Individual Differences in Children's Coping: The Independent and Interactive Roles of Coping Socialization and Parenting Behaviors in Families With and Without a History of Maternal Depression

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CHAPTER I

BACKGROUND

Exposure to chronic stress is a significant risk factor for the development of emotional and behavioral problems from childhood through adulthood (Grant et al., 2003; 2004; Monroe, 2008). Research has shown that individuals living under conditions of chronic stress, including living with a depressed parent, are at significantly greater risk for experiencing a wide range of problems. Because exposure to varying levels of stress is unavoidable in modern life, a critical avenue of research has been to identify factors that reduce the negative effects of stress on emotional and physical health outcomes.

Research indicates that the association between stress and psychopathology is mediated and moderated in part by the ways that children and adolescents cope with stress and regulate their emotions (Compas et al., 2001; Eisenberg et al., 2010). Consequently, the development and use of effective regulatory strategies is a fundamental resource in promoting adaptation in individuals who are faced with acute and chronic stress. Although extensive research has found associations between specific coping strategies with psychopathology (Compas et al., 2001; 2012), it remains much less clear *why* some individuals use adaptive strategies when faced with stressors while others rely on less effective strategies to cope.

A better understanding of the factors that contribute to the development of coping strategies is a potentially informative and important avenue of research for at least three reasons. First, knowledge about the factors that contribute to individual differences may

inform our basic understanding of coping processes. Second, it may allow early identification of individuals at greatest risk for developing and using maladaptive coping strategies in response to stressors. And lastly, factors that are found to predict children's regulatory strategies may be an avenue for intervention to indirectly influence children's coping strategies.

Given that children and adolescents are embedded within a family context, there has been a call for research on stress and coping to more fully consider the role of the family in socializing and shaping children's coping skills (Compas et al., 2001; Skinner & Zimmer-Gembeck, 2007). Two promising factors that have received attention are parental coping socialization processes (Kliewer, Sandler, & Wolchik, 1994) and parenting behaviors (Power, 2004). The aim of the current study is to develop and test a new paradigm and system for coding parental socialization behaviors in order to replicate and expand upon previous research by examining the direct and indirect parental influences on children's use of coping strategies as well as to examine these processes in the context of an important risk factor: parental depression.

Coping in Childhood and Adolescence

Decades of research examining processes of adaptation to stress in children and adolescents have identified specific coping strategies that are differentially associated with emotional and behavioral adjustment (Compas et al., 2001; 2014). Coping is broadly defined as, "conscious volitional efforts to regulate emotion, cognition, behavior, physiology, and the environment in response to stressful events or circumstances" (Compas et al., 2001, p. 89). Notably, despite substantial research on the important role of coping in reducing risk and enhancing resilience under prolonged periods of stress,

comprehensive reviews of the literature highlight the remarkable lack of consensus on the structure and organization of coping, as over 400 different "ways of coping" have been identified in the literature (Skinner et al., 2003).

Lazarus and Folkman (1984) provided a broad model of coping that has guided research for over three decades in which they posited coping is distinguished between problem-focused (i.e., acting on the problem) and emotion-focused responses (i.e., acting on one's emotions). Although this conceptual model shaped the field of coping and continues to guide current research, the categories in this organization of coping responses have been criticized for not being conceptually clear, exhaustive, or mutually exclusive (Skinner et al., 2003). Skinner et al. recommended that not only should this model of coping be abandoned, but also argued that any bottom-up, exploratory approach to the structure of coping (e.g., problem-focused and emotion-focused) is problematic, as such models capitalize on idiosyncrasies of samples used in different studies and contributes to inconsistencies in the literature. Consequently, Skinner et al. noted the need for future research to organize coping responses around top-down, theory-driven categories.

Connor-Smith, Compas, Wadsworth, Thomsen, and Saltzman (2000) posited a top-down, dual process model of responses to stress that distinguishes between automatic responses (i.e., stress reactivity) and voluntary responses (i.e., coping). Confirmatory factor analysis (CFA) of the model supported three distinct coping categories: primary control, secondary control, and disengagement coping (e.g., Connor-Smith et al.). Specifically, *primary control coping* refers to efforts to act directly on a problem or one's emotions through problem-solving, emotional modulation, or emotional expression;

secondary control coping refers to efforts to adapt to the problem through acceptance, positive thinking, cognitive reappraisal, or distraction; lastly, *disengagement coping* represents efforts to evade the problem or one's emotions through denial, avoidance, or wishful thinking. Notably, this conceptual model of stress responses has successfully been confirmed and validated in both child and adult samples, clinical and community samples, as well as cross-culturally (Benson et al., 2012; Compas et al., 2006a, 2006b; Connor-Smith & Calvete, 2004; Wadsworth, Raviv, Compas, & Connor-Smith, 2005; Wadsworth, Rieckman, Benson, & Compas, 2004; Yao et al., 2010; Xiao et al., 2010). As a consequence, this conceptual model of coping responses guides the current study.

Taken as a whole, research has shown that primary control and secondary control coping strategies are generally more adaptive than disengagement coping strategies in response to stressors (e.g., Compas et al., 2001; 2012; 2014; Connor-Smith et al., 2000). More specifically, research suggests that primary control coping efforts, which involve acting directly on the problem or one's emotions, are related to fewer psychological symptoms in the context of controllable stressors (e.g., academic stressors). In contrast, secondary control coping strategies, which involve adapting to the problem or one's emotions, has consistently been shown to be associated with lower internalizing and externalizing symptoms in response to uncontrollable stressors, such as the stress associated with living with a depressed parent (e.g., Langrock et al., 2002). In line with these findings, Jaser et al. (2007) found specificity in the relations between coping responses and children's adjustment in the context of peer and family stressors. Secondary control coping strategies (e.g., cognitive reappraisal, acceptance) were associated with fewer symptoms in the context of both parental depression and peer

stressors (Jaser et al.). Primary control coping strategies (e.g., problem-solving, emotional expression), however, were related to fewer symptoms in the context of peer stressors, but *more* symptoms in the context of parental depression (Jaser et al.). These findings suggest that it is important to consider the stressor the individual is experiencing to determine what coping strategies are the most effective.

On the other hand, findings have been largely mixed in the associations between disengagement coping and psychological symptoms, with some studies finding disengagement coping is related to poorer adjustment (e.g., Wadsworth et al., 2005), while other studies showing that this type of coping is unrelated to problems (e.g., Jaser et al., 2007). Importantly, however, research generally has not found the use of disengagement strategies (e.g., avoidance, denial) to be related to fewer emotional or behavioral problems. Nevertheless, despite the significant relations between responses to stress and psychological outcomes, empirical research on the processes contributing to their development remains relatively unexplored (Skinner & Zimmer-Gembeck, 2007).

Individual Differences in Children's Coping: The Parental Role

Extensive research has shown significant individual differences in the strategies that children and adolescents use to cope and regulate their emotions in response to stressors, although empirical research on the development of coping and the processes contributing to its development has lagged behind other areas of research on coping (see Skinner & Zimmer-Gembeck, 2007; Zimmer-Gembeck & Skinner, 2011, for reviews). There are a large number of factors that may contribute to individual differences in children and adolescents' coping strategies, including factors that are intrinsic (e.g., executive function, temperament) and extrinsic to the individual (e.g., parenting

behaviors, culture). Moreover, it is likely that these factors operate both independently and in combination to influence regulatory strategies.

Although considering all of the possible individual difference factors is beyond the scope of the current study, there is evidence to support parents as socializing agents of coping strategies in children and adolescents (Kliewer et al., 1994). While there likely are a number of significant relationships in children's lives that may contribute to the development of their coping (e.g., peers, siblings, teachers), to date the most extensive research has focused on the role of parents, as the family is thought to provide the earliest and most salient context by which children acquire strategies to respond and adapt to stress (e.g., Bradley, 2007). As Baumrind (1978) stated, "there is no way in which parents can evade having a determining effect upon their children's personality, character, and competence" (p. 239).

Parental Coping Socialization and Children's Coping

Parental coping socialization can be defined as, "parenting goals, practices, and styles that influence children's learning and utilization of emotional, cognitive, and behavioral strategies to manage personal (e.g., emotions, thoughts, behavior) and external (e.g., contexts, relationships) demands" (Miller, Kliewer, & Partch, 2010, p. 430). Kliewer et al. (1994) proposed a conceptual model of parental coping socialization that continues to guide the field and informs the present study in which parents are hypothesized to directly and indirectly influence their children's coping strategies through several pathways, including direct instruction and parental modeling of their own coping strategies in response to stressors. It is notable that other socialization models in childhood have theorized similar pathways, such as conceptual models of emotional

development (Eisenberg, Cumberland, & Spinrad, 1998), prosocial behavior and empathy (Eisenberg, 1983), and emotion regulation (Morris et al., 2007). The parallel pathways among these developmental frameworks provide support they are central mechanisms by which parents convey messages and influence child behavior.

Parental coping coaching. Parental coping coaching refers to the direct instructional messages parents communicate to their children about ways they should appraise a situation and manage the stress associated with the problem (e.g., Kliewer, Parrish, Taylor, Jackson, Walker, & Shivy, 2006). For instance, if a child is upset because s/he was not invited to a friend's birthday party, the parent may coach their child through the problem by either encouraging them to engage with the stressor (e.g., talk with your friend about the problem; try to think about the situation in a different way) or disengage from it (e.g., stay away from the friend who made you upset; pretend it never happened). Given that engagement coping strategies (i.e., primary and secondary coping) and disengagement coping strategies have been shown to be differentially related to psychological adjustment (e.g., Compas et al., 2012), these qualitatively distinct parental coping coaching instructions may have different consequences for the child's peer relationship and their ability to effectively deal with similar interpersonal stressors encountered in the future.

Theoretical support for the role of coping coaching comes from research on both scaffolding and emotion coaching. Scaffolding is a process of structured learning that enables a child to progressively acquire new abilities just beyond their reach through support and instruction by their caregivers (Maccoby, 1992). As children are exposed to novel or recurrent stressors in various life domains, parents are hypothesized to help their

children appraise these encounters and guide them through the process of managing and adapting to adversity. Through coaching, the child is thought to acquire regulatory skills and gain self-efficacy in managing stressors on their own. In addition, coping coaching shares similar characteristics with emotion coaching. Emotion coaching parents are those who, "are aware of the emotion in their lives, who can talk about those emotions in a differentiated manner, who are aware of these emotions in their children, and who assist their children with their emotions" (Gottman, Katz, & Hooven, 1996, p. 244). Research has found that children of emotion coaching parents are themselves better able to manage emotions and have fewer adjustment problems (e.g., Katz & Windecker-Nelson, 2004; Shipman & Zeman, 2001). However, coping coaching is distinct from emotion coaching in that the former represents the direct messages parents communicate to their children on specific ways to modulate emotions and cope with stressors, regardless of the valence of these messages or parents' awareness, acceptance, and ability to differentiate emotions in themselves or in their children.

Empirical evidence for the influence of coping coaching comes from studies that have shown that the direct messages parents communicate to their offspring about ways of coping with stress are related to children's psychological adjustment as well as children's use of specific coping strategies. Researchers have largely examined parental coping coaching through questionnaire measures in which parents rate on a Likert scale how often they encourage their child to use a particular coping strategy (e.g., Abaied & Rudolph, 2010a; Miller et al., 1994). For example, Abaied and Rudoph (2010a) found in a community sample that maternal-reported coping suggestions with both interpersonal and non-interpersonal stressors predicted children's emotional and behavioral problems

one year later, although these relations were dependent on the type and severity of the child's stress. However, the relationship between maternal-reported coping suggestions and children's coping strategies were not examined in this study. Miller et al. (1994) reported in a sample of children who experienced parental divorce that maternal-reported coping suggestions were significantly related to children's coping strategies as reported by the mother at both baseline and five months later. More recently, Abaied, Wagner, and Sanders (2014) examined the association between parental coping suggestions and child coping in a sample of emerging adults (*M* age = 19). Abaied et al. (2014) reported significant correlations between emerging young adults' reports of parental encouragement of engagement coping strategies (i.e., primary and secondary control coping) with emerging adults' reports of their own greater use of engagement coping and fewer disengagement coping strategies.

Parental coping suggestions have also been measured by coding the strategies parents instruct their child to use in discussion-based observational tasks (i.e., Kliewer et al., 2006; Miller et al., 2010). Coding actual parental statements in a dyadic discussion-based task reduces the possible effects of shared method variance or social desirability on associations with children's coping strategies. However, the studies to date that used an observational paradigm and a coding system have been limited in several important ways. First, the studies have used hypothetical scenarios. That is, the discussion tasks were based on movie clips the parent and child watched together that depicted a stressful scenario and the dyad was instructed to discuss what the parent in the video *could* suggest to the child in the video to do in that situation. As a consequence, it is not clear the extent to which the parent *actually* does instruct their child to use those coping strategies in the

context of real-life stressors. Although the dyad was told that after they finished discussing the film clip they should shift to discussing real-life situations the child had experienced, it is not clear how many parents and children made this shift in their discussion (e.g., Kliewer et al., 2006). Moreover, parents were rated as encouraging a particular coping strategy regardless of whether it was in reference to the hypothetical movie clip or to the child's real-life experiences. Second, children's coping strategies were coded from the same observational task as the parental socialization of coping messages, and so it is possible that the relationships were inflated because the measures were not independent (Kliewer et al., 2006). Third, the coping socialization suggestions and children's coping strategies were not based on the same theoretical coping model, which makes it difficult to draw clear associations. Consequently, it is important for future research to examine in observation-based tasks the strategies parents encourage and instruct their children to use in response to real-life stressors children experience or have experienced and to examine associations of socialization of coping messages with an independent measure of child coping based on the same coping model to better understand individual differences in children's coping.

Parental modeling. Parental modeling refers to the coping strategies the parent uses in response to stress that the child has the opportunity to directly observe (e.g., Kliewer et al., 2006). For instance, in response to a parent's friend spreading a rumor, a parent might use a primary control coping strategy (e.g., let someone or something know how they feel), they may rely on a secondary control coping strategy (e.g., do something else to get their mind off of the problem), or the parent may use a disengagement coping strategy (e.g., wish the problem would just go away) to deal with the problem. When a

child has the opportunity to watch their parent cope with a stressor, the child may learn their parent's coping behaviors and may later imitate those responses when they are confronted with a stressor in their own life.

Indirect support for parental modeling as an important influence on children's coping comes from both the social referencing literature and social learning theory. Social referencing is a developmental phenomenon in which young infants look to their caregivers for emotional cues on how to appraise and approach an ambiguous or novel situation (Campos & Stenberg, 1981). For instance, Sorce, Emde, Campos, and Klinnert (1985) showed in a series of visual cliff experiments that when 12-month-olds could not perceive the depth of a "cliff", they first looked to their mothers for information and guidance. The young children did not cross the platform to grab a toy when their mothers displayed anger or fear, but were significantly more likely to cross when their mothers expressed happiness or interest.

Further, social learning theory states that individuals learn through directly observing and imitating the behavior of salient models in their environment (Bandura, 1977). Bandura noted distinct factors that contribute to whether an observed behavior will be learned and modeled: attention, retention, reproduction, and motivation. Specifically, the observer must attend to the behavior of the model, must have learned and remembered the behavior at a later time, must be capable of imitating and applying the behavior to a new situation, and must have a reason to emulate the behavior. Notably, although social learning theory is central in developmental psychology, empirical evidence supporting children and adolescents modeling observed parental behavior is limited (Eisenberg & Valiente, 2001).

Empirical evidence for the influence of parental coping on children's coping through modeling is relatively limited. Previous studies to date have examined child modeling of parent's coping strategies as a parental socialization process by examining correlations between parent and child coping strategies from questionnaire measures (e.g., Kliewer et al., 1996). Although this is an initial step toward examining a modeling hypothesis, there may be significant correlations on questionnaires of parent and child coping for a variety of reasons, including shared method variance if parents report on both their own coping and their child's coping, not necessarily that the child has observed the parent cope with a stressor and modeled their behavior accordingly.

Nevertheless, several studies have taken a first step toward examining the relationship between parents' coping and children's coping, although evidence that parents and children use similar coping strategies is scarce. Rather, the majority of studies have reported significant correlations, both positive and negative, between a parent coping strategy and a different child coping strategy. For example, Kliewer and Lewis (1995) examined parental modeling of coping in children with sickle cell disease and reported that children used higher levels of avoidance coping when their parents used either low levels of cognitive restructuring or high levels of active coping. In addition, Kliewer et al. (2006) reported marginal associations between mothers' use of active coping and children's greater use of problem-focused coping as well as maternal avoidance coping and children's lower use of problem-focused coping.

Other parental socialization messages. To date, research on parental coping socialization processes has focused primarily on parental coping coaching (e.g., Abaied & Rudolph, 2010a; 2010b; 2011; Miller et al., 1994; 2010). More specifically, these

empirical studies have assessed how frequently the parent instructs the child to use specific strategies (e.g., "You should talk to your friend about why she didn't invite you to the party."). However, parents may also communicate coping messages to children in other ways, including through directions disguised as questions (e.g., "Have you tried talking to your friend about it?") and parental modeling of their own coping through disclosure (e.g., "When I have problems like that, I talk to the person about it and try to understand why s/he did that."). Additionally, although not a focus of the present study, parents may intervene in the coping process (e.g., parent talks to the child's parent to understand why the child was not invited and tries to fix the problem) or provide children feedback about the coping strategies they are already using (e.g., parent tells child s/he likes when the child uses distraction). These hypothesized parental communication styles are guided by theory and research from models of socialization, help-intended communication, parenting behavior in the context of illness, and the effects of positive reinforcement on learning (e.g., Goodman & Dooley, 1976; Kliewer et al., 1994).

Questions in service of advisement. Goodman and Dooley (1976) posited a framework to characterize different "response modes" of communication, including through *questions-in-service-of-advisement*. More specifically, they described a communication style in which an individual "overtly attempts to modify another's behavior…through [the use of] questions (e.g., 'Do you think it would work better if you tried…?')" (p. 109). Guided by this conceptual framework, it is plausible that parents communicate coping strategies to their children in a similar manner. For example, a parent may ask the child, "Have you ever tried thinking more positively about it?" In this

example, the parent is encouraging a specific coping strategy (i.e., cognitive reappraisal), but rather than state the strategy, the parent phrases it as a question.

Modeling through disclosure. As noted above, previous research has examined parental modeling of coping strategies as a possible coping socialization process by correlating measures of child and parent coping strategies. However, it is possible that parents also model their coping strategies through verbal reports and disclosures to the child (Goodman & Dooley, 1976). Guided by the work of Goodman and Dooley, disclosures are "statements in which the speaker reveals a non-obvious aspect of his condition (feelings, thoughts, and experiences) through a distinct self-reference" (p. 112). Applying this to coping socialization, the parent may tell the child in a conversation about a coping strategy the parent uses: "When I have problems with a friend, I usually talk to my friend about it and try to figure out what is bothering them." Through this disclosure, the parent is indirectly communicating to the child that s/he might find it helpful to talk to the individual with whom s/he is having an argument. Parental sharing of their own coping may be especially important for strategies that are covert and involve internal cognitive processes, such as cognitive reappraisal, as parental verbal disclosure may be the only avenue that children have to learn how the parent copes with stressors.

Parenting Behaviors and Children's Coping

Researchers have examined the potential role of broader parenting behaviors as a salient pathway by which parents can influence the coping strategies that their children use in response to stressors (Kliewer et al., 1994; Power, 2004). Parenting can be broadly defined as the general behaviors of a caregiver in interactions with their child (Darling & Steinberg, 1993). Researchers have theorized that parents who are sensitive to the

emotional experiences of their children may be more aware and accepting of their own and their children's emotions, thus communicating a message that emotions are understandable and can be expressed, and may engage their children in conversations about emotions (e.g., Shipman & Zeman, 2001). Further, caregivers who are warm and supportive may serve as resources through the provision of informational support (e.g., offer concrete ways to cope), emotional support (e.g., comfort and listen), or instrumental support (e.g., problem-solve with the child) and as a consequence, these children may be more likely to feel secure approaching their parents for support during stress (Bynum & Brody, 2005; Thompson & Meyer, 2007) as well as expressing, rather than suppressing, negative emotions (Eisenberg, Spinrad, & Eggum, 2010). Through these salient supportive experiences, children may become more comfortable seeking support from others (e.g., peers, teachers; McIntyre & Dusek, 1995). Additionally, Grolnik and Farkas (2002) argue that children need opportunities to practice coping strategies, and it is thought that structured and consistent environments create a safe context for children to refine their skills, having confidence in their parents' assistance if needed.

Several empirical studies have documented significant associations between children's coping strategies and dimensional measures of positive parenting behaviors. Taken as a whole, research has shown that children of parents who are more warm, responsive, and supportive use more engagement coping strategies and fewer disengagement coping strategies, including more positive cognitions (Gaylord-Harden, 2008), more problem-solving strategies (Meesters & Muris, 2004), and less emotional suppression (Jaffe, Gullone, & Hughes, 2010). Notably, there are also several promising and important preliminary findings on the role of warm and responsive parenting

behaviors on children's use of coping strategies from both longitudinal (McKernon et al., 2001) and intervention studies (e.g., Vélez et al., 2011; Watson et al., 2014).

Parental Socialization of Coping, Parenting, and Children's Coping

There is promising preliminary evidence to suggest from both theory and research that responsive and warm parenting behaviors and the specific socialization messages parents communicate to their children about ways to cope with stressors contribute to the ways children respond to life stressors. However, to date, these pathways have been examined independently and the potential interaction of these two processes has remained unexplored. Previous empirical studies have examined the interaction of parental socialization messages with other constructs, such as child stress reactivity (Abaied et al., 2014) and the type and level of stress exposure (Abaied & Rudolph, 2010a; 2011), although to my knowledge no study has examined the role of the emotional climate in which the socialization messages are conveyed by parents to their children.

Although preliminary research has shown that parents instruct children to use specific coping strategies (e.g., "You should do something to get your mind off the problem") and that these messages are concurrently and prospectively related to the coping strategies children use (e.g., Abaied & Rudolph, 2011), it may also be important to understand *how* the message is conveyed to the child and the environmental context in which messages are communicated. In their framework on communication, Goodman and Dooley (1976) noted the potential importance of considering the *valence* (i.e., positive or negative) of the messages that individuals express, as the valence may be the "reinforcing element" (p. 114). Similarly, Grusec and Goodwin (1994) theorized that children might be more likely to listen and process their parents' teachings when parents are warm,

supportive, and responsive to their children. Further, Abaied and colleagues (2014) suggested in the context of a warm and trusting parent-child relationship, children may be more likely to adopt the coping strategies that parents teach and instruct their children to use and called for future research to examine this possibility. Therefore, the present study will examine warm and responsive parenting behaviors as a potential moderator of the relationship between parental coping socialization messages and children's coping.

Parenting and Coping Socialization in the Context of Parental Depression

Parental depression presents a unique and important context in which to examine the socialization practices and the interactive role of parenting behaviors on children's use of coping strategies. Major Depressive Disorder is a prevalent and debilitating mental health problem that affects more than 20 million adults in the United States annually, and it is estimated that 7.5 million of these individuals are parents of school-age children and adolescents. Further, it is well established that children of depressed parents are at elevated risk for developing depression and other psychopathology in their lifetime, as it is estimated that at least 50% of these children will meet diagnostic criteria for at least one episode of depression by the time they reach adulthood (NRC/IOM, 2009).

Although the mechanisms of risk transmission are not fully understood, two particularly salient sources of risk for children's emotional and behavioral problems are children's use of ineffective strategies to cope with stress and exposure to disrupted parenting behaviors associated with parental depression (Compas et al., 2011). Research has shown that children of depressed parents use less adaptive coping strategies in response to stress (e.g., Maughan et al., 2007; Silk et al., 2006) relative to children of never depressed parents and children's coping strategies have been shown to be

positively correlated with parental depressive symptoms (e.g., Jaser et al., 2011; Langrock et al., 2002). For example, Silk et al. examined the regulatory strategies of young children of both depressed and non-depressed mothers using a mood induction task. They reported that children of depressed mothers used less effective strategies, including focusing their attention on the desired item or passively waiting for the task to end, while children of non-depressed mothers engaged in more adaptive strategies, including using distraction (e.g., singing or dancing around the room).

Further, extensive research has also shown that children of depressed parents are exposed to fewer positive parenting behaviors and higher levels of negative parenting behaviors (for reviews see, Dix & Meunier, 2009; Lovejoy et al., 2000). Lovejoy et al. conducted a meta-analysis of 46 observational studies examining parenting behaviors in the context of parental depression and found that depressed parents were significantly more negative relative to never depressed parents. Specifically, depressed parents were more irritable, withdrawn, inconsistent in their discipline, offered less praise, and displayed less positive affect toward their children; further, these disruptions were found to remain, although tempered, even after the remission of the parent's depression. Moreover, research has shown significant associations between responsive and warm parenting and children's coping strategies in a sample of parents with a history of depression (Watson et al., 2014).

