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Coping with stress, coping with violence: Links to mental health outcomes among at-risk youth

Paul Boxer

Department of Psychology, Rutgers University

Elizabeth Sloan-Power

Department of Social Work, Rutgers University

Ignacio Mercado and Ashley Schappell

Department of Psychology, Rutgers University

Abstract

Coping reactions to stressful events are important links between difficult experiences and the emergence of psychopathology. In this study we compared youths' negative coping with stress in general to their negative coping with violence in particular, and utilized a person-centered analytic approach to examine how patterns of coping relate to various mental health outcomes. We utilized survey interview measures to collect data from a sample of 131 youth (ages 11–14, 100% ethnic minority) residing in an economically distressed metropolitan area of the northeast. We observed significant relations between youths' tendencies to cope with stress and violence via externalized-internalized strategies (e.g., yelling to let off steam, crying) and their mental health symptoms. However, we generally did not observe relations between engagement in distancing coping strategies (e.g., making believe nothing happened) and any problematic outcomes. Negative coping does not appear to be a monolithic construct uniformly associated with negative outcomes for youth. Distancing coping might represent an especially useful short-term coping response for youth living in socioeconomically distressed conditions from the standpoint of inhibiting symptom development.

Keywords

coping; mental health; violence; PTSD

The importance of coping to the emergence or suppression of psychopathology and other adverse mental health reactions to stress and trauma cannot be underestimated. Coping strategies represent meaningful behavioral, cognitive, and emotional steps taken in order to reduce or eliminate stressors and/or the psychological distress associated with the stressors (Folkman, 1984). At the time of experiencing a discrete traumatic or highly stressful event, or under conditions of persistent stress, selected coping strategies can be the difference between successful or unsuccessful adaptation. Some coping strategies (e.g., constructive problem-solving, effortful emotion regulation) predict improved adjustment and adaptation whereas others (e.g., avoidance, withdrawal) lead to worse adjustment and maladaptation (Compas, Connor-Smith, Saltzman, Thomasen, & Wadsworth, 2001). At the same time, the effectiveness of coping strategies for protecting against deleterious effects of stress or trauma depends upon the goodness of fit or “match” between the stressor and the strategy

selected. Under conditions of uncontrollable stress, for example, problem-focused coping is likely to be far less successful in comparison to emotion-focused or acceptance-oriented coping (Tolan & Grant, 2009).

One uncontrollable stressor that can manifest as a chronic form of stress as well as episodic traumatic event is exposure to violence. A substantial literature exists documenting the robust negative impact of exposure to violence in families and communities on youths' mental health (Fowler et al., 2009; Kitzmann et al., 2003), yet the role of coping strategies in exacerbating or buffering that impact is less understood. Generally, the research indicates that negative coping – internalized (e.g., crying, worrying), externalized (aggressive acting-out), and avoidance (e.g., distancing, distraction) strategies – are associated with mental health difficulties in the context of exposure to violence (e.g., Boxer et al., 2008; Dempsey, 2002; Kliewer et al., 2006). However, these studies – and, in fact, much of the research on youth coping in general – fail to take into account two critical issues: First, to what extent does coping with stressful experiences broadly relate to coping with violence more specifically? Second, what can be gained with respect to understanding the link between coping styles and mental health outcomes through person-level assessment of tendencies to cope in one manner over others rather than variable-level assessment of various coping types independently? In the present study, we considered these issues in a sample of 131 early adolescents recruited from a metropolitan region marked by high levels of violence and crime. We examined the utility of a new measure of coping with violence and evaluated links between coping styles and three key mental health outcomes: internalizing problems, externalizing problems, and post-traumatic stress symptoms.

Coping with stress and violence

Discrete behaviors and generalized patterns of coping responses have been described in a number of different ways in the literature. In this study we focus on four key concepts: coping *dimensions*, reflecting the various typologies offered by other scholars to indicate broad classes of positive or negative coping efforts; coping *strategies*, meant to refer to the discrete coping reactions or behaviors that children might exhibit; coping *styles*, meant to refer to children's typical patterns of engagement in coping strategies; and coping *reactions*, meant to refer only to the particular strategy choice that a child makes in response to some stressor.

