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Stress, functioning, and coping during the COVID-19 pandemic:

Results from an online convenience sample

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Abstract

This study explored how individuals were experiencing and responding to stress related to the COVID-19 pandemic in May 2020. Adults (18 years and older) living in the United States were recruited through Amazon's Mechanical Turk, a crowdsourcing website that is commonly used for online survey administration. Participants ($N = 408$; 60% non-Hispanic White) completed an online survey regarding traumatic stress, functional impairment, and use and perceived helpfulness of various coping strategies. Results showed that 37% of participants endorsed clinically-elevated symptoms of traumatic stress. As many as 76% of participants reported changes in their daily functioning from before the pandemic to present, most notably in their number of social interactions, physical activity, and time spent working. To cope, participants reported engaging in safety planning and behavioral activation, which they also perceived to be helpful in managing stress. Avoidance coping strategies involving use of alcohol, tobacco products, or recreational substances were infrequently endorsed and perceived to be of relatively little help. These findings offer an initial, data-based glimpse into the mental health impact of the COVID-19 pandemic and shed light onto opportunities for promoting mental health and well-being during this unprecedented and multifaceted crisis.

Stress, functioning, and coping during the COVID-19 pandemic:**Results from an online convenience sample**

COVID-19 (SARS-CoV-2) has escalated into one of the biggest and most destructive pandemics of the 21st century. As of early May 2020, COVID-19 had spread to 214 countries, with 4.23 million cases confirmed worldwide (U.S. Department of Health and Human Services 2020b). The United States had reported the highest number of confirmed cases (1.34 million) in the world, and more than 82,000 of those cases had resulted in death (U.S. Department of Health and Human Services, 2020a). In an attempt to curtail the spread of this virus, numerous states implemented physical distancing and stay-at-home orders, which significantly altered everyday American life (Secon, 2020). All nonessential businesses were mandated to suspend in-person operations throughout state stay-at-home orders, leading to a record-setting 14.7% unemployment rate (U.S. Bureau of Labor Statistics, 2020). Additionally, governors of 48 states either advocated or demanded that schools close for the remainder of the 2019-2020 academic year (Chavez & Moshtaghian, 2020). The health and economic devastation of this pandemic has prompted mental health professionals to question not whether there will be psychological repercussions but rather what will be the extent of this human suffering and how can we address this surging mental health need (Gruber et al., 2020).

Early data indicate the COVID-19 pandemic has caused significant psychological distress, particularly among young adults, healthcare workers, persons of color, and low-income

communities, and the rising rates of depression, anxiety, insomnia, substance abuse, suicide, and post-traumatic stress disorder (PTSD) are alarming but unfortunately unsurprising (Achenbach, 2020; American Psychological Association, 2020; Huang & Zhao, 2020; Lai et al., 2020; McGinty, Presskreischer, Han, & Barry, 2020). The profound health, economic, and social consequences of COVID-19 are likely to be distressing for many, regardless of whether or not they have had direct exposure to the virus. Although most trauma survivors do not typically develop PTSD¹, rates of traumatic stress and other forms of psychological distress from the ongoing COVID-19 pandemic are anticipated to be pervasive. For reference, 59% of survivors from the 2003 SARS outbreak met criteria for a Diagnostic and Statistical Manual of Mental Disorders (DSM), 4th edition psychiatric disorder, primarily PTSD or major depressive disorder, in the months following their recovery (Mak et al., 2009). More recently, 64% of healthcare workers responding to the 2015 MERS outbreak endorsed hyperarousal, avoidance, intrusive thoughts, and/or sleep difficulties, and 52% reported clinically-elevated PTSD symptoms (Lee, Kang, Cho, Kim, & Park, 2018). Even though the COVID-19 pandemic represents an unprecedented stressor, it is expected that this collective trauma will precipitate an upsurge of traumatic stress, as well as an urgent need for widespread implementation of effective mental health interventions.

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¹ Individuals may be exposed to actual or threatened death, serious injury, or sexual violence and/or may experience intrusive thoughts, avoidance, negative thoughts or mood, and hyperarousal without meeting criteria for a DSM-5 diagnosis of PTSD.

