

# Coping with Parental Loss Because of Termination of Parental Rights

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This article addresses the process by which children and adolescents cope with severe acute stress of parental loss from causes other than divorce or death. Participants were 60 children and adolescents from a residential treatment facility. Most had experienced neglect, physical abuse, and sexual abuse, and their parents had their parental rights terminated. Measures of symptomatology indicated that children reported low levels of depressive symptoms, whereas caregivers reported the children were experiencing significant psychological problems. Children used avoidant coping strategies more often than emotion-focused coping strategies, which, in turn, were used more than problem-focused coping strategies. Results are discussed in terms of helping children cope with parental loss.

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Late childhood and early adolescence are part of a developmental stage filled with demands, such as forming one's identity, finding acceptance within a peer group, and forming romantic relationships (Seiffge-Krenke, 1993). Children and adolescents can perceive these normative demands as stressful. A small subset of children and adolescents, however, also must learn to cope with the non-normative demands of severe acute stressors, one of which is parental loss.

The topic of parental loss often is separated into three categories because of the cause of the loss: divorce, death, and other. Coping with parental divorce (Hetherington, 1999; Sandler, Tein, Mehta, Wolchik, & Ayers, 2000) and death (Bowlby, 1980; Mireault & Compas, 1996) has been studied more extensively than other factors.

One example of another type of parental loss is when outside agencies intervene to take children from their homes because of parental abuse, neglect, and maltreatment. These children often find themselves moving from one foster home to the next with no real sense of stability. In addition to the immense stress of parental loss, these children often face severe chronic stressors such as physical or sexual abuse, parental psychopathology, parental substance abuse, parental criminality, and poverty. All of these factors place this subset of adolescents at a risk for future psychopathology (Luthar, Burack, Cicchetti, & Weisz, 1997). Research indicates that although stress plays a role in psychological adjustment, a larger portion of the variance is attributed to applied coping mechanisms (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001; Sandler, Kim-Bae, & MacKinnon, 2000; Seiffge-Krenke, 1993).

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Therefore, it is important to ascertain which types of coping mechanisms are adaptive and maladaptive in these situations.

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## Models of Coping

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Although most researchers agree that *coping* refers to the process of responding to stressors, they greatly disagree about its various components and the functions it serves. Some researchers distinguish between problem-focused coping and emotion-focused coping (Folkman & Lazarus, 1980; Lazarus & Folkman, 1984). This model was first established with adults and later with children and adolescents (Compas, Malcarne, & Fondacaro, 1988). Studies of this model in both youngsters and adults indicate a positive association between emotion-focused coping and emotional distress. There are times, however, when emotion-focused strategies may be adaptive, such as in situations involving a stressor that is unchangeable (Folkman, 1984).

This finding may explain why there is a relationship between the perceived mutability of the situation and coping. Individuals tend to rely on problem-focused strategies in situations they perceive as changeable, whereas they turn to emotion-focused strategies in situations they perceive as immutable (Folkman & Lazarus, 1980; Folkman, Lazarus, Gruen, & DeLongis, 1986; Forsythe & Compas, 1987). For example, a cognitive strategy to reframe a stressor may be using an adaptive coping method with events that appear beyond the person's control (Forsythe & Compas, 1987). Compas, Orosan, and Grant (1993) state that interpersonal events often are seen as less controllable than noninterpersonal events and, in turn, elicit the use of more emotion-focused coping. Therefore, a comprehensive evaluation of adolescent stress must include both objective characteristics of the stressor and subjective cognitive appraisals.

