Family Coping as a Protective Factor for Poor Children

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FAMILY COPING AS A PROTECTIVE FACTOR FOR POOR CHILDREN

A Dissertation

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the Faculty of Social Sciences

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Doctor of Philosophy

by

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ABSTRACT

This study examined family influences on coping and adjustment among 90 low-income Latino middle school children (46% Female; Average age = 11.38, $SD = .66$) and their primary caregivers (93% Female; Average age = 36.12, $SD = 6.13$). All participants identified as Hispanic/Latino, with 75% of families identifying as Mexican-origin Latino, 77% of parents identifying as immigrants, and 32% of children identifying immigrants. All children participating in the study were receiving free or reduced lunch, a poverty indicator. Hierarchical linear modeling analyses revealed that family reframing is related to fewer symptoms of psychopathology and that familism enhances the protective effect of family reframing, while passive appraisal is linked to worse functioning. Path analyses showed that family reframing also has indirect effects on symptoms through child primary control coping. Additional analyses identified family mobilizing support and family ethnic socialization as potential contributors to child secondary control coping. Family mobilizing support may also be helpful for single-parent families, while family spiritual support is helpful for immigrant families. Qualitative findings from an initial focus group and from the larger sample are also discussed. Results are discussed with regard to the implications of this research for preventive interventions with families in poverty. Understanding the protective links of family coping and cultural strengths to mental health outcomes of poor children can influence intervention or prevention programming and policy targeting at-risk youth and families.
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Family Coping as a Protective Factor for Poor Children

Nearly one out of every five, 17.6%, children were living in poverty in 2003 (U.S. Census Bureau, 2003). This number is even more disturbing when considering ethnic minority children—34% of African American children and 30% of Latino children are living in poverty (U.S. Census Bureau, 2003). Garbarino (1998) described poverty for children as “social toxicity.” Poverty contributes to a host of negative outcomes for children, including symptoms of depression, anxiety, hostility, aggression, and elevated psychophysiological stress (Conger et al., 2002; Evans & English, 2002; Grant et al., 2003; Kim, Conger, Elder Jr., & Lorenz, 2002; Lempers, Clark-Lempers, & Simons, 1989; McLoyd, 1998). The relationship between exposure to poverty and negative outcomes such as depression, hyperactivity, and scholastic performance, intensifies for ethnic minority youth (McLeod & Owens, 2004). Because poverty is consistently linked with mental health problems in children, there is an interest in understanding both why poverty is so harmful and what might protect children from the harmful effects. The current study examines family and individual adaptation to poverty-related stress (PRS), as this stress is a mechanism that links poverty to maladjustment. In addition, the current study extends the coping literature by examining family coping as a protective factor that may buffer children from the stress of poverty.
Poverty-Related Stress (PRS)

Recent research has begun to examine mechanisms through which poverty is harmful for children, but often with limited or select samples, such as Caucasian families experiencing temporary income loss (Grant et al., 2004). Research suggests that poverty affects children and families through PRS, a collection of stressors that tend to co-occur more frequently in the lives of low-income families, including exposure to violence, economic stress, deteriorating family relationships, and discrimination (Ceballo & McLoyd, 2002; Conger, Rueter, & Conger, 2000; Wadsworth et al., 2008). The events and situations that create the context of PRS affect children and parents alike. Family-based stressors such as parental unemployment and living in a dangerous neighborhood affect everyone in the household. Although research has shown that poverty affects children through parenting (Mistry, Vandewater, Huston, & McLoyd, 2002), converging evidence has also shown that children and adolescents experience life stress directly, and that this stress is reciprocally related to the development of internalizing and externalizing symptoms (Kim et al., 2002).

Understanding how this combination of stressors affects children and families is essential because it is the accumulation of environmental stressors that puts children at higher risk for negative outcomes (Evans, 2004). Poor children are exposed to a multitude of environmental risks including family turmoil, violence, family separation, instability, chaotic households, less social support, less responsive parenting, polluted air and water, crowded and noisy homes, dangerous neighborhoods, and poor quality schools and day cares (Evans, 2004). These chaotic living conditions are associated with learned helplessness, poor self-regulatory behavior, and psychological distress (Evans, Gonnella,
Marcynyszyn, Gentile, & Salpekar, 2005). PRS captures stressors coming from a number of these risks. The current study aims to broaden our understanding of the multitude of stressors poor children face, and especially the positive efforts children and families are making (i.e. family coping and individual coping) to adapt to PRS.

The negative effects of PRS are especially damaging during child and adolescent development, compromising physiological and psychological functioning (Evans, Kim, & Ting, 2007; Wadsworth & Santiago, 2008). Economic stress alone is related to anxiety, depression and aggression among poor adolescents (Wadsworth & Compas, 2002). PRS also contributes to adolescent deviant behaviors, such as teen pregnancy, school dropout, and substance use, which have long-term negative consequences (e.g., Farrington & Loeber, 2000). PRS affects not only adolescents, but younger children as well, and these effects are of similar magnitude. Among younger and older children alike, PRS is associated with anxiety, depression, somatic complaints, delinquent behavior, and aggressive behavior (Wadsworth et al., 2008). Likewise, economic stress and exposure to violence predict externalizing and internalizing problems among poor ethnic minority children (Grant et al., 2004).

Poverty not only affects individual functioning, but also wreaks havoc on the family. Chronic stress, such as PRS, deteriorates the family system by disrupting positive family relationships and adaptive family structure—parental leadership, appropriate parent and child roles, adequate monitoring, and fair and consistent discipline (Kiser & Black, 2005). Families who can successfully cope with chronic stress by using family coping strategies such as problem solving, resource management, positive reframing and emotional expression, work to maintain positive family relationships and structure,
protecting against further upheaval in the family system. The current study specifically examines family coping in response to PRS in order to test if family coping buffers low-income Latino children from poor mental health outcomes.

Family Coping

European American culture tends to focus on individualism and competition (Howard & Scott, 1981). This cultural lens can be biased to focus primarily on individual processes in development of and protection against psychopathology, without acknowledging that many other cultures are less individualistic. In psychological research for example, we often conceptualize influences in terms of the individual. However, family processes, both negative and positive, are crucial considerations in the development of psychopathology among children (e.g. Kumpfer & Alvarado, 2003; Patterson, 2002). Coping as an individual has clear protective value (e.g. Wadsworth & Compas, 2002; Wadsworth & Santiago, 2008), however examining coping at a family level recognizes the rich influences family has for children, and how families may work together as a unit to cope with stress. Family coping is especially important to understand among Latino families because of the traditional value placed on family among many Latino cultures. In addition, identifying a cultural strength that protects children from developing psychopathology can inform prevention programs aimed at poor and at-risk children.

Unlike some identified protective factors such as high IQ, coping with PRS has considerable potential to be enhanced or taught (Raviv & Wadsworth, 2009). Thus, coping can be incorporated into psychological treatments and preventive interventions for poor children. Family coping is comprised of the family’s strategies and behaviors aimed
at maintaining or strengthening the family as a whole, maintaining emotional stability and well-being of family members, using family and community resources to manage a situation or event, and making efforts to problem-solve or resolve family hardships created by stress (McCubbin, McCubbin, Thompson, & Thompson, 1998). Although family coping may be related to positive parenting practices, it differs in important ways. For example, family coping is tied to explicit stressors that families are attempting to deal with. In addition, family coping measures the degree to which families engage in these strategies as a whole, which is broader than the parent-child relationship. Further, parenting is often conceptualized as having two components—affective, including nurturance and sensitivity, and parental control, or child management and discipline (Mistry et al., 2002). Family coping may involve sensitivity to child distress, but it is not necessarily tied to discipline.