To date, however, the research on the possible adverse consequences of parental depression on coping socialization processes remains much less clear. Given that individuals with elevated depressive symptoms have been shown to rely on less effective coping strategies (Churchill et al., 2010; Compas et al., 2001) and evidence that parents'

own coping strategies are a significant correlate of the coping strategies they instruct their children to use in response to stress (Kliewer et al., 1996; 2006), it is plausible that parents with elevated symptoms of depression would be less likely to instruct and encourage their children to use engagement (i.e., primary and secondary control) coping strategies. Rather, these parents may be more likely to teach their children to use disengagement strategies, which involve ignoring the problem, staying away from the stressor, and wishing it would go away.

To date, only one study has examined parental depressive symptoms as a correlate of parental socialization messages, specifically coping coaching (Monti et al., 2014). Although this study reported that parental depressive symptoms were significantly associated with greater parental encouragement of avoidance strategies and less encouragement of cognitive restructuring strategies, the study did not examine *how* the children actually coped with stress. That is, it is not clear whether those parental socialization messages were related to children using less effective coping strategies. Although research has not fully addressed whether parents with depression socialize ineffective strategies to their children, given the literature on the effects of parental depression on parenting behaviors and children's coping strategies, the coping socialization messages parents communicate may be one mechanism by which children of depressed parents use less adaptive coping strategies and lead to downstream effects on these children's increased risk for emotional and behavioral problems.

Limitations of Previous Studies

An emerging body of research, guided largely by the coping socialization model posited by Kliewer et al. (1994), has begun to examine the influential role of parents in

contributing to the coping strategies their children use in response to stress. Although there has been some empirical evidence for the role of parents through both their parenting behaviors and the coping socialization messages parents communicate to their children, the studies to date have been limited by a number of factors that will be important for future research to address.

First, a number of the studies have utilized single informant designs (e.g., Abaied et al., 2014; Kliewer et al., 1996; Meesters & Muris, 2004; Miller et al., 1994), and so the significant associations reported may be at least in part a result of shared method variance. Second, the points in development that have been examined in some studies may not be the most sensitive or optimal periods to understand the processes that contribute to individual differences in coping strategies (i.e., young adults rather than children and adolescents; Abaied et al., 2014). Third, studies have often examined the messages parents communicate using hypothetical scenarios (e.g., Kliewer et al., 2006; Miller et al., 2010), and so it is not clear the extent to which parents *actually* encourage those coping strategies to their children. Fourth, a number of studies have not examined how coping socialization messages are related to children's coping strategies, rather studies have focused on relations to child psychopathology (e.g., Abaied & Rudolph, 2010a) or have been interested in parental correlates of the messages (e.g., Abaied & Rudolph, 2010b; Kliewer, 2013; Monti et al., 2014), rather than consequences on children's coping. Fifth, no study to date has examined interactions of coping socialization messages with the context in which these messages are communicated to children (i.e., parenting behaviors). And lastly, given that children of depressed parents use less effective coping strategies in response to stressor, no study has examined

whether coping socialization messages partially account for the association between parental depressive symptoms and children's coping.

Current Study

The aim of the current study is to replicate previous research on parental socialization of children's coping strategies by examining the association among questionnaire reports of maternal coping socialization, mother and child coping strategies, maternal depressive symptoms, and child mixed anxiety/depression symptoms. Further, the goal of the present study is to build on previous research by investigating the reliability, validity, and utility of a new observational paradigm and coding system of maternal coping socialization behaviors in a discussion-based task and to examine the independent and joint roles of observed maternal coping socialization messages and observed parenting behaviors as correlates of maternal coping strategies, maternal depressive symptoms, and children's coping strategies.

The present study is designed in part to address limitations of previous research. First, the study will take a first step toward testing the reliability and validity of a new observational coding system designed to assess the coping socialization messages mothers communicate to their children in a dyadic discussion-based task. Additionally, the study will (a) recruit a sample of mothers and children in a sensitive period for examining the development of coping (i.e., childhood and adolescence), (b) use a real-life stressors the child currently or previously experienced both in observations of mothers and children and questionnaire reports, (c) utilize a multi-method and multi-informant approach, (d) recruit mothers with a varied history of past and current depression in order to examine a wide range of depressive symptoms, (e) test observed responsive/warm

parenting as a moderator of observed coping socialization messages on children's use of coping strategies, and (f) test maternal coping socialization processes as constructs that partially account for the relationship between maternal depressive symptoms and children's coping strategies (see Figure 1).

Primary Aims and Hypotheses[1]

Aim (1): To examine the frequency, reliability, and validity of a novel parental socialization of coping coding system for an observational discussion-based task to measure maternal coping socialization behaviors.

Aim (2): To examine the associations of observed maternal socialization of coping messages and maternal characteristics.

Hypothesis 1: Maternal coping strategies will be significantly associated with observed maternal coping coaching messages. Specifically, maternal use of primary and secondary control coping messages will be positively associated with maternal encouragement of primary and secondary control strategies and negatively associated with disengagement coping messages. Further, maternal use of disengagement coping strategies will be negatively associated with encouragement of primary and secondary control strategies and positively associated with disengagement coping messages.

Hypothesis 2: Maternal depressive symptoms will be associated with children's coping strategies and observed maternal coping coaching messages. Specifically, maternal depressive symptoms will be positively associated with children's disengagement coping strategies and negatively associated with children's primary and

[1] Supplementary analyses were conducted examining the relationship of maternal and child characteristics with the observed *process* and *content x process* codes. Tables are included in Appendix I, but are not addressed in detail in the dissertation.

secondary control strategies. Additionally, maternal depressive symptoms will be positively associated with maternal disengagement coping messages and negatively associated with primary and secondary control coping messages.

Hypothesis 3: The relationship between maternal depressive symptoms and children's coping strategies will be partially accounted for by observed maternal socialization of coping messages to their children.

Aim (3): To examine the associations of observed maternal socialization of coping messages and child characteristics.

Hypothesis 4: Maternal encouragement of children's primary and secondary control coping strategies will be positively associated with children's use of primary and secondary control strategies and negatively related to children's disengagement coping. Further, maternal encouragement of disengagement coping strategies will be negatively associated with children's use of primary and secondary control strategies and positively associated with children's disengagement coping.

Hypothesis 5: The relationship between observed maternal coping socialization messages and children's coping strategies will be moderated by observed levels of maternal responsive/warm parenting behaviors. Specifically, there will be a stronger association between maternal coping socialization messages and children's coping strategies in the context of high levels of responsive/warm maternal parenting behaviors.

CHAPTER II

METHOD

Participants

The sample for the current study was recruited between May 2011 and December 2013 and includes 120 mothers and their children (66 boys, 54 girls) between the ages of 9 and 15 years old (M = 12.27, SD = 1.89). Families that did not have complete data from the mother, child, and observational tasks were excluded from the present analyses (n = 20). There were no differences between those with missing data and those with complete data on mother and child age, household income, or maternal depressive symptoms. The final sample included 100 children (55 boys, 45 girls) between the ages of 9 and 15 (M = 12.24, SD = 1.85) and their mothers (M age = 41.22, SD = 5.95). At the assessment visit, five of the mothers were in a current depressive episode, 40 mothers met criteria for a past depressive episode in the lifetime of their target child, three of the mothers met criteria for a past depressive episode *only* prior to their child's birth, and 52 of the mothers never experienced an episode of depression in their lifetime. The sample was largely Euro-American (67.0% of mothers and 68.0% of children). Mothers' level of education varied with 77.0% reporting earning at least a college degree. The majority of mothers were married or co-habitating (63.0%). Annual household income of the sample ranged from less than $10,000 to more than $300,000, with a median income of $65,000.

Procedure

Participants were invited to participate in a study designed to better understand how mothers and children communicate about stress and emotions. Participants were recruited through a variety of sources, including the Vanderbilt Kennedy Center study finder, mass emails sent through Family Care Partners Database, and fliers placed in waiting rooms at private and public mental health clinics in Nashville, Tennessee. In an effort to obtain a sample of mothers with a wide range of current depressive symptoms, mothers with and without a history of Major Depressive Disorder were recruited.

Participants who expressed an interest in the study were contacted and screened over the telephone by trained doctoral students in clinical psychology as an initial step to determine eligibility. Exclusion criteria included a maternal history of bipolar I, bipolar II disorder, or schizophrenia; or a history of schizophrenia, a pervasive developmental disorder, or an intellectual disability in the target child. The oldest eligible child and the mother were invited to the laboratory to participate in more in depth clinical assessment as well as two videotaped mother-child interactions discussing two recent stressful events that the mother and child identified. In addition, mothers and children were asked to each separately complete a battery of questionnaires prior to the visit.

After completing the interviews, mothers and children participated in two 10-minute video recorded discussion tasks. In one task, the mother and child were instructed to discuss a recent family stressful event that involved the mother and child (e.g., not spending enough time together; mom nags too much) using a list of questions written to elicit information about how the child copes with family stress and how the mother may assist the child in coping (e.g., what does mom do to help you cope with this problem?).

Similarly, in the other task, the mother and child were instructed to discuss a recent peer stressful event (e.g., being around rude kids; not having enough friends) using the same list of questions written to elicit information about how the child copes with stress related to social interactions and peers and how the mother may assist the child in dealing with these problems. The order of the two interaction tasks was counterbalanced.

Maternal responsive/warm parenting behaviors were coded from both tasks, while maternal socialization of coping messages were coded from the peer stressor discussion task only. Both tasks were chosen to code parenting behaviors in an effort obtain a broad sample of maternal parenting behaviors. The peer stressor task was chosen as a focus of coping socialization for the current study because it is a salient context for children and adolescents as they begin to spend more independent time with peers and experience various forms of pressures, conflicts, and victimizations (e.g., Bradshaw et al., 2013; Larson & Richards, 1991). Further, the family discussion topic was focused on a stressor between the mother and child, which may limit and confound the messages the mothers communicate to their children about ways to cope with a stressor involving the mother.

The Institutional Review Board at Vanderbilt University approved all procedures. Clinical psychology graduate students conducted all semi-structured interviews and undergraduate research assistants conducted the parent-child interaction tasks. Families were compensated $100 in total for the assessment ($60 for the parent, $40 for the child). In addition, mothers received a packet of information about parent-child communication, parenting, and the effects of parental depression on parenting.

Measures

Maternal Depressive Symptoms

Mothers completed the widely used 21-item Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996; see Appendix B) to assess their current depressive symptoms in the past two weeks, including sadness, anhedonia, appetite, indecisiveness, guilt, and suicidality. Mothers rated the symptoms on a 4-point Likert scale ranging from 0 to 3. Internal consistency in the present sample was $\alpha = 0.93$.

Mixed Anxiety/Depression Symptoms

The Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001; see Appendix C) and the Youth Self-Report (YSR; Achenbach & Rescorla; see Appendix D) were used to assess children's mixed symptoms of anxiety and depression. The CBCL is a 118-item parent report of their child's behaviors based on rating the accuracy of statements on a 3-point Likert scale (0 = *not at all true*; 1 = *somewhat true*; 2 = *very true*). The mixed Anxious/Depressed scale was used and provides a measure of children's anxiety and depressive symptoms. The scale contains 13 items and the raw score on the scale was used, which represents the total number of symptoms endorsed. Example items include: cries a lot; fears going to school; feels worthless or inferior; is nervous, high strung, or tense; and worries. The internal consistencies of the Anxious/Depressed scales of the CBCL and YSR were $\alpha = 0.81$ and $\alpha = 0.83$, respectively.

Maternal and Child Coping Responses

Children and mothers completed the 57-item Responses to Stress Questionnaire – Peer Stress version (RSQ; Connor-Smith et al., 2000; Jaser et al., 2007; see Appendix E) to assess children's coping strategies. Mothers completed the 57-item Responses to Stress

Questionnaire – Family Stress version (RSQ; Wadsworth & Compas, 2002; see Appendix F) to assess mother's use of coping strategies. The measure is designed to assess the ways in which individuals cope with and react to the stress. All analyses in the present study focus on the three coping factors confirmed in factor analytic studies (e.g., Compas et al., 2006a; 2006b; Connor-Smith et al., 2000): primary control (i.e., emotional modulation, emotional expression, problem-solving), secondary control (i.e., acceptance, cognitive reappraisal, distraction, positive thinking), and disengagement (i.e., avoidance, denial, wishful thinking) coping. To control for response bias in item endorsement, proportion scores were calculated by dividing the total score for each coping factor by the total score obtained on the RSQ (Vitaliano, Maiuro, Russo, & Becker, 1987).

Internal consistencies of children's coping with peer-stress by child self-report and mother-report on child, respectively, were: $\alpha = .87$ and $\alpha = .78$ on primary control coping, $\alpha = .86$ and $\alpha = .82$ on secondary control, and $\alpha = .81$ and $\alpha = .76$ on disengagement coping. Internal consistencies of maternal coping with family-stress for the coping factors were: $\alpha = 0.77$ for primary control coping, $\alpha = 0.69$ for secondary control coping, and $\alpha = 0.77$ for disengagement coping.

Observation of Responsive/Warm Parenting Behaviors

Parenting behaviors in both the family and peer stressor mother-child interaction tasks were coded using a macro-level coding system, the Iowa Family Interaction Rating Scale (IFIRS), which is designed to code interactions at both the individual and dyadic level (Melby et al., 1998). Each code is rated on a 9-point Likert scale (1 = *not at all characteristic* to 9 = *mainly characteristic*) based on the frequency, intensity, and duration of such things as parental verbal and nonverbal behaviors, affect, and tone of

voice. IFIRS coding of each task was conducted by trained research assistants who were blind to maternal depression status and who coded each task independently by watching the 10-minute task five times before rating each code on the 9-point Likert scale. When both research assistants completed coding the task, they met to compare their codes and reach a consensus on any discrepant codes (i.e., codes that differed by two or more points from each other); if the coders differed by one point, the higher code was given. The IFIRS system has been validated through correlational and confirmatory factor analysis (Alderfer et al., 2008; Melby & Conger, 2001).

Mothers and children were coded separately on a number of emotional and behavioral codes. Following procedures used previously with the IFIRS codes (e.g., Compas et al., 2010; Lim, Wood, & Miller, 2008; Melby et al., 1998; Watson et al., 2014), scores were averaged across the two tasks and summed to create the composite code for *maternal responsive/warm parenting*. Specifically, parenting behaviors included warmth, listener responsiveness, communication, prosocial behaviors, quality time, and child-centeredness. Internal consistency for the parenting composite was $\alpha = 0.90$.

Socialization of Coping Questionnaire

The Socialization of Coping Questionnaire (SOC; Abaied, 2010; Abaied & Rudolph, 2010a, 2010b; see Appendix G) is a 24-item measure that was administered to the mother to assess the coping strategies they encourage their child to use in response to peer-related stress. Specifically, the questionnaire was written and developed guided by the coping factor structure of the Responses to Stress Questionnaire: primary control, secondary control, distraction (i.e., items from both the secondary control and disengagement scales), and behavioral avoidance (i.e., disengagement) coping strategies

suggestions. Example items for each factor included: deal with the situation head on instead of ignoring it (i.e., primary control coping), look for something good that is happening (i.e., secondary control coping), NOT focus on the problem (i.e., distraction), and keep away from things that make her/him feel bad (i.e., disengagement coping). For each item, mothers indicated on a 5-point Likert scale (*1* = not at all, *3* = some, and *5* = very much) the degree to which they suggest to their child to use the coping strategy in response to a peer stressor. The internal consistencies of the coping factors were as follows: $\alpha = 0.78$ for primary control coping messages, $\alpha = 0.80$ for secondary control coping messages, $\alpha = 0.88$ for distraction coping messages, and $\alpha = 0.76$ for behavioral avoidance coping messages.

Observation of Maternal Coping Socialization

An observational coding system to assess parental coping socialization processes in a dyadic discussion-based task was developed as part of the current study (see manual in Appendix H). The aim of the coding system is to capture both the *content* of the coping socialization messages that parents communicate to their children (i.e., which coping strategies to use) as well as the *process* by which parents communicate messages (i.e., instruction, modeling). The following steps were taken in the development of the coding system: (1) I reviewed the literature on coping socialization, (2) I wrote coping codes designed to capture both the *content* and *process* of parental messages, and (3) I read five randomly selected transcripts to confirm the written codes could be captured in the discussion-based task and were likely to be present with sufficient frequency.

Literature review. Two previous empirical studies coded parental coping coaching in an observational study based on separate coding systems developed as part of the

studies (i.e., Kliewer et al., 2006; Miller et al., 2010). The coding systems in the previous studies focused on the *content* of the coping messages; that is, what coping strategies the parents explicitly directed their child to use (e.g., "Go talk to someone about it"). However, the studies did not examine or code the communication *process* by which the parent conveyed their messages to the child. Guided by previous research on communication styles, there may be additional important ways in which parents communicate coping messages to their children that have not yet been examined and may be significant contributors to individual differences in children's use of coping strategies. These socialization messages may not have been coded in the previous studies using coding systems, and so maternal messages may have been underrepresented.

Content codes. The coping-relevant *content* of the parental messages specifically include the three coping factors based on a top-down, theory-driven model: primary control, secondary control, and disengagement coping. These coping factors have been well-validated and are consistent with the conceptual model of coping reflected in the RSQ (Connor-Smith et al., 2000) that mothers and children both completed as well as reflect the conceptual model of coping represented in the SOC Questionnaire (Abaied et al., 2010a) that the mothers completed about the content of their coping coaching suggestions. Using the same conceptual framework of coping across these different methodologies is advantageous because it allows for a more direct comparison of the influence of parental coping messages on the strategies children use to cope.

Maternal coping socialization *content* messages were quantified by calculating the total number of messages mothers communicated for each of the three coping factors separately by collapsing across three process codes (i.e., *Instruction, Questions in Service*

of Advisement, Modeling; see Table 3). Intervening codes were not included in the composite because it is unclear whether parental intervention will encourage the child to use that particular coping strategy or will communicate to the child they should rely on the parent. Analyses using the intervention codes are presented in supplementary analyses (see Appendix A).

Training and coding. Transcripts of the mother-child discussion about a peer stressor were used to code for maternal socialization of coping messages. Following procedures outlined by Rodriguez et al. (2013), trained doctoral students and undergraduate research assistants transcribed the discussion verbatim and divided the conversation into utterances, which is defined as "unit[s] of speech with complete semantic and syntactic content" (McLaughlin, Schutz, & White, 1980).

Transcripts were used to code the coping socialization messages of parents because they are likely to increase reliability of coding, as the coders assigned codes based on the same content rather than differences they may hear if they watched the videotape and transcribed the content independently. Similarly, it allowed for more efficient coding and consensus meetings because the content is already written out. And lastly, the discussion is divided into spoken utterances by the mother and child, which is likely to increase the reliability for assigning codes because the unit of measurement is pre-defined (i.e., when one parental message ends and a new one begins). For example, if the mother said "It makes me sad that she is so rude to you. Have you asked her why she is upset with you? You should talk to her about it." If those statements were transcribed, they would be clearly separated and written out like this:

M: It makes me sad that she is so rude to you.
M: Have you asked her why she is upset with you?

M: You should talk to her about it.

The first line would receive a *Modeling Primary Control Coping* code, the second line would receive a *Questions in Service of Advisement Primary Control* code, and the last line would receive an *Instruction Primary Control Coping* code. If those utterances were not transcribed and coders watched mothers and children on videotapes, one coder may not give the mother credit for the last *Instruction Primary Control Coping* code, but rather hear it as an extension of the *Questions in Service* code. Pre-defined utterances might increase the reliability of assigning codes to the maternal statements as well as increase the variability of the number of codes assigned, because longer statements and more elaborate maternal explanations were assigned a greater number of coping socialization codes than short statements without elaboration.

Coding training for the reliability coders was an iterative process that first involved the primary coder (KHW) developing the manual. Three reliability coders were required to pass a written test of the conceptual model of coping proposed by Connor-Smith et al. (2000) with 90% accuracy and pass a written test of the socialization of coping codes, including providing definitions and examples of each of the codes with 90% accuracy. Coding the transcripts first involved reading through the transcript one time to get an overall impression of the discussion task without applying codes to the utterances. The second time the coder read through the transcript she applied the appropriate codes to the coping-relevant content. The coder read the transcript a third time to double-check the socialization codes assigned. Importantly, not all mother or child utterances received a code.

The primary coder and the first trained reliability coder (KS) coded one transcript together while discussing and refining the coding system. The primary and first reliability coder (KS) then separately coded a transcript and met to discuss, resolve disagreements, and continue to refine the codes. The second reliability coder (FP) was trained after the primary and first reliability (KS) had coded five transcripts. FP independently coded five transcripts that were previously discussed and coded by primary (KHW) and the first reliability coder (KS). The third reliability coder (EKW) was trained following the same process as the second reliability coder (FP).

The primary coder (KHW) coded all of the transcripts for maternal coping socialization messages and 80% of those transcripts were double-coded by a reliability coder. These initial double-coded transcripts were not randomly selected. Therefore, an additional six transcripts were randomly selected to be double-coded by a reliability coder. Inter-rater reliability for the coping *content* messages was calculated by dividing the total number of inter-rater agreements by the total number of codes given by the primary coder (KHW) for each of the three coping factors: primary control, secondary control, and disengagement coping strategy messages.

Data Analytic Approach

Descriptive Statistics

All analyses were performed using SPSS (21st edition). Means, standard deviations, and ranges of scores on all measures were calculated and skewness was assessed for all variables (see Table 4). Results of the analyses indicate that the majority of the observed coping socialization codes were non-normal (i.e., skewness > 2; Tabachnick & Fidell, 2013), which is a violation of the assumption of the normality of

the disruption of the measure. Therefore, all of the observational socialization of coping codes were log transformed (Preacher, 2015). However, the untransformed means and standard deviations are presented in Table 4 and are referred to in the results to facilitate in interpreting the data.

Correlational Analyses

Bivariate Pearson's correlations were calculated to examine associations of the socialization of coping messages coded from an observational task with maternal and child characteristics (see Table 7).

Regression Analyses

A series of linear multiple regressions were performed to examine the indirect association of maternal depressive symptoms with children's coping strategies through maternal coping socialization of coping messages (see Table 8). Regressions were also performed to examine the main effects of observed coping socialization messages and interactive effects of responsive/warm parenting behaviors and coping socialization messages as predictors of children's coping strategies (see Tables 9 and 10). The interactions of parenting behaviors with each of the coping socialization *content* messages (i.e., primary control messages; secondary control messages; disengagement messages) were calculated by calculating the product of the variables. Post-hoc probing were conducted for significant interactions to determine whether simple slopes were significantly different from zero, and predicted associations will be plotted separately at high and low values (i.e., ± top and bottom third) of the moderator (Aiken & West, 1991; Holmbeck, 2002).

CHAPTER III

RESULTS

Preliminary Analyses

Table 5 presents correlations between child and mother coping strategies as well as child and mother psychopathology. Mothers and children both reported on children's coping strategies as well as children's symptoms of anxiety/depression. Consistent with previous research, children's coping strategies were significantly associated with symptoms in both single-informant (ranging from $r = .21$ to -.57, $p < .05$) and cross-informant (ranging from $r = -.23$ to -.36, $p < .05$) correlational analyses. Similarly, maternal depressive symptoms were significantly associated with maternal coping strategies: primary control coping ($r = -.51$, $p < .01$), secondary control coping ($r = -.55$, $p < .01$), and disengagement coping ($r = .26$, $p < .01$).

Table 6 presents correlations of maternal coping socialization messages as reported by mothers on the SOC (Abaied, 2010; Abaied & Rudolph, 2010a, 2010b) with maternal and child characteristics. Consistent with previous research, mother-reported depressive symptoms were significantly correlated with the coping messages mothers report communicating to their children: secondary control coping messages ($r = -.40$, $p < .01$), distraction ($r = .18$, $p < .10$), and disengagement messages ($r = .26$, $p < .01$). Maternal depressive symptoms were not related to maternal primary control coping

messages (r = .02, *ns*).

Maternal coping messages were also significantly associated with mother-report of their own coping strategies. That is, maternal primary control coping strategies were significantly associated with mothers communicating more secondary control (r = .31, p < .01) and fewer distraction (r = -.21, p < .05) and disengagement coping (r = -.26, p < .01) messages. Maternal secondary control coping strategies were significantly related to greater encouragement of secondary control strategies (r = .36, p < .01) and fewer primary control messages (r = -.30, p < .01). Lastly, maternal use of disengagement coping strategies was significantly related to greater encouragement of disengagement messages (r = .30, p < .01) and fewer secondary control messages (r = -.30, p < .01).