Coping reactions emitted in response to stressful or otherwise challenging events can be highly particular, emerging in the context of youths' construction of the controllability of the difficult event, the actual content and circumstances of the event itself, broader sociocultural factors, individual learning histories, and personal resources (Compas et al., 2001; Tolan & Grant, 2009). A number of studies thus support the key notion that how a youth responds situationally to a stressor is linked to relatively stable background factors as well as stress mobilization processes in which particular stressors elicit particular coping reactions, perhaps even idiosyncratically or in highly specific ways (Bjorck & Cohen, 1993; Dubow, Pargament, Boxer, & Tarakeshwar, 2000). Despite this potential for specificity, researchers have identified several more or less replicable dimensions of youths' coping strategies, divided conceptually across the two broad categories of *approach or engagement* coping and *avoidance or disengagement* coping (Causey & Dubow, 1992; Compas et al., 2001; Lazarus & Folkman, 1984). In the first category, typically linked to better outcomes, coping is aimed at modifying some aspect of a stressful event or emotional reactions to a stressful event (Causey & Dubow, 1992; Connor-Smith & Compas, 2004; Roth & Cohen, 1986; Weisz, McCabe, & Denning, 1994).

In the second broad category of avoidance or disengagement coping, youths' coping reactions typically are linked to emotional symptoms or problem behaviors such as high anxiety or maladaptive behavioral conduct (Causey & Dubow, 1992; Dempsey, 2002). This kind of coping involves distancing oneself psychologically or physically from a stressful event, acting out or “venting” negative arousal (i.e., externalized coping), or retreating inward emotionally through worry, sadness, or self-pity (i.e., internalized coping). As a category, due to links with poor mental health outcomes, these coping strategies typically have been construed broadly as “negative coping.” Generally, studies of coping have observed a fair degree of variability in the strategies youth select in response to a variety of stressors (e.g., Roecker, Dubow, & Donaldson, 1996). However, probably due to its uncontrollability, researchers typically have observed that youth respond with avoidant or disengaged or similarly negative coping in response to violence (Dempsey, 2002; Kliwer et al., 2006; Reid-Quñones et al., 2011; Scarpa & Haden, 2006; Tolan, Gorman-Smith, Henry, Chung, & Hunt, 2002). In the present study, we compare negative coping in response to stress with negative coping in response to violence.

Coping styles and coping strategies

As observed recently by Gaylord-Harden, Cunningham, Holmbeck, and Grant (2010), the wealth of research on various dimensions of generally positive or negative coping strategies has not necessarily led to an enhanced understanding of interactions among different strategies in relation to youths' outcomes. Part of the difficulty in capturing empirically the potential interactions among coping strategies is statistical – because discrete strategies tend to covary, especially in populations under chronically stressful circumstances, variables representing one form or another of coping might produce suppression in multivariate models predicting outcomes from blocks of multiple coping strategy indicators (Gaylord-Harden et al., 2010). Another concern, however, is more conceptual – layered onto the dimensions outlined above is an additional critical distinction that has been identified in the research: coping style, as evidence through *dispositional* versus *situational coping* (Bouchard, Guillemette, & Landry-Leger, 2004). Dispositional or *trait* coping refers to an individual's typical or characteristic style of coping in response to a number of potentially quite different stressful situations. Situational coping refers to the potential for more dynamic application of coping strategies, reflecting the idea that coping strategies might change from moment to moment during a particular episode, or across discrete events over time.