Although little research has focused specifically on family coping, there is strong evidence that family functioning can serve protective functions. For example, emotional cohesion and positive family relationships can buffer against the effects of violence exposure for violence-exposed youth (Gorman-Smith, Henry, & Tolan, 2004) and protect against internalizing and externalizing disorders for economically disadvantaged youth (Gorman-Smith, Tolan, Henry, & Florsheim, 2000). In addition, family support is protective in the face of family conflict and is related to better academic achievement for adolescents (Unger, McLeod, Brown, & Tressell, 2000). Family cohesion, defined as the degree of support and enjoyment among family members, has also demonstrated protective influences for children (Kliewer, Murrelle et al., 2006). Adolescents in Central America that have been exposed to violence but also have high levels of family cohesion,
are less likely to use alcohol and drugs than adolescents from families with low levels of family cohesion (Kliewer, Murelle et al., 2006). Middle school children living in high-crime and poor neighborhoods with higher levels of family cohesion, also show fewer externalizing problems compared to those with lower levels of family cohesion (Plybon & Kliewer, 2001). The current study examines whether there are specific volitional strategies beyond general functioning that families use in order to cope with PRS and if these strategies are protective for low-income Latino youths.

Thus far, studies that have examined family coping have not been in the context of PRS, but have found positive effects in adjusting to other types of stress, such as developmental disability, cerebral palsy, Down syndrome, and chronic illness (Korneluk & Lee, 1998; Lustig, 2002; Lin, 2000; Van Riper, 2000). Family strategies such as reframing, positive family appraisal and spiritual support are associated with positive adjustment for family members (Korneluk & Lee, 1998; Lustig, 2002; Lin, 2000; Van Riper, 2000). Family coping also predicted successful program completion for African American youth entering a delinquency treatment and was associated with less stress and greater life satisfaction for rural adolescents (McCubbin, Fleming, & Thompson, 1998; Plunkett, Henry, & Knaub, 1999).

The current study examines whether this positive influence can buffer low-income youth from the far-reaching negative effects of poverty by having direct positive effects on child adjustment, but also by encouraging adaptive child coping. Examining how families cope with stress together as a unit allows for a clear inclusion of the context in which a child is learning to cope and an exploration of the influence of family coping on individual child coping. Among low-income families exposed to violence, parental
coaching and modeling of effective coping influences children’s own coping, which predicts better adjustment (Kliwer, Parrish et al., 2006). Positive suggestions and coping communication among families helps children cope effectively, which in turn predicts lower levels of internalizing and PTSD symptoms (Kliwer, Parrish et al., 2006). This study examines how family coping with PRS is related to children’s own individual coping with a specific lab-based stressor.

**Individual Child Coping**

Coping as a family or as an individual often carries protective influences. The study of family coping can enrich our understanding of processes that influence individual coping. Current definitions of individual coping conceptualize it as a conscious process that includes volitional attempts to manage emotions and cognitions, regulate behavior and arousal, and act on the environment to alter or decrease the source of stress (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001). Most conceptualizations of coping distinguish between actively confronting and avoiding the problem (e.g. Compas, Malcarne, & Fondacaro, 1988; Ebata & Moos, 1991) as well as problem-focused and emotion-focused strategies (Ayers, Sandler, & Twohey, 1998).

Connor-Smith, Compas, Wadsworth, Thomsen, and Saltzman (2000) proposed the Responses to Stress Model, which distinguishes between coping (voluntary responses to stress), and involuntary stress responses (automatic responses to stress). The model then divides voluntary and involuntary responses into responses that demonstrate engagement with or disengagement from the stressor or reactions to the stressor. Voluntary engagement coping responses include primary control coping, strategies that are used to directly alter the stressor or one’s emotional reactions to it, and secondary control coping,
strategies that aim to adapt oneself to the stressor, while voluntary disengagement coping strategies include avoidance, denial, and wishful thinking (Connor-Smith et al., 2000).

Primary control coping strategies include problem solving, emotional expression, and emotional regulation. Secondary control coping strategies include acceptance, distraction, positive thinking, and cognitive restructuring, which involves thinking about a situation in a way that allows one to see what they are gaining or learning from the problem. Primary and secondary control coping are effective for managing PRS and are associated with fewer symptoms of both internalizing and externalizing disorders (Wadsworth & Compas, 2002; Wadsworth, Raviv, Santiago, & Moran, 2009; Wadsworth & Santiago, 2008). Disengagement coping, on the other hand, appears to be damaging in the long-term (Santiago & Wadsworth, 2009; Wadsworth et al., 2009).

Children who engage in adaptive strategies such as those included under primary and secondary control appear to benefit even when events are external and uncontrollable. Still, coping strategies come out of a context of influences such as family, where children learn to cope and handle problems and stress. Family is a critical social unit in transferring beliefs and practices, including those regarding the management of stressors and stressful life events (McCubbin, McCubbin et al., 1998). With difficulties like economic hardship, it is likely that parents assist their children in handling stress and that families cope as a unit with the multitude of stressors that poverty brings. Though PRS undermines effective coping (e.g., Wadsworth, Raviv, Compas, & Connor-Smith, 2005), high quality parenting and family relationships have been linked to positive coping (Skinner & Zimmer-Gembeck, 2007). Understanding more about how child coping is socialized will allow intervention and prevention efforts to
capitalize on factors that lead to adaptive child coping. The current study extends the coping literature by examining coping at a family level, and how family coping, in turn, shapes child coping.

*Cultural Considerations*

Family processes are embedded within a cultural context. This study adopts a multicultural framework in considering how families adapt to PRS. Family plays a central role in many cultures and adaptation to PRS likely occurs within families. In particular, family is highly valued in Latino cultures (Cuellar, Arnold, Gonzales, 1995; Martin, 1993). Latino families emphasize loyalty and sharing with family, or familism, while European American families often emphasize independence and individual achievement (Canino & Zayas, 1997). This traditional focus on the family may promote efforts to manage stress and get through hardships together among families of Latino origin. In turn, this exposure to cultural values and family coping strategies likely influences how children learn to cope with stress more generally. However, within the broad Latino culture, there are varying degrees of orientation towards culture of origin, familism, and acculturation. An important aspect of the current study is to gauge the overall protective nature of family coping as well as see if this effect is influenced by immigrant/generational status, cultural orientation, and cultural values. Thus among Latinos, cultural values may shape the importance of family and managing stress as a family as well as the amount or degree to which a family copes together. For example, for families that are more acculturated or less oriented to their culture of origin, family coping strategies may be less beneficial. However, for families high in familism, family coping may be especially effective for managing PRS.
Cultural strengths are particularly important to consider for minority youths because of their unique experiences with racism and discrimination (e.g., Ball, Armistead, & Austin, 2003). Strength-based approaches often emphasize strengths stemming from race, ethnicity, or culture in therapy (Erkut, Fields, Sing, & Marx, 1996; Johnson, 2003) and there is evidence that cultural strengths predict positive adjustment. Familism is associated with less substance use in ethnic minority youth (Gil, Wagner, & Vega, 2000; Klonoff & Landrine, 1999; Ramirez et al., 2004; Unger et al., 2002). In addition, among Latino families with young children, family pride predicts greater engagement in family coping strategies such as reframing and spiritual support (Hanline & Daley, 1992). Preliminary evidence suggests that incorporating family sessions into traditional cognitive-behavioral treatments for depression is helpful for and valued by Latino populations (Cardemil, Kim, Pinedo, & Miller, 2005). Likewise, programs that encourage a positive sense of ethnic identity and culture are associated with better academic achievement and mental health (Smith, Atkins & Connell 2003; Stevenson, Reed, Bodison, & Bishop, 1997). In studies involving Latino and African American adolescents, those with positive ethnic identity reported fewer symptoms of depression, substance use, and delinquent behavior (Arbona, Jackson, McCoy, & Blakely, 1999; Brook, Whiteman, Balka, Win, & Gursen, 1998; Jagers & Mock, 1993; McMahon & Watts, 2002; Roberts, Phinney, & Masse, 1999; Smith, Walker, & Fields 1999; Westermeyer, 1984). A sense of cultural or ethnic identity often comes from family values and cultural practices. The current study examines the influence of cultural practices and values in the context of family coping. Cultural orientation or familism may enhance family coping strategies or contribute to adaptive child coping.
Despite these potential strengths, Latino youths experience proportionately more depression, anxiety, and delinquency than do non-Hispanic white youth (Surgeon General, 2000) and may be especially vulnerable to depression or anxiety (Constantino, Malgady, & Rogler, 1994). Thus drawing on the particular strengths of this cultural group may increase our understanding of how best to prevent psychopathology.