Billings and Moos (1981) emphasize the method of coping rather than its focus, which had been emphasized in previous

models. Their definitions of those methods include the following: *Active-cognitive coping* refers to attempts to manage one's appraisal of a situation; *active-behavioral coping* refers to overt behavioral attempts to deal directly with a problem; and *avoidance coping* refers to attempts to avoid confronting the problem actively. Ebata and Moos (1991) use the term *approach-coping* to refer to both problem-focused and emotion-focused coping strategies—hence their two-dimensional, approach/avoidance model of coping. Seiffge-Krenke (1993) use a model of coping that is conceptually similar to Billings and Moos, but instead labels the facets *active coping*, *internal coping*, and *withdrawal*. In both of these studies, avoidant and withdrawal strategies are associated with increased problems. Others have replicated the relationship between avoidant coping strategies and increased maladjustment (Armistead, McCombs, Forehand, Wierson, Long, & Fauber, 1990; Ayers, 1991). Fewer active coping strategies, however, were used in response to irreversible life stressors, suggesting that irreversible life stressors may be an exception to the rule (Billings & Moos, 1981).

Carver, Scheier, and Weintraub (1989) argue that the process of coping is more complex and may involve more than just two or three factors, as had been previously implied. They designed a multidimensional coping inventory, the Cope Scale, to represent an integration of the various theoretical models of coping. When Phelps and Jarvis (1994) used the Cope Scale on a sample of adolescents, their factor analysis revealed four factors: active coping, avoidant coping, emotion-focused coping, and acceptance. Acceptance, which had not been considered a unique dimension in past models, consisted of restraint, positive reinterpretation and growth, and mental disengagement.

Other researchers also have found that a four-dimensional model explains the complexity of coping more accurately than the previous models. In a study involving elementary school children and a measure called the How I Coped Under Pressure Scale

(HICUPS), Ayers (1991) determines that there are four factors involved in coping: active coping, avoidance, distraction, and social support. The active coping factor was similar to Ebata and Moos's (1991) approach factor, including both problem-focused and emotion-focused strategies. Previous models had included both avoidance and distraction under the rubric of avoidance coping. Ayers concludes, however, that these two dimensions are conceptually distinct. *Distraction* refers to behavioral attempts to take one's mind off the stressor, such as watching television or exercising, whereas *avoidance* includes efforts to avoid thinking about the stressor through cognitive activity rather than behaviors. Avoidance also includes fantasizing that an incident did not happen or imagining that the incident was better than it actually was. *Social support* includes both emotion-focused support (involving other people in listening to the child's feelings about the problem) and problem-focused support (involving other people as resources to assist in problem solving). The components of this factor had been broken down into examples of either emotion-focused coping or problem-focused coping in more simplistic models. This model was replicated in a more specialized sample of children whose parents had divorced (Sandler, Tein, & West, 1994).

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### Perceptions of Control

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Perceptions of control over the environment or perceived mutability of situations has been shown to influence the choice of coping strategies (Compas et al., 1993; Folkman & Lazarus, 1980; Folkman et al., 1986; Forsythe & Compas, 1987). Therefore, any study investigating coping also must account for perceptions of control. Understanding control is defined as an individual's generalized perceptions about the causes of desired and undesired outcomes in his or her life (Skinner & Connell, 1986).

Although both of these models provide an explanation for differences in symptomatology because of stress, both refer to

perceptions or beliefs that are generalized across situations. Skinner and Connell (1986) argue these general models of understanding control cannot explain the extent of objective control perceived in specific situations. Therefore, when assessing coping in response to specific stressors such as parental loss, it is more appropriate to measure the amount of perceived control in reference to that specific situation. For example, when Compas and colleagues (1988) were interested in assessing coping in specific situations, they had adolescents rate the degree of control they felt they had over the cause of the event on a 5-point scale ("no control" to "complete control"). These researchers found an association between coping and appraisals of control for problem-focused coping, but not for emotion-focused coping. In addition, they found more emotional and behavioral problems were associated with a mismatch between appraisals of control and coping mechanisms. Adolescents who generated more problem-focused alternatives for stressors perceived as uncontrollable and fewer problem-focused alternatives for those perceived as controllable were more likely to display emotional and behavioral problems than adolescents whose coping mechanisms matched their appraisals of control.

