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Research Paper

# Coping Styles in Young Adults with Posttraumatic Stress Symptoms: Examining Adaptive & Maladaptive Coping

Gulshan Bhore[1]*, Tanmay Dubey[1], Sheena Thomas[2]

## ABSTRACT

After exposure to traumatic events, Post-traumatic Stress Symptoms may show up in young adults, and to cope with those symptoms of traumatic stress, individuals employ different coping strategies that are based on different adaptive and maladaptive coping styles depending upon the capacity of the coping style to alleviate stress. There is limited research on the ways young adults engage into coping that helps them relieve stress symptoms. It is often discussed as to which coping greatly predicts and affects PTSS, as different studies have showed contradictory results on the nature of adaptive, and maladaptive coping styles. We examined the relationship between Coping styles and PTSS in young adults, focusing on adaptive and maladaptive coping. Using the PCL-5 and Brief-COPE, data were collected from 105 participants aged 18 to 25 years, through an Online Survey. Results indicate that Avoidant Coping significantly predicts higher PTSS severity, while Problem-focused, and Emotion-focused coping showed weaker associations. These findings challenge the traditional assumptions of adaptive vs maladaptive coping, suggesting a need to reassess coping frameworks in trauma research. Implications for clinical interventions and future research are discussed.

***Keywords:*** *Coping Styles, PTSS, Young Adults, Trauma, Brief-Cope, PCL-5, Adaptive Coping, Maladaptive Coping, Avoidant Coping, Problem-Focused Coping, Emotion-Focused Coping*

Posttraumatic Stress Disorder is a debilitating mental health condition which may develop in people who have experienced or witnessed a traumatic event, such as death, violence, natural disaster etc., thereby affecting significant aspects of their life including, mental, emotional, social, physical, and spiritual aspects, often leading to distressing symptoms like intrusive flashbacks and memories, emotional numbing, hyperarousal etc. (American Psychiatric Association, 2013). However, most people who experience trauma do not always develop PTSD, yet may experience the symptoms of PTSD, though not in the same intensity, duration or other necessary criteria as required for a PTSD diagnosis as per DSM-5 or ICD-11, being termed as Post-traumatic Stress Symptoms (PTSS).

[1]Department of Psychology, The Bhopal School of Social Science, Bhopal (M.P.)
[2]Department of Education, The Bhopal School of Social Science, Bhopal (M.P.)
*Corresponding Author

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Post-traumatic stress affects different age groups differently with the younger ages being more susceptible to the adverse effects of post-traumatic stress (Reynolds et al., 2016). Nearly, two-thirds of youth get exposed to trauma by late adolescence, and by the age of 18, eight percent of traumatized youth meet the criteria for PTSD (McLaughlin et al., 2013). This study is focused on studying the coping styles that predict the subclinical trauma symptoms in the population of Young Adults that includes the age group from 18 to 25 years, viewing this age group as particularly vulnerable to PTSS since they are in their crucial phase of development with their coping mechanisms still evolving and being shaped by their everyday experiences. Young adults in their age undergo significant life transitions, including pursuing higher education, moving out for better opportunities, entering workforce, navigating through interpersonal relationships and conflicts etc. (Schoon, 2015). Post- traumatic stress can have incapacitating effects on their everyday normal functioning, disrupt their emotional health and restrict them from employing their full potential into performance.

People incorporate different coping styles to counter the negative impacts of post-traumatic stress. Coping styles play an important role in psychosocial and emotional adjustment. Coping styles are broadly categorized into two dimensions: While some coping styles may contribute to better health outcomes, i.e., adaptive coping, others might worsen the symptoms of PTSS, i.e., maladaptive coping (Campos et al., 2004; Carver, Scheier, & Weintraub, 1989). Lazarus & Folkman (1984) primarily distinguished between Problem-focused and Emotion-focused coping, without explicitly labelling these as adaptive or maladaptive. Later, studies like Carver et al. (1989) and Skinner et al. (2003) based on their effectiveness in reducing stress started viewing Problem-focused and Emotion-focused coping as Adaptive coping style, and other studies like Carver's COPE inventory and its variants (e.g., Carver, 1997) view Avoidant coping as Maladaptive coping style (Carver, Scheier, & Weintraub, 1989). However, for Emotion-focused coping, studies suggest that not all emotion-focused coping strategies are uniformly adaptive, and one coping style may help in one situation and not in another. According to Park et al. (2004), problem-focused strategies are effective if the stressor is controllable, whereas emotion-focused strategies are suitable if the stressor seems uncontrollable.