Neglecting the study of family coping may be overlooking a protective influence that is highly important for some Latino families, potentially those families with high degrees of cultural orientation and traditional cultural values such as familism.

Current Study

The first phase of this study consisted of a focus group conducted with low-income Latino parents, in order to assure cultural sensitivity and understanding from the ground up. The focus group was a small group discussion on how these families handle stress together and how culture might influence the way the family handles stress. In addition, the family coping measure was discussed. Qualitative findings from the focus group are included in the discussion.

The primary study targeted low-income Latino children from sixth grade classes. This age group was chosen because internalizing and externalizing problems increase with age (Bongers, Koot, & van der Ende, 2003), and also because some degree of sophistication is needed to complete questionnaires and be accurate reporters. Also, higher-level coping skills are believed to emerge and increase in sophistication during middle childhood and early adolescence (Compas et al., 2001). Sixth grade is also a time when children tend to struggle with the transition to middle school, placing these children at elevated risk for mental health problems, making the study of protective factors...
especially important for this age group. The context of poverty creates a potentially overwhelming burden of stress for poor children, and families coping positively with this stress may enable children to cope better with transitional stressors on their own. In addition, sixth graders are likely beginning to individuate from, but are still dependent on, their families for help and support, whereas older adolescents may be more focused on getting through difficulties on their own. Children reported on their own stress as well as levels of family coping, and adjustment. Individual child coping was measured in response to a specific event shown on a video clip. A parent/primary caregiver was asked to report on family coping, PRS, child adjustment, and culture. This study targeted Latino families because the importance of family in Latino cultures makes this an especially relevant group for the study of family coping.

This study examines family coping as a protective factor against the stress of poverty and poor mental health outcomes among a sample of low-income, at-risk Latino sixth graders. In addition, the influence of family coping on individual coping is also examined. Finally, this study examines how family coping is influenced by immigrant/generational status, cultural orientation and familism among Latino families. The primary outcomes of the study are internalizing symptoms, externalizing symptoms, depression, anxiety, aggression, and delinquency. Examining broadband scales tests for the overall protective nature of family coping. However, because Latino youths experience proportionately more depression, anxiety, and delinquency than do non-Hispanic white youths (Surgeon General, 2000), examining these additional narrow-band scales is key for increasing our understanding of the relevance of family coping across outcomes for which Latino youths are at increased risk. The hypotheses of the current
study are: (1) positive family coping strategies (e.g., family reframing, family spiritual support) will be related to fewer internalizing symptoms, externalizing symptoms, depression, anxiety, aggression, and delinquency, (2) family coping and cultural practices will be positively associated and cultural practices will enhance family coping strategies, and (3) family coping will support adaptive child coping, showing indirect effects on psychological symptoms through child coping.
METHOD

Focus Group

A focus group was conducted with four low-income Latina mothers (average age = 35.3). These mothers had 2-4 children, with at least one child falling between the ages of 10-13. Immigrant/Generational status ranged from identifying as an immigrant to having family in the United States for many generations. The focus group took place at the University of Denver in a private room. Participants gave informed consent before the discussion began. The discussion was audiotaped. Participants received financial compensation for their time.

Discussion focused on how these families handle stress as a unit and how culture influences the way the family handles stress. The group also reviewed the family coping measure and discussed how it captures what their families are doing to cope with stress. Participants were generally satisfied with the measure of family coping, so the standardized measure was not altered. They stated that it was generally culturally sensitive as well. However, participants did suggest additional strategies they believed were missing, including making dinners together to cope with stress, doing something active as a family to cope with stress, and playing games as a family to cope with stress. Thus, these additional family coping questions were asked, but were treated as separate from the standardized measure and exploratory in nature. Themes emerged including spirituality and culture as important family influences, extended family as important for coping with stress, spending family time over meals as protective, using humor and
acceptance to cope as a family, and utilizing agencies when necessary for additional help. These Latina mothers believed that these strategies helped keep their children from drugs and violence and contributed to positive relationships in the family, less withdrawal, anger, and sadness. This information guided the methodology of the larger study and measurement of family coping.

**Primary Study Participants**

Ninety low-income Latino middle school children (46% Female; Average age = 11.38, $SD = .66$) and a primary caregiver (93% Female; Average age = 36.12, $SD = 6.13$) participated in the study. All participants identified as Hispanic/Latino, with 75% of families identifying as Mexican-origin Latino, 1% identifying as Guatemalan, 2% identifying as biracial (Hispanic and Caucasian), and 22% describing themselves as Latino/Hispanic without additional descriptors. Among parents, 77% identified as immigrants, 9% identified as first generation Americans, 5% identified as second or third generation, and 9% indicated that their families had resided in the U.S. for many generations. Among children, 32% were immigrants, 45% were first generation Americans, 13% were second or third generation, and 10% indicated their families had been in the U.S. for many generations. Twenty percent of parents identified themselves as single parents, with the average family size being 5.02 ($SD = 1.45$) total family members including parents and children. The average monthly income reported was $1806.18 ($SD = 906.69$). All children participating in the study were receiving free or reduced lunch, a poverty indicator. An additional 18% of families indicated they were receiving food stamps. Parental occupation was coded using Hollingshead’s (1975) 100-point scale with higher scores indicating higher prestige jobs. The average coded
maternal occupation score was 18.59 ($SD = 14.41$; range 10-70), with 64% of mothers’ occupations coded at 10 (e.g., cleaning services, homemaker). The average coded paternal occupation score was 26.79 ($SD = 11.79$; range 10-70), with 63% of fathers’ occupations coded at 20 (e.g., construction, food services).

*Procedure*

Participants were recruited through Denver-area middle schools with above 90% enrollment in the free or reduced lunch program and with greater than 95% of children identifying as Latino/Hispanic. Recruitment also occurred through summer programs serving these children. Invitations were posted and sent home with sixth-graders at middle schools. In addition, researchers attended school meetings, including parent nights, registration, and school banquets. At these events, parents were invited to participate and sign up for the study after a brief presentation describing participant involvement and general study aims. Participants either signed up to participate at events or called to make an appointment. Participants were screened in person or over the phone for eligibility (identifying as Latino/Hispanic, child in sixth grade, and child receiving free or reduced lunch). If eligible, appointments were made at schools or summer program sites. During appointments, bilingual research assistants obtained informed consent from parents and assent from children. With a research assistant, parents completed a short interview that included demographic, family, and economic hardship questions, and then competed questionnaires on PRS, family coping, culture, and the psychological functioning of their child. Another research assistant administered questionnaires and videos to children. Children began by completing a questionnaire on PRS, followed by a questionnaire on their family’s coping with PRS. Next, they watched
a video and then completed a questionnaire about how they would cope with the situation portrayed in the video. Finally, children completed questions on current functioning and culture. All questionnaires were available in Spanish and English. Among parents, 77% chose to complete questionnaires in Spanish. Among children, 23% chose to complete the questionnaires in Spanish.

Before watching the video clip, children were instructed to think of themselves as the main person in the video. In the video clip, the target student is being teased by other children in the class. When the target student eventually retaliates by pushing a book off another student’s desk, the teacher responds by criticizing only the target student. The clip was chosen because it has been shown that children tend to interpret this scene as negative or stressful, regardless of gender (Chen, Langer, Raphaelson, & Matthews, 2004). This video clip was developed and validated as part of the Cognitive Appraisal and Understanding of Social Events (CAUSE) videos and has been used to investigate stress in low-income children (Chen & Matthews, 2003; Chen et al., 2004). Low-SES children have negative threat appraisals about this scenario and demonstrate greater diastolic blood pressure, indicating that the scenario is mildly stressful for them (Chen et al., 2004). In addition this scene provides a scenario that children can potentially cope with in numerous ways. For example, children can attempt to problem solve by talking to the teacher or another adult at a later time, express their feelings to a friend after the class, think differently about the situation by recognizing it was not completely their fault, etc. The goal of the current study is to use a situation low-income children tend to interpret as mildly stressful and examine how these children report coping with the hypothetical event.
After finishing questionnaires, parents and children were debriefed. Children received gift certificates worth $20 for their participation. Parents completed similar measures and received $20 for their participation.