Dispositional coping and situational coping are not necessarily mutually exclusive concepts – Bouchard et al. (2004) found evidence supporting a partially mediated effect of dispositional coping on outcomes through situational coping – but they do raise an important challenge for the implications of research on youth coping for interventions that rely on the teaching of coping strategies to prevent or reduce mental health problems. Variable-centered modeling of coping strategies can meaningfully inform the design of preventive interventions by identifying key risk or promotive factors to target through universal or selected programming (Dubow, Roecker, & D'Imperio, 1997; Institute of Medicine, 1994). Yet person-centered modeling of coping styles can lead to greater specificity in the identification of individuals in need of particular intervention strategies or modalities through, for example, identifying more personalized arrays of strengths and deficits associated with variations in functioning (Connell, Dishion, & Deater-Deckard, 2006). A person-centered approach of examining predominant coping styles rather than a variable-centered approach of examining discrete, multiple coping strategies might hold special utility for understanding how experiences with violence link to particular behavioral and mental health outcomes.

Recent studies and theoretical work have underscored the critical observation that even under generally similar conditions of exposure to violence, some youth react primarily with internalizing/emotional distress outcomes whereas others react primarily with antisocial behavioral outcomes (Ng-Mak, Salzinger, Feldman, & Steuve, 2002, 2004); coping styles have been implicated as key links in the relation between violence exposure and outcomes (Boxer et al., 2008). Though it might further be the case that specific types of violence exposure (e.g., witnessing as compared to victimization) might beget situationally-variant coping strategies and hence different outcomes (Boxer et al., 2008; Reid-Quinones et al., 2011), more basic issues with great relevance to prevention and intervention are whether youth show characteristic styles of coping in the context of violence construed broadly, and whether those styles link to different mental health outcomes. In the present study, we examine coping styles in response to violence via person-centered analyses designed to highlight relations of styles to outcomes.

The present study

This study uses data collected from a sample of 131 youth residing in a northeastern city marked by high levels of violence, crime, and related sociodemographic risk conditions (e.g., poverty) to target two as-yet unaddressed issues in the coping literature: First, how does coping with stress in general relate to coping with violence more specifically? There are no known studies documenting differences in coping with these two classes of challenging situations. Second, how might a person-centered analysis of coping styles advance our knowledge on relations between coping and mental health outcomes? In contrast to the wealth of research examining how coping strategies relate independently to different outcomes, far fewer studies have considered the relation between coping styles and outcomes. In the present study, we considered these issues in a sample of 131 early adolescents recruited from a metropolitan region marked by high levels of violence and crime. Based on prior work related to how children respond to violence and stress, we anticipated that greater use of negative coping strategies would be associated with higher levels of maladjustment and lower levels of competent behavior.

Method

Participants

Participants for this study were 131 youth (43% male; M age = 12.56 years, SD = 1.08, range = 11–14 years; 86% Black/African-American, 10% Hispanic/Latino/a, 4% multiethnic). All youth and their families were residents of a large northeastern city comprised of economically distressed “inner-city” and relatively better-off urban neighborhoods. The city is a major urban center with levels of violent crime higher than national averages on most indicators, and levels of economic risk factors on par with or worse than other major metropolitan regions. Caregiver reports of demographic data indicated that the average household income of participants was in the range of about \$10,000–\$30,000 yearly (M income level = 2.74, SD = 2.11, and median = 2 on scale where 1 = “under \$10,000” through 11 = “\$100,000 or more”) and the average highest level of education among all adults in participants’ households was between high school diploma/GED and some college education (M education level = 2.83, SD = 1.27, and median = 3 on scale where 1 = “less than high school” and 8 = “graduate degree, doctoral”). Most families were headed by single parents, either alone (56%) or with other adult relatives (21%); most parents were biological (92%).

Similar to other studies drawing predominantly ethnic minority samples from inner-city and urban areas (Clay et al., 2003; Hatchett et al., 2000; Kliewer et al., 2006; Reed et al., 2003), participants were recruited through a mix of targeted outreach efforts to the community,

including the distribution of project fliers, presentations to community groups (e.g., public school social workers, parents attending community center activities), and “word of mouth” snowball recruitment through higher-profile community agents (e.g., school principals, recreation center directors, church officials).