Many scales have been developed to measure coping strategies (e.g., Ways of Coping Scale, Folkman and Lazarus, 1988; the Measure of Affect Regulation Styles, Larsen and Prizmic, 2006), and one of them used widely is the Brief-COPE (Carver, 1997) which is a 28-item, self-report questionnaire designed to measure effective and ineffective ways to cope with a stressful life event. We found it suitable to study the coping styles employed by young adults to alleviate the symptoms of post-traumatic stress. Brief-COPE helps determine a person's primary coping style with scores on three subscales: Problem-focused coping, Emotion-focused coping, and Avoidant coping.

***Purpose of the Study***

In this study, we have identified the age group that includes the individuals in their early adulthood or commonly known as 'Young Adults' that come within the age group of 18 to 25 years, to investigate their primary coping styles in response to their traumatic experiences. There is limited research on how young adults cope with post-traumatic stress, and which coping style best works for them. We gathered data on presence, nature, and duration, of their trauma, and the coping strategies they have been using to endure or fight the negative effects of the stressful event. We aim to predict which coping style out of the

three coping styles, including problem-focused, emotion-focused, and avoidant coping style best helps in alleviating the post-traumatic stress symptoms in young adults. This would help gain insight about which coping style works best for this age group, and help understand the coping dynamics that can be used to develop more precise, and appropriate interventions, and trauma management techniques for young adults.

### *Hypotheses*

For the study, the following hypotheses were formed:

- **Null Hypothesis ($H_0$):** There is no significant relationship between Coping Styles, including Avoidant Coping, Emotional-focused Coping, and Problem-focused Coping, and the severity of Posttraumatic Stress Symptoms in young adults.
- **Hypothesis 1 ($H_1$)**: There is a significant relationship between Coping Styles, including Avoidant Coping, Emotional-focused Coping, and Problem-focused Coping, and the severity of Posttraumatic Stress Symptoms.
- **Hypothesis 2 ($H_2$)**: Young adults who engage in Maladaptive Coping Styles, such as Avoidant Coping, will report significantly higher levels of PTSS compared to those who do not employ these coping strategies.
- **Hypothesis 3 ($H_3$)**: Young adults who engage in Adaptive Coping Styles, such as Problem-focused Coping, and Emotion-focused Coping, will report significantly lower levels of PTSS.

## METHOD

### *Sampling*

We conducted this study on individuals within the age group of 18 to 25 years, or individuals in their early adulthood, being referred to as 'young adults' in this study, through the method of Convenient Sampling. Convenient Sampling method was chosen for its feasibility, and easier accessibility to young adults, and time-efficiency. The individuals were mostly, school pass-outs, students enrolled in undergraduate and postgraduate level programs, and those employed in corporate sector. The total number of participants were (n)= 105 participants, which included 42 males, and 63 females.

### *Instrument*

Since we viewed Posttraumatic Stress Symptoms and the different Coping Styles as the variables in the study, two scales: PCL-5 and Brief COPE, were used to gather data about the PTSS and coping styles in the sample. The Survey Method was employed to obtain responses on the two scales through a Google Form.

The PTSD Checklist for DSM-5 (PCL-5) with Criterion A (Weathers et al., 2015) was used to gather information about the kind of traumatic experience they have undergone, how long ago the traumatic experience happened, if it involved actual/perceived death, and more statements that check the intensity of their symptoms, that could have developed in response to a stressful event that qualified for them as traumatic. The PCL-5 is a 20-item, self-report questionnaire, based on the Likert Scale, that assesses the presence and severity of post-traumatic stress symptoms. Each item is rated on a 5-point scale: *(1) Not at all, (2) A little bit, (3) Moderately, (4) Quite a bit, and (5) Extremely;* the total score of which indicates symptom severity. The PCL-5 has shown a strong reliability, with an internal consistency of $\alpha = .94$ and a test-retest reliability of $r = .82$, and the validity of the PCL-5 is demonstrated through convergent validity, with correlation coefficients ranging from $r_s = .74$ to .85, and

discriminant validity, with coefficients ranging from $r_s$ = .31 to .60, indicating a strong validity, and therefore is a psychometrically sound measure of PTSD symptoms (Blevins et al., 2015).