Measures

Demographic Information. Children and parents reported demographic information on surveys they are asked to complete. Children’s ages, gender, immigrant/generational status, and ethnicity were assessed. In addition, parents reported on family income, family structure, and any financial assistance the family received during initial interviews.

Poverty-related stress. Children and parents completed the Multicultural Events Schedule for Adolescents (MESA; Gonzales, Gunnoe, Samaniego, & Jackson, 1995; Gonzales, Tein, Sandler, & Friedman, 2001). Five subscales (57 items) relevant to adolescents and used in previous research to create a reliable composite were used in the current study: economic strain, family moves and transitions, exposure to violence, family conflict, and daily hassles/discrimination (Wadsworth et al., 2008). The MESA was developed and validated using an ethnically diverse, low-income population and has demonstrated adequate test-retest reliability (r = .71). The five subscales were summed for an overall score of PRS. Cronbach’s alphas in this sample were .88 for child report of PRS and .75 for parent report of PRS.

Parents were also interviewed using the Economic Hardship Questionnaire (EHQ), a measure that assesses the number of constraints the family felt as a result of economic hardship and the adjustments they have had to make in order to make ends meet in the last six months (Lempers, Clark-Lempers, & Simons, 1989). Questions were completed on a
5-point scale indicating how often each of 11 items was true for them in the last 6 months. Sample items include: “We have had to sell possessions to make ends meet” and “We had to apply for federal assistance.” Cronbach’s alpha was .88 in this sample. For parent report of PRS, EHQ and MESA scores were standardized and averaged to create a total parent-report PRS variable. Scores from the EHQ and MESA were significantly correlated ($r = .45$).

**Family Coping.** Children and parents completed a survey assessing family coping, *Family Crisis Oriented Personal Evaluation Scales* (FCOPES; McCubbin, Olson, & Larsen, 1987). The FCOPES is a measure designed to assess family coping strategies and adjustment to life stressors. Items are rated on a five-point Likert scale, and responses indicate the extent to which the individual agrees or disagrees with the statement. The FCOPES is a 30-item measure and includes the following subscales: Acquiring Social Support (from relatives), Family Reframing, Spiritual Support, Mobilizing Support, and Passive Appraisal. Higher scores are indicative of families with more adaptive coping mechanisms, with the exception of Passive Appraisal, which is considered maladaptive. Items on this measure include, “Seeking advice from relatives (grandparents, etc.)” (Acquiring Social Support), “Defining the problem in a more positive way so that we do not become too discouraged” (Family Reframing), “Attending church services” (Spiritual Support), “Seeking assistance from community agencies and programs designed to help families in our situation” (Mobilizing Support), and “Believing if we wait long enough, the problem will go away” (Passive Appraisal). Past research has found this measure to show reliability, with overall Cronbach’s alphas ranging from .71 to .86. Test-retest reliability ranged from .61 to .95. In this study, participants were instructed to complete
the measure thinking about how they would respond to the stressful events they just reported on in the PRS measure. For parent report, Cronbach’s alphas in this sample were .79 (Acquiring Social Support), .86 (Family Reframing), .78 (Spiritual Support), .72 (Mobilizing Support), and .60 (Passive Appraisal). For child report, Cronbach’s alphas in this sample were .76 (Acquiring Social Support), .79 (Family Reframing), .65 (Spiritual Support), .75 (Mobilizing Support), and .53 (Passive Appraisal). Sandler, Tein, and West (1994) suggest that coping strategies are best understood in the context of other coping strategies, and Connor-Smith and colleagues (2000) recommend proportion scoring to take into account other responses to stress. Thus, raw scores were utilized in the primary analyses where the effects of other strategies were controlled for in the analysis. Among correlations, proportion scores were utilized.

*Individual child coping.* Children completed the *Responses to Stress Questionnaire* (RSQ; Connor-Smith et al., 2000) in response to the scenario portrayed on the video-clip. Children were asked to complete the questionnaire thinking about how they would respond to the scenario if it had happened to them. The RSQ is a 57-item measure, consisting of 19 subscales that represent coping and responses to stress. These 19 scales comprise five theoretical and empirically supported factors. The three coping factors used in this study are Primary Control, Secondary Control, and Voluntary Disengagement. The other two factors represent involuntary responses to stress and include Involuntary Engagement and Involuntary Disengagement. The psychometric characteristics of the RSQ have been well established for a variety of samples, including a Spanish-speaking population (Connor-Smith et al., 2000). Cronbach’s alphas in this
sample ranged from .78 to .86 for the three coping factors. As recommended by Connor-Smith and colleagues (2000), proportion scoring was utilized.

Child Mental Health. Children completed the Youth Self Report (YSR) and parents completed the Child Behavior Checklist (CBCL), both of which are part of the Achenbach System for empirically based assessment (Achenbach & Rescorla, 2001). The YSR and CBCL contain 118 items that describe behavioral and emotional problems, rated on a scale of zero to two. The YSR and CBCL yield scores for Internalizing symptoms and Externalizing symptoms, the primary outcomes examined in this study. In addition, narrow-band scores for Delinquent Behavior and Aggressive Behavior, and DSM-oriented scores for Anxiety and Affective symptoms were utilized in this study. A Total Problems score was also utilized when examining influences on child coping. Excellent reliability and validity have been established for the YSR and CBCL for children of a variety of ethnicities.

Culture. Parents and children also completed a revised version of the Familial Ethnic Socialization Measure as a measure of orientation to culture of origin (FESM; Umaña-Taylor, 2001). This measure assesses the degree to which cultural or ethnic practices occur within the family. The 12 items (e.g., “My family teaches me about our family’s ethnic/cultural background” and “Our home is decorated with things that reflect my ethnic/cultural background”) are rated on a 5-point Likert scale. Responses are coded so that higher scores indicate higher levels of cultural orientation or ethnic socialization. The original version, consisting of 9 items, obtained Cronbach’s alpha of .82 with a sample of Mexican-origin adolescents (Umaña-Taylor & Fine, 2004). For the revised version, Cronbach’s alphas ranged from .92 to .94 with ethnically diverse samples.
(Umaña-Taylor, Yazedijan, & Bámaca-Gómez, 2004). Cronbach’s alphas in this sample were .91 for child report and .90 for parent report.

Parents and children also completed the Familism Scale (Gil, et al., 2000). This 7-item scale has been used with multiple Latino samples and includes items such as “We are proud of our family,” “Family members respect one another,” and “We share similar values and beliefs as a family.” It has consistently demonstrated reliability, with Cronbach’s alpha of .87 (Gil & Vega, 1996; Vega & Gil, 1998). Cronbach’s alphas in this sample were .89 for child report and .90 for parent report.
RESULTS

Preliminary Analyses

Data were checked for skewness and kurtosis as well as extreme outliers before primary analyses were conducted. Correlations and descriptive statistics are reported in Tables 1-3. Child and parent reports were not adequately correlated across all variables. Thus composites were not appropriate. Instead, hierarchical linear modeling was chosen to allow both reports to be included in the same analysis without concern for non-independence.

Preliminary analyses also included examining demographic variables including language preference, immigrant/generational status, single parent status, SES indicators, and child gender for differences or associations among the primary variables in the study (family coping scales, familism, family ethnic socialization, child coping scales, and psychological symptoms).

T-tests were conducted to examine differences among key variables based on language preference (Spanish or English). Among parents, Family Passive Appraisal was significantly different among groups ($t = -2.27, p = .03$), with Spanish speaking parents reporting higher levels of passive appraisal ($M = 12.28, SD = 3.28$) compared to English speaking parents ($M = 10.38, SD = 3.56$). Parent-report of internalizing symptoms were different among groups ($t = -3.71, p < .01$), with Spanish speaking parents reporting more child internalizing symptoms ($M = 11.77, SD = 7.89$) compared to English speaking parents ($M = 5.05, SD = 4.53$). In addition, parent-report of anxiety ($t = -2.91, p = .01$),
and depression ($t = -3.70, p < .01$), were also different across groups. Spanish speaking parents reported more child anxiety and depression respectively ($M = 2.80, SD = 2.29; M = 4.16, SD = 3.59$) compared to English speaking parents ($M = 1.29, SD = 1.15, M = 1.19, SD = 1.36$).