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## Overview

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Most studies on coping in childhood and adolescence neglect the manner in which it mediates the effects of a severe acute stressor in a clinical sample. Phelps and Jarvis (1994) suggest that more research on coping is needed in underrepresented populations, such as adolescents under great stress. Seiffge-Krenke (1993) investigated coping in a group of adolescents and found that the clinical participants (as compared with nonclinical participants) displayed disturbed appraisals of problems, felt more readily threatened by minor stressors, showed a more ambivalent pattern of coping strategies, and were more likely to respond with withdrawal, which had been identified as a dysfunctional form of coping.

However, Seiffge-Krenke assessed the role of coping with normative minor stressors, rather than a nonnormative major stressor, like parental loss.

Plante, Goldfarb, and Wadley (1993) studied stress and coping in children, some of whom had experienced physical or sexual abuse. These researchers found that a history of abuse was associated with lower quality coping, as measured by the Global Assessment of Functioning Scale (American Psychiatric Association, 1987). The researchers acknowledge that the scale may not be an accurate measure and argue that future research should incorporate more adequate measures of coping. Although literature on the psychological and behavioral effects of child physical abuse and sexual abuse is significant (Kaplan, Pelcovitz, Salzinger, Weiner, Mandel, & Lesser, 1998; Lutzker, Bigelow, Swenson, Doctor, & Kessler, 1999; Saywitz, Mannarino, Berliner, & Cohen, 2000), little is known about the coping mechanisms when this abuse leads to the termination of parental rights. There is a great need to understand the functioning of children whose parents' rights have been terminated (Azar, Benjet, Fuhrmann, & Cavallero, 1995).

This article addresses the process by which children and adolescents cope with the severe acute stressor of parental loss. The focus is on parental loss because of causes other than divorce or death. These issues were examined in a clinical sample of children, most of whom experienced neglect, maltreatment, physical abuse, sexual abuse, and multiple residential placements. The processes involved in coping with these major stressors were examined using an adequate assessment.

Based on previous research, perceptions of control were expected to be related to coping mechanisms (Compas et al., 1993; Folkman & Lazarus, 1980; Folkman et al., 1986; Forsythe & Compas, 1987). Individuals who consider the loss of their parent to be out of their control were expected to have a minimal reliance on problem-focused strategies. It was also expected that coping would be related to levels of symptomatology, as indicated by previous studies

(Ayers, 1991; Compas, Connor, Saltzman, Thomsen, & Wadsworth, 1999; Sandler, Kim-Bae, et al., 2000). Folkman (1984) states that emotion-focused strategies may be adaptive in situations involving a stressor that is unchangeable. Therefore, emotion-focused coping strategies, which are not avoidant in nature, were expected to be adaptive because parental loss is an irreversible life stressor. In turn, these coping strategies were expected to be related to lower levels of symptomatology. Avoidant strategies were expected to be related to greater symptomatology, as well.

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## Method

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### *Participants*

Participants for this study were 60 children, ages 9 to 18, who were in residential treatment moderate to severe emotional difficulties. The sample consisted 39 boys and 21 girls. The mean age was 12.27 ( $SD = 2.18$ ). The sample was ethnically diverse: 72% Caucasian, 16% African American, 10% biracial, and 2% Latino. The average stay at the residential facility was approximately two years. These children had been in an average of 8.45 placements ( $SD = 5.02$ ) before their current residence. As seen in Table 1, all had experienced neglect, physical abuse, or sexual abuse in the past (with the exception of one child, for whom this information was not available). These numbers are possibly underestimated because they are based on reported incidents of neglect and abuse. Approximately 72% of the parents of these children had their parental rights terminated, while an additional 10% were in the process of termination. Most children had not been in contact with their biological parents for approximately three to four years. Note that nearly all children and adolescents were placed in this residential facility because of child protective service involvement and not solely because of their emotional or behavioral problems.