An instrumental factor in determining the development and severity of psychological distress after a traumatic event is the use of coping strategies. For example, seeking social support, finding hope, and positive reframing have been identified as effective coping strategies for managing psychological distress; whereas use of avoidance coping strategies (e.g., using substances, avoiding intrusive memories or thoughts about the traumatic event, avoiding situations that serve as reminders of the traumatic event) have been shown to exacerbate trauma-related suffering (Clohessy & Ehlers, 1999; Ehring, Razik, & Emmelkamp, 2011). Accordingly, to progress toward addressing the psychological and functional impact of COVID-19, it will be important to understand how individuals are managing their stress and to promote the use of effective coping strategies among those in need.

The current study sought to understand how individuals are experiencing and responding to stress related to the COVID-19 pandemic. More specifically, this study aimed to: (1) estimate the prevalence of traumatic stress during the COVID-19 pandemic; (2) assess the functional impact of the COVID-19 pandemic; (3) identify coping strategies that individuals are using to manage stress; and (4) evaluate the perceived helpfulness of various coping strategies. Findings from this study will lend insights into the psychological impact of the COVID-19 pandemic on Americans—as well as illuminate opportunities for supporting individuals' mental health needs as the nation recovers from this crisis.

Method

This study was classified as exempt by the Institutional Review Board of the University of California, Los Angeles.

Procedure

Adults (18 years or older) living in the United States were invited to participate in this study through Amazon's Mechanical Turk (MTurk), a crowdsourcing website that is commonly used for online survey administration. Study announcements were posted on May 6th and 7th, 2020, and all surveys were completed within 48 hours of postings. Upon completing the survey, participants received \$1.00 in payment and were directed to a list of free mental health resources, including the National Suicide Prevention Lifeline, Crisis Text Line, and National Alliance on Mental Illness Helpline.

Participants

Individuals ($N = 408^2$) from 42 states completed the online survey. Participants identified predominantly as early adults (70% 25-44 years old), European Americans (60%), and men (57%). Participants reported that they were living with an average of 3.57 ($SD = 4.90$) other individuals at the time of survey administration. See Table 1 for additional demographic information.

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² Power analysis determined a necessary sample size of 400 for a power of .80 at $\alpha = .05$ to detect a small to medium effect size for up to 10 predictors on levels of stress and functioning. These associations will be explored in a separate manuscript.

Measures

The survey was hosted through the Qualtrics online survey platform and included questions related to demographics, traumatic stress, functioning, and use and perceived helpfulness of coping strategies.

Background Questionnaire

This questionnaire is a 14-item self-report measure that prompts individuals to report on their personal demographics (e.g., age, gender, race/ethnicity, education, employment), as well as their exposure to COVID-19. Specifically, participants were asked to indicate whether they, someone they lived with, and/or someone they knew has symptoms of COVID-19 (e.g., fever, cough, difficulty breathing), got tested for COVID-19, tested positive for COVID-19, needed to be hospitalized for COVID-19 complications, and/or died from COVID-19.

PTSD Checklist for DSM-5 (PCL-5)

The PCL-5 (Weathers et al., 2013) is a 20-item self-report measure that assesses for symptoms of PTSD, as defined by the DSM-5. This measure prompts respondents to indicate the extent to which they are bothered by intrusion symptoms, persistent avoidance, negative cognitions and mood, and hyperarousal using a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely), with higher scores indicating greater symptom severity. The PCL-5 has demonstrated strong internal consistency, test-retest reliability, and convergent and discriminant validity (Blevins et al., 2015). For the purposes of this study, slight modifications were made to

the instructions (i.e., specifying “keeping in mind your experiences during the COVID-19 pandemic...”) and one item (i.e., changing “suddenly feeling or acting as if the stressful experience were actually happening again” to “suddenly feeling or acting as if you were in danger”).

Functional Assessment

This measure is a 12-item self-report questionnaire that prompts individuals to compare their current functioning with their pre-pandemic functioning along various indices of functioning (e.g., appetite, hygiene, sleep; see Tables 3 and 4 for a list of the indices of functioning that were assessed). As an example, participants were asked to indicate any changes in their appetite using a 5-point Likert scale ranging from “much less than usual” to “much more than usual.”