The Brief-Coping Orientation to Problems Experienced Inventory (Brief-COPE) (Carver, 1997) was used to obtain information about the kind, nature, and frequency of their coping style, since every individual has a different coping style, or they practice more or less than others. The Brief COPE is a 28-item, self-report questionnaire, also based on the Likert Scale, that rates responses as *(1) I have not been doing this at all, (2) Doing this a little bit, (3) Doing this a medium amount, (4) I have been doing this a lot.* The scale has 14 subscales comprising of two items in each for: Self-distraction, Denial, Substance Use, Behavioral disengagement, Emotional Support, Venting, Humor, Acceptance, Self-Blame, Religion, Active Coping, Use of Instrumental Support, Positive Reframing, and Planning. The subscales account for the three coping styles, namely, Problem-focused Coping (items 2, 7, 10, 12, 14, 17, 23, 25), Emotion-focused Coping (items 5, 9, 13, 15, 18, 20, 21, 22, 24, 26, 27, 28), and Avoidant Coping (Items 1, 3, 4, 6, 8, 11, 16, 19). The Cronbach's alpha for the total Brief COPE scale exceeded the minimum value of 0.60 suggested by Nunnally & Bernstein (1995), indicating adequate internal consistency. The Brief COPE shows adequate reliability and validity for coping assessment (Carver, 1997).

### *Design*

We employed a correlational design to examine the relationship between coping styles (problem-focused, emotion-focused, avoidant) and PTSS in young adults who may have experienced trauma. This research design is suitable to determine the predictability of a coping style that is most effective in predicting post-traumatic stress symptom. Here, we do not intend to manipulate the effects of coping styles, rather measuring, and predicting the occurrence of the coping styles and post-traumatic stress symptoms.

### *Variables*

The PTSS severity measured by the PTSD Checklist for DSM-5 (PCL-5) serves as the dependent variable. The different coping styles categorized into Emotion-focused, Problem-focused, and Avoidant Coping styles, assessed through the Brief COPE subscales are the independent variables.

### *Statistical Analysis*

We analyzed the data using the IBM SPSS Statistics Software and computed the descriptive statistics for all variables to summarize the sample characteristics and distribution of PTSS and coping styles. The study required the prediction of coping style that is most effective in counteracting the effects of PTSS. Therefore, we performed a Multiple Linear Regression Analysis to examine the relationship between PTSS and coping styles. The regression analysis helped to determine the extent to which each coping style predicted PTSD symptom severity, while controlling for the effects of the other coping styles, through the Stepwise method for detecting the most significant model. We examined the Beta coefficients (β) and p-values to assess the direction, strength, and statistical significance of the contribution of each coping style to Posttraumatic Stress Symptoms, and reported the R-squared ($R^2$) value to indicate the proportion of variance in Posttraumatic Stress Symptoms explained by the combination of coping styles. All tests were two-tailed, with a significance level of $p < 0.01$.

## RESULTS

Criterion A for the Post-traumatic Stress Disorder in the PCL-5 as per the DSM-5 was an indispensable part of the survey. Screening out individuals who qualified the Criterion that whether the stressor/ stressful event was traumatic was an essential step in the study. From the sample of 105 participants, the sample that met the Criterion A in the DSM-5 (n = 71), obtained a mean score (M = 48), (SD = 20.436), on the PCL-5. It was found that 53 % individuals (n = 38) were directly exposed to the traumatic event, whereby 25.3 % individuals (n = 18) witnessed it, and the 21.1 % individuals (n =15) reported of the traumatic event happening to a close friend/ family member. The descriptive statistics are discussed in *Table 1*, below.

***Table 1 Descriptive Statistics***

| | Sample | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| **PCL-5** | 71 | 20 | 94 | 48.00 | 20.437 |
| **Problem-foc** | 71 | 8 | 29 | 17.21 | 5.870 |
| **Emotion-foc** | 71 | 12 | 44 | 25.03 | 7.041 |
| **Avoidant** | 71 | 8 | 29 | 13.80 | 4.312 |

The most frequently reported events were: Death of a loved one (32.4 %), followed by Family Dysfunction /Conflict /Abuse (29.6%), Sexual Assault/ Harassment (24 %), and Bullying / Harassment by peers (14.8 %). Most reported the occurrence of traumatic event being more than 5 years ago (32.3 %), followed by 26.7 % reported 1 to 2 years ago, 15.4 % reported within 6 months, while 25.3 % reported traumatic event in their childhood years.