Mother-report of their coping socialization messages were also significantly associated with children's coping strategies based on mother-report. Specifically, mothers reported that their children used more secondary control coping strategies when mothers encouraged their children to use secondary control strategies (r = .29, p < .01) and fewer secondary strategies when mothers encouraged primary strategies (r = -.21, p < .05). Additionally, there was a trend for children to use more primary control coping strategies when mothers encouraged fewer distraction (r = -.18, p < .10) and fewer disengagement coping strategies (r = -.17, p < .10). However, there were no significant associations with child-report of their coping strategies (i.e., cross-informant analyses).

Aim (1): Measurement Development of Observed Maternal Coping Socialization Frequency

Descriptive statistics for the observed coping *content* socialization messages (i.e., primary control, secondary control, disengagement) communicated by mothers are

presented in Table 1. The means and standard deviations for each code provide preliminary evidence that mothers do communicate messages for each coping factor on how to deal with peer-related stressors. The three variables, however, were positively skewed and therefore were log transformed to approximate normality.

Mothers primarily encouraged their children to use primary control ($M = 7.35$) and secondary control ($M = 6.58$) coping strategies to cope with peer-related stress, with 86% and 75% of mothers communicating at least one primary control and secondary control coping message, respectively. For example, mothers told their children: "So you should just tell the teacher to keep y'all from fighting," or "It's better to think about something else about some different ways instead of just sitting and being upset about the thing that you can't get." Mothers offered fewer disengagement coping messages ($M = 1.60$) to their children, with only 47% of mothers communicating at least one disengagement coping strategy during the discussion-based task, such as "Stay away from him," or "Have you tried walking away?"

Reliability

One aim of the current study was to examine if two independent raters could reliably code the maternal socialization messages from the observational discussion-based task. Most broadly, the inter-rater agreement of coding an utterance as a socialization of coping message was 77%. The inter-rater reliability for the coping *content* messages was calculated for each coping factor separately. Inter-rater reliability was acceptable: primary control coping (78%; 446 agreements, 124 disagreements), secondary control coping (73%; 375 agreements, 138 disagreements), and disengagement coping (74%; 107 agreements, 38 disagreements). Inter-rater reliability was calculated on

an additional random selection of transcripts that were double-coded: primary control coping (81%; 13 agreements, 3 disagreements), secondary control coping (53%; 23 agreements, 20 disagreements), and disengagement coping (100%; 1 agreement, 0 disagreements).

Construct Validity

The Socialization of Coping Questionnaire (SOC) is a validated parent-report measure of coping socialization messages that provides scores for the frequency with which parents encourage children to use primary control, secondary control, distraction, and behavioral avoidance coping strategies in response to a peer-related stressor (e.g., Abaied, 2010; Abaied & Rudolph, 2010a; 2010b; 2011). Table 6 presents bivariate correlations between mother-reported coping messages endorsed on the SOC and the messages coded from the observational discussion-based task.

A number of significant correlations emerged. First, observed maternal encouragement of their children to use disengagement coping strategies was related to mother-report of encouraging fewer primary control (r = -.31, p < .01) and secondary control (r = -.18, p < .10) messages and greater distraction (r = .25, p < .05) and behavioral avoidance strategies (r = .32, p < .01). Additionally, the correlations approached significance between observed maternal encouragement of primary control coping strategies and mother-report of encouraging greater primary control coping strategies (r = .19, p < .10) and fewer distraction strategies (r = -.19, p < .10). Observed maternal encouragement of secondary control coping strategies was unrelated to maternal report of coping socialization messages.

Aim (2): Relations of Maternal Coping Socialization and Maternal Characteristics

Hypothesis 1: Correlations between Maternal Coping Strategies and Observed Coping Socialization Messages

Bivariate Pearson's correlations among maternal coping strategies and observed coping socialization messages are presented in Table 7. Two significant correlations emerged. Specifically, observed maternal encouragement of disengagement coping messages was related to mothers' own greater use of disengagement coping ($r = .23$, $p < .05$) and less use of primary control coping ($r = -.27$, $p < .01$) to deal with family-related stress. Maternal encouragement of primary control and secondary control coping messages was unrelated to mother self-report of coping.

Hypothesis 2: Correlations among Maternal Depressive Symptoms, Maternal Coping Socialization Messages, and Children's Coping Strategies

Bivariate Pearson's correlations among maternal depressive symptoms and maternal coping socialization messages are presented in Table 7. There were no significant associations between mother-report of their depressive symptoms on the BDI-II with observed maternal coping socialization messages from the discussion-based task: primary control ($r = .00$), secondary control ($r = .07$), or disengagement ($r = .12$) coping.

Table 5 presents correlations between maternal depressive symptoms and children's coping strategies. Based on mother-report of child coping, maternal depressive symptoms were significantly associated with children's primary control ($r = -.21$, $p < .05$) and secondary control ($r = -.43$, $p < .01$). Maternal depressive symptoms were unrelated to children's coping strategies based on child self-report of coping.

Hypothesis 3: Role of Coping Socialization Messages in the Association between Maternal Depressive Symptoms and Children's Coping Strategies

As shown in Table 8, a series of multiple linear regressions were performed to examine whether observed maternal coping socialization messages partially accounted

for the relationship between maternal depressive symptoms and children's coping strategies. Separate analyses were run for mother- and child-report of child coping.

Primary control coping. In Step 1, maternal depressive symptoms were a significant predictor of children's primary control coping based on maternal-report (β = -.21, $p < .05$) but not child-report (β = -.10). In Step 2, adding the three observed coping socialization *content* messages, based on maternal-report of child coping, there was a significant main effect of maternal encouragement of disengagement coping strategies (β = -.21, $p < .05$) and the effect of maternal depressive symptoms was reduced marginally significant (β = -.18, $p < .10$). A Sobel test was conducted to test for the indirect effect of maternal depressive symptoms to child primary control coping through maternal disengagement coping messages and it was not significant (p = .26; Sobel, 1982). Based on child self-report of coping, there were no significant main effects at Step 2.

Secondary control coping. In Step 1, maternal depressive symptoms were a significant predictor of children's secondary control coping based on maternal-report (β = -.43, $p < .01$) but not child-report (β = -.15). In Step 2, adding the observed coping socialization *content* messages, there was a significant main effect of maternal encouragement of secondary control coping (β = -.19, $p < .05$) and maternal depressive symptoms remained a significant predictor (β = -.42, $p < .01$). A Sobel test was conducted to test for the indirect effect of maternal depressive symptoms to child secondary control strategies through maternal secondary control coping messages and it was not significant (p = .48). There were no significant main effects for child-report of secondary control coping.

Disengagement coping. In Step 1, maternal depressive symptoms were not a significant predictor of children's disengagement coping based on either maternal-report (β = .10) or child-report (β = .12). However, adding the main effects of maternal observed socialization of coping *content* messages, a significant main effect emerged for secondary control messages (β = .20, $p < .05$) for maternal-report of child coping and for primary control coping messages (β = .21, $p < .05$) based on child self-report of coping.

Aim (3): Relations of Maternal Coping Socialization and Child Characteristics

Hypothesis 4: Correlations between Maternal Observed Coping Socialization Messages and Children's Coping Strategies

Table 7 also presents correlations of observed maternal coping socialization messages with children's coping strategies based on both mother- and child-report. Several significant correlations emerged based on mother-report of child coping. Specifically, observed maternal encouragement of secondary control coping strategies was related to children's use of secondary control (r = -.22, $p < .05$) and disengagement (r = .21, $p < .05$) coping strategies. Additionally, maternal encouragement of disengagement strategies was related to children's use of less primary control coping strategies (r = -.23, $p < .05$) in response to peer stress. In contrast, only one significant correlation emerged for child-report of their coping with peer stress. That is, observed maternal encouragement of primary control coping strategies was related to child-reported use of greater disengagement strategies (r = .20, $p < .05$).

Hypothesis 5: Interactive Effect of Observed Maternal Responsive/Warm Parenting and Coping Socialization Messages Predicting Children's Coping Strategies

As shown in Tables 9 and 10, multiple linear regressions were conducted to examine the interactive contributions of maternal coping messages and observed

responsive/warm parenting behaviors. Maternal depressive symptoms and child age were entered at the first step as covariates. The main effects of observed maternal primary control, secondary control, and disengagement coping suggestions as well as observed responsive/warm parenting behaviors were entered at the second step. The interactions of observed maternal coping suggestions x observed responsive/warm parenting behaviors were entered at the third step. Analyses were conducted separately for mother-report of child coping (see Table 9) and child self-report of coping (see Table 10). A number of significant main effects and interaction effects emerged.

Primary control coping. First, based on maternal-report of children's coping, maternal depressive symptoms (β = -.23, p < .05) and child age (β = -.20, p < .05) were significant predictors of child primary control coping strategies in Step 1. In the second step, maternal depressive symptoms remained a significant predictor (β = -.20, p < .05) while child age approached significance (β = -.18, p < .10). There were no main effects of observed socialization of coping messages or responsive/warm parenting. In the final step, maternal depressive symptoms remained significant (β = -.20, p < .05) and child age approached significance (β = -.19, p < .10). Further, a significant main effect of observed maternal primary control coping messages emerged (β = -1.07, p < .05) as well as a significant interaction effect of responsive/warm parenting with primary control suggestions (β = 1.20, p < .05). Table 10 presents the main effects and interactions for child-report of primary control coping. In the final step, observed primary control coping messages approached significance (β = -.87, p < .10) as well as the interaction effect of responsive/warm parenting and primary control coping messages (β = -1.04, p < .10).

In order to examine the significant interaction effects for both mother-report (Table 9) and child-report (Table 10) of children's coping, high and low responsive/warm parenting groups were created based on the top and bottom third values of the current sample (see Figures 2 and 3). An examination of the slopes of the two lines provides evidence that in the context of high levels of responsive/warm parenting behaviors (β = .02), children used greater levels of primary control coping strategies when their mothers' were observed to encourage these coping strategies than did children whose mothers were low in responsive/warm parenting behaviors (β = -.03).

Secondary control coping. Based on maternal-report of child coping, maternal depressive symptoms (β = -41, $p < .01$) were a significant predictor of child secondary control coping at all three steps of the regression. Additionally, at Step 2, a significant main effect for observed maternal secondary control coping suggestions emerged (β = -.19, $p < .05$), but was no longer significant at Step 3. There were no other significant main or interaction effects for mother- or child-report of secondary control coping.

Disengagement coping. Maternal depressive symptoms or child age were not significant predictors of children's use of disengagement coping based on both mother- and child-report. At Step 2, observed maternal encouragement of secondary control coping strategies emerged as a significant main effect (β = .23, $p < .05$) based on maternal report of child disengagement coping and maternal encouragement of primary control coping emerged as a significant main effect (β = .21, $p < .05$) based on child self-report. At Step 3, there were no significant main or interaction effects for child self-reported coping. Based on maternal-report, two effects approached significance: main effect of observed maternal disengagement coping messages (β = -.99, $p < .10$) and

interaction effect of responsive/warm parenting and maternal disengagement coping messages ($\beta = .99$, $p < .10$). The interaction term was plotted based on high and low levels of responsive/warm parenting (see Figure 4). Similar to the findings for primary control coping strategies, in the context of high levels of responsive/warm parenting behaviors ($\beta = .03$), children used greater levels of disengagement coping strategies when their mothers' were observed to encourage these coping strategies than in the context of low responsive/warm parenting behaviors ($\beta = .00$).

CHAPTER IV

DISCUSSION

There is strong evidence that emotional and behavioral problems in childhood and adolescence is mediated and moderated in part by how individuals cope with stress and regulate their emotions (Compas et al., 2001; Eisenberg et al., 2010). To date, however, it remains much less clear why some individuals use adaptive coping strategies to respond to stress (i.e., primary control and secondary control coping strategies) while other individuals use less adaptive coping strategies (i.e., disengagement coping). As a consequence, research has begun to investigate the role of parents in contributing to individual differences in children's coping responses, specifically through the coping messages they communicate to their children (Kliewer et al., 1994). Examining potential individual difference factors for children's coping is an important area of research, as it may help to identify those at greatest risk of developing psychopathology as well as provide avenues for both prevention and intervention.

Consequently, the aim of the present study was to replicate and extend previous research on maternal coping socialization by examining observed coping socialization messages assessed with a novel observational paradigm and coding system as correlates of children's coping responses to peer-related stress. Additionally, maternal depressive symptoms and maternal coping strategies were examined as potential correlates of maternal socialization messages. The current study also extended previous research by

examining responsive/warm parenting behaviors as a possible moderator of the relation between maternal socialization of coping messages and children's coping strategies.

Measurement of Maternal Coping Socialization Messages

Previous research has primarily examined maternal coping socialization messages by mother-report on two different questionnaires: the Parental Socialization of Coping Questionnaire (PSCQ; Miller et al., 1994) and the Socialization of Coping Questionnaire (SOC; Abaied & Rudolph, 2010a; 2010b; 2011). Studies using these questionnaires have reported a variety of significant correlates of parental coping socialization messages, including maternal attachment (Abaied & Rudolph, 2010b), maternal depressive symptoms (Monti et al., 2014), child psychopathology (Abaied & Rudolph, 2010a), child level of hope (Kliewer & Lewis, 1995), child memory recall of socialization messages (Miller et al., 2010), and children's coping strategies (e.g., Abaied & Rudolph, 2011; Miller et al., 1994). While these studies have provided important preliminary evidence that parental socialization messages are related to a number of important variables, including the ways in which children approach and respond to stress in their lives, many of these studies have been single-informant, single-method designs.

Limited research has utilized multi-method designs to examine maternal coping socialization messages and associations with both mother and child correlates (see Kliewer et al., 2006, and Miller et al., 2010, for exceptions). Although these two prior studies are notable exceptions, the observational methods used in these studies were limited by using stressors/situations that were hypothetical (i.e., parent-child watching a film clip and discussing how the child in the movie could cope with the stressor) and by coding children's coping responses from either the same task as the coping socialization

messages (Kliewer et al., 2006) or coding children's coping after the discussion-task (Miller et al., 2010), which may have inflated significant findings. Consequently, the present study sought to build on these studies by developing and testing the utility of a new observational paradigm and novel coding system intended to capture, in real-time, maternal coping socialization messages to children in response to a recent peer stressor.

Development of Observational Paradigm and Coding System

The observational paradigm involved the mother-child dyad talking together for 10 minutes about a recent peer stressor experienced by the child. The dyad's discussion was guided by a list of prompts that were written to elicit a conversation about the ways in which the child does and/or could cope with the problem (e.g., How does [child] cope with [stressor]? How does mom help [child] when problems like this happen?). The intention was for mothers and children to discuss a stressor the child currently was experiencing or recently had experienced with a peer. Consistent with the goals of the current study, all of the dyads were able to talk about a peer-related stressor the child had experienced, such as being teased, not having enough friends, getting rejected, being physically hurt, and being the subject of a false rumor. It is notable, however, that several children had a difficult time recalling a recent peer stressor, and so some dyads discussed a situation that occurred over a year ago. On the other hand, other dyads discussed several recent peer stressors during the 10-minute task. Further, some of the mothers were already aware of the problem and the dyad talked about the advice the mother had already given the child, while other mothers were unaware of the problem and gave "in the moment" coping advice to their children.

The mother-child conversations were all video recorded and later transcribed

verbatim. The transcripts were used to code the maternal coping socialization messages using the newly developed coding system. The novel coding system was based on the conceptual coping model proposed by Connor-Smith et al. (2000) and was written to capture a broad range of coping messages. That is, prior studies have focused on the direct instruction from the parent (e.g., "you should tell an adult," or "go to the teacher next time that happens"), but it is possible that parents communicate coping messages in ways that have not previously been coded from observational tasks. For example, parents may model coping strategies through their behavior or verbal disclosure or parents may indirectly communicate a message disguised as a question (Goodman & Dooley, 1976). Consequently, the present study coded maternal coping messages communicated in three separate ways: Instruction, Modeling, and Questions in Service of Advisement.[2] These codes were combined to form a coping composite for each of the three coping factors: (1) Primary Control Coping messages (i.e., mothers encouraged their children to act directly on a problem or their emotions), (2) Secondary Control Coping messages (i.e., mothers encouraged their children to adapt to the problem), and Disengagement Coping messages (i.e., mothers encouraged their children to evade the problem or their emotions).

Frequency, Reliability, and Validity of the Coding System

A primary aim of the current study was to examine the utility of the newly developed observational coding system to investigate if: (1) mothers communicate messages that can be captured from the coding system, (2) the coping messages can be reliably coded, and (3) the coded coping messages are a valid reflection of coping advice

[2] Other ways parents may communicate coping messages were also coded (e.g., intervening, feedback), but were not included in the present analyses (see Appendix VIII for the coding manual and Appendix I for supplementary analyses).

mothers report communicating to their children. Descriptive statistics for each of the observed coping codes provided preliminary support that mothers *do* communicate coping messages to their children *and* that the messages can be captured and coded in the discussion-based task used in the study. However, it is important to note that the majority of the coping codes were positively skewed (i.e., a large number of mothers failed to coach one or more of the three types of coping).

Inter-rater reliability for each of the coping factors was calculated on 80% of the transcripts. Taken as a whole, reliability was acceptable for each of the coping factors: primary control (78%), secondary control (73%), and disengagement coping (74%). However, there were several challenges to establishing reliability of the coping codes that are worth noting (see Appendix I for a list of challenges and important rules and clarifications established). One difficulty involved the distinction between primary control and disengagement coping when the mother suggested strategically walking away from the problem or avoiding kids or situations that cause problems. For example: "M: After they do something that's hurtful again then you need to just step back and say you know what I don't want to be hurt anymore because it's too much effort on my part to get over it and just walk away." While this maternal coping suggestion has a strong element of problem-solving by considering how the person makes the child feel and strategically deciding to not be friends any longer, the mother is ultimately communicating to the child to walk away from the friendship, which is the definition of disengagement coping. Consequently, a rule was set and all of these responses were coded as disengagement regardless of the amount of problem solving involved if the focus was on ignoring, walking away, or avoiding.

There were also challenges faced in achieving reliability for secondary control coping messages. Disengagement coping strategies are largely concrete behaviors (e.g., avoiding situations), while secondary control coping strategies (e.g., cognitive reappraisal, positive thinking) largely involve more covert, abstract, higher-order cognitive processes and were notably more difficult to capture in an interpersonal exchange between mothers and children. For example, maternal statements made in reference to a child's stressor and with a positive valence were coded as modeling of secondary control coping. However, maternal statements varied widely in the level of positive valence and at times were difficult to reliably code. For example, "So it is not that big of a deal," or "You're not stupid."

Other times mothers provided their children with cognitive reappraisals, but the mother's reappraisal likely would have the effect of causing the child to feel worse. For example, in one discussion, a child was upset because she did not have as many friends as she would like. Her mother tried to get her daughter to recognize that she (her daughter) is mean to others, which is why she does not have friends. For example, the mother said, "They're going to think you're the bully right? Who wants to be friends with a bully?" This and other similar examples led to a number of disagreements in coding, because mothers offered reappraisals of situations, but often these were reappraisals that would have the effect of making the child feel worse in the short-term. This ultimately resulted in a rule that these would not be coded as secondary control coping.

An additional difficulty encountered in reliability was for coding maternal modeling of emotional expression (i.e., primary control coping). In earlier transcripts, coders had a difficult time reaching agreement on if the mother was expressing an

emotion when mothers used non-traditional emotion words (e.g., bummed, freaked out, good). As a consequence, a non-exhaustive list of emotion words was created to aid in reliability (see Appendix J). Another difficulty faced in reliability was for the Questions in Service of Advisement code. Although the majority of these codes were straightforward (e.g., "So just kind of avoid it?"), there were other times that it was not as clear because the maternal message was more indirect. For example, a daughter said, "He is mean to everybody." Her mother then said, "Okay, so maybe it is just him?" In this example, the mother appears to be trying to get her child to recognize that the other child is the root of the problem, not her own child. This is a more indirect example than a mother who might say: "Okay, but don't you think you would feel better if you thought it was just him and not you?"

A final difficulty faced involved utterances that on the surface appear as primary control coping strategies, but were not actually specific enough to know what the mother was trying to communicate, such as "Don't let it upset you," or "You need to treat other people on your terms, not their terms." Coders were instructed to judge whether the child could accomplish the parent's advice by using primary control, secondary control, *or* disengagement strategies. For example, for the suggestion "Don't let it upset you", the child could possibly accomplish it by talking to someone about it, using distraction, *or* avoiding the problem. Therefore, the maternal utterance was not specific enough to give it a coping code. Despite these specific challenges, inter-rater reliability for each of the coping codes was acceptable.

As a first step towards establishing the validity of the new observational coding system, the present study administered a widely used questionnaire measure of maternal

coping socialization reported by the mother (SOC; Abaied, 2010; Abaied & Rudolph, 2010a; 2010b). First, correlations of the questionnaire with maternal and child correlates were examined to replicate previous research. Overall, findings from the SOC were consistent with earlier studies. Maternal coping socialization messages were significantly associated with maternal depressive symptoms and maternal coping in response to family stress in the expected directions (e.g., mothers who reported encouraging their children to use greater secondary control coping strategies were less depressed and reported using more secondary control strategies in response to stress). Further, coping messages were significantly associated with children's mixed anxiety/depression symptoms as reported by the mother (e.g., Abaied & Rudolph, 2011), although the messages were unrelated to child-report of their symptoms. Lastly, maternal coping messages were related to several child coping strategies as reported by the mother, but associations with child-report of coping was considerably more limited. Taken as a whole, the findings with the SOC replicate previous research and provide evidence that maternal coping messages are related to mother and child correlates, although the majority of significant relations emerged from single-informant analyses.

The present study provided preliminary evidence and partial support for the validity of the newly developed observational socialization of coping coding system, as a number of significant correlations emerged with the SOC questionnaire. Specifically, observed maternal encouragement of disengagement strategies was significantly associated with mother-report of encouraging fewer primary control and greater distraction and disengagement coping strategies. Several more associations approached statistical significance (i.e., observed primary control suggestions related to greater

mother-report of primary suggestions and fewer distraction strategies; observed disengagement strategies related to fewer mother-report of secondary suggestions).

This is the first observational study of maternal coping socialization to examine the validity of the codes. While there were a number of expected relationships between the observed and questionnaire messages that were non-significant, the present study provided preliminary evidence that the observational paradigm provided a sufficient context for mothers to communicate coping advice to their children, the study showed that mothers do in fact provide their children with coping advice, and the findings suggest that the novel coding system was sensitive enough to capture these coping messages. Yet, nearly all the coping codes were positively skewed, and so the coping messages did not occur as frequently as expected. In addition, the findings from the study provided initial support that the coping socialization codes in the new system can be reliably captured and that the observed messages are related in part to what mothers report telling their children to do to cope with peer-related stress. Given the preliminary evidence for reliability and validity of the coded socialization messages, the second and third aims of the present study to examine mother and child correlates are described in detail below.

Maternal Correlates of Coping Socialization Messages

Maternal Coping

In partial support of the first hypothesis, there was some evidence that mothers' own coping strategies were significantly related to the coping socialization messages that they communicated to their children. Specifically, mothers who were observed to encourage their children to use more disengagement strategies in response to peer-related stressors (e.g., avoid) also reported using more disengagement coping strategies and

fewer primary control strategies (e.g., problem-solve) to cope with their own stress. This is the first study to examine maternal coping as a correlate of their observed socialization messages, and the findings provide some support that mothers tell their children to cope with stressors similar to how mothers cope with stress. Maternal coping socialization messages involving primary control and secondary control strategies were unrelated to maternal coping.

It is important to note that in the present study mothers' own coping strategies were assessed in reference to family-related stressors, while maternal coping socialization messages were in reference to peer-related stressors. Given the stressor-specific nature of coping, it is possible that mothers cope differently with family stressors than they do with peer stressor, and perhaps there would have been a greater number of significant correlations if the mother reported on the same stressor for her own coping and the socialization messages

Maternal Depressive Symptoms

Contrary to the second hypothesis, there was no evidence that observed maternal coping socialization messages were related to maternal depressive symptoms. Monti et al. (2014) found that maternal depressive symptoms were related to mothers suggesting fewer primary and secondary control strategies and greater disengagement coping strategies. Further, these findings were largely replicated in the present study using the SOC questionnaire. It is possible that these previously reported significant correlations are actually a reflection of shared method variance given that mothers reported on both maternal depressive symptoms and coping socialization messages from questionnaire measures. However, it is also possible that the coding system used in the present study

was not sensitive to differences in socialization messages that were expected from higher levels of maternal depressive symptoms. It is important to note, however, that the present sample varied widely in level of depressive symptoms with a limited number of mothers reporting a high number of depressive symptoms, as the median score of 8 on the BDI-II fell in the minimally depressed range on this scale. Consequently, it is possible that the depression measure was not sensitive to important differences observed in the discussion-based task. It will be important for future research to recruit a sample of more severely depressed parents to examine associations with observed coping socialization messages.