Coping Strategies Questionnaire

This measure is a self-report questionnaire that assesses use and perceived helpfulness of 20 different coping strategies (e.g., getting social support, using alcohol; see Tables 5 and 6 for the full list of coping strategies). This measure first prompts respondents to indicate the frequency with which they have used each coping strategy (i.e., “Below is a list of ways that people sometimes cope with a very stressful experience. Over the last 2 weeks, how often have you done the following to cope with stress?”) using a 4-point Likert scale ranging from 0 (not at all) to 3 (nearly every day), with higher scores indicating greater use. This measure then asks

respondents to rate the helpfulness of each coping strategy (i.e., “In your opinion, how helpful are the following ways of coping with stress?”) using a 5-point Likert scale ranging from 0 (not at all helpful) to 4 (extremely helpful), with higher scores indicating greater perceived helpfulness.

Results

Nearly half of participants (45%) reported that they knew someone who tested positive for COVID-19; 5% of participants endorsed that they tested positive for COVID-19 (see Table 2 for more information about the health impact of COVID-19 among this sample).

Traumatic Stress

Participants scored an average of 28.26 ($SD = 20.09$) on the PCL-5. Most participants endorsed at least one symptom related to intrusive recollections (62%), persistent avoidance (68%), negative mood and cognitions (71%), or hyperarousal (72%). Fifty-five percent of participants endorsed at least one symptom from all four symptom clusters. Thirty-seven percent of participants reported experiencing clinically-elevated symptoms of traumatic stress, as indicated by a PCL-5 score of 38 or higher (cf. Hoge, Riviere, Wilk, Herrell, & Weathers, 2014).

Functioning

Many participants reported changes in their daily functioning as a result of the COVID-19 pandemic (see Figures 1 and 2). Specifically, 76% of participants endorsed changes in their number of social interactions; 65% in their physical activity; 61% in their time spent working;

57% in their time spent caregiving; 57% in their sleep; 55% in their mood; 51% in their quality of social interactions; 49% in their quality of caregiving; 49% in their appetite; 48% in their quality of work; 47% in their hygiene; and 46% in their concentration.

Logistic regression analyses revealed that relative to participants with minimal or subthreshold symptoms of traumatic stress (as indicated by a PCL-5 score of 37 or lower), significantly more participants with clinically-elevated symptoms of traumatic stress (as indicated by a PCL-5 score of 38 or higher) reported changes in their quality of work ($OR = 4.03$, $p < .001$; 15% vs. 51% better or much better than usual, respectively), mood ($OR = 3.52$, $p < .001$; 10% vs. 37% better or much better than usual), bathing ($OR = 3.30$, $p < .001$; 15% vs. 45% more or much more than usual), time spent working ($OR = 3.01$, $p < .001$; 18% vs. 49% more or much more than usual), quality of caregiving ($OR = 2.85$, $p < .001$; 26% vs. 51% better or much better than usual), concentration ($OR = 2.71$, $p < .001$; 6% vs. 35% better or much better than usual), and sleep ($OR = 2.62$, $p < .001$; 22% vs. 45% more or much more than usual) (see Tables 3 and 4).

Use of Coping Strategies

Participants endorsed using a variety of coping strategies (see Table 5). The five most common coping strategies that participants used were: (1) taking precautions to keep themselves safe (e.g., physical distancing, disinfecting items) ($M = 2.15$, $SD = .88$); (2) engaging in pleasurable activities ($M = 1.99$, $SD = .85$); (3) engaging in mastery activities ($M = 1.82$, $SD = .92$); (4) adjusting to the “new normal” ($M = 1.80$, $SD = .91$); and (5) following a routine ($M =$

1.79, $SD = .88$). The five least commonly used coping strategies were: (1) using marijuana or other recreational substances ($M = .87$, $SD = 1.04$); (2) using tobacco products ($M = .93$, $SD = 1.10$); (3) using alcohol ($M = .91$, $SD = 1.00$); (4) journaling ($M = .94$, $SD = .97$); and (5) seeking help from a professional ($M = 1.01$, $SD = 1.02$).