### *Correlation Analysis*

Pearson's correlations (two-tailed, $p < 0.01$) revealed significant positive associations between Post-Traumatic Stress Symptoms (PTSS) severity and all the three coping styles as presented in *Table 2* below.

***Table 2 Correlations between Coping Styles and PCL-5 scores (PTSS severity)***

| | r | p value |
|---|---|---|
| **Problem-foc** | .508** | <.001 |
| **Emotion-foc** | .572** | <.001 |
| **Avoidant** | .598** | <.001 |

Note: **. Correlation is significant at the 0.01 level (2-tailed). Pearson correlation was used.

Avoidant Coping demonstrated the strongest correlation with PTSS severity ($r = 0.598$, $p < 0.01$), followed closely by Emotion-focused Coping ($r = 0.572$, $p < 0.01$), and Problem-focused Coping ($r = 0.508$, $p < 0.01$). All correlations suggest that all three coping styles are positively associated with PTSS severity, with moderate strength.

### *Multiple Regression Analysis*

We conducted a stepwise Multiple Regression Analysis with PTSS severity as the dependent variable and the three coping styles, i.e., Problem-focused, Emotion-focused, and Avoidant Coping as the predictor variables of PTSS severity, with the emergence of two models as shown in *Table 3*.

Model 1 included Avoidant Coping as the sole predictor and demonstrated the highest statistical significance [F (1,103) = 38.495, $p < 0.001$], with an $R^2$ value of 0.358, suggesting that Avoidant Coping alone explained 35.8 % of the variance in the PTSS severity. The statistical analysis showed that Avoidant Coping has an unstandardized coefficient (B) of 2.837 and a standardized beta (β) of 0.598 (significant at $p < 0.001$), implying that for each unit increase in Avoidant Coping, PTSS scores increase by 2.837 units. The positive beta indicates that Avoidant Coping is positively related to PTSS severity.

***Table 3 Regression Analysis***

| Model | R | $R^2$ | Predictor(s) | Beta | p value |
|---|---|---|---|---|---|
| **Model 1** | .598 | .358 | Avoidant | .598 | <.001 |
| **Model 2** | .649 | .421 | Avoidant | .460 | <.001 |
| | | | Problem-foc | .286 | .009 |

*Note: Regression was significant at p < 0.01 (2-tailed), through Stepwise Method in Multiple Linear Regression*

Model 2 had two predictors of PTSS severity, Avoidant Coping, and Problem-Focused Coping. In this model, the R value increased to 0.649, and $R^2$ increased to 0.421. The additional predictor (Problem-Focused Coping) raised the explained variance to 42.1 %. This was an improvement, though Avoidant Coping remains the dominant predictor, explaining the larger part of the variance. Here, Avoidant Coping still has an unstandardized β coefficient of 2.182, and a standardized beta (β) of 0.460 ($p < 0.001$), however, with a slight reduction in the strength when Problem-Focused Coping is added. Problem-focused Coping had an unstandardized coefficient (B) of 0.995, and a standardized β of 0.286 ($p = 0.009$), showing that it also positively predicts PTSS severity, though being a weak predictor. The positive association of Problem-focused Coping with PTSS severity was counter-intuitive, as we deemed it to have a negative relationship with PTSS severity.
Emotion-focused Coping showed a small but significant partial correlation ($r = 0.295$), suggesting a weak association with PTSS, with $\beta = 0.314$ (significant at 0.013, $p < 0.05$) in Model 1*, as shown in Table 4*. In Model 2, Emotion-focused Coping had a partial correlation of $r = 0.145$, with $\beta = 0.182$ (significance = 0.233), indicating further drop in the significance level, showing it is less relevant with both Avoidant and Problem-focused Coping in the model.

***Table 4 Excluded Variables***

| Model | | Beta In | t | Sig. | Partial Correlation | Collinearity Stats. Tolerance |
|---|---|---|---|---|---|---|
| **1** | Problem-foc | .286[b] | 2.710 | .009 | .312 | .767 |
| | Emotion-foc | .314[b] | 2.542 | .013 | .295 | .564 |
| **2** | Emotion-foc | .182[c] | 1.203 | .233 | .145 | .371 |

a. Dependent Variable: PCL-5
b. Predictors in the Model: (Constant), Avoidant
c. Predictors in the Model: (Constant), Avoidant, Problem-foc

## DISCUSSION

In this study, we explored the relationship between the three coping styles, namely, Problem-focused Coping, Emotion-focused Coping, and Avoidant Coping, and the severity of Post-traumatic Stress Symptoms in Young Adults. We aimed to study the predictability of

each coping style for Post-traumatic Stress Symptom severity, which coping style do young adults engage more into, and how it affects them. The findings revealed several key insights with theoretical, clinical, and practical implications, offering an understanding of how individuals manage their trauma-related stress. It was crucial to identify the coping style that individuals engaged more into, which shall give us necessary insights about the lifestyle, coping mechanisms, personality dynamics and other aspects of the lives of people in this age group.