**TABLE 1**  
**Frequency of Neglect, Physical Abuse, and Sexual Abuse**  
**as Indicated in Clinical Files**

<i>Type of abuse</i>	<i>Frequency</i>	<i>Percentage</i>
Physical abuse only	3	5
Sexual abuse only	0	0
Neglect only	2	3
Both physical abuse and sexual abuse	3	5
Both physical abuse and neglect	15	25
Both sexual abuse and neglect	4	7
Physical abuse, sexual abuse, and neglect	32	53
Information not available	1	2
Total	60	100

Based on a power analysis (Cohen, 1992), a minimum of 58 participants would adequately test the hypotheses for a medium effect size, with alpha set at .05 and a power of .80. Thus, the final sample size of 60 is considered adequate to test the hypotheses.

### *Measures*

**Child coping strategies.** Child and adolescent coping was assessed using the HICUPS developed by Ayers (1991). The HICUPS is a theoretically based self-report measure of coping that children use in response to a specific stressful event. This measure consists of 45 items developed from a content analysis of self-reports of coping by children who had experienced parental loss through divorce (Sandler, Ayers, Bernzweig, Harrison, Wampler, & Lustig, 1989). The HICUPS also is a situational form of a dispositional measure of coping—the Children's Coping Strategies Checklist (CCSC) (Ayers, 1991). Sandler et al. (1994) later endorsed the validity of the CCSC in a specialized sample of children whose parents had divorced. For this article, the instructions on the HICUPS were modified in order to address the specific event of parental loss. The modified instructions were as follows:

Sometimes kids feel bad or upset when they are taken away from their parents. When this happens people think or do many different things to help make their situation better or make themselves feel better. Please tell me how much you thought or did *each* of the different things listed below to try and make things better or to make yourself feel better when you've felt bad or upset about being taken away from your parents. There are no right or wrong answers; just mark how often *you* did each of these things when you were separated from your parents.

Participants were asked to indicate how often they used each coping strategy on a 4-point Likert-type scale: (1) not at all, (2) a little, (3) somewhat, and (4) a lot.

The items on the HICUPS form 11 subscales. Internal consistency alphas for 10 of the subscales ranged from .57 to .74, with an average internal consistency of .64. An internal consistency alpha for the 11th subscale—expressing feelings—was not available. The scales are hypothesized to form four factors: active coping, avoidant coping, distraction, and support (Ayers, 1991; Sandler et al., 1994). Because these factors were not consistent with most of the past research that conceptualizes coping, the subscales were regrouped into problem-focused coping, emotion-focused coping, and avoidant coping mechanisms for the purposes of this study.

Problem-focused coping consisted of the following subscales: cognitive decisionmaking (CDM), direct problem solving (DPS), and problem-focused support (PFS). Emotion-focused coping consisted of positive cognitive restructuring (PCR), distracting actions (DA), physical release of emotions (PRE), emotion-focused support (EFS), and expressing feelings (EF). Avoidant coping consisted of cognitive avoidance (CA) and avoidant action (AVA). The assigning of each of the subscales into one of these three categories was based on decision rules that past researchers used to

make similar distinctions between coping mechanisms (Billings & Moos, 1981; Compas et al., 1988; Folkman & Lazarus, 1980; Folkman et al., 1986; Lazarus & Folkman, 1984; Seiffge-Krenke, 1993). Ayers (1991) dropped the expressing feelings subscale due to "low reliability, inability to test the single factor model and theoretical considerations" (p. 115).

**Appraisals of control.** Based on Compas et al. (1988), appraisals of control were assessed on a 5-point Likert-type scale (1 = no control; 5 = complete control). Participants were asked to rate the degree of control they felt they had over the cause of the loss of their parents (e.g., "How much control did you feel you had over the situation of being separated from your parents?").

**Child psychological symptomatology.** Children's levels of symptomatology were assessed with the broadband scores obtained on the Child Behavior Checklist (CBCL) (Achenbach, 1991). The CBCL consists of 118 behavior problem items rated by the parent or primary caregiver as "not true," "sometimes true," or "often true" for the child. The measure is appropriate for ages 4–18.