Independent samples t-tests showed that compared with participants with minimal or subthreshold symptoms of traumatic stress, participants with clinically-elevated symptoms of traumatic stress engaged in significantly more help-seeking from a professional [$t(372) = -13.98$, $p < .001$], emotional spending [$t(372) = -12.38$, $p < .001$], journaling [$t(371) = -11.91$, $p < .001$], emotional eating [$t(373) = -9.44$, $p < .001$], tobacco use [$t(374) = -9.24$, $p < .001$], alcohol use [$t(371) = -9.10$, $p < .001$], relaxation techniques [$t(375) = -9.07$, $p < .001$], marijuana use [$t(371) = -8.50$, $p < .001$], avoidance of triggering thoughts [$t(373) = -7.15$, $p < .001$], positive reframing [$t(373) = -5.52$, $p < .001$], prayer [$t(373) = -5.30$, $p < .001$], and mindfulness [$t(371) = -4.03$, $p < .001$]. Participants with minimal or subthreshold symptoms of traumatic stress engaged in more safety planning, pleasurable activities, mastery activities, routines, and acceptance than participants with clinically-elevated symptoms of traumatic stress, although these differences were not significant after applying a Bonferroni correction of $\alpha = .05/20$.

Perceived Helpfulness of Coping Strategies

Participants indicated that many coping strategies could be helpful for managing stress (see Table 6). Participants identified the five most helpful coping strategies as: (1) taking precautions ($M = 2.68$, $SD = 1.10$); (2) engaging in pleasurable activities ($M = 2.66$, $SD = 1.02$); (3) engaging in mastery activities ($M = 2.54$, $SD = 1.03$); (4) following a routine ($M = 2.51$, $SD = 1.04$); and (5) engaging in physical activity ($M = 2.50$, $SD = 1.10$). The five coping strategies that were perceived to be least helpful were: (1) using tobacco products ($M = 1.13$, $SD = 1.28$); (2)

using marijuana or other recreational substances ($M = 1.22$, $SD = 1.32$); (3) using alcohol ($M = 1.23$, $SD = 1.26$); (4) emotional spending ($M = 1.62$, $SD = 1.21$); and (5) journaling ($M = 1.62$, $SD = 1.29$).

Independent samples t-tests showed that compared with participants with minimal or subthreshold symptoms of traumatic stress, participants with clinically-elevated symptoms of traumatic stress perceived more benefit from tobacco use [$t(374) = -14.13$, $p < .001$], emotional eating [$t(374) = -10.49$, $p < .001$], journaling [$t(354) = -8.60$, $p < .001$], marijuana use [$t(348) = -8.49$, $p < .001$], alcohol use [$t(324) = -8.12$, $p < .001$], emotional spending [$t(330) = -7.45$, $p < .001$], avoiding triggering thoughts [$t(374) = -5.66$, $p < .001$], searching for information [$t(359) = -5.43$, $p < .001$], seeking help from a professional [$t(333) = -5.16$, $p < .001$], praying [$t(375) = -3.65$, $p < .001$], mindfulness [$t(320) = -3.37$, $p < .001$], and positive reframing [$t(316) = -3.37$, $p < .001$]. Participants with minimal or subthreshold symptoms of traumatic stress perceived more benefit from safety planning, engaging in mastery activities, engaging in physical activity, and following a routine than participants with clinically-elevated symptoms of traumatic stress, but these differences were not significant.

Discussion

The present study sought to provide an initial glimpse into how Americans experienced and responded to stress in the early months of the COVID-19 pandemic. Findings showed that approximately half of participants were acquainted with at least one individual whose health had been compromised by COVID-19, including a sizeable proportion of individuals whose lives were lost from this virus. These statistics are grim, especially considering that the number of cases and deaths in the United States are expected to continually increase in the coming months

and that experts are warning about a second peak when the economy begins to re-open (World Health Organization, 2020).

Given these circumstances, there is an urgent need to develop formal supports for attending to the mental health concerns of the general population. After five months of growing cases (e.g., Holshue et al., 2020) and two months of mandated physical distancing (e.g., County of San Mateo, 2020) (as of May 2020), there are already disquieting rates of stress and functional impairment. Consistent with rates of psychological distress following previous pandemics, more than one-third of participants in this study endorsed clinically-elevated symptoms of traumatic stress, and many endorsed increased functional impairment as a result of the pandemic. Interestingly, as many as one-third of participants reported improved functioning since the start of the pandemic, and the reasons behind the differential functional impact of the COVID-19 pandemic warrants further exploration. For example, it is possible that individuals with relative privilege may be experiencing less stress and functional impairment than those from traditionally underserved communities (e.g., persons of color, families living in poverty) or those whose physical, emotional, and/or financial well-being has been directly compromised by COVID-19 (e.g., essential workers, loved ones grieving a COVID-19 death, individuals facing unemployment). Another possibility is that state stay-at-home orders may have forced some individuals to reallocate their time (e.g., spending more time working and/or caregiving than usual), resulting in increased distress but perhaps improved quality of certain activities. Although levels of stress and functional impairment among the general population may improve when COVID-19 cases and deaths eventually begin to decrease, the health, economic, and social consequences of this pandemic are likely to have mental health repercussions that could last a generation without active prevention and early intervention efforts.