We observed a determining relationship between the three coping styles, and the severity of PTSS symptoms, which leads us to rejecting the Null Hypothesis and accepting the Alternate Hypothesis (Hypothesis 1), confirming that there exists a significant relationship between them. The results show consistency with the existing literature, thereby also confirming Hypothesis 2. Avoidant Coping, as hypothesized, emerged as the strongest positive predictor of PTSS severity with moderately strong beta coefficient ($\beta = 0.598$), and high level of significance ($p < 0.001$) in both the models of regression, implying that individuals who rely on avoidance strategies tend to report more severe symptoms of post-traumatic stress. Studies such as Najdowski & Ullman (2009), Gil (2005), and Hooberman et al. (2010) support that greater maladaptive coping was associated with increased PTSD symptoms and lower self-rated recovery. Moritz et al. (2016) shows that maladaptive coping was more strongly related to psychopathology than adaptive coping both cross-sectionally and longitudinally.

The results align with similar research by Suls & Fletcher (1985) which in addition also suggested that avoidance was associated with more positive adaptation in the short-term outcomes. However, for long-term outcomes, avoidance indicated better outcomes initially, but with time, other coping strategies such as active coping were associated with more positive outcomes. This suggests that Avoidant Coping, while temporarily alleviates distress, but may interfere with long-term trauma processing, for the trauma may not be completely resolved and the symptoms keep coming back, mandating them to engage more in maladaptive coping. This may occur because denying the severity of a problem and trying not to think about it may lead to more recurrent and intrusive recollections of the trauma (Tiet et al., 2006). Individuals who resort to avoidant coping strategies after a trauma do not happen to adequately process their fear responses, which may cause their PTSD symptoms to persist (Foa & Riggs, 1995).

Unexpectedly, and in contrast to the previous literature, Problem-focused Coping also showed a positive association with PTSS severity, and emerged as a significant predictor in the second regression model. This counter-intuitive positive association is not new or surprising despite it being an adaptive coping. Najdowski & Ullman (2009) shows that adaptive coping partially mediated the effects of other traumas, self-blame, and perceived control over recovery on PTSD symptoms but showed a small positive association with increased PTSD symptoms. Baker & Berenbaum (2007) posits that Problem-focused coping can be counter-productive if one hastily decides on a particular strategy without using one's emotions as a guide to help solve the problem. It has also been observed as counter-productive in cases of childhood trauma resulting from sexual abuse, where individuals often display a sense of powerlessness towards the stressful situation. Studies (Courtois, 1988; Herman, 1992) suggests that the primary means of self-protection they use is to manage their emotional reactions as best they can. It is possible that individuals with high PTSS severity employ Problem-focused strategies to regain control, even though it may

prove ineffective against past, unchangeable traumatic experiences. The way the nature of Problem-focused coping does not stay constant in predicting symptom severity may suggest that active coping styles may not be definitive in their effectiveness of alleviating the negative effects of trauma.

Emotion-focused Coping in presence of stronger predictors did not enter the regression models. Despite playing a role in trauma-related distress as seen through its moderate correlation with PTSS severity, it does not significantly predict PTSS severity ($\beta = 0.182$, significance = 0.233), not directly at least when stronger predictors like Avoidance, and Problem-solving efforts dominate. Emotion-focused coping may not be entirely adaptive in many situations (Park et al., 2004; Gill, 2005; Austenfeld & Staton, 2004), and may instead lead to greater PTSD, which was also demonstrated by the positive correlations in the results. Brown et al. (2005) suggests that while certain emotion-focused strategies like positive self-talk can be helpful, other emotion-focused strategies such as self-blame and emotional venting are generally regarded as maladaptive. It is proposed that individuals who are aware of their emotions and actively express them often struggle to resolve their problems. They risk becoming too focused on their feelings, which can result in overthinking, ruminating, and heightened negative emotions (Salovey et al., 1999; Nolen-Hoeksema & Morrow, 1993). Since, both the active coping strategies (Problem-focused, and Emotion-focused coping) shared a positive relationship with the PTSS severity, we are bound to decline Hypothesis 3, implying that individuals who use active coping may not necessarily have lowered symptom severity.