It was also expected that maternal depressive symptoms would be significantly associated with children's coping strategies based on previous findings that children of depressed parents use less adaptive strategies to cope (e.g., Silk et al., 2006). However, evidence for significant associations with maternal depressive symptoms was limited and only emerged for mother-report of both constructs. That is, children used fewer primary control and secondary control strategies as maternal depressive symptoms increased. There was no evidence when children reported on their coping strategies.

Partial support was found for the third hypothesis, as maternal encouragement of disengagement coping strategies may partially account for the significant negative association between maternal depressive symptoms and children's use of primary control coping strategies. That is, both maternal depressive symptoms and encouragement of disengagement coping strategies accounted for variance in children's use of primary control coping strategies. However, after taking into account the effect of maternal disengagement coping messages, maternal depressive symptoms no longer predicted children's primary control coping. Additionally, there was a significant negative

association between maternal depressive symptoms and children's secondary control coping strategies. After accounting for the significant main effect for maternal encouragement of secondary control coping strategies on children's secondary control strategies, maternal depressive symptoms remained significant.

And lastly, after accounting for maternal depressive symptoms on children's disengagement strategies, significant main effects emerged for fewer primary control and secondary control messages predicting children's greater use of disengagement strategies. This findings provide some preliminary evidence that the reason children of mothers with higher levels of depressive symptoms use less adaptive coping strategies in response to stress may be because of the coping socialization messages mothers communicate to their children. For example, children used fewer primary control coping strategies (e.g., problem-solving) as maternal depressive symptoms increased perhaps in part because these mothers encouraged their children to use greater disengagement strategies (e.g., avoidance) to cope with peer-related stressors. However, these findings are limited in that mothers reported on both their depressive symptoms and children's coping strategies.

Child Correlates of Coping Socialization Messages

Partial support for the fourth hypothesis emerged, as a number of children's coping strategies were significantly associated with observed maternal coping socialization messages. However, the majority of significant correlations were not in the hypothesized directions. Specifically, mothers' encouragement of primary control strategies (e.g., problem-solving) was related to children's greater use of disengagement strategies (e.g., avoidance). Additionally, greater maternal encouragement of secondary control coping strategies (e.g., cognitive reappraisal) was related to children's use of

fewer secondary control and greater use of disengagement coping strategies.

These hypotheses were based on the idea that parents influence what children do in response to stressors; however, findings may better be interpreted as *responding* to what children do in response to stressors. That is, parents may communicate to their children to use greater primary control coping messages when parents know their children are using greater disengagement coping strategies, as primary control strategies have been shown to be associated with better psychological adjustment in response to peer-related stress (e.g., Jaser et al., 2007). It may be that the more adaptively children are coping, the fewer coping messages parents need to provide their children.

The present study recruited a sample of children between the ages of 9 and 15 years because it is thought that prior to age 9 children do not have the cognitive abilities to engage in more complex coping skills (e.g., cognitive reappraisal). However, it is possible that by the age of 15 children have already established their typical ways of responding to stress. Research is limited on the development of coping and the stability of coping across ages, and so it is possible that parents play more of a significant role in children's coping prior to age 9. It will be important for future research to examine the developmental progression of coping. Nevertheless, the present study suggests that mothers do communicate coping messages to their children and there is evidence that what parents say to their children is related to what children do in response to stressors.

The present study also built on previous research by examining observed responsive/warm parenting behaviors as a potential moderator of the association between maternal socialization of coping and children's coping strategies (Hypothesis 5). To date, no study has examined parenting behavior as a moderator, but Grusec and Goodwin

(1994) suggested it is important to examine because children may be more likely to listen to their parents' advice if the message is conveyed in the context of a warm and nurturing environment. The present study is the first to provide evidence that responsive/warm parenting is a moderator of the association between maternal coping socialization messages and the strategies that children use to cope with stress. Specifically, children used greater primary control coping (based on mother-report) in response to peer-related stress when mothers communicated primary control messages in the context of a responsive and warm environment.

Additionally, two other interactions approached significance, but the findings were similar: there was a stronger association between maternal coping socialization messages and children's coping when parents were responsive and warm in their interactions with their children. Despite preliminary evidence for a moderating role of parenting behaviors, a number of interactions were non-significant. These findings provide initial and partial support that it is not only important that parents provide their children with coping messages in response to stressors that children face, but it is also essential that parents communicate these messages in the context of responsiveness and warmth to increase the probability that their children will adopt the coping strategies.

Limitations

The present study has several limitations that should be noted. First, the study was cross-sectional and so the direction of effects cannot be determined. Second, although the sample had adequate representation of racial and ethnic minorities, the sample was limited in regard to the range of maternal education and income (i.e., the sample was primarily middle and upper socioeconomic status). Third, 20 mother-child dyads had at

least some missing data, notably reducing the sample size. However, there were no demographic differences between dyads missing data from those with complete data. Fourth, although detailed information was collected about maternal depression history, other types of maternal psychopathology (i.e., anxiety disorders) were not assessed and may have an effect on socialization processes. Fifth, although child age was selected for reasons specific to certain parts of the study, there may be important maternal socialization processes that occur prior to age 9. Sixth, mother self-report of coping and mother coping socialization messages were assessed in reference to different stressors (i.e., family stress and peer stress, respectively), and so non-significant correlations may be a result of differences in coping with these stressors. Lastly, fathers were not included, and so it was not possible to examine potential gender differences in the relations between socialization messages and children's coping strategies.

Strengths

However, these limitations were offset in part by several strengths, including the use of multi-informants, recruiting a heterogeneous sample in reference to current maternal depressive symptoms, collecting observational measures of both parenting and coping socialization messages, and taking a first step at testing the reliability and validity of a new paradigm and observational coding system to assess maternal coping socialization messages. Lastly, the present study obtained data on maternal parenting behaviors, and so parenting was observed as a moderator of coping socialization messages and child coping strategies.

Future Directions

Findings from the present study should be both replicated and extended in future

research. First, this is the third study to date to use an observational discussion-based task to assess maternal coping socialization messages (i.e., Kliewer et al., 2006; Miller et al., 2010). The present study was designed to build on the two previous paradigms by asking the mother-child dyad to discuss a real-life stressor the child experienced rather than a hypothetical scenario. While the discussion-based task did elicit coping socialization messages from the mother, the data was positively skewed and a number of the dyads had a difficult time thinking of a recently experienced stressor to discuss.

Future research should consider using an activity-based paradigm in which the child experiences a stressor and the parent is given the opportunity to provide coping assistance. As such, the present study has data on an activity-based task that will be coded and the target of future analyses. That is, children were told they were going to be video recorded giving a 5-minute speech about themselves and a research assistant would be in the room evaluating their performance. Children were told they would be given a score of their public speaking skills relative to their peers and if children received at least a 7 out of 10, they would receive a special prize. Mothers and children video recorded for 5-minutes preparing for the speech together. Maternal coping socialization messages will be coded to examine the maternal role in an immediate stressor experienced by the child.

Second, there were a number of codes from the coding system developed for the present study that were beyond the scope of the study, but will be important for future research to more fully address (see Appendix H for manual and Appendix A for supplementary analyses). The present study focused on the coping *content* messages communicated by mothers (i.e., what category of coping did mothers suggest). However, the present study also coded the *process* by which mothers communicated their message

(i.e., Instruction, Questions in Service of Advisement, Modeling, Feedback, and Intervening) and *content x process* codes (e.g., Instruction of Primary Control strategies). Future research should more fully examine these codes to understand if children are more likely to listen to their parents' messages if they are presented through a particular process (e.g., Instruction vs. Intervening) and examine if there are particular parental characteristics that predict which *process* codes parents use (e.g., depressive symptoms). This information may be important for interventions designed to improve children's coping strategies, because if it is found that parental Modeling is not as effective as parental Instruction, interventions should teach parents to clearly and directly instruct their children to use particular coping strategies.

Third, research on coping socialization has primarily focused on examining the role of the parent in the coping of adolescents and young adults. There has been limited research on the developmental course of coping, and so it is unclear when coping strategies come online, how stable coping strategy use is across development, and if influences to coping changes across development (e.g., parents vs. peers), although there was some evidence for a main effect of age from the regression analyses predicting children's coping strategies. It is possible that by the time children reach adolescence, parents have already had a significant influence in the strategies that children use to cope. Additionally, as peers become more important and influential in adolescence, they may have a stronger influence on children's coping strategies than parents. It will be important for future research to investigate these processes in younger children and examine the parental role across development. Additionally, future work should consider examining the role of peers and other significant relationships in children's lives.

Fourth, prior research on coping socialization has primarily focused on the role of mothers (see Kliewer et al., 1996, for a notable exception). Kliewer et al. (1996) examined the role of mothers and fathers in elementary school children's coping strategies and reported that maternal coping suggestions were more strongly related to children's coping. However, no recent studies have examined the unique role of fathers. It will be important for future research to recruit fathers alongside of mothers. It is possible that messages communicated by fathers are more strongly related to children's coping at certain stages of development, for sons more than daughters, or depending on their level of responsive/warm parenting behaviors.

Fifth, an aim of the present study was to examine these coping socialization messages in the context of maternal depression. However, the present sample had a limited number of severely depressed mothers based on questionnaire reports of depressive symptoms. Consequently, it will be important for future research to recruit a more chronically and severely depressed sample to examine maternal depression as a correlate and predictor of maternal coping socialization messages, as this information can be used to identify those who are most at risk of communicating maladaptive strategies to their children and identify children at risk of using less adaptive strategies.

Lastly, future research should consider how skilled children are in using coping strategies. To date, research on coping has primarily used questionnaire reports to assess the frequency of children's use of a variety of coping strategies. However, it is unclear from these reports how *skilled* children are in using these coping strategies. That is, two children could both report using problem-solving to cope with peer-related stress, but one child may have difficulty generating a variety of solutions or may choose a poor solution.

It is possible that maternal coping socialization messages contribute not only to the strategies that children use, but potentially more importantly their *skill* in using these strategies. For example, some mothers in the observational task provided their children with more versus less information on how to cope with the stressor (e.g., Mother 1: "You should think more positively," vs. Mother 2: "You should remind yourself of all of the friends and family that love you"). While Mother 1 encouraged a secondary control strategy, Mother 2 gave more detailed information about *how* the child could do so.

Conclusion

The present study utilized a cross-informant, multi-method design to replicate and expand on previous research on the socialization of coping in childhood and adolescence. A novel discussion-based paradigm was used and an observational coding system was developed to assess how mothers may communicate coping messages, in real-time, to their children. Preliminary evidences provided support that mothers do communicate coping messages in an interpersonal discussion-task with their children. Further, many of the observed coping socialization messages were significantly related to the strategies mothers reported intentionally communicating to their children on a validated questionnaire measure. Maternal coping socialization messages were related to mothers' own coping strategies, although unexpectedly they were unrelated to maternal current depressive symptoms. Lastly, there was limited evidence that maternal coping messages were concurrently related to children's coping strategies, although this study was the first to show the associations might be moderated in part by responsive/warm parenting. The findings suggest that this novel paradigm is a promising method to capture processes through which parents socialize their children's coping for use in future research.

Table 1. Description of IFIRS Codes for Composite.

Parental Responsiveness/Warmth Composite Codes	**Definition**	**Examples**
Warmth (WM)	This code assesses the degree to which the parent expresses liking, appreciation, praise, care, concern, or support for the child.	1. "I love you."' 2. "You're wonderful." 3. "You were very brave."
Listener Responsiveness (LR)	This code assesses the parent's listening skills. It is a measure of how well the parent attends to, shows interest in, acknowledges, and validates the child's statements.	1. A smile that says, "I like your idea." 2. A brief verbal response such as, "yeah" while the person is speaking. 3. Nodding
Communication (CO)	This code assess the parent's skill in communication, including the extent to which the parent conveys ideas in a neutral/positive manner, considers the child's point of view, solicits information from the child, and offers explanations and reasoning for their opinions.	1. "This is really important to me because…" 2. "I realize that you think…" 3. "That is an interesting idea."
Prosocial Behaviors (PR)	This code assesses the extent to which the parent relates competently and effectively with the child. It measures the parent's interpersonal skills, cooperation, sensitivity, and helpfulness.	1. "I'm sorry, I didn't know that bothered you." 2. "I liked your idea about how to clean the house." 3. "Mary, what do you think about our plans?"
Quality Time (QT)	This code assesses the extent or quality of the parent's "well-spent" involvement in the child's life outside of the immediate setting.	1. "I really enjoy spending time with you." 2. "I always look forward to our Saturday evenings together playing games and eating popcorn." 3. Evidence of meaningful and mutually enjoyable routines
Child-Centeredness (CC)	This code assesses the extent to which the parent's behavior is centered on the needs, feelings, and desires of the child.	1. "How did that make you feel when she did that?" 2. "I know this is upsetting to you. Let's try the next question." 3. "What do you want to talk about?"

Table 2. Description of the Codes from the Socialization of Coping Coding Manual.

Process Code	Description of the Code	Examples of the Content
Instruction	The parent provides the child with direct instruction on the specific strategies that the child *should* use to cope with the stressor.	**Primary Control Instruction** P: "You should come talk to me about it or tell the teacher if that happens."
		Secondary Control Instruction C: "You encourage me to focus on the positive."
		Disengagement Instruction P: "There are some people that are evil and you need to avoid."
Questions in Service of Advisement	This code is given to a leading question asked by the parent that is intended to communicate to the child that there is a particular coping strategy the parent wants the child to use.	**Primary Control Question in Service of Advisement** P: "Would you go tell the teacher or go tell your mom?"
		Secondary Control Question in Service of Advisement P: "I wonder if it would be helpful to remind yourself that a lot of people love you?"
		Disengagement Question in Service of Advisement P: "Don't you think you should just ignore kids like that?"
Modeling	This code is given to a parent who demonstrates coping skills in the immediate task or shares with/tells the child about what they do to cope with stressors experienced *outside* of the immediate task.	**Primary Control Modeling** P: "I am having a similar problem with a friend. I could call her to talk it over. Maybe I could apologize in a card. Or actually maybe I should let her cool off for a while since I really think I hurt her feelings."
		Secondary Control Modeling P: "I am sad that other kids are rude to you, but I know a lot of people love you and it is helpful to remind myself of that."
		Disengagement Modeling P: "I tend to try to stay away from people who act that way."

Table 3. Socialization of Coping Codes: *Content* x *Process* of the Maternal Messages

Process Codes	**Content Codes**		
	Primary Control Messages	Secondary Control Messages	Disengagement Messages
Instruction			
Questions in Service of Advisement			
Modeling			

Table 4. Descriptive Statistics for Symptoms, Coping, Maternal Coping Socialization Messages, and Parenting Behaviors.

Variable	Min	Max	M	SD	Skew
Symptoms Variables					
BDI-II Maternal Depressive Symptoms (M)	0	51	10.94	10.58	1.48
CBCL Anxious/Depressed (M on C)	0	19	3.54	3.78	1.61
YSR Anxious/Depressed (C)	0	18	4.89	4.22	.89
Coping Variables					
RSQ Mother Primary Control (M)	.09	.30	.20	.04	-.34
RSQ Mother Secondary Control (M)	.14	.34	.25	.05	-.14
RSQ Mother Disengagement (M)	.09	.20	.14	.03	.12
RSQ Child Primary Control Coping (M on C)	.07	.30	.20	.05	-.22
RSQ Child Secondary Control Coping (M on C)	.10	.39	.25	.06	-.31
RSQ Child Disengagement Coping (M on C)	.09	.22	.15	.03	.41
RSQ Mother on Child Primary Control (C)	.08	.30	.18	.04	.16
RSQ Mother on Child Secondary Control (C)	.11	.39	.26	.06	-.11
RSQ Mother on Child Disengagement (C)	.10	.24	.16	.03	.12
Observed Coping Socialization Messages					
Content Codes					
Primary Control Coping Total (O)	0	47	7.35	7.06	2.47
Secondary Control Coping Total (O)	0	41	6.58	6.29	2.04
Disengagement Coping Total (O)	0	15	1.60	2.87	2.67
Mother-Report Coping Socialization Messages					
SOC Proportion of Primary Control (M)	.23	.47	.32	.05	.72
SOC Proportion of Secondary Control (M)	.10	.32	.22	.04	-.12
SOC Proportion Distraction (M)	.13	.39	.30	.05	-.58
SOC Proportion of Behavioral Avoidance (M)	.08	.22	.16	.03	-.45
IFIRS Responsive/Warm Parenting Behaviors (O)	2.75	7.25	4.82	.92	.11

Note. N = 100, BDI-II = Beck Depression Inventory – II, CBCL = Child Behavior Checklist, YSR = Youth Self-Report, RSQ = Responses to Stress Questionnaire, SOC = Socialization of Coping Questionnaire

Table 5. Bivariate Pearson's Correlation Matrix of Symptoms and Coping.

		1	2	3	4	5	6	7	8	9	10	11	12
1	Mother Depression Symptoms (M)	--											
2	Child Anxiety / Depression (M on C)	.53**	--										
3	Child Anxiety / Depression (C)	.27**	.50**	--									
4	Mother Primary Control (M)	-.51**	-.18†	-.06	--								
5	Mother Secondary Control (M)	-.55**	-.26**	-.23*	.52**	--							
6	Mother Disengagement (M)	.26**	.03	.08	-.55**	-.36**	--						
7	Child Primary Control (M on C)	-.21*	-.35**	-.17†	.25*	.24*	-.03	--					
8	Child Secondary Control (M on C)	-.43**	-.57**	-.36**	.27**	.48**	-.08	.43**	--				
9	Child Disengagement (M on C)	.10	.21*	.24*	-.06	-.16	.02	-.60**	-.36**	--			
10	Child Primary Control (C)	-.10	-.07	-.23*	.09	.00	-.04	.18†	.06	-.16	--		
11	Child Secondary Control (C)	-.15	-.28**	-.46**	-.06	.08	-.02	.10	.28**	-.14	.20*	--	
12	Child Disengagement (C)	.12	.06	.27**	-.18†	-.11	.18†	-.16	-.03	.17†	-.57**	-.16	--

Note. N = 100, M = Mother self-report, C = Child self-report, M on C = Mother-report on child

Table 6. Bivariate Pearson's Correlations of Questionnaire Measure of Maternal Coping Socialization with Mother and Child Characteristics.

	SOC Primary Control (M)	SOC Secondary Control (M)	SOC Distraction (M)	SOC Disengagement (M)
Maternal Characteristics				
BDI-II Depressive Symptoms (M)	.02	-.40**	.18†	.26**
RSQ Primary Control Coping (M)	.09	.31**	-.21*	-.26**
RSQ Secondary Control Coping (M)	-.30**	.36**	.08	-.14
RSQ Disengagement Coping (M)	.06	-.30**	-.03	.30**
IFIRS Responsive/Warm Parenting (O)	.20*	.23*	-.26**	-.25*
Child Characteristics (Mother-Report)				
CBCL Mixed Anxiety/Depression (M)	.14	-.28**	.08	.08
RSQ Primary Control Coping (M)	.14	.16	-.18†	-.17†
RSQ Secondary Control Coping (M)	-.21*	.29**	.01	-.10
RSQ Disengagement Coping (M)	-.01	-.12	.06	.08
Child Characteristics (Self-Report)				
YSR Mixed Anxiety/Depression (C)	.15	-.03	-.04	-.10
RSQ Primary Control Coping (C)	-.12	-.02	.04	.12
RSQ Secondary Control Coping (C)	-.18†	.03	.08	.10
RSQ Disengagement Coping (C)	.00	-.01	.02	.00
Coping Content Messages (Observed)				
Primary Control Messages (O)	.19†	-.02	-.19†	-.01
Secondary Control Messages (O)	.08	-.09	-.01	.02
Disengagement Messages (O)	-.31**	-.18†	.25*	.32**

Note. N = 100, BDI-II = Beck Depression Inventory – II, RSQ = Responses to Stress Questionnaire; IFIRS = Iowa Family Interaction Rating Scale, CBCL = Child Behavior Checklist, M = Mother self-report C = Child self-report, O = Observation

Table 7. Bivariate Pearson's Correlations of Observed Maternal Coping Socialization with Mother and Child Characteristics.

	Total Primary Control Messages (O)	Total Secondary Control Messages (O)	Total Disengagement Messages (O)
Maternal Characteristics			
BDI-II Depressive Symptoms (M)	.00	.07	.12
RSQ Primary Control Coping (M)	.02	-.02	-.27**
RSQ Secondary Control Coping (M)	-.11	-.11	.04
RSQ Disengagement Coping (M)	.05	.11	.23*
IFIRS Responsive/Warm Parenting (O)	.09	.24*	-.30**
Child Characteristics (Mother-Report)			
CBCL Mixed Anxiety/Depression (M)	-.02	.11	-.05
RSQ Primary Control Coping (M)	-.05	-.08	-.23*
RSQ Secondary Control Coping (M)	-.04	-.22*	-.01
RSQ Disengagement Coping (M)	.06	.21*	.05
Child Characteristics (Self-Report)			
YSR Mixed Anxiety/Depression (C)	-.13	-.07	.04
RSQ Primary Control Coping (C)	-.02	.01	.05
RSQ Secondary Control Coping (C)	-.13	.02	-.06
RSQ Disengagement Coping (C)	.20*	-.08	.04

Note. N = 100, BDI=II = Beck Depression Inventory – II, RSQ = Responses to Stress Questionnaire, IFIRS = Iowa Family Interaction Rating Scale, CBCL = Child Behavior Checklist, YSR = Youth Self-Report, M = Mother self-report, C = Child self-report, O = Observation

Table 8. Multiple Linear Regressions Examining Maternal Depressive Symptoms and Maternal Coping Socialization Messages Predicting Children's Coping.

Predictor Variables	RSQ Child Primary Control (M on C)		RSQ Child Secondary Control (M on C)		RSQ Child Disengagement (M on C)	
Peer RSQ (Mother-Report)	*β*	*t*	*β*	*t*	*β*	*t*
Step 1						
BDI-II Mother Depressive Symptoms (M)	-.21	-2.15*	-.43	-4.65**	.10	1.03
Step 2						
BDI-II Mother Depressive Symptoms (M)	-.18	-1.84†	-.42	-4.56**	.09	.85
Primary Control Coping Messages (O)	-.04	-.44	-.03	-.30	.04	.44
Secondary Control Coping Messages (O)	-.07	-.71	-.19	-2.11*	.20	1.99*
Disengagement Coping Messages (O)	-.21	-2.10*	.04	.38	.04	.43
Predictor Variables	RSQ Child Primary Control (C)		RSQ Child Secondary Control (C)		RSQ Child Disengagement (C)	
Peer RSQ (Child-Report)	*β*	*t*	*β*	*t*	*β*	*t*
Step 1						
BDI-II Mother Depressive Symptoms (M)	-.10	-.99	-.15	-1.48	.12	1.18
Step 2						
BDI-II Mother Depressive Symptoms (M)	-.11	-1.05	-.15	-1.44	.12	1.23
Primary Control Coping Messages (O)	-.03	-.25	-.13	-1.32	.21	2.08*
Secondary Control Coping Messages (O)	.02	.18	.04	.40	-.10	-.99
Disengagement Coping Messages (O)	.06	.60	-.04	-.40	.02	.16

Note. N = 100, BDI-II = Beck Depression Inventory – II, RSQ= Responses to Stress Questionnaire, M = Mother self-Report, C = Child self-report, O = Observation

Table 9. Multiple Linear Regressions Examining Maternal Coping Socialization and Parenting Behaviors Predicting Children's Coping (Mother-Report).