Similar differences were found between parents who identified as immigrants versus those who did not. Passive appraisal was significantly different among groups ($t = -2.75, p = .01$), with immigrant parents reporting higher levels of passive appraisal ($M = 12.36, SD = 3.23$) compared to non-immigrant parents ($M = 10.10, SD = 3.53$). In addition, internalizing symptoms ($t = -2.27, p = .03$) and depression ($t = -3.18, p < .01$) were different among groups with immigrant parents reporting more child internalizing and depression symptoms respectively ($M = 11.20, SD = 7.46; M = 4.07, SD = 3.59$) compared to non-immigrant parents ($M = 6.90, SD = 8.04; M = 1.48, SD = 1.89$). Parent-report of anxiety approached significance ($t = -1.77, p = .08$) with immigrant parents reporting more child anxiety ($M = 2.64, SD = 2.26$) compared to non-immigrant parents ($M = 1.81, SD = 1.75$). Language preference and immigrant/generational status were highly correlated ($r = .73, p < .01$) and theoretically overlap. Because including both variables in analyses would undoubtedly result in multicollinearity, immigrant/generational status was chosen for consideration in analyses due to more fine-grained categories. Immigrant/generational status is explored more thoroughly under Hypothesis 2. No significant differences were found among language preference or immigrant/generational status and child report of the primary variables included in the study.
T-tests were also conducted to examine differences among single parent versus two-parent households on the primary variables included in this study. Only parent-report of Family Mobilizing support was significantly different among groups ($t = 2.14, p = .04$), with single parents reporting more mobilizing support ($M = 14.86, SD = 3.56$) compared to parents with spouses/partners ($M = 12.69, SD = 3.90$). Because of this finding, a single parent status by family mobilizing support interaction was explored under Hypothesis 1.

SES was also examined among the primary variables included in the study. There were no significant correlations among income and parent-report or child-report of the primary variables in this study. Income-to-needs (a ratio of income to the federal poverty line based on family size) was significantly correlated to parent-report of family passive appraisal ($r = -.23, p = .03$) and child-report of internalizing and externalizing symptoms ($r = -.23, p = .03; r = -.22, p = .04$) and child-report of anxiety and depression ($r = -.24, p = .02; r = -.22, p = .04$). No significant correlations were found for coded parental occupation. Analyses conducted under Hypothesis 1 were repeated controlling for income-to-needs, and findings were highly consistent.

T-tests were conducted to examine differences across child gender. No significant differences were found across child gender except for child-report of Family Social Support ($t = -2.47, p = .02$). Female children reported significantly more family social support ($M = 30.44, SD = 7.35$), compared to male children ($M = 26.61, SD = 7.32$). Analyses conducted under Hypothesis 1 were repeated controlling for gender, and findings were highly consistent.
Hypothesis 1

Hierarchical linear modeling was used to examine the hypothesis that positive family coping strategies would be related to fewer psychological symptoms. Models were run using hierarchical linear modeling (HLM 6.03 software; Raudenbush, Bryk, & Congdon, 2004). Hierarchical linear modeling was chosen as an ideal analytic strategy because it allows for measures to be nested within persons. Thus, both child reports and parent reports on each variable could be included within the same analysis. Level 2 consisted of the 90 children, while level one consisted of measures (two measures per variable). All independent variables were entered at level 1. PRS, along with the five family coping scales were entered as independent variables. Interaction-terms, created from the product of PRS centered and each centered family coping variable were entered and tested sequentially. The final model with only main effects is as follows (where $i$ refers to person and $m$ refers to measure/reporter):

Level 1:
\[
\text{(Psychological Outcome)}_{mi} = \pi_{0i} + \pi_{1i}(PRS)_{mi} + \pi_{2i}(Family \ Social \ Support)_{mi} + \pi_{3i}(Family \ Reframing)_{mi} + \pi_{4i}(Family \ Spiritual \ Support)_{mi} + \pi_{5i}(Family \ Mobilizing \ Support)_{mi} + \pi_{6i}(Family \ Passive \ Appraisal)_{mi} + e_{mi}
\]

Level 2:
\[
\pi_{0i} = \beta_{00} + r_{0i}
\]
\[
\pi_{1i} = \beta_{10}
\]
\[
\pi_{2i} = \beta_{20}
\]
\[
\pi_{3i} = \beta_{30}
\]
\[
\pi_{4i} = \beta_{40}
\]
\[
\pi_{5i} = \beta_{50}
\]
\[
\pi_{6i} = \beta_{60}
\]

The models were conducted for the following outcomes: internalizing symptoms, externalizing symptoms, anxiety, depression, aggression, and delinquency. A main effects model was conducted first. Next, interaction terms between PRS and each family
coping scale were entered. These terms were products of the centered variables for each reporter. Models with interaction terms were conducted sequentially. No significant interaction terms emerged (two trends emerged, see below) for any of the six outcomes, thus the main effects models for internalizing symptoms, externalizing symptoms, anxiety, depression, delinquency, and aggression are presented (see Table 4). PRS was significantly related to more symptoms for all six outcomes. Family Reframing was related to fewer internalizing symptoms, externalizing symptoms, depression, aggression, and delinquency. Family Passive Appraisal was related to more internalizing symptoms, externalizing symptoms, depression, and aggression. In addition, Acquiring Social Support was related to more externalizing symptoms and aggression.

Besides the main effects, the interaction between PRS and passive appraisal approached significance for both externalizing symptoms (coefficient = .2173, \( p = .08 \)) and depression (coefficient = .1232, \( p = .08 \)), showing that passive appraisal exacerbated the negative effects of PRS on symptoms (see Figure 1 for depiction of interaction on externalizing symptoms).

*Additional Tests.* Because significant differences were found in preliminary analyses on income-to-needs and gender, hierarchical linear modeling analyses were repeated controlling for income-to-needs at level 2 and gender at level 2. Income-to-needs was non-significant in all models, and the results were highly consistent. Similarly, gender was non-significant in all models and was dropped from the analyses. In addition, because family social support differed by gender, an additional interaction between family social support and gender was tested. This interaction was non-significant for all outcomes and was also removed from the models.
Hierarchical linear models were also conducted including an interaction between single parent status and family mobilizing support because preliminary analyses revealed significant differences on utilization of mobilizing support across single and two-parent households. Single parent status was entered as an independent variable at level 2 and the interaction with family mobilizing support was tested across levels. The interaction was significantly related to the following outcomes: internalizing symptoms, externalizing symptoms, anxiety, depression, and aggression, showing that for single parents high levels of mobilizing support is related to fewer child symptoms, but for two-parent households, this relationship reverses. Coefficients ranged from .1827-.5657, $p < .05$. See Figure 2 for the interaction on internalizing symptoms.

Hypothesis 2

Hierarchical lineal modeling analyses were also used to test the hypothesis that cultural practices will enhance family coping strategies. The model tested was the same model shown above including PRS, family coping scales, but also included an additional independent cultural predictor variable. Immigrant/generational status, familism, or family ethnic socialization was entered as the additional independent predictor. To conserve power, the cultural variables were tested separately. In addition, two-way interaction terms including each family coping scale with immigrant/generational status, familism, and family ethnic socialization were tested sequentially. Non-significant interaction terms were dropped from the models. The models were conducted for the following outcomes: internalizing symptoms, externalizing symptoms, anxiety, depression, aggression, and delinquency.
An interaction between familism and family reframing emerged significant for all six outcomes, showing that familism enhanced family reframing and high levels of both were especially helpful (see Figure 3 for the interaction on internalizing symptoms). Main effects of familism also emerged for externalizing symptoms, aggression, delinquency, anxiety, and depression. In addition, an interaction between immigrant/generational status and family spiritual support emerged as a significant predictor of aggression. This interaction shows that family spiritual support is helpful for immigrant families, but that for families that have been in the country longer, family spiritual support is not helpful. This interaction also approached significance for externalizing symptoms (coefficient = .2449, \( p < .09 \); see Figure 4). HLM models with significant interaction terms are presented in Table 5.

