggest that clinicians might be advised to administer the Brief COPE to patients presenting with a traumatic loss. Patients evidencing a strong avoidant emotional coping strategy may benefit from learning to decrease their reliance on this coping style.

Furthermore, students may attend college at a considerable distance away from their families. Students whose peer and familial support systems are not proximal may have difficulty engaging in active emotional coping, and may have to rely on the use of avoidant emotional coping instead. Thus, clinicians working with college students should pay particularly close attention to students' support systems.

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