Predictor Variables	RSQ Child Primary Control (M on C)		RSQ Child Secondary Control (M on C)		RSQ Child Disengagement (M on C)	
Peer RSQ (Mother-Report)	β	t	β	t	β	t
Step 1						
BDI-II Mother Depressive Symptoms (M)	-.23	-2.38*	-.41	-4.49**	.11	1.09
Child Age	-.20	-.2.03*	.14	1.54	.06	.62
Step 2						
BDI-II Mother Depressive Symptoms (M)	-.20	-2.06*	-.40	-4.32**	.09	.87
Child Age	-.18	-1.81†	.13	1.36	.07	.64
IFIRS Warm Parenting (O)	.03	.25	.04	.45	-.11	-.97
Primary Control Coping Messages (O)	-.07	-.72	-.01	-.14	.06	.60
Secondary Control Coping Messages (O)	-.09	-.87	-.19	-2.07*	.23	2.20*
Disengagement Coping Messages (O)	-.17	-1.64	.02	.28	.00	.01
Step 3						
BDI-II Mother Depressive Symptoms (M)	-.20	-2.02*	-.40	-4.37**	.10	.93
Child Age	-.19	-1.88†	.13	1.33	.07	.66
IFIRS Warm Parenting (O)	-.13	-.50	.05	.20	-.01	-.03
Primary Control Coping Messages (O)	-1.07	-2.21*	-.40	-.88	.70	1.38
Secondary Control Coping Messages (O)	.63	1.32	.11	.25	-.07	-.13
Disengagement Coping Messages (O)	.25	.45	.90	1.66	-.99	-1.67†
Warm Parenting x Primary Control Messages (O)	1.20	2.17*	.48	.91	-.77	-1.33
Warm Parenting x Secondary Control Messages (O)	-.90	-1.62	-.37	-.71	.37	.64
Warm Parenting x Disengagement Messages (O)	-.43	-.77	-.87	-1.64	.99	1.71†

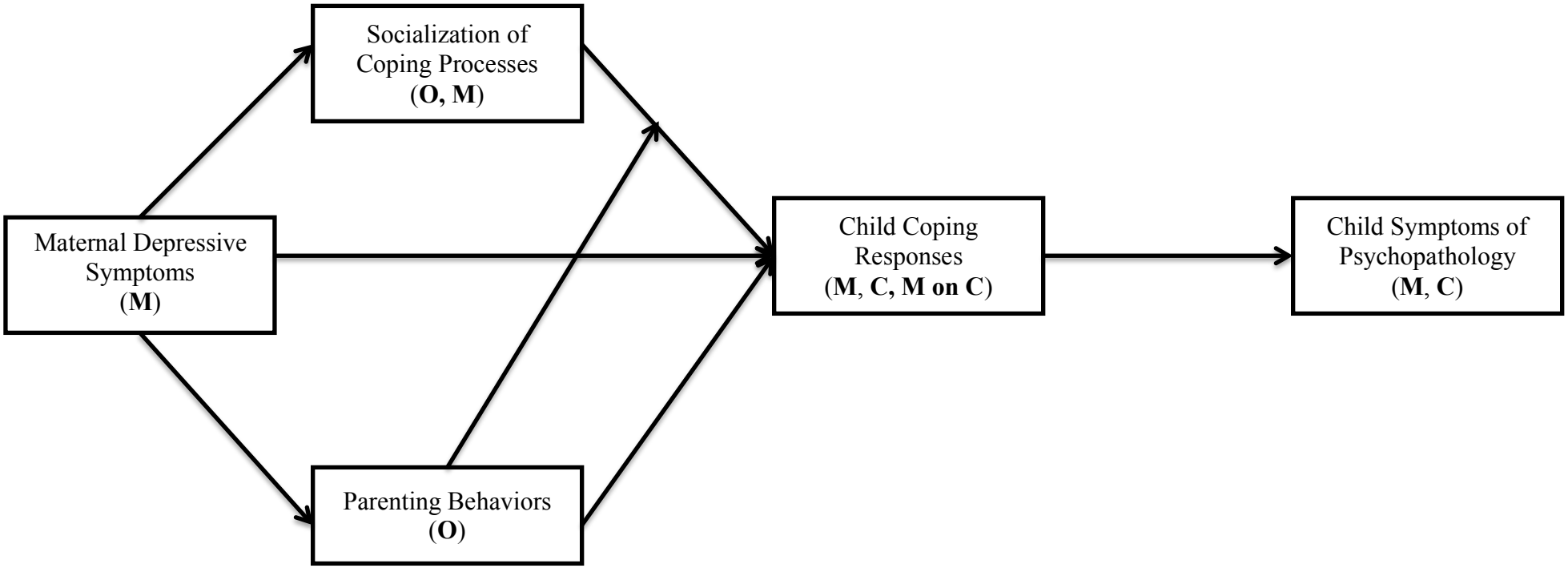
N = 100, BDI-II = Beck Depression Inventory – II, RSQ = Responses to Stress Questionnaire, IFIRS = Iowa Family Interaction Rating Scale, M = Mother self-report, C = Child self-report, M on C = Mother-report on child, O = Observation

Table 10. Multiple Linear Regressions Examining Maternal Coping Socialization and Parenting Behaviors Predicting Children's Coping (Child-Report).

Predictor Variables	RSQ Child Primary Control Coping (C)		RSQ Child Secondary Control Coping (C)		RSQ Child Disengagement Coping (C)	
Peer RSQ (Child-Report)	*β*	*t*	*β*	*t*	*β*	*t*
Step 1						
BDI-II Mother Depressive Symptoms (M)	-.09	-.91	-.13	-1.30	.12	1.16
Child Age	.07	.65	.17	1.70†	.00	-.04
Step 2						
BDI-II Mother Depressive Symptoms (M)	-.10	-.99	-.12	-1.20	.13	1.23
Child Age	.05	.48	.17	1.66	.02	.18
IFIRS Warm Parenting (O)	-.04	-.31	.03	.30	.02	.17
Primary Control Coping Messages (O)	-.02	-.15	-.11	-1.10	.21	2.05*
Secondary Control Coping Messages (O)	.03	.28	.04	.42	-.10	-.98
Disengagement Coping Messages (O)	.04	.40	-.06	-.55	.02	.18
Step 3						
BDI-II Mother Depressive Symptoms (M)	-.10	-.94	-.12	-1.18	.13	1.22
Child Age	.05	.46	.17	1.60	.03	.28
IFIRS Warm Parenting (O)	-.20	-.69	.11	.37	-.28	-.98
Primary Control Coping Messages (O)	-.87	-1.68†	-.32	-.62	.20	.40
Secondary Control Coping Messages (O)	.58	1.12	.42	.82	-.78	-1.54
Disengagement Coping Messages (O)	.38	.62	.37	.62	-.73	-1.22
Warm Parenting x Primary Control Messages (O)	1.04	1.73†	.27	.45	-.04	-.07
Warm Parenting x Secondary Control Messages (O)	-.68	-1.15	-.45	-.78	.78	1.34
Warm Parenting x Disengagement Messages (O)	-.34	-.58	-.43	-.73	.74	1.27

Note. N = 100, BDI-II = Beck Depression Inventory – II, RSQ = Responses to Stress Questionnaire, IFIRS = Iowa Family Interaction Rating Scale, M = Mother self-report, C = Child self-report, O = Observation

Figure 1. Heuristic Model.



Note. O = Observation, M = Mother self-report, M on C = Mother-report on Child, C = Child self-report.

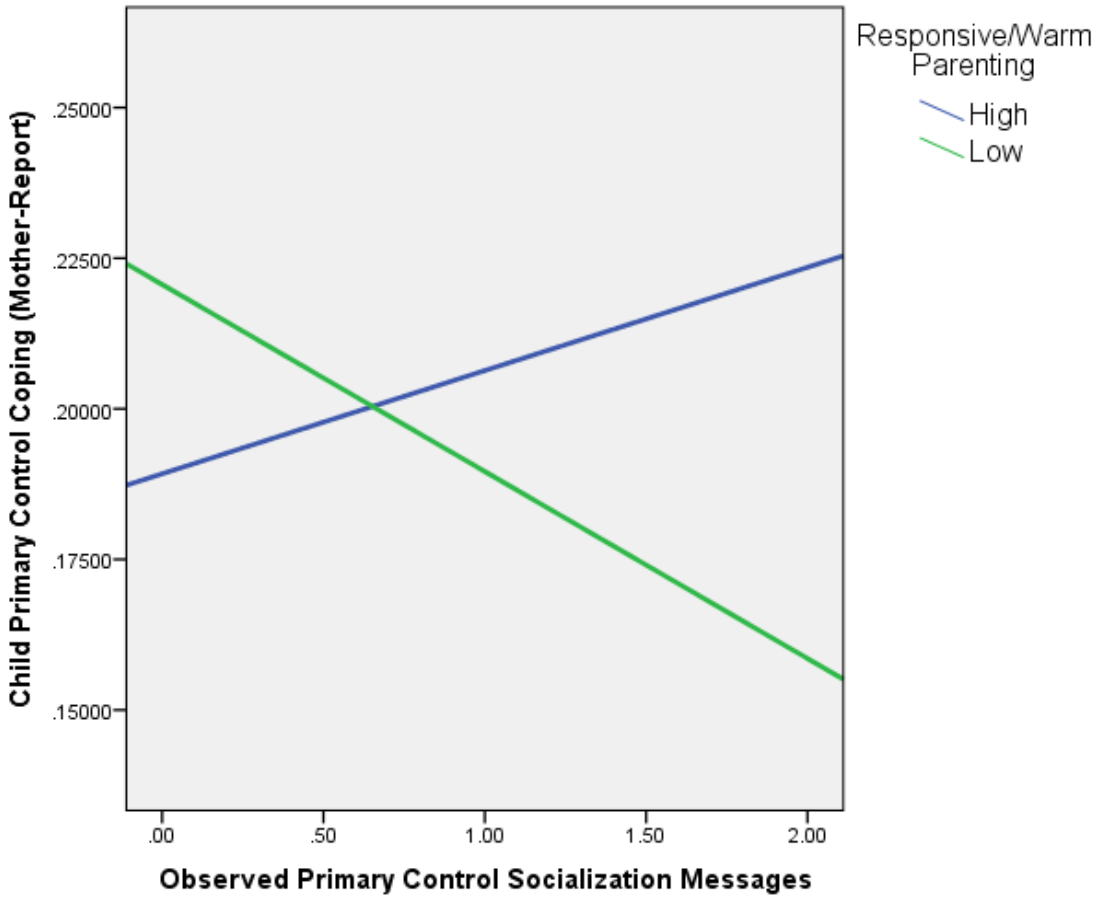


Figure 2. Maternal Socialization of Primary Control Coping Messages x Parenting Predicting Children's Primary Control Coping (Mother-Report).

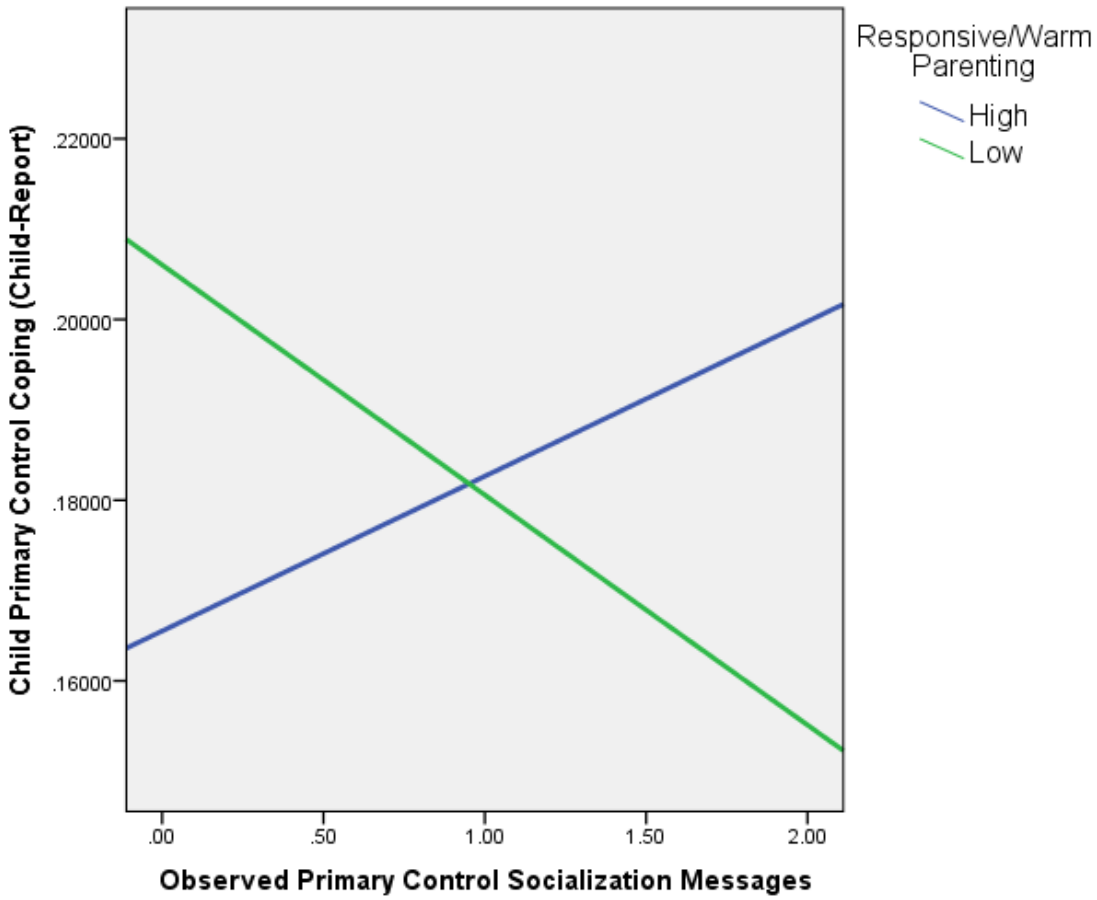


Figure 3. Maternal Socialization of Primary Control Coping Messages x Parenting Predicting Children's Primary Control Coping (Child-Report).

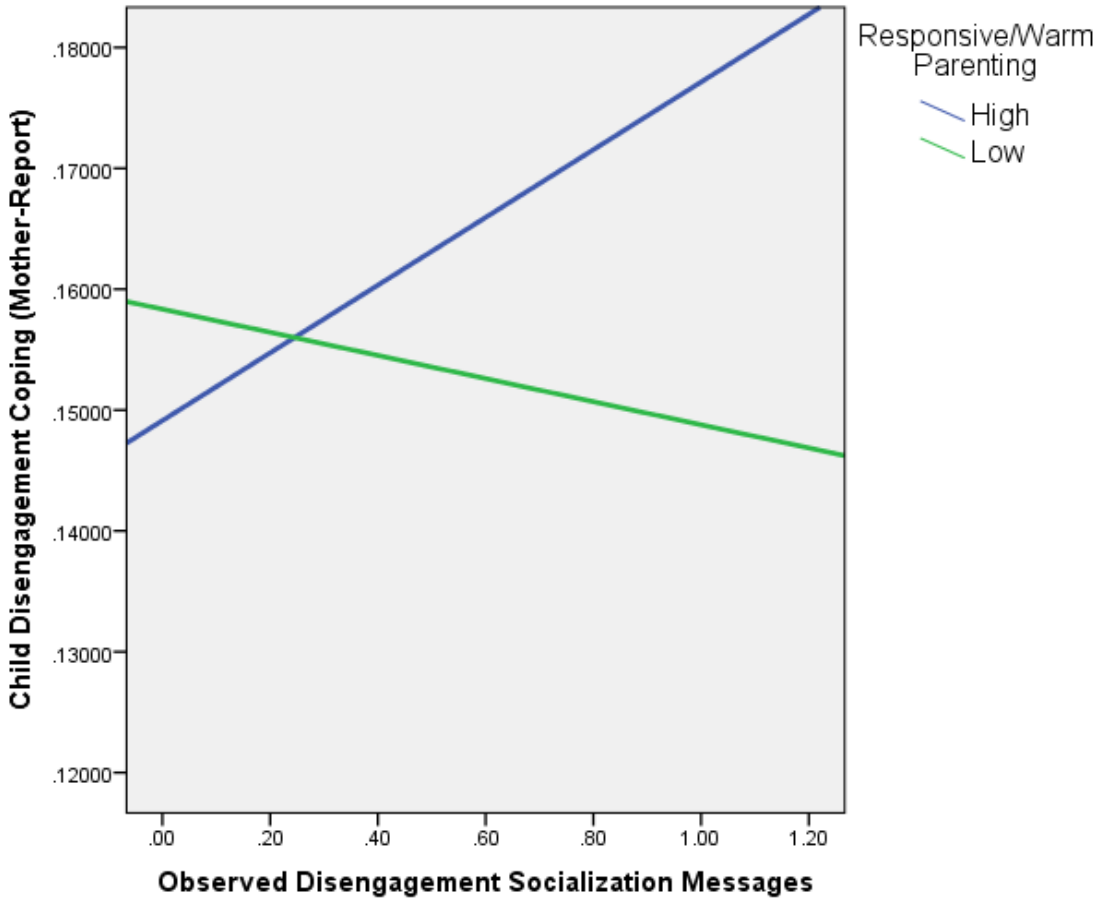


Figure 4. Maternal Socialization of Disengagement Coping Messages x Parenting Predicting Children's Disengagement Coping (Mother-Report).

Appendix A. Supplementary Analyses

Table 11. Descriptive Statistics for the Process and Content x Process Codes.

Variable	Min	Max	M	SD	Skew
Process Codes					
Instruction	0	45	5.00	6.64	3.02
Questions in Service	0	17	3.03	3.23	1.96
Modeling	0	35	7.50	6.05	1.48
Intervention	0	9	1.26	2.09	1.87
Content x Process Codes					
Instruction Primary Control	0	42	3.59	5.59	3.95
Instruction Secondary Control	0	9	.38	1.25	4.58
Instruction Disengagement	0	11	1.03	2.31	3.10
Questions in Service Primary Control	0	10	1.46	1.83	2.38
Questions in Service Secondary Control	0	9	1.32	2.04	2.06
Questions in Service Disengagement	0	4	.25	.61	3.37
Modeling Primary Control	0	20	2.30	2.90	2.81
Modeling Secondary Control	0	33	4.88	4.98	2.20
Modeling Disengagement	0	4	.32	.75	3.20
Intervention Primary Control	0	9	1.09	1.91	2.06
Intervention Secondary Control	0	1	.04	.20	4.77
Intervention Disengagement	0	6	.13	.71	6.85

Table 12. Bivariate Pearson's Correlations of Questionnaire Measure of Maternal Coping Socialization and Observed Maternal Coping Socialization Messages.

	SOC Primary Control (M)	SOC Secondary Control (M)	SOC Distraction (M)	SOC Disengagement (M)
Process Codes				
Instruction	.00	-.06	.08	.13
Questions in Service	.08	.01	-.18†	-.17†
Modeling	-.07	-.11	-.07	-.02
Intervention	.10	-.04	.05	.12
Primary Control x Process Codes				
Instruction	.08	-.14	-.02	.08
Questions in Service	.18†	.19†	-.24**	-.20†
Modeling	.16	.08	-.19†	-.09
Intervention	.01	-.10	-.01	.10
Secondary Control x Process Codes				
Instruction	-.04	.01	.07	-.04
Questions in Service	.33**	-.05	-.19†	-.14
Modeling	-.04	-.06	.05	.08
Intervention	.08	-.14	.11	-.03
Disengagement x Process Codes				
Instruction	-.32**	-.12	.23*	.28**
Questions in Service	-.12	.04	.02	.09
Modeling	-.18†	-.22*	.24*	.23*
Intervention	-.06	-.07	.02	.12

Table 13. Bivariate Pearson's Correlations of Observed Process and Content x Process Maternal Coping Socialization Messages and Mother Characteristics.

	BDI-II (M)	Primary Control (M)	Secondary Control (M)	Disengagement (M)
Process Codes				
Instruction	.07	-.17†	-.02	.11
Questions in Service	.03	-.03	-.08	.06
Modeling	.05	.01	-.13	.19†
Intervention	.15	-.11	-.13	.15
Primary Control x Process Codes				
Instruction	.02	-.07	-.03	.03
Questions in Service	.02	.01	-.11	.10
Modeling	-.04	.17†	-.09	.04
Intervention	.05	-.05	-.07	.17†
Secondary Control x Process Codes				
Instruction	.00	-.11	-.10	.11
Questions in Service	.08	-.02	-.13	.06
Modeling	.05	-.02	-.10	.13
Intervention	-.05	-.05	-.04	-.11
Disengagement x Process Codes				
Instruction	.15	-.22*	.05	.13
Questions in Service	-.05	-.14	.07	.08
Modeling	.14	-.25*	-.06	.28**
Intervention	.32**	-.15	-.19†	.05

Table 14. Bivariate Pearson's Correlations of Observed Process and Content x Process Maternal Coping Socialization Messages and Child Characteristics.

	CBCL and YSR AX/DEP Symptoms		RSQ Primary Control		RSQ Secondary Control		RSQ Disengagement	
Process Codes	Child-Report	Parent-Report	Child-Report	Parent-Report	Child-Report	Parent-Report	Child-Report	Parent-Report
Instruction	-.06	-.05	.02	-.05	-.09	-.02	.07	.02
Questions in Service	-.07	.09	-.04	-.04	-.06	-23*	.15	.16
Modeling	-.04	.07	.03	-.20†	-.03	-.09	.00	.17†
Intervention	.09	.20*	.07	-.10	.02	-.05	-.04	-.01
Primary Control x Process Codes	Child-Report	Parent-Report	Child-Report	Parent-Report	Child-Report	Parent-Report	Child-Report	Parent-Report
Instruction	-.10	-.02	-.01	.04	-.10	.00	.10	.05
Questions in Service	-.05	-.02	-.05	.05	-.11	-.14	.25*	-.01
Modeling	-.05	.04	.03	-.12	-.04	.03	.05	.03
Intervention	.02	.14	.08	-.02	.02	.00	.02	.01
Secondary Control x Process Codes	Child-Report	Parent-Report	Child-Report	Parent-Report	Child-Report	Parent-Report	Child-Report	Parent-Report
Instruction	-.01	-.11	.03	-.01	-.08	-.13	-.10	-.03
Questions in Service	-.05	.18†	-.02	-.04	-.02	-.25*	.01	.19†
Modeling	-.06	.09	.04	-.08	.03	-.14	-.09	.19†
Intervention	-.03	.00	-.01	-.03	-.01	-.07	-.10	-.14
Disengagement x Process Codes	Child-Report	Parent-Report	Child-Report	Parent-Report	Child-Report	Parent-Report	Child-Report	Parent-Report
Instruction	.02	-.02	.04	-.16	-.03	-.01	-.06	-.02
Questions in Service	.01	.01	.00	-.17†	-.07	-.09	.11	.08
Modeling	.11	-.04	-.07	-.26**	-.10	-.01	.11	.09
Intervention	.21*	.22*	.01	-.21*	.01	-.12	-.09	.01

Appendix B. Beck Depression Inventory – II

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more then one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failure.
3 I feel I am a total failure as a person.

4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty more of the time.
3 I feel guilty all of the time.

6. Punishment Feelings
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or activities.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b. I sleep somewhat less than usual.
2a. I sleep a lot more than usual.
2b. I sleep a lot less than usual.
3a. I sleep most of the day.
3b. I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite.

0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2a My appetite is much less than before.
2b My appetite is much greater than before.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Appendix C. Child Behavior Checklist

Please print

CHILD BEHAVIOR CHECKLIST FOR AGES 6-18

For office use only
ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl

CHILD'S AGE

CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Day ____ Year _____

CHILD'S BIRTHDATE Mo. ____ Day ____ Year ____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now.
(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

THIS FORM FILLED OUT BY: (print your full name)

_____

Your gender: ☐ Male ☐ Female

Your relation to the child:

☐ Biological Parent ☐ Step Parent ☐ Grandparent
☐ Adoptive Parent ☐ Foster Parent ☐ Other (specify)

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None ☐

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do ***not*** include listening to radio or TV.)

None ☐

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

None ☐

	Compared to others of the same age, how active is he/she in each?			
	Less Active	Average	More Active	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

None ☐

	Compared to others of the same age, how well does he/she carry them out?			
	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

Be sure you answered all items. Then see other side.

Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. Performance in academic subjects. **Does not attend school because** _____

_____

Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

Other academic subjects–for example: computer courses, foreign language, business. Do ***not*** include gym, shop, driver's ed., or other nonacademic subjects.

2. Does your child receive special education or remedial services or attend a special class or special school?

☐ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe:

When did these problems start? _____

Have these problems ended? ☐ No ☐ Yes–when?

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

Be sure you answered all items.

Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Drinks alcohol without parents' approval (describe):_____
_____
0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts
0 1 2 5. There is very little he/she enjoys
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Breaks rules at home, school, or elsewhere
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sound or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe): _____
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired without good reason
0 1 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
_____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

Please print. Be sure to answer all items.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up too many things he/she doesn't need (describe): _____
_____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (***don't*** include alcohol or tobacco) (describe):
_____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

Please be sure you answered all items.

Appendix D. Youth Self-Report

ASEBA

Please print

YOUTH SELF-REPORT FOR AGES 11-18

For office use only
ID #

YOUR FULL NAME First Middle Last

YOUR GENDER ☐ Boy ☐ Girl

YOUR AGE

YOUR ETHNIC GROUP OR RACE

TODAY'S DATE Mo._____ Date _____ Yr. _____

YOUR BIRTHDATE Mo._____ Date _____ Yr. _____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

IF YOU ARE WORKING, PLEASE STATE YOUR TYPE OF WORK:

_____

_____

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

Please fill out this form to reflect *your* views, even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on pages 2 and 4. ***Be sure to answer all items.***

I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

a. _____

b. _____

c. _____

Compared to others of your age, about how much time do you spend in each?