**Hypothesis 3**

To examine the hypothesis that family coping will support child coping, showing indirect effects on psychological symptoms through child coping, path analyses were conducted. Path models were tested and to examine whether family coping has indirect effects on psychological outcomes through child individual coping. Each family coping scale was tested separately with each child coping scale (primary control, secondary control, and disengagement coping). In addition, models were run separately for parent report of family coping and psychological outcomes and child report of these variables. Only children reported on their own coping. Models were tested for internalizing symptoms, externalizing symptoms, anxiety, depression, aggression, and delinquency. Models that showed significant indirect effects (i.e. a significant pathway from family coping to child coping, and a significant pathway from child coping to psychological
symptoms) are presented in Figures 5-8. Because these models are fully saturated, the fit is perfect and not useful to interpret. Parent-report of family reframing showed indirect effects through child primary control coping for all six outcomes. In addition, child report of family mobilizing support showed a significant indirect relationship through child secondary control coping on internalizing symptoms.

**Influences on child coping**

To further explore family influences on child coping, multiple regressions were conducted. Independent variables included PRS, the five family coping scales, familism, family ethnic socialization, and immigrant/generational status. In addition, to examine if these variables had influences controlling for concurrent psychological distress, we controlled for total problems as an indicator of psychological distress. Dependent variables were primary control coping, secondary control coping, and disengagement coping. Each regression model was conducted once utilizing parent-report of independent variables and once utilizing child-report of independent variables. Child coping dependent variables were child-report only.

**Parent-report Regressions.** Family reframing was positively associated with child primary control coping, while psychological distress was negatively associated with child primary control coping. There were no other significant predictors. The $R^2$ for the model was .18. Similarly, family reframing was positively associated with child secondary control coping, while psychological distress was negatively associated. There were no other significant predictors. The $R^2$ for the model was .18. The parent-report disengagement coping regression model was non-significant. See Table 6 for summary of regression models.
**Child-report Regressions.** The child-report primary control coping regression model was non-significant. For child secondary control coping, family mobilizing support and family ethnic socialization were positively associated with coping, while psychological distress was negatively associated with coping. The $R^2$ for the model was .27. With regard to disengagement coping, immigrant/generational status and family acquiring social support were related to less disengagement coping, showing that the longer a child has been residing the U.S. and the more social support acquired, the less disengagement coping. Passive appraisal approached significance, showing that family passive appraisal is related to more child disengagement. Family ethnic socialization also approached significance with higher levels of ethnic socialization associated with less child disengagement. The $R^2$ for the model was .21. See Table 6 for the significant regression models.

**Exploratory family coping items**

Based on discussion from the focus group three additional questions were asked on the family coping questionnaire along with an open-ended questions that allowed for qualitative responses. Qualitative responses are included in the discussion section. The three additional items asked for ratings on how much families make dinners together to cope with stress, do something active as a family to cope with stress, and play games as a family to cope with stress. Parent reports of these items were significantly correlated with each other ($r$’s ranged from .41 to .69, $p < .01$). These items were also significantly correlated with parent report of Family Reframing ($r$’s ranged from .26 to .36, $p < .02$). Additional significant correlations included making dinners together with spiritual support ($r = .29, p = .01$) and delinquency ($r = -.24, p = .03$), doing something active as a
family with internalizing symptoms ($r = -0.22, p = .04$), and playing games with mobilizing support ($r = 0.31, p < .01$). Parent and child reports of these items were not significantly correlated.

Child reports of these items were significantly correlated with each other ($r$’s ranged from 0.37 to 0.66, $p < .01$). These items were also significantly correlated with child report of Family Reframing, Acquiring Social Support, Spiritual Support, and Mobilizing Support ($r$’s ranged from 0.25 to 0.50, $p < .02$). Additional significant correlations included doing something active as a family with externalizing symptoms and delinquency ($r = -0.24, p = .02$; $r = -0.38, p < .01$), and playing games with delinquency ($r = -0.24, p = .02$).
DISCUSSION

This study examined family coping and family cultural influences on child adjustment and coping. PRS was associated with more psychological symptoms, while family reframing was associated with fewer symptoms of psychopathology and supported adaptive child coping. In contrast, family passive appraisal was associated with worse functioning. Familism enhanced family reframing and high levels of both were associated with the fewest mental health problems. Other findings suggest that mobilizing support is helpful for single parent families and supports child secondary control coping, while family spiritual support is helpful for immigrant families. In addition, analyses suggest that family ethnic socialization may also support child adaptive coping, while maladaptive coping may decrease the longer a child has been residing the U.S. and the more family social support acquired.

In addition to identifying protective factors for poor children, this study confirmed that PRS is detrimental to child functioning. Consistent with prior research (e.g., Wadsworth et al., 2008), higher levels of PRS were associated with more internalizing symptoms, externalizing symptoms, depression, anxiety, aggression, and delinquency. Stressors tend to aggregate in conditions of poverty (Evans, 2004), and the resulting accumulation of poverty-related stressors is overwhelmingly damaging for poor children (Wadsworth et al., 2008). PRS is considered the more proximal variable for explaining startling SES differences in mental and physical health conditions than income or SES indicators. Even among a constrained sample in terms of SES, PRS explained variance in
mental health functioning. Given the multitude of research demonstrating the negative effects of PRS on psychological functioning, there is a large need to identify factors that may ameliorate this association.

Family reframing appears to be one factor that is linked to better mental health functioning in the context of PRS. Family reframing includes strategies that attempt to restructure stressors with active acceptance, define problems in a positive way, maintain the belief that the family has the strength and power to solve problems, and discuss the problems in a way that the family does not become too discouraged. Families that can capitalize on these strategies have children with fewer symptoms of psychopathology, including internalizing symptoms, externalizing symptoms, depression, delinquency, and aggression. Ample research demonstrates that positive family relationships and functioning are helpful in the face of poverty-related stressors (Gorman-Smith et al., 2004; Gorman-Smith et al., 2000). However, PRS undermines effective parenting and disrupts family relationships (e.g., Conger et al., 2002). Family coping strategies such as family reframing may be an effective means of managing PRS in a way that maintains positive family bonds and supports positive mental health functioning among poor children.

In addition to supporting children’s positive psychological functioning, family reframing also encourages children’s ability to manage stressors on their own in an effective way. Primary and secondary control coping are protective in the face of PRS concurrently and over time (Wadsworth et al., 2009; Wadsworth & Santiago, 2008). Children from families utilizing more family reframing reported they would use more primary control coping strategies to manage a school-related stressor on their own. Thus,
children may be better equipped to problem-solve, express emotions, and regulate their emotions to cope with difficulties on their own when their families utilize family reframing strategies to cope with PRS. Family reframing strategies may bolster a sense of efficacy, which influences enactment of coping and the types of coping selected (Cunningham, Brandon, & Frydenberg, 2002). Although indirect effects were not found in path analyses, regression analyses indicate that family reframing may also support secondary control coping. From a theoretical perspective, family reframing should be more likely to encourage secondary control than primary control coping. Families that are able to reframe stressors stemming from PRS may instill hope for the future, providing a foundation for children to think positively, utilize acceptance, and engage in positive distraction (secondary control coping strategies) when managing stressors on their own. Though we have preliminary evidence that family reframing does encourage secondary control coping in regression analyses, it was more robustly associated with high levels of primary control coping. Numerous family reframing strategies focus on believing that the family will make it through tough times, or a sense of efficacy. Efficacy and control beliefs encourage a number of primary control coping strategies such as planning, problem solving, and emotional expression (Compas, Malcarne, Banez, & Worsham, 1993; Ebata & Moos, 1994; Lopez & Little, 1996).

Qualitative findings from the focus group also suggest that reframing stressors and “making the best of it” helps families get through difficult times. One parent told this story:

My daughter plays volleyball and so we go to the park and set up a net, but we didn’t have stakes for the net. So one person had to hold the net down while the other two played. (laughs) We made a game out of it. She missed the point –
that we are too poor to buy stakes. We had fun. You make the best of it. That’s all you can do.

Other mothers commented:

I tell ‘em the truth and that we’re going to get through it.
We try to accept things we can’t change.
We believe we can handle things.