Where one part of this study ruled out to be as expected for Avoidant Coping being maladaptive and positively predicting PTSS severity, the other coping styles do not correspond to the conceiving of their stress symptom-alleviating nature although being adaptive. Previous researches (Lazarus & Folkman, 1984; Skinner et al., 2003; Carver et al., 1989) have shown the nature of the three coping styles, and deemed Avoidant Coping as maladaptive, and Problem-focused, and Emotion-focused Coping to be adaptive. However, this has not been entirely congruent for many other studies on adaptive coping. For instance, Austenfeld & Stanton (2004) explains that Emotion-focused coping is believed to be less adaptive due to the obstruction of negative emotion management on rational decision-making. Similarly, Brown, Westbrook, & Challagalla (2005) shed light on the complex interplay of emotion and coping in relation to performance, suggesting that the moderating effects of emotion-focused coping tactic can be adaptive, and at the same time, direct effects of problem-focused coping can be maladaptive. In their study, Britt et al. (2016) posits that active coping was less predictive of functioning in the face of stressors and in the prediction of symptoms overtime. Whereby, Moritz et al. (2016) suggests that a mild positive relationship between adaptive and certain maladaptive styles partially accounts for the attenuated relationship between adaptive coping and depressive symptoms.

Overall, seen as an adaptive coping style typically associated with reduced symptoms of stress, these findings challenge conventional views about Problem-focused coping, and Emotion-focused coping. This result suggests that in context of trauma, adaptive coping styles may not always function as effectively, therefore, it is important to examine the context or situation in order to determine coping effectiveness (Coyne & Racioppo, 2000), thereby potentially highlighting the need for coping interventions that are more context-based.

### *Limitations*

We used convenient sampling method in this study with a considerably smaller representation of the population. Evidently, a larger sample size adds to the representation of the population more effectively. In this study, we exclusively employed Criterion A of the Post-traumatic Stress Disorder, according to the DSM-5. For further rigorous screening of the respondents, the other Criteria may be incorporated including, Criteria B, C, D, and E. The survey method used in the study employed self-report questionnaires for the assessment of trauma. Individuals may be influenced by their self-perception or desire to answer in socially acceptable ways. In such situations, a checklist method is more effective to gather information, however, it requires the physical presence of an expert, and is a tedious task for a large sample size. Hence, refinements in the screening procedure may come out as the best resort for appropriate responses from a larger sample.

### *Future Recommendations*

This research was a cross-sectional design which makes it difficult to establish cause-and-effect relationships between coping styles and PTSS. Longitudinal research may help explore how coping styles evolve overtime and their long-term effects on PTSS. There is decent amount of present literature and researches on coping in elderly, adults, and women. However, there needs to be more researches on individuals in their young adulthood, children, adolescents, and how trauma impacts them differently. There is a need for the understanding of context-based coping styles. The present findings indicate that coping may not always lead to decreased severity of symptoms, instead they might aggravate them further. Coping styles are found to be effective in certain contexts, and ineffective in others. Research could be focused upon situation and context based coping strategies for ruling out their effectiveness.

## CONCLUSION

We examined the relationship between coping styles and PTSS in young adults, with a particular focus on understanding the roles of adaptive and maladaptive coping strategies. The findings revealed that Avoidant Coping, often categorized as maladaptive, was a significant predictor of PTSS severity, besides challenging the conventional assumptions that that adaptive coping strategies would show stronger relationship with lower symptom levels. The implications of these findings suggest that future interventions for young adults with PTSS should reconsider the role of avoidant coping and explore how maladaptive strategies may influence symptom severity. Interventions may benefit from focusing not only on promoting adaptive coping but also on addressing avoidant coping behaviors that can exacerbate PTSS.

The cross-sectional design and reliance on self-report data may, however, limit the ability to draw causal conclusions. Additionally, the demographic homogeneity of the sample may affect the generalizability of the results. Future research should incorporate longitudinal designs to examine the long-term impacts of coping styles on PTSS, and consider more diverse populations to enhance the applicability of the findings across different cultural contexts.