In this article, the child's primary caregiver at the residential treatment facility completed the CBCL. Primary caregivers had known the children at least six months and usually for the entire length of children's stay at the residential facility. In addition to a total behavior problem *T* score, scores for both internalizing and externalizing problem behaviors were used. The CBCL has excellent psychometric properties and is used routinely in clinical research with children and adolescents.

Emotional and behavioral problems also were assessed with the Children's Depression Inventory (CDI) (Kovacs, 1992). The CDI is a 27-item self-report measure that discriminates between clinically depressed and nondepressed patients. The CDI has excellent psychometric properties and is used routinely as a self-report measure in child and adolescent research.

**Demographics and abuse history.** Background information about each child was culled from his or her clinical records. Any

demographic data or abuse history data missing from the files were obtained from the child's primary caregiver whenever possible.

### *Procedure*

Consent was obtained at the level of the agency, and verbal assent was obtained from each participating child. Children were interviewed individually in a private room by the primary investigator. After initial rapport was established, the interviewer asked memory enhancement questions about the child's loss situation. Interviewers asked who children considered to be their original parents and when they were first separated from them. For a few children who had difficulty identifying a parent, the interviewer had to ask additional questions to obtain a response, such as if there were any adults in the child's life that he or she were as close to as a parent. All children in the study were able to give a response with the additional questions.

They also were asked if they had any contact with their parents. Children then were provided with five circles of increasing size to respond to the question referring to their appraisals of control. The circles were visual cues for children, with the smaller circle representing small amounts of good feelings (and thus, large amounts of bad feelings). After this task, children were presented with another poster of five circles, increasing in size to answer the question, "How do you feel about being separated from your mom/dad?" The circles had the following labels: (1) really bad, (2) a little bad, (3) not sure, (4) a little good, and (5) really good. This question was included to determine if children had a positive or negative interpretation of the separation.

These questions were followed by the administration of the HICUPS. During the HICUPS, children again were provided with circles of increasing size to help them visualize increasing amounts in the use of coping strategies. The interviewer ended this portion of the interview with more cheerful questions, such as asking the children to list the best qualities about themselves and their favorite

activities. These latter questions served a clinical function—to try to counter any distress that might have been created during the data collection. These questions were not used for research purposes. The interview then concluded with the administration of the CDI. At the end of the interview, if the child or adolescent was significantly distressed, appropriate measures were taken depending on the clinical needs of the child or adolescent (e.g., further discussion with the interviewer, discussion of the child's or adolescent's concerns with the primary caregiver or therapist). A few children initially were distressed after discussing issues about their parents; however, their distress dissipated after a brief discussion with the interviewer. The CBCL was completed by the primary caregiver within six months of the interview.

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## Results

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### *Descriptive Statistics*

The mean amount of control ( $M = 1.88$ ,  $SD = 1.22$ ) shows that children felt they had little to no control over being separated from their parents. This interpretation of the situation was appropriate in most cases, because these children were usually removed from their parents' custody because of issues of neglect or abuse.

Although the majority of these children were neglected or abused by at least one of their parents, the mean response to the question pertaining to how they feel about being separated from their mothers ( $M = 2.28$ ,  $SD = 1.29$ ) and fathers ( $M = 2.38$ ,  $SD = 1.35$ ) indicates that they feel "a little bad" about the separation. This information is important, because an essential component of most coping measures is that the person is responding to an event perceived as stressful or upsetting.

The reported level of children's emotional and behavioral functioning differed greatly depending on the informant. The mean  $T$  score on the CDI was 45.75 ( $SD = 8.46$ ), which falls in the

nonclinical range. In essence, children reported that they were not currently experiencing depressive symptoms. When the primary caregivers at the treatment facility were asked to rate children's emotional and behavioral functioning, they indicated the children's problems fell in the clinical range ( $M = 67.02$ ,  $SD = 8.86$ ) of total emotional and behavioral problems. The caregivers reported that children were experiencing borderline clinical levels of internalizing problems ( $M = 63.23$ ,  $SD = 9.82$ ) and clinical levels of externalizing problems ( $M = 67.70$ ,  $SD = 8.96$ ). Overall, children denied experiencing depressive symptoms, whereas their caregivers reported that the children were experiencing significant psychological problems.