Unlike the medical field, which has been forced to respond to COVID-19 with a limited supply of personal protective equipment, hospital beds, and ventilators, the field of mental health may be uniquely equipped to flatten the curve of the anticipated mental health pandemic. That is, hundreds of evidence-based treatments have been developed, tested, and shown to be efficacious for addressing a variety of mental health concerns (Chorpita et al., 2011), including treatments for traumatic stress in post-disaster contexts (e.g., CATS Consortium, 2007; Hamblen et al., 2009). In other words, the mental health field is entering this pandemic with an ample supply of treatments for addressing the psychological and functional impairment caused or exacerbated by COVID-19. However, to meet the elevated mental health needs of the nation, it will be imperative to complete the challenging but achievable tasks of disseminating these evidence-based treatments to front-line providers and of promoting the widespread implementation of this mental health programming.

Accordingly, this is a call to action for mental health professionals to use their expertise and to leverage the vast evidence base on effective mental health interventions to promote psychological recovery and well-being in the months and years to come (cf. Gruber et al., 2020). Encouragingly, results from this study show that many members of the general population are already aware of and using evidence-informed coping strategies, such as safety planning, engaging in behavioral activation, and following a routine. At the same time, some coping strategies with great potential to promote human well-being (e.g., journaling, seeking help from a professional) seem to be underutilized and/or perceived to have little benefit. Additionally, ineffective coping strategies, such as alcohol or substance use, emotional eating, and emotional spending, were seen to have greater use and perceived helpfulness than desired, particularly among individuals reporting clinically-elevated symptoms of traumatic stress. Therefore,

concerted efforts are necessary to disseminate evidence-informed coping strategies to individuals in need, promote appropriate and consistent use of coping strategies, and reduce use of avoidance coping strategies that can have harmful consequences. As such, potential action items include:

(a) distilling the extensive evidence base on effective treatments to identify the best-fitting strategies for addressing the mental health needs stemming from this pandemic; (b) preparing a mental health workforce for implementing these evidence-informed strategies through the provision of training, supervision, and consultation; (c) considering ways for these evidence-informed strategies to reach the general population, particularly individuals with barriers to receiving mental health services such as stigma, limited access to technology, or poor mental health literacy; (d) brainstorming innovative options for implementing evidence-informed strategies that may be difficult or impractical to practice under current circumstances (e.g., engaging in pleasurable activities while complying with public health guidelines); and (e) partnering with professionals from other disciplines to facilitate dissemination of evidence-informed coping strategies and to take an interdisciplinary approach to addressing the health, economic, and social consequences of this multifaceted stressor.

Although this study has several strengths, including its data-based description of COVID-19-related stress, functioning, and coping among a large sample of Americans, some caveats are in order. First, this study features an online convenience sample of predominantly middle-class, non-Hispanic White participants and, therefore, these findings may not be generalizable to individuals from different backgrounds. Further attention should be granted to identifying and implementing strategies for promoting mental health and well-being among communities disproportionately affected by the COVID-19 pandemic (e.g., persons of color, homeless persons; Baggett et al., 2020; Webb Hooper, Napoles, & Perez-Sable, 2020). Second, this study

includes only self-report data, which is subject to response bias, and may not reflect actual rates of PTSD symptoms, functional impairment, or use of coping strategies. Relatedly, given the unprecedented nature of the COVID-19 pandemic, functioning and coping in this context were assessed using measures that have not yet been validated. Additionally, this cross-sectional study was designed to assess stress, functioning, and coping at a single point in time and relatively early in the pandemic. It is thus possible that these findings may represent reactions to acute stress and that rates of psychological distress may vary encouragingly or discouragingly as the outbreak continues. Future research investigating the psychological impact of the COVID-19 outbreak should consider incorporating more objective measures, such as structured interviews or behavioral observation, and collecting longitudinal data.