	Less Than Average	Average	More Than Average
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

Compared to others of your age, how well do you do each one?

	Below Average	Average	Above Average
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

II. Please list your favorite hobbies, activities, and games, other than sports. For example: cards, books, piano, cars, computers, crafts, etc. (Do ***not*** include listening to radio or watching TV.)

☐ None

a. _____

b. _____

c. _____

Compared to others of your age, about how much time do you spend in each?

	Less Than Average	Average	More Than Average
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

Compared to others of your age, how well do you do each one?

	Below Average	Average	Above Average
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups you belong to.

☐ None

a. _____

b. _____

c. _____

Compared to others of your age, how active are you in each?

	Less Active	Average	More Active
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

IV. Please list any jobs or chores you have. For example: paper route, babysitting, making bed, working in store, etc. (Include ***both*** paid and unpaid jobs and chores.)

☐ None

a. _____

b. _____

c. _____

Compared to others of your age, how well do you carry them out?

	Below Average	Average	Above Average
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

Be sure you answered all items. Then see other side.

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V. 1. About how many close friends do you have? (Do *not* include brothers & sisters)

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week do you do things with any friends outside of regular school hours? (Do *not* include brothers & sisters)

☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of your age, how well do you:

	Worse	Average	Better	
a. Get along with your brothers & sisters?	☐	☐	☐	☐ I have no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Get along with your parents?	☐	☐	☐	
d. Do things by yourself?	☐	☐	☐	

VII. 1. Performance in academic subjects. ☐ **I do not attend school because** _____

_____

Check a box for each subject that you take	Failing	Below Average	Average	Above Average
a. English or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

Other academic subjects–for example: computer courses, foreign language, business. Do ***not*** include gym, shop, driver's ed., or other nonacademic subjects.

Do you have any illness, disability, or handicap? ☐ **No** ☐ **Yes—please describe:**

Please describe any concerns or problems you have about school:

Please describe any other concerns you have:

Please describe the best things about youself:

Be sure you answered all items.

Please print. Be sure to answer all items.

Below is a list of items that describe kids. For each item that describes you ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of you. Circle the ***1*** if the item is ***somewhat or sometimes true*** of you. If the item is ***not true*** of you, circle the ***0***.

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. I act too young for my age
0 1 2 2. I drink alcohol without my parents' approval (describe): _____
_____
0 1 2 3. I argue a lot
0 1 2 4. I fail to finish things that I start
0 1 2 5. There is very little that I enjoy
0 1 2 6. I like animals
0 1 2 7. I brag
0 1 2 8. I have trouble concentrating or paying attention
0 1 2 9. I can't get my mind off certain thoughts; (describe); _____
_____
0 1 2 10. I have trouble sitting still
0 1 2 11. I'm too dependent on adults
0 1 2 12. I feel lonely
0 1 2 13. I feel confused or in a fog
0 1 2 14. I cry a lot
0 1 2 15. I am pretty honest
0 1 2 16. I am mean to others
0 1 2 17. I daydream a lot
0 1 2 18. I deliberately try to hurt or kill myself
0 1 2 19. I try to get a lot of attention
0 1 2 20. I destroy my own things
0 1 2 21. I destroy things belonging to others
0 1 2 22. I disobey my parents
0 1 2 23. I disobey at school
0 1 2 24. I don't eat as well as I should
0 1 2 25. I don't get along with other kids
0 1 2 26. I don't feel guilty after doing something I shouldn't
0 1 2 27. I am jealous of others
0 1 2 28. I break rules at home, school, or elsewhere
0 1 2 29. I am afraid of certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. I am afraid of going to school
0 1 2 31. I am afraid I might think or do something bad
0 1 2 32. I feel that I have to be perfect
0 1 2 33. I feel that no one loves me
0 1 2 34. I feel that others are out to get me
0 1 2 35. I feel worthless or inferior
0 1 2 36. I accidentally get hurt a lot
0 1 2 37. I get in many fights
0 1 2 38. I get teased a lot
0 1 2 39. I hang around with kids who get in trouble
0 1 2 40. I hear sounds or voices that other people think aren't there (describe): _____
_____
_____
0 1 2 41. I act without stopping to think
0 1 2 42. I would rather be alone than with others
0 1 2 43. I lie or cheat
0 1 2 44. I bite my fingernails
0 1 2 45. I am nervous or tense
0 1 2 46. Parts of my body twitch or make nervous movements (describe): _____
_____
_____
0 1 2 47. I have nightmares
0 1 2 48. I am not liked by other kids
0 1 2 49. I can do certain things better than most kids
0 1 2 50. I am too fearful or anxious
0 1 2 51. I feel dizzy or lightheaded
0 1 2 52. I feel too guilty
0 1 2 53. I eat too much
0 1 2 54. I feel overtired without good reason
0 1 2 55. I am overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feel sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

 Be sure you answered all items. Then see other side.

Please print. Be sure to answer all items.

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. I physically attack people
0 1 2 58. I pick my skin or other parts of my body (describe): _____
_____
0 1 2 59. I can be pretty friendly
0 1 2 60. I like to try new things
0 1 2 61. My school work is poor
0 1 2 62. I am poorly coordinated or clumsy
0 1 2 63. I would rather be with older kids than kids my own age
0 1 2 64. I would rather be with younger kids than kids my own age
0 1 2 65. I refuse to talk
0 1 2 66. I repeat certain acts over and over (describe):
_____
_____
0 1 2 67. I run away from home
0 1 2 68. I scream a lot
0 1 2 69. I am secretive or keep things to myself
0 1 2 70. I see things that other people think aren't there (describe):_____
_____
0 1 2 71. I am self-conscious or easily embarrassed
0 1 2 72. I set fires
0 1 2 73. I can work well with my hands
0 1 2 74. I show off or clown
0 1 2 75. I am too shy or timid
0 1 2 76. I sleep less than most kids
0 1 2 77. I sleep more than most kids during day and/or night (describe): _____
_____
0 1 2 78. I am inattentive or easily distracted
0 1 2 79. I have a speech problem (describe): _____
_____
0 1 2 80. I stand up for my rights
0 1 2 81. I steal at home
0 1 2 82. I steal from places other than home
0 1 2 83. I store up too many things I don't need (describe): _____
_____
0 1 2 84. I do things other people think are strange (describe): _____
_____
0 1 2 85. I have thoughts that other people would think are strange (describe):_____
_____
0 1 2 86. I am stubborn
0 1 2 87. My moods or feelings change suddenly
0 1 2 88. I enjoy being with people
0 1 2 89. I am suspicious
0 1 2 90. I swear or use dirty language
0 1 2 91. I think about killing myself
0 1 2 92. I like to make others laugh
0 1 2 93. I talk too much
0 1 2 94. I tease others a lot
0 1 2 95. I have a hot temper
0 1 2 96. I think about sex too much
0 1 2 97. I threaten to hurt people
0 1 2 98. I like to help others
0 1 2 99. I smoke, chew, or sniff tobacco
0 1 2 100. I have trouble sleeping (describe): _____
_____
0 1 2 101. I cut classes or skip school
0 1 2 102. I don't have much energy
0 1 2 103. I am unhappy, sad, or depressed
0 1 2 104. I am louder than other kids
0 1 2 105. I use drugs for nonmedical purposes (***don't*** include alcohol or tobacco) (describe): _____
_____
_____
_____
0 1 2 106. I like to be fair to others
0 1 2 107. I enjoy a good joke
0 1 2 108. I like to take life easy
0 1 2 109. I try to help other people when I can
0 1 2 110. I wish I were of the opposite sex
0 1 2 111. I keep from getting involved with others
0 1 2 112. I worry a lot

Please be sure you answered all items.

Please write down anything else that describes your feelings, behavior, or interests:

Appendix E. Responses to Stress Questionnaire – Peer Version

RESPONSES TO STRESS – Peer (SR-C)

Even when things are going well for kids and teenagers, almost everyone still has some tough times getting along with other people. So that we can find out how things have been going for you lately, please put a check mark by all the things on this list that have been a problem for you in the last 6 months.

	Not at All	A Little	Somewhat	Very
a. Being around kids who are rude	1	2	3	4
b. Not having as many friends as you want	1	2	3	4
c. Having someone stop being your friend	1	2	3	4
d. Being teased or hassled by other kids	1	2	3	4
e. Feeling pressured to do something	1	2	3	4
f. Fighting with other kids	1	2	3	4
g. Having problems with a friend	1	2	3	4
h. Being left out or rejected	1	2	3	4
i. Asking someone out and being turned down	1	2	3	4
j. Other: _____	1	2	3	4

***** Circle the number that shows how much control you think you have over these problems.**

1	2	3	4
None	A little	Some	A lot

This is a list of things that people sometimes do, think, or feel when something stressful happens. Everybody deals with problems in their own way - some people do a lot of the things on this list or have a bunch of feelings, other people just do or think a few things.

Think of the situations you just indicated above as stressful for you. For each item on the list below, circle **one** number from 1 (not at all) to 4 (a lot) that shows **how much** you do or feel these things when you have problems with other kids like the ones you indicated above. Please let us know about everything you do, think, and feel, even if you don't think it helps make things better.

WHEN HAVING PROBLEMS WITH OTHER KIDS:	**How much do you do this? Not at all**	**A little**	**Some**	**A lot**
1. I **try** not to feel anything.	1	2	3	4
2. When I have problems with other kids I feel sick to my stomach or get headaches.	1	2	3	4
3. I try to think of different ways to change the problem or fix the situation. **Write one plan you thought of** :_____ _____	1	2	3	4
4. When problems with other kids happen I don't feel anything at all, it's like I have no feelings.	1	2	3	4
5. I wish that I were stronger, smarter, or more popular so that things would be different.	1	2	3	4
6. I **keep remembering** what happened with the other kids or **can't stop thinking** about what might happen.	1	2	3	4

WHEN HAVING PROBLEMS WITH OTHER KIDS:

	How much do you do this? Not at all	A little	Some	A lot
7. I let someone or something know how I feel. (Remember to circle a number.) ----------→	1	2	3	4
Check all you talked to: ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Pet ☐ Clergy Member ☐ Teacher ☐ God ☐ Stuffed Animal ☐ Other Family Member ☐ None of these				
8. I decide I'm okay the way I am, even though I'm not perfect .	1	2	3	4
9. When I'm around other people I act like the problems never happened.	1	2	3	4
10. I just **have** to get away when I have problems with other kids, I can't stop myself.	1	2	3	4
11. I deal with the problem by wishing it would just go away, that everything would work itself out.	1	2	3	4
12. I get really jumpy when I'm having problems getting along with other kids.	1	2	3	4
13. I realize that I just have to live with things the way they are.	1	2	3	4
14. When I have problems with other kids, I just **can't** be near anything that reminds me of the situation.	1	2	3	4
15. I **try** not to think about it, to forget all about it.	1	2	3	4
16. When problems with other kids come up I really don't know what I feel.	1	2	3	4
17. I ask other people for help or for ideas about how to make the problem better. ----------→ (Remember to circle a number.)	1	2	3	4
Check all you talked to: ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Pet ☐ Clergy Member ☐ Teacher ☐ God ☐ Stuffed Animal ☐ Other Family Member ☐ None of these				
18. When I'm having problems getting along with other kids, I **can't stop** thinking about them when I try to sleep, or I have bad dreams about them.	1	2	3	4
19. I tell myself that I can get through this, or that I'll do better next time.	1	2	3	4
20. I let my feelings out. (Remember to circle a number.) ----------→	1	2	3	4
I do this by: (Check all that you did.) ☐ Writing in his/her journal/diary ☐ Complaining to let off steam ☐ Listening to music ☐ Exercising ☐ Crying ☐ Drawing/painting ☐ Being sarcastic/making fun ☐ Punching a pillow ☐ Yelling ☐ None of these				
21. I get help from other people when I'm trying to figure out how to deal with my feelings. ---------→	1	2	3	4
Check all that you went to: ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Pet ☐ Clergy Member ☐ Teacher ☐ God ☐ Stuffed Animal ☐ Other Family Member ☐ None of these				
22. I **just can't** get myself to face the person I'm having problems with or the situation.	1	2	3	4
23. I wish that someone would just come and get me out of the mess.	1	2	3	4
24. I do something to try to fix the problem or take action to change things. **Write one thing you did:**_____ _____	1	2	3	4
25. Thoughts about the problems with other kids just pop into my head.	1	2	3	4

You're half done! Before you keep working, look back at the first page so you remember what kinds of problems with other kids you told us about. Remember to answer these questions thinking about those problems.

WHEN HAVING PROBLEMS WITH OTHER KIDS:	**How much do you do this? Not at all**	**A little**	**Some**	**A lot**
26. When I have problems with other kids, I feel it in my body. (Remember to circle a number.) ----------→	1	2	3	4
Check all that happen: ☐ His/her heart races ☐ His/her breathing speeds up ☐ None of these ☐ He/she feels hot or sweaty ☐ His/her muscles get tight				
27. I **try** to stay away from people and things that make me feel upset or remind me of the problem.	1	2	3	4
28. I don't feel like myself when I have problems with other kids, it's like I'm far away from everything.	1	2	3	4
29. I just take things as they are, I go with the flow.	1	2	3	4
30. I think about happy things to take my mind off the problem or how I'm feeling.	1	2	3	4
31. When problems with other kids come up, I **can't stop** thinking about how I am **feeling**.	1	2	3	4
32. I get sympathy, understanding, or support from someone. (Remember to circle a number.) ----------→	1	2	3	4
Check all you went to: ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Pet ☐ Clergy Member ☐ Teacher ☐ God ☐ Stuffed Animal ☐ Other Family Member ☐ None of these				
33. When problems with other kids happen, I **can't** always control what I do. ----------→ (Remember to circle a number.)	1	2	3	4
Check all that happen: ☐ He/she can't stop eating ☐ He/she can't stop talking ☐ He/she does dangerous things ☐ He/she has to keep fixing/checking things ☐ None of these				
34. I tell myself that things could be worse.	1	2	3	4
35. My mind just goes blank when I have problems with other kids, I can't think at all.	1	2	3	4
36. I tell myself that it doesn't matter, that it isn't a big deal.	1	2	3	4
37. When I have problems with other kids right away I feel really: . ----------→ (Remember to circle a number.)	1	2	3	4
Check all you feel: ☐ Angry ☐ Sad ☐ None of these ☐ Worried/anxious ☐ Scared				
38. It's really hard for me to concentrate or pay attention when I have problems with other kids.	1	2	3	4
39. I think about the things I'm learning from the situation, or something good that will come from it.	1	2	3	4
40. When I have problems with other kids I **can't stop** thinking about what I **did or said**.	1	2	3	4
41. When something goes wrong with other kids, I say to myself, "This isn't real."	1	2	3	4
42. When I'm having problems with other kids I end up just lying around or sleeping a lot.	1	2	3	4
43. I keep my mind off problems with other kids by: (Remember to circle a number.) ----------→	1	2	3	4
Check all that you do: ☐ Exercising ☐ Seeing friends ☐ Watching TV ☐ Playing video games ☐ Doing a hobby ☐ Listening to music ☐ None of these				

WHEN HAVING PROBLEMS WITH OTHER KIDS:	**How much do you do this? Not at all**	**A little**	**Some**	**A lot**
44. When problems with other kids come up, I get upset by things that don't usually bother me.	1	2	3	4
45. I do something to calm myself down when I'm having problems with other kids. ----------→ (Remember to circle a number.) **Check all that you do:** ☐ Take deep breaths ☐ Pray ☐ Walk ☐ Listen to music ☐ Take a break ☐ Meditate ☐ None of these	1	2	3	4
46. I just freeze when I have a problem with other kids, I **can't** do anything.	1	2	3	4
47. When I'm having a problem with other kids, sometimes I act without thinking.	1	2	3	4
48. I keep my feelings under control when I have to, then let them out when they won't make things worse.	1	2	3	4
49. When problems with other kids happen I can't seem to get around to doing things I'm supposed to do.	1	2	3	4
50. I tell myself that everything will be all right.	1	2	3	4
51. When I have problems with other kids, I **can't stop** thinking about **why** they happened to me.	1	2	3	4
52. I think of ways to laugh about it so that it won't seem so bad.	1	2	3	4
53. My thoughts start racing when I'm having a tough time with other kids.	1	2	3	4
54. I imagine something really fun or exciting happening in my life.	1	2	3	4
55. When a rough situation with other kids happens, I can get so upset that I can't remember what happened or what I did.	1	2	3	4
56. I try to believe it never happened.	1	2	3	4
57. When I have problems with other kids, sometimes I **can't** control what I do or say.	1	2	3	4

Appendix F. Responses to Stress Questionnaire – Family Version

RESPONSES TO STRESS – Family Stress (SR-M)

Even when things are going well almost everyone still has some tough times getting along with people in their family, like children, step-children, spouses and significant others. So that we can find out how things have been going for you lately, please circle the number indicating how stressful the following things have been for *you in the last 6 months*.

	Not at All	A Little	Somewhat	Very
a. Arguing with your child(ren)	1	2	3	4
b. Arguing with your spouse or significant other	1	2	3	4
c. Your children competing with each other	1	2	3	4
d. Your children arguing or fighting with each other	1	2	3	4
e. Your children not being as close to each other as you would like	1	2	3	4
f. Your spouse or significant other not understanding you	1	2	3	4
g. Having a hard time talking with your child(ren)	1	2	3	4
h. Your children not respecting each other's property	1	2	3	4
i. Your child(ren) having problems with your spouse or significant other	1	2	3	4
j. Not spending as much time as you would like to with your child(ren)	1	2	3	4
k. Not spending as much time as you would like to with your spouse or significant other	1	2	3	4
l. Having other kinds of problems with your family	1	2	3	4

Explain _____

***** Circle the number that shows how much control you think you have over these problems.**

1 None 2 A little 3 Some 4 A lot

Below is a list of things that people sometimes do, think, or feel when something stressful happens. Everybody deals with problems in their own way - some people do a lot of the things on this list or have a bunch of feelings, other people just do or think a few things.

Think of all the problems that you indicated above. For each item below, circle **one** number from 1 (not at all) to 4 (a lot) that shows **how much** you do or feel these things when you have problems with your family like the ones you indicated above. Please let us know about everything you do, think, and feel, even if you don't think it helps make things better.

WHEN DEALING WITH PROBLEMS IN MY FAMILY:	**How much do you do this? Not at all**	**A little**	**Some**	**A lot**
1. I **try** not to feel anything.	1	2	3	4
2. When I have problems with my family, I feel sick to my stomach or get headaches.	1	2	3	4
3. I try to think of different ways to change or fix the situation. **Write one plan you thought of**:_____ _____	1	2	3	4
4. When problems with my family happen, I don't feel any emotions at all, it's like I have no feelings.	1	2	3	4
5. I wish that I were stronger, smarter, or more popular so that things would be different.	1	2	3	4

WHEN DEALING WITH PROBLEMS IN MY FAMILY:

		How much do you do this? Not at all	A little	Some	A lot
6.	I **keep remembering** what happened with my family or **can't stop thinking about** what might happen.	1	2	3	4
7.	I let someone or something know how I feel. (*remember to circle a number.)* → **Check all you talked to:** ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Therapist/Counselor ☐ Clergy Member ☐ Child(ren) ☐ God ☐ Spouse/Significant Other ☐ Other Family Member ☐ None of these	1	2	3	4
8.	I decide I'm okay the way I am, even though I'm not perfect.	1	2	3	4
9.	When I'm around other people I act like the problems in my family never happened.	1	2	3	4
10.	I just **have** to get away when I have problems with my family, I can't stop myself.	1	2	3	4
11.	I deal with the problem by wishing it would just go away, that everything would work itself out.	1	2	3	4
12.	I get really jumpy when I'm having problems with my family.	1	2	3	4
13.	I realize that I just have to live with things the way they are.	1	2	3	4
14.	When I have problems with my family, I just **can't** be near anything that reminds me of the situation.	1	2	3	4
15.	I **try** not to think about it, to forget all about it.	1	2	3	4
16.	When problems with my family come up I really don't know what I feel.	1	2	3	4
17.	I ask other people or things for help or for ideas about how to make the problem better. (*remember to circle a number.*) → **Check all you talked to:** ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Therapist/Counselor ☐ Clergy Member ☐ Child(ren) ☐ God ☐ Spouse/Significant Other ☐ Other Family Member ☐ None of these	1	2	3	4
18.	When I'm having problems with my family, I **can't stop** thinking about them when I try to sleep, or I have bad dreams about them.	1	2	3	4
19.	I tell myself that I can get through this, or that I'll do better next time.	1	2	3	4
20.	I let my feelings out. (*remember to circle a number.*) → **I do this by: (Check all that you did.)** ☐ Writing in my journal/diary ☐ Drawing/painting ☐ Complaining to let off steam ☐ Being sarcastic/making fun ☐ Listening to music ☐ Punching a pillow ☐ Exercising ☐ Yelling ☐ Crying ☐ None of these	1	2	3	4
21.	I get help from other people or things when I'm trying to figure out how to deal with my feelings. (*remember to circle a number.*) → **Check all that you went to:** ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Therapist/Counselor ☐ Clergy Member ☐ Child(ren) ☐ God ☐ Spouse/Significant Other ☐ Other Family Member ☐ None of these	1	2	3	4
22.	I **just can't** get myself to face the person I'm having problems with or the situation.	1	2	3	4

23. I wish that someone would just come and get me out of the mess. 1 2 3 4

You're half done. Before you keep working, look back at the first page so you remember what kinds of problems with your family you told us about. Remember to answer the questions below thinking about these things.

WHEN DEALING WITH PROBLEMS IN MY FAMILY:	**How much do you do this? Not at all**	**A little**	**Some**	**A lot**
24. I do something to try to fix the problem or take action to change things. **Write one thing you did:**_____	1	2	3	4
25. Thoughts about the problems with my family just pop into my head.	1	2	3	4
26. When I have problems with my family, I feel it in my body. (*remember to circle a number.)* →	1	2	3	4
27. I **try** to stay away from people and things that make me feel upset or remind me of the problem.	1	2	3	4
28. I don't feel like myself when I am dealing with problems in my family, it's like I am far away from everything.	1	2	3	4
29. I just take things as they are; I go with the flow.	1	2	3	4
30. I think about happy things to take my mind off the problem or how I'm **feeling**.	1	2	3	4
31. When problems with my family come up, I **can't stop** thinking about how I am feeling	1	2	3	4
32. I get sympathy, understanding, or support from someone. (*remember to circle a number.)* →	1	2	3	4
33. When problems with my family happen, I **can't** always control what I do. (*remember to circle a number.)* →	1	2	3	4
34. I tell myself that things could be worse.	1	2	3	4
35. My mind just goes blank when I have problems with my family, I can't think at all	1	2	3	4
36. I tell myself that it doesn't matter, that it isn't a big deal.	1	2	3	4
37. When I have problems with my family, right away I feel really: (*remember to circle a number.)* →	1	2	3	4

Check all that happen:

☐ My heart races ☐ My breathing speeds up ☐ None of these
☐ I feel hot or sweaty ☐ My muscles get tight

Check all you went to:

☐ Parent ☐ Friend ☐ Brother/Sister ☐ Therapist/Counselor ☐ Clergy Member
☐ Teacher ☐ God ☐ Spouse/Significant Other ☐ Other Family Member ☐ None of these

Check all that happen:

☐ I can't stop eating ☐ I can't stop talking
☐ I do dangerous things ☐ I have to keep fixing/checking things
☐ None of these

Check all that you feel:

☐ Angry ☐ Sad ☐ None of these
☐ Worried/anxious ☐ Scared

38. It's really hard for me to concentrate or pay attention when I have problems with my family. 1 2 3 4

39. I think about the things I'm learning from the situation, or something good that will come from it. 1 2 3 4

40 When I have problems with my family, I **can't stop** thinking about what I did or said. 1 2 3 4

41. When I'm having problems with my family, I say to myself, "This isn't real." 1 2 3 4

WHEN DEALING WITH PROBLEMS IN MY FAMILY:	**How much do you do this?** Not at all	A little	Some	A lot
42. When I'm having problems with my family, I end up just lying around or sleeping a lot.	1	2	3	4
43. I keep my mind off problems with my family by: (*remember to circle a number.)* → **Check all that you do:** ☐ Exercising ☐ Seeing friends ☐ Watching TV ☐ Playing video games ☐ Doing a hobby ☐ Listening to music ☐ None of these	1	2	3	4
44. When problems with my family come up, I get upset by things that don't usually bother me.	1	2	3	4
45. I do something to calm myself down when having problems with my family. (*remember to circle a number.)* → **Check all that you do:** ☐ Take deep breaths ☐ Pray ☐ Walk ☐ Listen to music ☐ Take a break ☐ Meditate ☐ None of these	1	2	3	4
46. I just freeze when I have problems with my family, I **can't** do anything.	1	2	3	4
47. When I'm having problems with my family, sometimes I act without thinking.	1	2	3	4
48. I keep my feelings under control when I have to, then let them out when they won't make things worse.	1	2	3	4
49. When problems with my family happen, I can't seem to get around to doing things I'm supposed to do.	1	2	3	4
50. I tell myself that everything will be all right.	1	2	3	4
51. When I have problems with my family, I **can't stop** thinking about **why** this is happening.	1	2	3	4
52. I think of ways to laugh about it so that it won't seem so bad.	1	2	3	4
53. My thoughts start racing when I am having problems with my family.	1	2	3	4
54. I imagine something really fun or exciting happening in my life.	1	2	3	4
55. When I'm having problems with my family, I can get so upset that I can't remember what happened or what I did.	1	2	3	4
56. I try to believe that it never happened.	1	2	3	4
57. When I am having problems with my family, sometimes I **can't** control what I do or say.	1	2	3	4

Appendix G. The Socialization of Coping Questionnaire

WHEN OTHER KIDS ARE MEAN TO MY CHILD

	When other kids are mean to my child, I ENCOURAGE MY CHILD TO…	Not At All	A Little Bit	Some	Pretty Much	Very Much
1.	Deal with the situation head on rather than ignoring it.	1	2	3	4	5
2.	Look for something good in what is happening.	1	2	3	4	5
3.	Think that everything will be all right.	1	2	3	4	5
4.	Try to stop her/himself from thinking about the problem.	1	2	3	4	5
5.	Think about happy things to take her/his mind off the problem.	1	2	3	4	5
6.	**NOT** focus on things that make her/him feel bad.	1	2	3	4	5
7.	Get help from me or others when figuring out how to deal with her/his feelings.	1	2	3	4	5
8.	Find something positive that came from the experience.	1	2	3	4	5
9.	Keep her/his mind off how s/he is feeling by getting involved in other activities.	1	2	3	4	5
10.	Keep away from things that make her/him feel bad.	1	2	3	4	5
11.	Do something to try to fix the problem or take action to change things.	1	2	3	4	5
12.	Stay away from the kids that make her/him feel upset.	1	2	3	4	5
13.	Discuss her/his feelings with me or others.	1	2	3	4	5
14.	Think about ways to deal with the problem.	1	2	3	4	5
15.	Try **NOT** to think about things that make her/him upset.	1	2	3	4	5

	When other kids are mean to my child, I ENCOURAGE MY CHILD TO…	Not At All	A Little Bit	Some	Pretty Much	Very Much
16.	Keep away from things related to the problem.	1	2	3	4	5
17.	Think of ways to laugh about it so it won't seem so bad.	1	2	3	4	5
18.	Think about things s/he is learning from the situation.	1	2	3	4	5
19.	Stay away from the kids that remind her/him of the problem.	1	2	3	4	5
20.	Keep busy so that s/he does not focus on the problem.	1	2	3	4	5
21.	Let someone know how s/he feels.	1	2	3	4	5
22.	Keep from thinking about her/his negative feelings.	1	2	3	4	5
23.	Do something to calm her/himself down.	1	2	3	4	5
24.	**NOT** focus on the problem.	1	2	3	4	5

Appendix H. Socialization of Coping Coding Manual

SOCIALIZATION OF COPING CODING MANUAL FOR PARENT-CHILD OBSERVATION TASKS

2014-2015

TABLE OF CONTENTS

WHAT IS COPING?