### *Inferential Statistics*

For the following analyses, all relevant subscales were added together. For example, to test a hypothesis involving the problem-focused subscales, a sum score was obtained for the CDM, DPS, and PFS subscales. Sum scores also were obtained for analyses involving emotion-focused coping strategies, avoidant strategies, and cognitively oriented coping strategies. If the analyses involving the grouped subscales failed, however, the data were analyzed again using the individual subscales.

Three dependent  $t$  tests were performed to determine if there were differences in the types of coping children used. Because this study was conducted within a clinical setting, the authors expected that children would use avoidant coping significantly more than other coping methods. This hypothesis was confirmed because avoidant coping was used significantly more than both emotion-focused coping— $t(59) = 6.5$ ,  $p < .001$ —and problem-focused coping— $t(59) = 9.07$ ,  $p < .001$ . In addition, children were expected to be more likely to use emotion-focused coping mechanisms than problem-focused because of the immutable nature of the loss situation. This expectation also was confirmed; emotion-focused coping was used significantly more:  $t(59) = 4.38$ ,  $p < .001$ .

The mean scores for avoidant coping, emotion-focused coping, and problem-focused coping were 3.05, 2.49, and 2.26, respectively (based on a possible range from 1 to 4).

A correlational analysis was performed to determine the relation between appraisals of control and coping mechanisms. A positive correlation was expected for appraisals of control and the sum score of the problem-focused coping mechanisms (CDM, DPS, and PFS), with lower levels of perceived control related to less use of the problem-focused coping. The relation between these two variables was not significant, however:  $r(60) = .07, p = .62$ . When data were analyzed using the individual subscale scores instead of a sum score for the problem-focused coping mechanisms, all of the correlations remained insignificant (see Table 2).

The relationship between level of symptomatology and coping mechanisms was determined through four correlational analyses. Negative correlations were expected for the sum score of the emotion-focused coping strategies that are not avoidant in nature (PCR, PRE, DA, EFS) with both measures of symptomatology (total

**TABLE 2**  
Zero-Order Correlations for the Coping Subscales of the How I Coped Under Pressure Scale and the Measures of Adjustment and Control

Scale	CDM	DPS	PFS	PCR	DA	PRE	EFS	EF	CA	AVA	SU
Control	.10	-.02	.08	.04	-.11	.02	.04	-.15	-.17	-.19	-.06
CDI (Total T)	.15	.20	.20	-.03	.15	.04	.28*	.45**	.13	-.12	.31*
CBCL (Total T)	.29*	.38**	.20	.15	.26*	-.04	.25	.39**	.19	.11	.35**
CBCL (Internalizing T)	.07	.19	.10	.08	.14	.06	.08	.31*	.09	.06	.20
CBCL (Externalizing T)	.24	.32**	.09	.07	.26*	-.09	.14	.41**	.01	-.01	.27*

\* $p \leq .05$ ; \*\* $p \leq .01$

Note: CDM = Cognitive Decision-Making; DPS = Direct Problem Solving; PFS = Problem-Focused Support; PCR = Positive Cognitive Restructuring; DA = Distracting Actions; PRE = Physical Release of Emotions; EFS = Emotion-Focused Support; EF = Expressing Feelings; CA = Cognitive Avoidance; AVA = Avoidant Actions; SU = Seeking Understanding; CDI = Children's Depression Inventory; CBCL = Child Behavior Checklist.

problem behavior *T* scores obtained on both the CBCL and the CDI). In addition, positive correlations were expected for the sum score of the avoidant coping strategies (AVA, CA) with both measures of symptomatology. The correlations between emotion-focused coping strategies and *T* scores on the CBCL and the CDI were  $r(60) = .23, p = .07$ , and  $r(60) = .17, p = .20$ , respectively. The correlations between avoidant coping strategies and *T* scores on the CBCL and the CDI were  $r(60) = .17, p = .20$ , and  $r(60) = .01, p = .97$ , respectively. Because none of these correlations were significant, the data were analyzed using the individual subscales.