Conclusion

This study offers an initial depiction of stress, functional impairment, and coping related to the COVID-19 pandemic. Results from this study suggest an anticipated upsurge of mental health needs stemming from this unprecedented stressor and call for mental health professionals to mobilize in an effort to facilitate the widespread implementation of effective coping strategies. These findings shed light onto opportunities for promoting mental health and well-being during a time of significant need and for helping individuals recover from this ongoing and compounding crisis. We hope that these findings can normalize some of the difficulties that individuals across the country have been and are currently facing and can inspire and inform efforts for addressing this collective trauma.

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2019.

Table 1

Participant demographics

Participant demographics (N = 408)	%
Age	
18-24 years old	6%
25-34 years old	45%
35-44 years old	25%
45-54 years old	13%
55-64 years old	7%
Over 65 years old	3%
Gender (male)	57%
Race	
European American	60%
Latinx	17%
Mixed race	10%
African American	6%
Asian American	4%
Religion (Roman Catholic)	46%
Marital status (married or in a domestic relationship)	64%
Education (Bachelor's degree)	53%
Employment status (full-time)	71%
Essential worker	42%
Living with child or adolescent	58%
Annual family income	
Less than \$40,000	25%
\$40,000 to \$79,999	51%
Over \$80,000	22%

Table 2

Health impact of COVID-19

COVID health status	Someone participants knew	Someone participants lived with	Participants
Experienced symptoms (e.g., fever, coughing, shortness of breath)	43%	20%	7%
Got tested	45%	15%	12%
Tested positive	45%	15%	5%
Needed to be hospitalized	40%	15%	6%
Died	40%	15%	—

Note: As of May 2020, the United States was making concerted efforts to test individuals who were symptomatic – and, in some cases, asymptomatic, as individuals without any symptoms might still be at risk of spreading the virus to others.

Figure 1

Functional impact of COVID-19: Duration of activities

Figure 2

Functional impact of COVID-19: Quality of activities

Table 3

Functional impact on duration of activities by level of traumatic stress

Indices of functioning	Much/ less than usual		The same as usual		Much/ more than usual		Logistic regression statistics		
	Minimal stress	Elevated stress	Minimal stress	Elevated stress	Minimal stress	Elevated stress	OR	SE	p
Number of social interactions	70%	34%	24%	25%	6%	41%	.94	.25	.813
Physical activity	42%	26%	36%	34%	21%	40%	1.11	.22	.628
Time spent working	32%	26%	50%	25%	18%	49%	3.01	.23	<.001**
Time spent caregiving	14%	11%	50%	34%	36%	55%	1.92	.23	.005*
Sleeping	25%	25%	53%	30%	22%	45%	2.62	.22	<.001**
Eating	21%	17%	58%	45%	21%	38%	1.70	.21	.012*
Bathing	19%	17%	66%	37%	15%	45%	3.30	.22	<.001**

Note: * $p < .05$, ** $p < .004$ (Bonferroni correction of $\alpha = .05/12$), as determined by logistic regression analyses testing the association between level of traumatic stress (minimal or subthreshold versus clinically-elevated) and change in functioning (the same as usual versus more or less than usual).

Table 4

Functional impact on quality of activities by level of traumatic stress

Indices of functioning	Much/ worse than usual		The same as usual		Much/ better than usual		Logistic regression statistics		
	Minimal stress	Elevated stress	Minimal stress	Elevated stress	Minimal stress	Elevated stress	OR	SE	p
Quality of social interactions	32%	19%	54%	41%	14%	40%	1.71	.21	.011*
Mood	32%	35%	58%	28%	10%	37%	3.52	.23	<.001**
Quality of caregiving	9%	11%	64%	39%	26%	51%	2.85	.23	<.001**
Concentration	29%	24%	65%	41%	6%	35%	2.71	.22	<.001**
Quality of work	17%	15%	67%	34%	15%	51%	4.03	.23	<.001**

Note: * $p < .05$, ** $p < .004$ (Bonferroni correction of $\alpha = .05/12$), as determined by logistic regression analyses testing the association between level of traumatic stress (minimal or subthreshold versus clinically-elevated) and change in functioning (the same as usual versus better or worse than usual).