Concludingly, understanding the complex relationships between coping styles and PTSS is imperative for developing effective therapeutic strategies. By reconsidering the effects of adaptive coping, and maladaptive coping styles, this study contributes to a more nuanced

view of coping in the context of traumatic stress, paving the way for future research and interventions aimed at improving mental health outcomes for young adults.

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## APPENDIX

***Descriptives***

**Descriptive Statistics**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| PCL-5 | 71 | 20 | 94 | 48.00 | 20.437 |
| PROBLEM-FOC | 71 | 8 | 29 | 17.21 | 5.870 |
| EMOTION-FOC | 71 | 12 | 44 | 25.03 | 7.041 |
| AVOIDANT | 71 | 8 | 29 | 13.80 | 4.312 |
| Valid N (listwise) | 71 | | | | |

***Correlation matrix***

**Correlations**

| | | PCL-5 | PROBLEM-FOC | EMOTION-FOC | AVOIDANT |
|---|---|---|---|---|---|
| PCL-5 | Pearson Correlation | 1 | .508** | .572** | .598** |
| | Sig. (2-tailed) | | <.001 | <.001 | <.001 |
| | N | 71 | 71 | 71 | 71 |
| PROBLEM-FOC | Pearson Correlation | .508** | 1 | .704** | .483** |
| | Sig. (2-tailed) | <.001 | | <.001 | <.001 |
| | N | 71 | 71 | 71 | 71 |
| EMOTION-FOC | Pearson Correlation | .572** | .704** | 1 | .660** |
| | Sig. (2-tailed) | <.001 | <.001 | | <.001 |
| | N | 71 | 71 | 71 | 71 |
| AVOIDANT | Pearson Correlation | .598** | .483** | .660** | 1 |
| | Sig. (2-tailed) | <.001 | <.001 | <.001 | |
| | N | 71 | 71 | 71 | 71 |

**. Correlation is significant at the 0.01 level (2-tailed).

## Multiple Linear Regression

**Variables Entered/Removed[a]**

| Model | Variables Entered | Variables Removed | Method |
|---|---|---|---|
| 1 | AVOIDANT | . | Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100). |
| 2 | PROBLEM-FOC | . | Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100). |

a. Dependent Variable: PCL-5

**Model Summary**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .598[a] | .358 | .349 | 16.492 |
| 2 | .649[b] | .421 | .404 | 15.782 |

a. Predictors: (Constant), AVOIDANT

b. Predictors: (Constant), AVOIDANT, PROBLEM-FOC

**ANOVA[a]**

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 10469.619 | 1 | 10469.619 | 38.495 | <.001[b] |
| | Residual | 18766.381 | 69 | 271.977 | | |
| | Total | 29236.000 | 70 | | | |
| 2 | Regression | 12298.996 | 2 | 6149.498 | 24.689 | <.001[c] |
| | Residual | 16937.004 | 68 | 249.074 | | |
| | Total | 29236.000 | 70 | | | |

a. Dependent Variable: PCL-5

b. Predictors: (Constant), AVOIDANT

c. Predictors: (Constant), AVOIDANT, PROBLEM-FOC

**Coefficients[a]**

| Model | | Unstandardized Coefficients B | Unstandardized Coefficients Std. Error | Standardized Coefficients Beta | t | Sig. |
|---|---|---|---|---|---|---|
| 1 | (Constant) | 8.848 | 6.607 | | 1.339 | .185 |
| | AVOIDANT | 2.837 | .457 | .598 | 6.204 | <.001 |
| 2 | (Constant) | .759 | 6.992 | | .109 | .914 |
| | AVOIDANT | 2.182 | .500 | .460 | 4.367 | <.001 |
| | PROBLEM-FOC | .995 | .367 | .286 | 2.710 | .009 |

a. Dependent Variable: PCL-5

**Excluded Variables[a]**

| Model | | Beta In | t | Sig. | Partial Correlation | Collinearity Statistics Tolerance |
|---|---|---|---|---|---|---|
| 1 | PROBLEM-FOC | .286[b] | 2.710 | .009 | .312 | .767 |
| | EMOTION-FOC | .314[b] | 2.542 | .013 | .295 | .564 |
| 2 | EMOTION-FOC | .182[c] | 1.203 | .233 | .145 | .371 |

a. Dependent Variable: PCL-5

b. Predictors in the Model: (Constant), AVOIDANT

c. Predictors in the Model: (Constant), AVOIDANT, PROBLEM-FOC