Coping is defined as "conscious, volitional efforts to regulate emotion, cognition, behavior, physiology, and the environment in response to stressful events or circumstances" (Compas et al., 2001, p. 89). The model of coping that guides the present coding system is the theory-driven, empirically tested and validated conceptual framework of voluntary responses to stress posited by Connor-Smith and colleagues (2000) that includes three distinct coping responses: primary control coping, secondary control coping, and disengagement coping (see Table 1 for definitions and items). Notably, this conceptual model has successfully been confirmed and validated in both child and adult samples, clinical and community samples, as well as cross-culturally (e.g., Benson et al., 2012; Compas et al., 2006a, 2006b; Connor-Smith et al.; Wadsworth, Raviv, Compas, & Connor-Smith, 2005; Yao et al., 2010).

WHY IS COPING IMPORTANT?

Extensive research indicates that the association between stress and psychopathology is mediated and moderated in part by the ways that children cope with stress and regulate their emotions (Compas et al., 2001, Compas et al., 2012). Decades of research examining processes of adaptation to stress in children and adolescents have identified specific coping strategies that are differentially associated with emotional and behavioral adjustment. Consequently, the development and use of effective regulatory strategies is a fundamental resource in promoting adaptation in individuals who are living under acute and chronic stress.

WHAT IS THE SOCIALIZATION OF COPING?

Extensive research has shown significant individual differences in the strategies that children and adolescents use to cope in response to stressors. However, it is much less clear *why* some individuals use adaptive strategies when faced with stressors while others rely on less effective strategies to cope with stress. Given that children and adolescents are embedded within a family context, there has been a call for research on stress and coping to more fully consider the role of the family, particularly parents, in socializing and shaping children's coping skills (Compas et al., 2001; Skinner & Zimmer-Gembeck, 2007). An important step is to better understand the role of parents in the development of children's coping strategies, as this knowledge may inform future preventive interventions and parental educational programs. Kliewer, Sandler, and Wolchik (1994) proposed a conceptual model of coping socialization in which parents are hypothesized to both indirectly and directly influence children's coping strategies through three pathways: (1) coaching, (2) modeling, and (3) the family context. Parental coping coaching refers to the instructional messages that parents communicate and convey to their children about ways that they should appraise a situation and manage the stress associated with the problem (e.g., Kliewer, Parrish, Taylor, Jackson, Walker & Shivy, 2006). Although parents likely provide children with direct instructions on how to cope with a stressor (e.g., you should avoid those kids), parents may also teach and convey messages more subtly and indirectly (e.g., validate what the child says s/he does; disclose their own coping behaviors).

Table 1. Coping factors, definitions, parcels, and example items.

Coping Factor	Definition	Parcels	Items from the Responses to Stress Questionnaire
Primary Control Coping	Efforts to act directly on a stressor or emotions	Problem-Solving	I try to think of different ways to change the problem or fix the situation.
		Emotional Modulation	I keep my feelings under control when I have to, then let them out when they won't make things worse.
		Emotional Expression	I let someone or something know how I feel.
Secondary Control Coping	Efforts to adapt a stressor or emotions	Acceptance	I realize that I just have to live with things the way they are.
		Positive Thinking	I tell myself that everything will be all right.
		Cognitive Restructuring	I think about the things that I am learning from the situation, or something good that will come from it.
		Distraction	I keep my mind off the problem by (check all that you do): exercising, playing video games, seeing friends, doing a hobby, watching TV.
Disengagement Coping	Efforts to evade the stressor or emotions	Denial	When something goes wrong with peers, I tell myself, "This isn't real."
		Avoidance	I try to stay away from people and things that make me feel more upset or remind me of the problems.
		Wishful Thinking	I deal with the problem by wishing it would just go away, that everything would work itself out.

Table 2. Coping socialization "during the task" coding categories.

During the Task	Explicit Direction	Instruction	Primary Control Coping
			Secondary Control Coping
			Disengagement Coping
		Questions in Service of Advisement	Primary Control Coping
			Secondary Control Coping
			Disengagement Coping
	Modeling		Primary Control Coping
			Secondary Control Coping
			Disengagement Coping
	Feedback	Endorsement	Primary Control Coping
			Secondary Control Coping
			Disengagement Coping
		Non-Endorsement	Primary Control Coping
			Secondary Control Coping
			Disengagement Coping
	Intervening		Primary Control Coping
			Secondary Control Coping
			Disengagement Coping

Table 3. Coping socialization "external" coding categories.

External	Explicit Direction	Instruction	Primary Control Coping
			Secondary Control Coping
			Disengagement Coping
	Modeling		Primary Control Coping
			Secondary Control Coping
			Disengagement Coping
	Intervening		Primary Control Coping
			Secondary Control Coping
			Disengagement Coping

Table 4. A description of the codes and example utterances.

CODE	DESCRIPTION OF THE CODE	EXAMPLE OF THE CODE
INSTRUCTION		
DURING THE TASK	In the task, the parent provides the child with direct instruction on a specific strategy that the child should use to cope with the stressor.	P: "You need to think more positively when you have problems with friends."
EXTERNAL	The parent or child describe that outside of the task, the parent suggests a particular coping strategy to the child.	C: "You typically tell me that I need to think more positively when I have problems with my friends."
QUESTIONS IN SERVICE OF ADVISEMENT	The parent asks a leading question that is intended to communicate to the child that there is a particular coping strategy the parent thinks the child should use.	P: "Have you tried being more positive about the situation and thinking more positive thoughts?"
MODELING		
DURING THE TASK	The parent demonstrates coping skills to deal with their own stressor during the task.	P: "My boss yelled at me today, but I know that I am a good worker. I do my best and I think he just had a bad day."
EXTERNAL	The parent shares with/tells the child about what s/he does to cope with stressors experienced *outside* of the immediate task.	P: "When I have problems with my co-workers, I tend to try to think of positive thoughts to make myself feel better."
FEEDBACK		
ENDORSEMENT	The parent endorses or validates the child's strategy when s/he describes what the child does in a neutral or positive manner or provides positive feedback to the child's description of how they cope.	P: "I think it is great that you try to think positive when you have problems with other kids."
NON-ENDORSEMENT	The parent invalidates or does not endorse a child's strategy when s/he critically describes what the child does to cope with a stressor.	P: "I know you try to think positive, but I don't think that is so great to do."

INTERVENING		
DURING THE TASK	The parent tries to intervene in the stressor the child is experiencing by providing coping assistance in the immediate task.	P: "I know that talking about this upsets you, but remember all of the people that love you, including me. You are a great friend and you have a lot of close friends."
EXTERNAL	The parent tries to intervene *outside* of the immediate task to help the child deal with a stressor.	C: "You help me think of thoughts that make me feel better."
TASK-RELATED QUESTIONS	Any question that the parent asks the child that is related to the task discussion.	P: "When you have problems with friends like that, what are some things you could do that might be helpful?"

EXPLICIT DIRECTION

INSTRUCTION

PARENTAL INSTRUCTION [INSX DTT]. The parent instructs the child in the immediate task with specific coping strategies the parent thinks the child should use to cope with the stressor. The parent explicitly tells the child to use a coping strategy to use in response to a stressor.

PRIMARY CONTROL COPING [PCC]

P: "You should come talk to me about it or tell the teacher if that happens again."

P: "Next time you should plan ahead and figure out how to solve that problem."

P: "You should pray about it."

SECONDARY CONTROL COPING [SCC]

P: "You should do something to get your mind off of that like listen to music."

P: "Don't pretend like it is not happening. You need to accept that it is happening, but I also don't want you to dwell on it. I think you need to move on."

DISENGAGEMENT COPING [DCC]

P: "There are some people that are evil and you need to avoid contact with."

P: "You should try not to think about it."

PARENTAL INSTRUCTION [INSX EXTX]. The parent or child report what the parent has instructed the child to do to cope with a stressor in the past (outside of the task).

PRIMARY CONTROL COPING [PCC]

P: "I tell you that you need to talk it out with him."

C: "You tell me that I should call a friend to talk when I get upset like that."

SECONDARY CONTROL COPING [SCC]

P: "I encourage you to focus on the positive!"

P: "I tell you to do something to distract yourself."

C: "You tell me to think about the good things that are coming out of the situation."

P: "I tell you to pray about it because God will work it out."

DISENGAGEMENT COPING [DCC]

C: "You usually say that I should pretend that it isn't happening."

P: "I tell you to stay away from kids who are like that."

QUESTIONS IN SERVICE OF ADVISEMENT [QSA]. This code is given to a leading question asked by the parent that is intended to communicate to the child that there is a particular coping strategy the parent thinks the child should use. While the parental Instruction code is given to statements made by the parent, the Questions in Service of Advisement code is given to a question raised by the parent that clearly communicates a particular coping strategy that the parent believes may be beneficial to the child. This code will only be given to utterances made by the parent.

Note: This code will trump parental MODELING. That is, if the parent models a coping strategy in the form of a question, the QSA code should be given. For example, "but you have improved so much since you started, you know?"

PRIMARY CONTROL COPING [PCC]

P: "Would you go tell the teacher or go tell your mom?"

P: "You mean you wouldn't go tell the teacher if he did that?"

SECONDARY CONTROL COPING [SCC]

P: "If playing the piano didn't work, you would go swimming, right?"

P: "I wonder if it would be helpful to remind yourself that a lot of people love you?"

P: "Next time she is rude to you, would you like to watch a movie together to get your mind off of it?"

P: "But do other kids have speech problems?"

DISENGAGEMENT COPING [DCC]

P: "Don't you think you should just ignore kids like that?"

P: "Have you ever tried just telling yourself it wasn't actually happening?"

MODELING

PARENTAL MODELING [MODX DTT]: The parental modeling "during the task" code is given to the parent who demonstrates coping skills in the immediate task. The parent may model how they cope with a stressor they are experiencing in their life. Alternatively, the parent may model ways that the child can cope with a stressor (e.g., give the child other ways to think about the problem; problem-solve with the child on different ways to respond to the stressor).

Note. In order to give an instruction code, the utterance needs to be an explicit directive from the parent. Otherwise, default to the Modeling code. For example, "my emotion around it is that there are enough friends that can share their phone with you."

PRIMARY CONTROL COPING [PCC]

P: "It makes me upset to hear that other kids are rude to you."

P: "You have the home phone or the cell phone you can use."

SECONDARY CONTROL COPING [SCC]

P: "It upsets me that other kids are rude to you, but I know that you have a lot of people that love you and it is helpful for me to remind myself of that."

P: "The emotions I have? I get frustrated when I see parents getting treated that way, but then I realize if they are treating their parents that way in public the parents probably let them get away with it at home."

P: "I think that he does love you, but he just doesn't know how to show it."

P: "So I guess there is something positive in that."

P: "I don't think this is going to cause other problems in your life."

P: "I think that you will end up with a good teacher."

DISENGAGEMENT COPING [DCC]

C: "I know that work is very stressful for you."
P: "What do you want to do after we finish with this?

P: "That didn't happen. It isn't real."

P: "Maybe he will move to another state!"

PARENTAL MODELING [MODX EXT]: The "external" code is given to the parent who shares with/tells the child about what the parent does to cope with stressors that s/he has experienced *outside* of the immediate task. Alternatively, the modeling code is given to statements made by the parent or child that describe how the parent models ways to cope with a stressor the child is experiencing outside of the task (e.g., problem-solve together ways to deal with the problem; provide the child alternative ways to think about it).

PRIMARY CONTROL COPING [PCC]

P: "When I have problems with co-workers, I always try to talk it out with them and figure out how to fix the problem."

C: "When I had the problem with that kid in my class, you helped me think of a lot of different ways to fix it so he would stop bothering me."

SECONDARY CONTROL COPING [SCC]

P: "When I am feeling upset, I try to get my mind off of it by watching television or reading a good book."

P: "I always tell you that kids can be rude when they are jealous or want attention."

C: "When I get upset, you remind me of all of the people that love me."

DISENGAGEMENT COPING [DCC]

P: "I tend to try to stay away from people who act that way."

P: "Together we list all of the ways that we wish kids were nicer to you."

FEEDBACK

ENDORSEMENT OF A STRATEGY [ENDX]. The parent endorses or validates the child's strategy when s/he describes what the child does in a neutral or positive manner or the parent provides positive feedback to the child's description of how they cope with stressors. Within the transcripts, this code is given to all of the content that precedes a verbal or nonverbal endorsement (e.g., nodding head). If the child states that s/he tries to ignore the problem sometimes and other times tries to fix it and the parent nods, this should be coded as endorsement of both disengagement and primary control coping strategies.

Note that this code should be given only when referencing a strategy that the child and/or parent report that the child uses in response to a stressor. This will not be given if the parent *generally* endorses a particular strategy (e.g., the parent says: "it is a good thing to ignore problems" and the child or parent previously did not reference that the child ignores problems).

PRIMARY CONTROL COPING [PCC]

C: "I usually tell you about it."
P: "Good."

C: "When kids are rude, I feel really sad."
P: "You feel sad."

SECONDARY CONTROL COPING [SCC]

P: "I like how you try to find something to do to get your mind off of the problem."

C: "I go to my room and just listen to some music."
P: [nods]. I know you do that.

DISENGAGEMENT COPING [DCC]

P: "I think it is a good thing that you try to avoid kids who are rude."

C: "Well, I just pretend that he has gone to Jupiter!"
P: [nod].

C: "How am I coping? By walking away when I see him."
P: [nods] "That is a good way."

P: "You are very accommodating, so when problems occur, like you said, you walk away from them."

NON-ENDORSEMENT OF A STRATEGY [NONX]. The parent invalidates or does not endorse a child's strategy when s/he critically describes what the child does to cope with a stressor. Alternatively, the parent may tell the child that they wish the child did something else to cope or may provide critical feedback to the child's description of their coping process. Within the transcripts, this code is given to all of the content that precedes a verbal or nonverbal non-endorsement (e.g., shaking head). If the child states that s/he tries to ignore the problem sometimes and other times tries to fix it and the parent shakes their head, code as non-endorsement of both disengagement and primary control coping strategies.

Similar to Endorsement of a Strategy, this code should be given only when referencing a strategy that the child and/or parent report that the child uses in response to a stressor. This will not be given if the parent *generally* does not endorse a particular strategy (e.g., the parent says: "it's not good to ignore your problems" and the child or parent previously did not reference that the child ignores problems).

PRIMARY CONTROL COPING [PCC]

C: "When that happens, I usually will cry."
P: "I know you do that. I wish you would just come talk to me instead."

P: "That's not good though. You shouldn't even be in it if you don't have a dog in the fight."

SECONDARY CONTROL COPING [SCC]

C: "I find something else to do, like watch TV or go for a run."
P: "I think you need to talk to him about it. The problem won't go away by itself."

C: "I tell myself that it is going to be alright."
P: "Do you really think that is true if you don't do something about it?"

DISENGAGEMENT COPING [DCC]

P: "I don't think it is a good thing that you try to avoid kids who are rude."

C: "Well, I just pretend that he has gone to Jupiter!"
P: [shakes head]. "Well what could you do instead?"

INTERVENING

PARENTAL INTERVENTION [INTX DTT]: The parent tries to intervene in the stressor the child is experiencing by providing coping support. This code is intended to capture assistance that the parent provides in the immediate task. For example, the parent may initiate an activity to distract the child from the stressor. This code will only be given to a statement made by the parent (never the child).

PRIMARY CONTROL COPING [PCC]

N/A

SECONDARY CONTROL COPING [SCC]

P: "Lets think together about some of the fun memories you have with [name]."

In response to the child being upset: P: "What was your favorite part of the movie that we went to last week?"

DISENGAGEMENT COPING [DCC]

P: "I know this makes you upset. Lets not talk about it anymore."

P: "I know this is hard for you. Let's be done with this."

PARENTAL INTERVENTION [INTX EXTX]: Similar to the parental intervention "during the task" code described above, the parent tries to intervene in the stressor the child is experiencing. However, this code is intended to capture the things that the parent does outside of the immediate task. This code is given when the parent *directly* tries to intervene in the stressor. For example, if the child is having difficulties with a peer, the parent may talk directly to a teacher or the parents of the other child to help resolve the problem. Alternatively, the parent or child may report that the parent initiates activities to distract the child when s/he is experiencing a stressor or the parent/child dyad may describe ways the parent helps the child think differently about the problem.

PRIMARY CONTROL COPING [PCC]

P: "If I saw someone treating you rudely, I would probably intervene or step in and tell them that you didn't mean to do that. I tend to want to protect you guys when I see someone doing something wrong."

P: "I go and talk to the parents of the kids when other children are being rude."

SECONDARY CONTROL COPING [SCC]

C: "When I'm upset, you ask if I want to watch a movie and make popcorn together."

P: "How do you think I help?"
C: "You make me laugh."

DISENGAGEMENT COPING [DCC]

P: "I don't let you go to that child's house. I don't think you should be around him."

TASK-RELATED QUESTIONS [TRQ]. Any question that the parent asks the child that is related to the discussion task. These questions would include inquiring about the child's feelings, behaviors, and thoughts related to the stressor or the questions may be in reference to the parent trying to gather more detailed information about the situation. This code should not be given to questions that are off topic (e.g., what do you want to do when we are finished here? How much time do you think is left? Did you watch that TV show last night?).

P: "When those kids said those mean words to you, what were you thinking?"

P: "I bet that really hurt your feelings. Is there anything you think you could do to make yourself feel better?"

P: "When that happened to you, how did it make you feel?"

P: "When you said that to her, how do you think she felt?"

REFERENCES

Compas, B.E., Connor-Smith, J.K., Saltzman, H., Thomsen, A.H., & Wadsworth, M.E. (2001). Coping with stress during childhood and adolescence: Progress, problems, and potential in theory and research. *Psychological Bulletin, 127,* 87-127.

Compas, B.E., Boyer, M.C., Stanger, C., Colletti, R.B., Thomsen, A.H., Dufton,, L.M., & Cole, D.A. (2006a). Latent variable analysis of coping, anxiety/depression, and somatic symptoms in adolescents with chronic pain. *Journal of Consulting and Clinical Psychology, 74,* 1132-1142.

Compas, B.E., Beckjord, E., Agocha, B., Sherman, M.L., Langrock, A., Grossman, C., Dausch, B., Glinder, J., Kaiser, C., Anderson-Hanley, C., & Luecken, L. (2006b). Measurement of coping and stress responses in women with breast cancer. *Psycho-Oncology, 15,* 1038-1054.

Connor-Smith, J.K., Compas, B.E., Wadsworth, M.E., Thomsen, A.H., & Saltzman, H. (2000). Responses to stress in adolescence: Measurement of coping and involuntary stress responses. *Journal of Consulting and Clinical Psychology, 68,* 976-992.

Kliewer. W., Sandler, I., & Wolchik, S. (1994). Family socialization of threat appraisal and coping: Coaching, modeling, and family context. In F. Nestmann & K. Hurrelmann (Eds.), *Social networks and social support in childhood and adolescence. Prevention and intervention in childhood and adolescence* (pp. 271-291). Oxford, England: Walter De Gruyter.

Kliewer, W., Parrish, K.A., Taylor, K.W., Jackson, K., Walker, J.M., & Shivy, V.A (2006). Socialization of coping with community violence: Influences of caregiver coaching, modeling, and family context. *Child Development, 77*(3), 605-623.

Skinner, E.A., & Zimmer-Gembeck, M.J. (2007). The development of coping. *Annual Review of Psychology, 58,* 119-144.

Wadsworth, M.E., Raviv, T., Compas, B.E., & Connor-Smith, J.K. (2005). Parent and adolescent responses to poverty-related stress: Tests of mediated and moderated coping models. *Journal of Child and Family Studies, 14,* 283-298.

Yao, S., Xiao, J., Zhu, X., Zhang, C., Auerbach, R.P., McWhinnie, C.M., Abela, J., & Wang, C. (2010). Coping and involuntary responses to stress in chinese university students: Psychometric properties of the responses to stress questionnaire. *Journal of Personality Assessment, 92*4), 356-361.

Appendix I. Socialization of Coping Coding System Rules

REMEMBER, IF DATA ARE VALID, THEY MUST BE RELIABLE. WE NEED TO FOCUS FIRST ON RELIABILITY!

1. **In order to be coded as emotional expression (i.e., mother modeling or endorsing the child's emotional expression), the utterance has to have an emotion word.**

MODX PCC: has to have the emotion word in *each* utterance.

- Example 1: The first utterance would get a MODX PCC DTT code, but the second utterance would not because it does not have an emotion word in it, even though it is a logical extension from the previous utterance.

  M I am sad to hear that other kids are so mean to you. **[MODX PCC DTT]**

  M Because I don't want you to have to go through something like that.

- Example 2: Both utterances would get a MODX PCC DTT code because they both have an emotion word in it.

  M I am sad to hear that other kids are mean to you.

  M Because I hate that you have to go through something like that.

- Non-Example: The mother will not get a MODX PCC DTT if she is not expressing her *own* emotion.

  M yeah so it could be fearful (if somebody is) if you're in a room full of kids and everybody is doing it but you nods[EN:yes].

ENDX PCC: the mother's endorsement must either be (1) in the same utterance as the child's emotion word, or (2) in a maternal utterance that immediately follows the child's utterance with an emotion word.

- Example 1:

  S Well it made me really mad that he got away with it [m:{nods}][EN:yes] **[ENDX PCC]**

- Example 2:

  S Well it made me really mad that he got away with it.

M yeah I know that upset you. **[ENDX PCC]**

- Example 3: The maternal utterance would *not* get ENDX PCC because the maternal nod doesn't *immediately* follow the child's utterance with an emotion-word

  S Well it made me really mad that he got away with it.