When these analyses were conducted, a significant correlation was obtained between the use of DA and total problem behavior *T* scores obtained on the CBCL:  $r(60) = .26, p = .046$ . This correlation is in the opposite direction of that which was hypothesized, however. In other words, greater use of an emotion-focused coping strategy, DA, was associated with more, rather than fewer, total problem behaviors on the CBCL. Behavioral problems associated with the use of DA apparently are best explained by externalizing problems instead of internalizing problems. The correlation between externalizing problems reported on the CBCL and the use of DA was significant— $r(60) = .26, p = .046$ —whereas the correlation between this subscale and internalizing problems reported on the CBCL was not. A significant correlation also was obtained between the use of EFS and total *T* scores obtained on the CDI:  $r(60) = .28, p = .03$ . This correlation is in the opposite direction of that which was hypothesized, as well. Greater use of EFS was associated with more problems reported on the CDI. Neither of the avoidant coping subscales (AVA, CA) were significantly correlated with either measure of symptomatology (Table 2).

### *Post-Hoc Analyses*

One of the most interesting findings revealed in these post-hoc analyses was the relevance of the 11th subscale on the HICUPS, EF. According to Ayers (1991), this subscale refers to the overt



expression of feelings by an action, a verbal expression of feelings, or an overt release of emotion. An example of an item from this subscale is "Wrote down my feelings." Ayers decided to drop this scale; however, the data in the current sample indicate that this subscale had a strong relationship with both measures of symptomatology. The use of EF was positively correlated with children's self-reports of depressive symptoms— $r(60) = .45, p < .001$ —and with caregivers' reports of child symptomatology— $r(60) = .39, p = .002$ . Further examination of the relationship between this subscale and scores on the CBCL indicate that the use of EF positively correlated with both internalizing behaviors— $r(60) = .31, p = .02$ —as well as externalizing behaviors— $r(60) = .41, p = .001$ .

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## Discussion

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This article examined the process by which children in a clinical setting cope with the severe acute stressor of parental loss. Children usually have little control over the process of parental loss because of issues of abuse or neglect; therefore, most children predictably stated that they had little to no control over the separation from their parents. Shapiro, Schwartz, and Astin (1996) argue that when events are beyond a person's control, efforts to gain control, a belief in one's own efficacy, or a high desire for active control may result in a multitude of negative personal consequences. The fact that children reported a lack of control over the loss situation also is consistent with a statement made by Compas and colleagues (1993), indicating that interpersonal events often are seen as less controllable than noninterpersonal ones. Folkman (1984) states that emotion-focused coping strategies may be adaptive in situations involving an unchangeable stressor. Given the immutable nature of the loss situation in this study, children may show more adaptive responses when they use emotion-focused coping strategies more often than problem-focused and avoidant ones. Although levels of perceived control were low and emotion-

focused coping strategies were high as expected, there was no relationship between control and coping, perhaps because of a problem of range restriction in the control variable. The authors conclude that the variable had a restricted range because 75% of the children stated they had little to no control over the loss of their parents. Restricting the range of one variable may severely decrease the correlation with other variables (Bobko, 1995).

Although emotion-focused coping strategies were expected to be associated with lower levels of psychological symptomatology, the opposite was found. Three of the emotion-focused coping strategies—DA, EFS, and EF—were related to higher levels of psychological symptomatology. These results contradict past researchers, who suggested that using emotion-focused coping strategies to deal with uncontrollable immutable stressors may be adaptive (Billings & Moos, 1981; Compas et al., 1993; Folkman, 1984). On the other hand, the obtained results are consistent with a plethora of studies that ascertained emotion-focused coping strategies are positively related to psychological symptomatology (Billings, Cronkite, & Moos, 1983; Billings & Moos, 1984; Compas et al., 1988; Folkman et al., 1986; Fondacaro & Moos, 1987).