Table 5

Use of coping strategies

	Minimal stress	Elevated stress	<i>t</i>	<i>p</i>
Taking precautions to keep myself safe	2.28 (.93)	2.02 (.80)	2.84	.005*
Doing activities that I enjoy	2.06 (.89)	1.96 (.81)	1.04	.298
Focusing on my work or other productive activities	1.93 (.96)	1.72 (.87)	2.10	.037*
Following a routine	1.83 (.95)	1.76 (.80)	.77	.445
Adjusting to the “new normal”	1.82 (1.01)	1.78 (.79)	.40	.693
Searching for the most up-to-date information	1.63 (1.05)	1.82 (.82)	-1.94	.053
Exercising or being physically active	1.48 (1.06)	1.62 (.88)	-1.34	.183
Getting support from family or friends	1.46 (.98)	1.72 (.89)	-2.65	.008*
Practicing mindfulness	1.29 (1.05)	1.69 (.75)	-4.03	<.001**
Saying encouraging statements to myself	1.24 (1.05)	1.80 (.84)	-5.52	<.001**
Praying or meditating	1.13 (1.15)	1.71 (.89)	-5.30	<.001**
Trying to avoid thinking about the pandemic	1.10 (1.00)	1.80 (.86)	-7.15	<.001**
Deep breathing or other relaxation techniques	.89 (.98)	1.77 (.87)	-9.07	<.001**
Eating for comfort	.89 (.94)	1.80 (.90)	-9.44	<.001**
Buying things to make myself feel better	.64 (.78)	1.68 (.83)	-12.38	<.001**
Using alcohol	.51 (.81)	1.37 (1.00)	-9.10	<.001**
Using marijuana or other drugs	.48 (.90)	1.32 (1.02)	-8.50	<.001**
Using cigarettes or other tobacco products	.47 (.94)	1.43 (1.05)	-9.24	<.001**
Seeking help or advice from a professional	.47 (.76)	1.68 (.92)	-13.98	<.001**
Journaling	.46 (.77)	1.49 (.90)	-11.91	<.001**

Note: * $p < .05$, ** $p < .0025$ (Bonferroni correction of $\alpha = .05/20$), as determined by independent samples t-tests evaluating the association of level of traumatic stress on use of coping strategies.

Table 6

Perceived helpfulness of coping strategies

	Minimal stress	Elevated stress	<i>t</i>	<i>p</i>
Taking precautions to keep myself safe	2.79 (1.18)	2.59 (1.00)	1.75	.082
Doing activities that I enjoy	2.67 (1.10)	2.70 (.90)	-.22	.827
Focusing on my work or other productive activities	2.62 (1.07)	2.49 (.96)	1.19	.233
Exercising or being physically active	2.59 (1.18)	2.44 (.99)	1.29	.198
Following a routine	2.56 (1.12)	2.45 (.90)	1.02	.306
Getting support from family or friends	2.46 (1.18)	2.50 (.98)	-.32	.753
Adjusting to the “new normal”	2.25 (1.26)	2.31 (1.01)	-.46	.650
Practicing mindfulness	2.04 (1.25)	2.48 (1.03)	-3.37	.001**
Saying encouraging statements to myself	2.02 (1.40)	2.49 (.95)	-3.37	.001**
Deep breathing or other relaxation techniques	2.02 (1.25)	2.37 (1.03)	-2.69	.007
Praying or meditating	1.87 (1.45)	2.37 (1.15)	-3.65	<.001**
Searching for the most up-to-date information	1.87 (1.21)	2.52 (1.00)	-5.43	<.001**
Seeking help or advice from a professional	1.72 (1.22)	2.39 (1.10)	-5.16	<.001**
Trying to avoid thinking about the pandemic	1.68 (1.25)	2.39 (1.12)	-5.66	<.001**
Eating for comfort	1.06 (1.18)	2.32 (1.11)	-10.49	<.001**
Buying things to make myself feel better	1.20 (1.16)	2.15 (1.09)	-7.45	<.001**
Journaling	1.14 (1.25)	2.24 (1.08)	-8.60	<.001**
Using alcohol	.74 (1.06)	1.77 (1.21)	-8.12	<.001**
Using marijuana or other drugs	.72 (1.18)	1.82 (1.20)	-8.49	<.001**
Using cigarettes or other tobacco products	.44 (.88)	1.97 (1.22)	-14.13	<.001**

Note: * $p < .05$, ** $p < .0025$ (Bonferroni correction of $\alpha = .05/20$), as determined by independent samples t-tests evaluating the association of level of traumatic stress on perceived helpfulness of coping strategies.