These strategies appear to benefit children by protecting against poor psychological health and by supporting adaptive child coping. Prevention programs that bolster family reframing strategies may in turn bolster adaptive child coping and reduce risk for mental health problems.

Another family influence that supports healthy functioning is familism. Familism, or a sense of value, pride, and closeness in the family, is linked to more positive outcomes among Latino youths (Ramirez et al., 2004; Unger et al., 2002). In this study, familism enhanced the positive effects of family reframing on both internalizing and externalizing child mental health outcomes, and across depression, anxiety, delinquency, and aggression. Thus, one way in which familism may contribute to positive outcomes is by enhancing family coping strategies that benefit poor children. Familism supports healthy functioning among young low-income children (Gamble & Modry-Mandell, 2008) and increases parental monitoring and involvement among adolescents (Romero & Ruiz, 2007). Likewise, familism may encourage more active family coping strategies and increase their positive impact on Latino youths faced with PRS. Among families that place high value on family, family reframing strategies are even more effective. Prevention and intervention programs that can capitalize on these cultural strengths may increase their effectiveness.
Although familism and family reframing have positive influences on child functioning, family passive appraisal is detrimental. Families that believe they have little control in managing PRS or that they will have difficulty managing PRS are more likely to have children with more depressive symptoms and aggressive behavior. When a child’s family appraises a situation in this passive way, it likely contributes to feelings of demoralization and hopelessness. In addition, children that believe they and their family have little control over their circumstances may be more likely to feel frustrated and act out aggressively. Among poor children and adolescents, feelings of little or no control were related to more distress, shame, anxiety, and embarrassment (Santiago, Wolff, & Wadsworth, 2009). Likewise, passive appraisal of the circumstances at the family level is related to more internalizing symptoms, externalizing symptoms, aggression, and depression among children in this study. Feeling little control or efficacy over one’s circumstances is understandable and common in the context of PRS. Prevention and intervention efforts that can minimize these types of passive appraisals, while bolstering family reframing, will benefit poor children.

The effectiveness of several forms of family coping appears to vary based on family structure (i.e. single parent families, two-parent families) and family cultural beliefs or practices. For example, a family’s attempts to mobilize support by seeking advice from others with similar problems or seeking advice or assistance from community agencies, doctors, or professional counselors, appear to be differentially related to child functioning based on family structure. For single parent homes, mobilizing support in this way is linked to fewer child symptoms, including internalizing symptoms, externalizing symptoms, depression, anxiety, and aggression. However, this
relationship reverses for two-parent homes, suggesting that mobilizing support may actually be detrimental for these families. Prospective data are needed to fully understand the directionality of these relationships. Mobilizing support for two-parent homes may signify distress among the family, lack of support from the spouse or partner, or conflict among partners about getting support from the community. Mobilizing support for single parents may be a healthy way to get the extra help and support needed when one does not have the support of a spouse or partner. In the focus group, a single-mother commented:

For financial problems sometimes we don’t want to seek help from agencies and stuff. But that’s reality and sometimes you need to.

For single parents, this form of family coping with PRS may help single parent families get the support they need and ultimately benefit children.

Similarly, the relationship of family spiritual support and child functioning appears to vary by immigrant/generational status. For immigrant families, relying on spiritual support strategies including attending and participating in church activities together or having faith and praying together are protective and related to less aggression. However, for families that have resided in the U.S. for lengthier amounts of time, these strategies do not appear to be helpful. Perhaps, family spiritual support is helpful in protecting against PRS while children are still dealing with the acculturative stress common for immigrant families. However, when children become more acculturated, they may be less interested in family church activities or those activities are no longer as helpful. For example, acculturation gaps between parents and adolescents are inversely related to positive family dynamics, family cohesion, and familism (Smokowski, Rose, &
Bacallao, 2008). Perhaps family spiritual support is a traditional form of family coping or practice that is helpful for immigrant families, but may be a source of conflict for more acculturated children, increasing aggressive behavior. Still spiritual support may be an important and relevant set of strategies for immigrant families that are facing PRS and acculturative stress.

Contrary to hypotheses, family acquiring of social support from relatives was actually related to more externalizing symptoms. Family social support includes sharing difficulties with relatives or friends, seeking encouragement or advice from relatives, getting help from neighbors or relatives, and spending time with relatives to relieve stress. Social support, in general, has been difficult to capture in research. Social support is often helpful, but studies have also found that people who are more distressed tend to seek more social support. For example, seeking social support when coping with discrimination is related to lower levels of distress (Scott & House, 2005), but seeking support when coping with family conflict is often associated with distress or depression among children (e.g. Sandler, Tein, & West, 1994). Thus, among families with a distressed child, seeking additional support from relatives may be a way to manage this distress. Longitudinal data are needed to disentangle the effects of acquiring social support from relatives among families facing PRS.

Child report of family mobilizing support, or mobilizing support from community agencies or professionals, was also related to more child secondary control coping in both path analyses and regression analyses. Although family mobilizing may be more helpful for single parent families in terms of child psychological functioning, it appears to support child adaptive coping. Children whose families mobilize community supports
are more likely to manage their own stressors by thinking positively, using acceptance or
cognitive restructuring, and using positive distraction. Children who are confident their
families can get the help needed in difficult times, may in turn think positively when
faced with their own stressors. More research is needed to examine when and for which
families it is appropriate to encourage family mobilizing support.

Additional preliminary evidence was found suggesting that family ethnic
socialization or cultural practices also support secondary control coping. A strong ethnic
identity develops through cultural practices occurring within the family (Umaña-Taylor,
Bhanot, & Shin, 2006). A positive sense of ethnic identity, in turn, protects ethnic
minority youths from stressors such as discrimination (Umaña-Taylor & Updegraff,
2007). One mechanism through which cultural practices and ethnic identity have a
positive effect may be through supporting adaptive coping. Positive cultural practices
and identity may build a child’s sense of efficacy and strength, which translates to
adaptive enacted coping in difficult situations. Positive cultural practices may be
particularly important for immigrant families, where children are doing more
disengagement coping. Immigrant/generational status and family acquiring social
support were related to child disengagement coping, showing that maladaptive coping
may decrease with more family social support and decrease the longer a child has been
residing in the U.S. Disengagement coping often has little effect on concurrent
symptoms, but is detrimental in the long-term (e.g., Santiago & Wadsworth, 2009).
Thus, identifying factors that minimize use of disengagement coping are important for
protecting children’s future mental health. Still, more research that incorporates
longitudinal data is needed to understand how and when social support is helpful in the
context of child adjustment and coping. Trends also emerged suggesting that family
ethnic socialization may be related to less child disengagement coping, while family
passive appraisal may encourage child disengagement. Though these findings were only
trend level, they warrant future investigation.

This study highlights the importance of understanding cultural and family factors
in risk and resilience processes for families dealing with PRS. Not all strategies work for
all families and there is an increased need for understanding what works and for whom.
For example, mobilizing support may be helpful for single parent families, but not as
helpful for two-parent families, while family spiritual support may be helpful for
immigrant families, but not for families that have been residing in the U.S. for
generations. Thus, determining what intervention and prevention might be most helpful
will likely depend on family structure, levels of acculturation and traditional values.
Family reframing was particularly helpful for families with high levels of familism, but
was related to fewer symptoms regardless. For other strategies, careful assessment of
cultural values and acculturation is warranted. Acculturation gaps between parents and
children can be sources of conflict, deteriorating family relationships and ultimately
leading to mental health problems (Hwang & Wood, 2009; Smokowski et al., 2008).
Intervention and prevention can support both children and parents by teaching strategies
that are helpful across levels of acculturation and/or tailoring strategies based on a
family’s specific characteristics and needs. For example, positive reframing and
discussion of stress may bridge acculturation gaps between children and parents and
foster healthy family functioning, while encouraging traditional religious activities might
widen these gaps and lead to more aggressive behavior. More exploration of how family
coping strategies operate across diverse families is needed to more fully understand which strategies are beneficial for which families.