There are two possible explanations for this pattern of results. First, several of these past studies combined avoidant coping strategies with emotion-focused coping strategies, which could make these strategies more likely to be associated with problematic behaviors. The second may explain why the positive relationship between emotion-focused strategies and emotional or behavioral problems exists even when avoidant coping strategies are parceled out. Nolen-Hoeksema (1991) hypothesizes that women are more prone to depression than men because they have a tendency to ruminate and focus on their emotions, whereas men distract themselves. Unsurprisingly, children of either gender who endorsed items referring to focusing on feelings (e.g., "Write down my feelings," "Talked with one of my friends about my feelings") were more likely to exhibit higher levels of psychological symptomatology.

These results also have interesting implications for the controversy over the need to grieve for a parental death. Some researchers argue that grieving is a necessary phase children must go through to adequately cope with their parent's death (Bertoia & Allan, 1988; Bowlby, 1980). Others argue that the grieving process may not be related to children's mental health or may even have a detrimental effect on children's psychological well-being (Sandler, Gersten, Reynolds, Kallgren, & Ramirez, 1988; Wortman & Silver, 1989). The results of this article's study suggest that focusing on emotions involved with a loss situation (which could also be conceptualized as grieving over the loss) is associated with more psychological problems.

Post-hoc analyses revealed that the subscale EF had a strong positive relationship with both measures of symptomatology. In addition, the use of this type of coping seems to relate to both internalizing and externalizing problems. Although Ayers (1991) decided to drop this subscale, this article indicates that scores on this subscale may be meaningfully related to psychological problems. On the other hand, this subscale only has three responses, one of which is, "Cried to myself." Such a face valid response would be related to measures of psychological problems. Although the coping questions were asked with a retrospective time frame and the psychological problems questions were asked for present day, the possibility that the variables are confounded still exists.

In addition to the limitations already discussed, another is that the HICUPS may have served to induce a negative mood, which then was reported on the CDI because its administration followed the HICUPS for all interviews. There are two reasons why this problem does not invalidate the significant findings of this article. First, the mean CDI score was 45.75, which is in the nonclinical range. This finding indicates that on average, children reported that they were not depressed. Secondly, most of the significant findings in this study were between the HICUPS and CBCL (not the CDI). Because the CBCL was not self-reported,

the possible mood induction with the children would have been unrelated to the caregivers' reports on the CBCL.

In the future, researchers may wish to compare the emotional and behavioral functioning and coping processes of children who have experienced the loss of a parent because of factors other than divorce or death with a control group consisting of children of divorce or bereaved children. In addition, longitudinal studies are necessary to determine the temporal features of these phenomena. Ideally, children's mental health and coping processes first should be examined at the time of initial child protection agency involvement with parents whose rights may be terminated. Then, follow-up assessments could be completed throughout the entire process of the termination of parental rights, as well as after the child has been placed. Future research must consider the temporal connections between coping and symptoms in relation to the timing of the loss. In addition, it would be quite interesting to determine if the process by which children cope with parental loss and their subsequent psychological functioning is related to the likelihood of future adoption.

The information obtained from this article should aid in the understanding of the mechanisms children use to cope with the severe acute stressor of parental loss, specifically loss caused by factors other than divorce or death. The results of this study indicate that abuse and neglect do not preclude children from feeling bad about being separated from their parents. Most children perceive the loss situation as both upsetting and out of their control. Children seem to use emotion-focused coping strategies to deal with this severe acute stressor; however, several of these strategies are related to higher levels of emotional or behavioral problems. This fact has important treatment implications. Mental health counselors may be able to help children who have experienced parental loss by shifting their focus from promoting "healthy grieving" to answering children's questions, normalizing the situation, increasing the children's resources (problem-solving skills,

interpersonal skills, self-esteem), and increasing children's social support network. In addition, clinicians should try to ascertain the child's own reactions to the loss events, before assuming that the child is reacting like others. Hopefully, these results and results from future studies in this area can help children cope with the severe acute stressor of parental loss because of termination of parental rights.

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