  S I just did not think it was fair.
  M Nods[EN:yes] I understand that.

2. **We will not code the parent asking the child how s/he feels in the broad sense or if the child feels a specific emotion as QSA PCC.**

   - Non-Examples of QSA PCC:

     M Did it make you mad?

     M Did you get really sad about it?

     M How did you feel when you were left out?

3. **The coding system is a contextual coding system, so you should take into account the entire transcript and consider what the mom is trying to communicate to the child. However, each individual utterance is coded as a stand-alone utterance. Therefore, each utterance should have enough content to be given a SOC code.**

   - Example 1: The mom's utterance below should not also get an INSX code. Even though we know from the context that mom is agreeing that she tells him to walk away, "that's true" stand-alone is not an INSX, MODX, ENDX, INTX, QSA, etc. code.

     S You tell me to walk away. **[INSX DCC EXTX]**

     M That's true.

   - Example 2: The mom's utterance in this example *would* get an INSX code because mom said "I have told you", which is enough content to give it an INSX code.

     S You tell me to walk away. **[INSX DCC EXTX]**
     M That's true, I have told you that in the past. **[INSX DCC EXTX]**

- Example 3: The mom's second utterance in this example would not get a QSA code because mom did not elaborate and it is unclear what she is too ambiguous to know what she is trying to communicate.

    M You should tell me when other kids are rude to you.

    M Okay?

4. **Coding QSA can be tricky. Ask yourself: is the mother *clarifying* something or *communicating* something to the child. If the mother is clarifying (or if it is difficult to determine), then QSA would not be an appropriate code. If the parent is communicating a particular coping strategy, then QSA should be used.**

   Hint: Keywords like *actually, per se, really, "I wonder"* may change the meaning of the utterance and push it more towards a QSA code. For example, "Are you left out?" would not warrant a QSA code; however, "Are you actually left out?" has more of a flavor of QSA SCC.

   - Examples:

     M So I guess you are not the only one, huh? **[QSA SCC]**

     M Have you tried to talk to someone about it? **[QSA PCC]**

     M Are you actually left out? **[QSA SCC]**

   - Non-Examples:

     M Does he pick on other kids at your school?

     M Why do you think problems with other kids happen?

     M Do you have friends at school?

5. **We will only consider it cognitive reappraisal (i.e., a form of secondary control coping) if the reappraisal would likely lead the child to either feel better or at least not worse. At this point in time, we are not going to code reappraisals that are intended to get the child to think differently about a situation, but that would actually make the child feel worse in the short term.**

   - Example:

     M nods[EN:yes] are you mad at Name?

S nope.

M nods[EN:yes] good I don't think you should be shakeshead[EN:yes].

M because (I) I think he's probably had a super [s:{nods}][EN:yes] busy summer [s:mhm][BACK]. **[MODX SCC DTT]**

M shakeshead[EN:no] I think he's playing football [s:yeah][BACK] I think he has practice like every single day I think. **[MODX SCC DTT]**

- Non-Example: In this example, the mother is trying to get the child to recognize that they are also the source of the problem and it is not *just* the other people. Likely the mom wants to then take this reappraisal and help the child to be nicer to other kids if he wants to have more friends.

M Is it because of them or you?

S Them!

M It's always them?

S Yes it's always them.

M You're always Mr. Perfect?

S Yes nods[EN:yes] I'm Mr. Perfect.

M You never get in a bad mood and are rude to anybody <first>?

S <This is> Mr. Perfect right here.

6. **We will code statements that communicate to the child that s/he should walk away from peer pressure, quit an activity that is part of the stressor, stay away from kids/situations, ignore others, etc. as disengagement coping EVEN IF it is in the context of problem-solving. It is important to consider that parts of an utterance might be problem-solving, but the content "walk away" will be coded as disengagement.**

- Example 1: This utterance would get an INSX PCC code *and* an INSX DCC code. Mom provides a problem-solving strategy, but then ends it with a disengagement strategy.

M You want to give people the benefit of the doubt that maybe they're really not as wacked up as you think they are but when somebody does something hurtful to you once like I said you want to give them

the benefit of the doubt but definitely after they do something that's hurtful again then you need to just step back and say you know what (I) I don't want to be hurt anymore because it's too much effort on my part to get over it and you just have to walk away. **[INSX PCC DTT] [INSX DCC DTT]**

- Example 2: The mother's utterance would get an INSX DCC DTT code because mom is suggesting that the child quit the club to get away from kids who are rude.

  S I am having a hard time being around the kids in running club because they are rude to me and other kids there.

  M I think a solution would be to quit the running club. **[INSX DCC DTT]**

- Non-Example 3: The mother's utterance in this example *would not* get an INSX DCC DTT, but rather an INSX PCC DTT because the stressor is not having time to get homework done. Mom tells the child to quit the running club as a solution to having more time for homework. Therefore, it is a problem-solving strategy.

  S I am having a hard time getting my homework done.

  M I think a solution would be to quit the running club. **[INSX PCC DTT]**

7. **If you are having a difficult time determining what the mom or child is saying or communicating, it is OKAY to not code the utterance. If you are working really hard to understand and even still are guessing, do not code the utterance!**

8. **Be careful to not code utterances that on the surface appear as primary control coping strategies, but are not specific enough to know that mom is communicating about changing the problem or one's emotions. Ask yourself, could the child do this by avoiding the problem or think differently about it?**

   - Examples:

     M Don't let it upset you!

     M What can you do to make this better?

     M You need to treat other people on your terms, not their terms.

M Don't worry about what other people say.

M Keep your chin up.

9. **Emotional suppression is a primary control coping strategy. The definition that I am considering emotional suppression is the child not expressing and showing their emotions. This is not including a child who says that they do not have emotions or the parent who tells the child to not have emotions.**

   - Example 1:

     S I try to not let other's see what I am feeling on the inside.

     M That is good. **[ENDX PCC]**

   - Example 2:

     M You need to control your emotions. **[INSX PCC DTT]**

   - Non-Example:

     M Don't get angry or lose your temper.

10. **Do not confuse the parent providing social and emotional support to the child as coping socialization. Although these two constructs are likely related, they are not the same thing. The coding system does not capture social support.**

    - Non-Examples:

      M Dad and I always have your back.

      M I always give you a shoulder to cry on.

      M I give you the support that you need.

      M I remember we talked about when that happened and I tried to make you feel better.

Appendix J. Emotion Words for Socialization of Coping Coding

Agitated
Aggravated
Amused
Angry
Annoyed
Anxious
Apprehensive
Ashamed
Bashful
Betrayed
Blue
Bored
Brave
Calm
Cautious
Confident
Confused
Content
Dejected
Delighted
Depressed
Disappointed
Disgusted
Distressed
Eager
Ecstatic
Elated
Embarrassed
Empty
Enjoy
Enraged
Envious
Euphoric
Excited
Exuberant
Fearful
Frantic
Frightened
Frustrated
Furious
Glad
Grateful
Greedy
Grief
Grouchy
Grumpy
Guilt
Happy
Hate
Heartbroken
Hesitant
Hopeful
Hopeless
Horrified
Hostile
Hurt
Hysterical
Ignored
Insecure
Intimidated
Irritated
Jealous
Joy
Lonely
Love
Mad
Miserable
Moody
Nervous
Optimistic
Outraged
Overjoyed
Overwhelmed
Panicked
Petrified
Pity
Pleased
Proud
Regretful
Rejected
Relieved
Remorseful
Sad
Satisfied
Scared
Shame
Shocked
Shy
Sorry
Smug
Stunned
Surprise
Sympathetic
Terrified
Threatened
Thrilled
Timid
Uneasy
Unhappy
Upset
Worried
Zealous

REFERENCES

Abaied, J. (2010). Socialization of coping with peer victimization and negative emotionality: Interactive contribution to children's responses to stress and depressive symptoms. Retrieved from PsycINFO.

Abaied, J.L. & Rudolph, K.D. (2010a). Mothers as a resource in times of stress: Interactive contributions of socialization of coping and stress to youth psychopathology. *Journal of Abnormal Child Psychology, 38,* 273-289.

Abaied, J.L. & Rudolph, K.D. (2010b). Contributions of maternal adult attachment to socialization of coping. *Journal of Social and Personality Relationships, 27*(5), 637-657.

Abaied, J.L., & Rudolph, K.D. (2011). Maternal influences on youth responses to peer stress. *Developmental Psychology, 47*(6), 1776-1785.

Abaied, J.L., Wagner, C., & Sanders, W. (2014). Parent socialization of coping in emerging adulthood: Moderation by respiratory sinus arrhythmia. *Journal of Applied Developmental Psychology*, *35*(4), 357-369.

Achenbach, T.M. & Rescorla, L.A. (2001). *Manual for ASEBA School-Age Forms & Profiles.* Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Aiken, L. S., & West, S. G. (1991). *Multiple regression: Testing and interpreting interactions*. Newbury Park: Sage.

Alderfer, M. A., Fiese, B. H., Gold, J. I., Cutuli, J. J., Holmbeck, G. N., Goldbeck, L., Chambers, C. T., Abad, M., Spetter, D., & Patterson, J. (2008). Evidence-based assessment in pediatric psychology: Family measures. *Journal of Pediatric Psychology, 33,* 1046-61.

Bandura, A., (1977). *Social learning theory.* Englewood Cliffs, NJ: Prentice-Hall.

Baumrind, D. (1978). Parental disciplinary patterns and social competence in children. *Youth and Society, 9*, 239-276.

Beck, A.T., Steer, R.A., & Brown, G.K. (1996). *Manual for the beck depression inventory – II.* San Antonio, TX: Psychological Corporation.

Bradley, R.H. (2007). Parenting in the breach: How parents help children cope with developmentally challenging circumstances. *Parenting: Science and Practice, 7*, 99-148.

Bradshaw, C.P., Waasdrop, T.E., O'Brennan, L.M. (2013). A latent class approach to examining forms of peer victimization. *Journal of Educational Psychology, 105,* 839-849.

Bynum, M.S., & Brody, G.H. (2005). Coping behaviors, parenting, and perceptions of children's internalizing and externalizing problems in rural African American mothers. *Family Relations, 54,* 58-71.

Campos, J., & Stenberg, C. (1981). Perception, appraisal, and emotion: The onset of social referencing. In M.E. Lamb & L.R. Sherrod (Eds). *Infant social cognition* (pp. 273-314). Hillsdale, NJ: Erlbaum.

Churchill, S.S., Villareale, N.L., Monaghan, T.A., Sharp V.L., & Kieckhefer, G.M. (2010). Parents of children with special health care needs who have better coping skills have fewer depressive symptoms. *Maternal and Child Health Journal, 14,* 47-57.

Compas, B.E., Boyer, M.C., Stanger, C., Colletti, R.B., Thomsen, A.H., Dufton., L.M., & Cole, D.A. (2006a). Latent variable analysis of coping, anxiety/depression, and somatic symptoms in adolescents with chronic pain. *Journal of Consulting and Clinical Psychology, 74,* 1132-1142.

Compas, B.E., Beckjord, E., Agocha, B., Sherman, M.L., Langrock, A…Luecken, L. (2006b). Measurement of coping and stress responses in women with breast cancer. *Psycho-Oncology, 15,* 1038-1054.

Compas, B.E., Connor-Smith, J.K., Saltzman, H., Thomsen, A.H., & Wadsworth, M.E. (2001). Coping with stress during childhood and adolescence: Progress, problems, and potential in theory and research. *Psychological Bulletin, 127,* 87-127.

Compas, B.E., Keller, G., & Forehand, R., (2011). Preventive intervention in families of depressed parents: A family cognitive-behavioral intervention. In T.J. Strauman, P.R. Costanzo, J. Garber, and L.Y. Abramson (Eds.), *Preventing depression in adolescent girls: A multidisciplinary approach*. New York: Guilford Press.

Compas, B.E., Jaser, S.S., Dunbar, J.P., Watson, K.H., Bettis, A.H., Gruhn, M.A., & Williams, E.K. (2014). Coping and emotion regulation from childhood to early adulthood: Points of convergence and divergence. *Australian Journal of Psychology, 66,* 71-81.

Compas, B.E., Jaser, S.S., Dunn, M.J., & Rodriguez, E.M. (2012). Coping with chronic illness in childhood and adolescence. *Annual Review of Clinical Psychology, 8*(15), 15.1-15.26.

Connor-Smith, J.K., & Calvete, E. (2004). Cross-cultural equivalence of coping and involuntary responses to stress in Spain and the United States. *Anxiety, Stress, and Coping: An International Journal, 17,* 163-185.

Connor-Smith, J.K., Compas, B.E., Wadsworth, M.E., Thomsen, A.H., & Saltzman, H. (2000). Responses to stress in adolescence: Measurement of coping and involuntary stress responses. *Journal of Consulting and Clinical Psychology, 68,* 976-992.

Darling, N. & Steinberg, L. (1993). Parenting style as context: An integrative model. *Psychological Bulletin, 113(3),* 487-496.

Dix, T. & Meunier, L.N. (2009). Depressive symptoms and parenting competence: An analysis of 13 regulatory processes. *Developmental Review, 29,* 45-68.

Eisenberg, N., Cumberland, A., & Spinrad, T.L. (1998). Parental socialization of emotion. *Psychological Inquiry, 9*(4), 241-273.

Eisenberg, N., Spinrad, T.L., & Eggum, N.D. (2010). Emotion-related self-regulation and its relation to children's maladjustment. *Annual Review of Clinical Psychology, 6,* 495-525.

Eisenberg, N. & Valiente, C.E. (2001). Parenting and children's prosocial and moral development. In M.H. Bornstein (Ed.), *Handbook of parenting: Vol. 5, Practical issues in parenting* (pp. 111-142). Mahwah, NJ: Lawrence Erlbaum Associates.

Gaylord-Harden, N.K. (2008). The influence of student perceptions of parenting and coping on achievement and classroom behavior among African American children. *Psychology in the Schools, 45*(8), 763-777.

Goodman, G., & Dooley, D. (1976). Help-intended communication. *Psychotherapy: Theory, Research, and Practice*, *13*(2), 106-117.

Gottman, J.M., Katz, L.F., & Hooven, C. (1996). Parental meta-emotion philosophy and the emotional life of families: Theoretical models and preliminary data. *Journal of Family psychology, 10*(3), 243-268.

Grant, K.E., Compas, B.E., Stuhlmacher, A., Thurm, A.E., McMahon, S., & Halpbert, J. (2003). Stressors and child and adolescent psychopathology: Moving from markers to mechanisms of risk. *Psychological Bulletin, 129,* 447-466.

Grant, K.E., Compas, B.E., Thurm, A.E., McMahon, S.D., & Gipson, P. (2004). Stressors and child and adolescent psychopathology: Measurement issues and prospective effects. *Journal of Clinical Child and Adolescent Psychology, 33*, 412-425.

Grolnik, W.S. & Farkas, M. (2002). Parenting and the development of children's self-regulation. In Bornstein, M.H. (Ed.), *Handbook of parenting, Vol. 5, Practical issues in parenting* (pp. 89-110). Mahwah, NJ: Lawrence Erlbaum Associates.

Holmbeck, G. N. (2002). Post-hoc probing of significant moderational and mediational effects in studies of pediatric populations. *Journal of Pediatric Psychology, 27*, 87-96.

Jaffe, M., Gullone, E., & Hughes, E.K. (2010). The roles of temperamental dispositions and perceived parenting behaviours in the use of two emotion regulation strategies in late childhood. *Journal of Applied Developmental Psychology, 31,* 47-59.

Jaser, S.S., Champion, J.E., Dharamsi, K.R., Reising, M.M., & Compas, B.E. (2011). Coping and positive affect in adolescents of mothers with and without a history of depression. *Journal of Child and Family Studies, 20,* 353-360.

Jaser, S.S., Champion, J.E., Reeslund, K.L., Keller, G., Merchant, M.J…Compas, B.E. (2007). Cross-situational coping with peer and family stressors in adolescent offspring of depressed parents. *Journal of Adolescence, 30,* 917-932.

Jaser, S.S., Fear, J.M., Reeslund, K.L., Champion, J.E., Reising, M.M., & Compas, B.E. (2008). Maternal sadness and adolescents' responses to stress in offspring of mothers with and without a history of depression. *Journal of Clinical Child and Adolescent Psychology, 37,* 736-746.

Jaser, S.S., Langrock, A.M., Keller, G., Merchant, M.J., Benson, M.A…Compas, B.E. (2005). Coping with the stress of parental depression II: Adolescent and parent reports of coping and adjustment. *Journal of Clinical Child and Adolescent Psychology, 34,* 193-205.

Katz, L.F. & Windecker-Nelson, B. (2004). Parental meta-emotion philosophy in families with conduct-problem children: Links with peer relations. *Journal of Abnormal Child Psychology, 32*(4), 385-398.

Kliewer, W., Fearnow, M.D., & Miller, P.A. (1996). Coping socialization in middle childhood: Tests of maternal and paternal influences. *Child Development, 67*(5), 2339-2357.

Kliewer, W. & Lewis, H. (1995). Family influences on coping processes in children and adolescents with sickle cell disease. *J. of Pediatric Psychology, 20*(4), 511-525.

Kliewer, W., Parrish, K.A., Taylor, K.W., Jackson, K., Walker, J.M., & Shivy, V.A (2006). Socialization of coping with community violence: Influences of caregiver coaching, modeling, and family context. *Child Development, 77*(3), 605-623.

Kliewer. W., Sandler, I., & Wolchik, S. (1994). Family socialization of threat appraisal and coping: Coaching, modeling, and family context. In F. Nestmann & K. Hurrelman (Eds.). *Social networks and social support in childhood and adolescence. Prevention and intervention in childhood and adolescence* (pp. 271-291). Oxford, England: Walter De Gruyter.

Langrock, A.M., Compas, B.E., Keller, G., Merchant, M.J., & Copeland, M.E. (2002). Coping with the stress of parental depression: Parents' reports of children's coping, emotional, and behavioral problems. *Journal of Clinical Child and Adolescent Psychology, 31,* 312-324.

Larson, R., & Richards, M.H. (1991). Daily companionship in late childhood and early adolescence: Changing developmental contexts. *Child Development, 62, 284-300.*

Lazarus, R.S., & Folkman, S. (1984). *Stress, Appraisal, and Coping.* New York:Springer.

Lovejoy, M.C., Graczyk, P.A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Child Psychology Review, 20(5),* 561-592.

Maccoby, E.E. (1992). The role of parents in the socialization of children: An historical overview. *Developmental Psychology, 28(6),* 1006-1017.

Maughan, A., Cicchetti, D., Toth, S.L., & Rogosch, F.A. (2007). Early-occurring maternal depression and maternal negativity in predicting young children's emotion regulation and socioemotional difficulties. *Journal of Abnormal Child Psychology, 35*, 685-703.

McIntyre, J.G., & Dusek, J.B. (1995). Perceived parental rearing practices and styles of coping. *Journal of Youth and Adolescence, 24*(4), 499-509.

McKernon, W.L., Holmbeck, G.N., Colder, C.R., Hommeyer, J.S., Shapera, W., & Westhoven, V. (2001). Longitudinal study of observed and perceived family influences on problem-focused coping behaviors of preadolescents with spina bifida. *Journal of Pediatric Psychology, 26*(1), 41-54.

McLaughlin, B., Schutz, C., & White, D. (1980). Parental speech to five-year-old children in a game-playing situation. *Child Development, 51,* 580-582.

Meesters, C., & Muris, P. (2004). Perceived parental rearing behaviors and coping in young adolescents. *Personality and Individual Differences, 37,* 513-522.

Melby, J.N., & Conger, R.D. (2001). The Iowa Family Interaction Rating Scales: Instrument summary. In P.K. Kerig & K.M. Lindahl (Eds.), *Family observational coding systems* (pp. 33-58). Mahwah, NJ: Erlbaum.

Melby, J.N., Conger, R.D., Book, R., Reuter, M., Lucy, L., & Repinski, D. (1998). *The Iowa Family Interaction Rating Scales* (5th ed.). Unpublished manuscript, Ames Institute for Social and Behavioral Research, Iowa State University, Ames.

Miller, P.A., Kliewer, W., Hepworth, J.T., & Sandler, I.N. (1994). Maternal socialization of children's postdivorce coping: Development of a measurement model. *Journal of Applied Developmental Psychology, 15,* 457-487.

Miller, P.A., Kliewer, W., & Partch, J. (2010). Socialization of children's recall and use of strategies for coping with interparental conflict. *Journal of Child and Family Studies, 19,* 429-443.

Monroe, S.M. (2008). Modern approaches to conceptualizing and measuring human life stress. *Annual Reviews of Clinical Psychology, 4,* 33-52.

Monti, J.D., Rudolph, K.D., & Abaied, J.L. (2014). Contributions of maternal emotional functioning to socialization of coping. *Journal of Social and Personal Relationships, 31,* 247-269.

Morris, A.S., Silk, J.S., Steinberg, L., Myers, S.S., & Robinson, L.R. (2007). The role of the family context in the development of emotion regulation. *Social Development, 16*(2), 361-388.

National Research Council and Institute of Medicine. (2009*). Depression in parents, parenting, and children: Opportunities to improve identification, treatment and prevention*. Washington, DC: The National Academies.

Power, T.G. (2004). Stress and coping in childhood: The parents' role. *Parenting: Science and* Practice, 4(4), 271-317.

Preacher, K. (2015). Personal communication.

Rodriguez, E.M., Dunn, M.J., Zuckerman, T., Hughart, L., Vannatta, K…Compas, B.E. (2013). Mother-child communication and maternal depressive symptoms in families of children with cancer: Integrating macro and micro levels of analysis. *Journal of Pediatric Psychology, 38*(7), 732-743.

Shipman, K.L., & Zeman, J. (2001). Socialization of children's emotion regulation in mother-child dyads: A developmental psychopathology perspective. *Development and Psychopathology, 13,* 317-336.

Skinner, E.A., Edge, K., Altman, J., & Sherwood, H. (2003). Searching for the structure of coping: A review and critique of category systems for classifying ways of coping. *Psychological Bulletin, 129*(2), 216-269.

Skinner, E.A., & Zimmer-Gembeck, M.J. (2007). The development of coping. *Annual Review of Psychology, 58,* 119-144.

Sobel, M.E. (1982). Asymptotic confidence intervals for indirect effects in structural equation models. In S. Leinhart (Ed.), *Sociological methodology* (pp. 290-312). San Francisco, CA: Jossey-Bass.

Sorce, J.F., Emde, R.N., Campos, J., & Klinnert, M.D. (1985). Maternal emotional signaling: Its effect on the visual cliff behavior of 1-year-olds. *Developmental Psychology, 21*,195-200.

Tabachnick, B.G., & Fidell, L.S. (2013). *Using multivariate statistics (6th ed.).* Boston: Pearson.

Vélez, C.E., Wolchik, S.A., Tein, J.Y., & Sandler, I. (2011). Protecting children from the consequences of divorce: A longitudinal study of the effects of parenting on children's coping responses. *Child Development, 82*, 244-257.

Vitaliano, P.P., Maiuro, R.D., Russo, J., & Becker, J. (1987). Raw versus relative scores in the assessment of coping strategies. *Journal of Behavioral Medicine, 10,* 1-18.

Wadsworth, M.E., & Compas, B.E. (2002). Coping with family conflict and economic strain: The adolescent perspective. *Journal of Research on Adolescence, 12,* 243-274.

Wadsworth, M.E., Reickmann, T., Benson, M., & Compas, B.E. (2004). Coping and responses to stress in Navajo adolescents: Psychometric properties of the Responses to Stress Questionnaire. *Journal of Community Psychology, 32,* 391-411.

Watson, K.H., Dunbar, J.P., Thigpen, J.C., Reising, M.M., Hudson, K…Compas, B.E. (2014). Observed parental responsiveness/warmth and children's coping: Cross-sectional and prospective relations in a family depression preventive intervention. *Journal of Family Psychology, 28*(3), 278-286.

Xiao, J., Yao, S., Zhu, X., Zhang, C., Auerbach, R.P., McWhinnie, C.M., & Abela, J.R.Z. (2010). The responses to stress questionnaire: Construct validity and predictions of depressive and social anxiety symptoms in a sample of Chinese adolescents. *Stress and Health, 26,* 238-249.

Yao, S., Xiao, J., Zhu, X., Zhang, C., Auerbach, R.P., McWhinnie, C.M., Abela, J., & Wang, C. (2010). Coping and involuntary responses to stress in chinese university students: Psychometric properties of the responses to stress questionnaire. *Journal of Personality Assessment, 92*4), 356-361.

Zimmer-Gembeck, M.J. & Skinner, E.A. (2011). The development of coping across childhood and adolescence: An integrative review and critique of research. *International Journal of Behavioral Development, 35*(1), 1-17.