Exploratory analyses conducted with three additional family coping items asked based on the focus group suggest that these additional strategies are related to the family coping scales tapped by the standardized measure. For example, both child and parent reports of these items (making dinners together to cope with stress, doing something active as a family to cope with stress, and playing games as a family to cope with stress) were positively associated with family reframing. These activities may be related to other family coping strategies, but still have important implications for child and family functioning. Likewise, qualitative findings that were collected via write-in family coping questions on the questionnaires centered on three primary themes that both parents and children identified as important strategies. Similar to the focus group, many participants commented that they do family activities together to take their mind off stress.

Comments included:

We go to the yard to play soccer with the kids and forget our problems a little bit. We go bowling, play golf, play and share a dinner, a movie or jokes as a family. We take walks, go for rides to the mountains, attend church, stay home and watch movies. We talk about other stuff, instead of bringing up so much problems; we try to take the kids’ minds off the problems. We play dominos so that we are not so stressed. To not be stressed, we tell jokes or see comedy movies. We do a lot of fun things so if we have a problem we won't think of it while we play the game and get sad. We try to relax or sometimes we do something to forget about it. We watch movies together.

Another theme that emerged was discussing the problems as a family to think differently about them or to make sure everyone is feeling alright. These strategies are consistent
with quantitative data showing that family reframing strategies are helpful in the face of PRS and support healthy adjustment. Parents and children wrote:

First we discuss everything as a family and think positively then we can move forward.
We talk and share opinions.
We talk about our own experiences when mom and dad were kids and how we dealt with our problems and how we all have problems no matter where you are or go.
We talk it out between us so that we all understand what is going on and so that one of the family members does not feel sad or have bad feelings.
We help by talking about our stress; when we are done talking we feel better.

Finally, some parents and children identified problem solving as something their family does to manage stress. Examples of what parents and children wrote include:

We always discuss the problems each of us has and exchange ideas and who ever has the best resolution, they take this idea most seriously.
We communicate and try to find a resolution.
We help each other with problems and work together.
We discuss every type of thing and resolve difficulties that we can see or that present themselves.
We sit down and talk how to improve it and how not to commit that error again.
We try to figure out a way to solve it.
We talk about our problems and see how we can resolve the problem and see if we are ok with the resolution.

These findings call for continued research on how to best assess family coping. Much of the qualitative findings are consistent with quantitative data (i.e. family reframing strategies are helpful), providing additional support that these key strategies are helpful in the face of PRS. However, qualitative data also suggest that the standardized measures available may be missing strategies that families’ view as helpful and important, such as family distraction activities and problem solving. Exploratory correlational analyses with the additional family coping items also provide preliminary evidence that family activities (e.g., dinners, games) are associated with fewer symptoms. Further
investigation and development of family coping measures, including questionnaires and in vivo assessments is needed to advance our understanding of these complicated family processes.

This study also highlights the importance of utilizing multiple reporters. Children and parents often provide unique perspectives on family processes and child functioning. Indeed, parent and child reports were not associated across all the constructs included in this study. Analyses that included both child and parent reports robustly showed that family reframing was helpful and that familism enhanced family reframing. However, other findings were found only with parent or child report, calling for additional research and/or different methods and measures to replicate findings.

This study has additional limitations that are important to note. Though sufficiently powered to detect medium or large effects, this study had a relatively small sample size, making it difficult to detect small effects. Likewise, among this sample, reliabilities for the Passive Appraisal scale were relatively low, limiting interpretations of findings involving this scale because low reliability scales introduce more error. Though we gained valuable information about family coping among low-income Latino families, we cannot yet generalize to other populations. In addition, longitudinal data are needed to understand the effects of family coping over time. Longitudinal data will help to disentangle directionality of influences. Although the interpretation of the results is limited by the cross-sectional nature of the design, the study remains a crucial step in the investigation of family coping and child mental health. Further, PRS, symptoms, and coping tend to remain fairly constant in a community sample without intervention, thus it is appropriate to test models of associations that do not account for change across time.
along with longitudinal investigations. Conger, Rueter, and Elder (1999) suggest chronic stress such as economic pressure maintains high levels of distress across time, suggesting equilibrium models, or cross-sectional models, are also appropriate and important to examine. Also, the design mitigates cross-sectional limitations by employing multiple methods and utilizing multiple informants.

Despite limitations, this study provides useful and important findings. The study extends previous research on coping and protective factors for low-income, at-risk children in numerous ways. The Hispanic/Latino population is the fastest growing population in the U.S., increasing by 21% from 2000 to 2005 (U.S. Census Bureau, 2005). Research must focus on how to best serve this growing population. This study is the first to examine family coping in response to PRS among Latino families. This study builds on cultural strengths among Latino families, providing information that can inform and guide intervention and prevention programs aimed at Latino families coping with PRS. By drawing on cultural strengths as well as skills that are amenable to intervention such as coping and family coping, culturally sensitive treatments and interventions for child psychopathology can be developed. Family-based interventions are promising, but need continued evaluation. Family-based interventions that include learning coping skills and practicing these skills as a family suggest that improving family coping can have positive effects for child mental health (Kumpfer & Alvarado, 2003). This study suggests that building in family reframing strategies and capitalizing on cultural values such as familism will be particularly helpful.

This study provides empirical support that family coping is helpful in the face of PRS and supports adaptive child coping among low-income Latino families. Future
research should include longitudinal investigations of family coping strategies. Longitudinal data are needed to disentangle the effects of acquiring social support from relatives among families facing PRS in addition to exploring long-term effects of positive family coping. Examining family coping across diverse families in terms of size, structure, immigrant status, and culture or race is also warranted. For example, more research is needed to examine when and for which families it is appropriate to encourage family mobilizing support or family spiritual support. This research can also be extended to other cultural or racial groups to test the effectiveness of family coping for other populations. This study also calls for continued research on how to best assess family coping. Further investigation and development of family coping measures and assessments is needed to further our understanding of these complex family processes.
LITERATURE CITED


Grant, K.E., Compas, B.E., Stuhlmacher, A.F., Thurm, A.E., McMahon, S.D., & Halpert,


Kim, K.J., Conger, R.D., Elder, G.H., Jr., & Lorenz, F.O. (2002). Reciprocal influences
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regulation in the social domain. Developmental Psychology, 32, 299-312.


U.S. Census Bureau (2005). Race and Hispanic Origin in 2005: *Population Profile in the*


Table 1: Parent Report Correlations and Descriptive Statistics (Child coping variables are child-report)

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SD: 0.88 7.35 6.17 3.82 3.91 3.42 10.18 5.34 7.77 6.69 2.07 5.11 3.44 2.17 0.03 0.03 0.02

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Table 2: *Child Report Correlations and Descriptive Statistics*

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SD    5.77 7.54 6.27 3.58 4.43 3.51 10.79 5.35 8.14 7.31 3.31 4.72 3.40 2.22 .03 .03 .02

\(^*p < .10\)  \(^*p < .05\)  \(^**p < .01\)
Table 3: *Parent and Child Report Correlations*

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*p < .10  *p < .05  **p < .01
Table 4: Hierarchical Linear Models – Main Effects

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Table 5: Hierarchical Linear Models with significant interactions between cultural variables and family coping

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*p < .05  **p < .01
Table 6: *Regressions Testing Influences on Child Coping*

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\(+p < .10\) \( *p < .05\) \( **p < .01\)
Figure 1: Interaction between PRS and family passive appraisal on externalizing symptoms.
Figure 2: Interaction between single parent status and family mobilizing support on internalizing symptoms.
Figure 3: Interaction between familism and family reframing on internalizing symptoms.
Figure 4: Interaction between immigrant/generational status and family spiritual support on externalizing symptoms.
Figure 5: Indirect effects model showing indirect effect of family reframing through child primary control coping on internalizing symptoms/externalizing symptoms.

Note: First number corresponds to internalizing model, second number corresponds to externalizing model.
Figure 6: Indirect effects model showing indirect effect of family reframing through child primary control coping on aggression/delinquency.

Note: First number corresponds to aggression model; second number corresponds to delinquency model.
Figure 7: Indirect effects model showing indirect effect of family reframing through child primary control coping on depression/anxiety.

Note: First number corresponds to depression model; second number corresponds to anxiety model.
Figure 8: Indirect effects model showing indirect effect of family mobilizing support through child secondary control coping on internalizing symptoms.