Measures

Coping with stress and with violence—Youth completed two survey measures of their negative coping strategies in response to stress and violence. The two measures were similar except for the instructions and item stems. For stress, youth were prompted by: “These next questions ask about what you do when you get very stressed out about something. People deal with stress in a lot of different ways. How do you deal with stress?” Each item then began with “When I get really stressed out about something, I...” For violence, youth were prompted by: “These next questions ask about what you do when you see or hear somebody hurting someone, getting into a fight with someone, or threatening to hurt someone really badly, or when these kinds of things happen to you. People experience and deal with violence in a lot of different ways. How do you deal with violence?” Each item then began with: “When I see, hear, or get hurt by violence, I...”

The general form and content of the two measures followed Causey and Dubow's (1992) *Self-Report Coping Survey for Children*. The coping with violence measure represents an expansion of Boxer et al.'s (2008) version of the measure. Both the coping with stress and coping with violence measure included 16 items designed to assess three different negative coping reactions: externalized (5 items; e.g., “want to punch or kick something,” “yell to let off steam”), internalized (5 items; e.g., “get so upset that I can't talk to anyone,” “cry about I”), and distancing (6 items; e.g., “forget the whole thing,” “do something to take my mind off it”). Youth indicated responses on a 5-point scale ranging from 1 = “never” to 5 = “always.”

To explore the structure of item relations on these new measures, we computed two principal components analysis (PCA) with varimax rotation, one for the measure of coping with stress and one for the measure of coping with violence. In each PCA we retained factor solutions based on component eigenvalues greater than 1 in tandem with consideration of percentages in variance accounted for, breaks in the scree plot, and the meaningfulness of item groupings for items with factor loadings $\geq .40$.

A full table showing the results of these analyses is available upon request from the first author. The pattern of PCA results across the two measures was highly similar with few exceptions. In both cases we retained three subscales generally matching the intended item groupings. (A fourth component had been identified in the PCAs for each measure, but in both cases this component produced eigenvalues closer to 1, appeared after the visual break in the scree plot, and yielded less interpretable item groupings.) Cronbach's alpha coefficients for the subscales were as follows: *Coping with stress*: externalized, 5 items, $\alpha = .79$; internalized, 4 items, $\alpha = .68$; distancing, 6 items, $\alpha = .72$. *Coping with violence*: externalized, 5 items, $\alpha = .83$; internalized, 3 items, $\alpha = .69$; distancing, 6 items, $\alpha = .79$. Subscale composites were computed as the raw mean of all items representing the scale.

Post-traumatic stress symptoms—Youth completed the *Child PTSD Symptom Scale* (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001), a self-report survey measure tapping all 17 hallmark symptoms of post-traumatic stress disorder (PTSD) as delineated in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition-Text revision* (American Psychiatric Association, 2000). Youth first were asked to describe briefly “the most distressing (upsetting) thing that has happened in the last three months.” If they could not identify just one event they could write “a few words describing the kinds of things that

have been upsetting [them] in the last three months.” In case youth could not identify specific upsetting experiences, the first item expanded the response set to incorporate “the distressing event (or other upsetting things that have happened).” Survey items represented the three PTSD syndrome clusters of re-experiencing (5 items; e.g., “having bad dreams or nightmares,” “feeling upset when you think about or hear about the [traumatic] event”), avoidance (7 items; e.g., “try not to think about, talk about, or have feelings about the [traumatic] event,” “trying to avoid activities, people, or places that remind you of the upsetting event”), and hyperarousal (5 items; e.g., “having trouble falling or staying asleep,” “feeling irritable or having fits of anger”). For all items, youth were prompted to indicate how often during the two weeks prior they experienced each symptom along a response scale of 0 = “not at all,” 1 = “once a week or less,” 2 = “2 to 4 times a week / half the time,” or 3 = “5 or more times a week / almost always.” Items can be combined as three separate indicators of syndrome severity and as a total PTSD symptom severity indicator; our interest was in overall PTSD symptom levels so we relied only on the total score computed as the mean of all items on the measure ($\alpha = .88$).

We also coded youths' responses categorically to indicate the presence or absence of clinically meaningful symptoms in order to generate estimates of risk for meeting DSM criteria for a PTSD diagnosis. Item scores of 2 or 3 (i.e., symptoms experienced at least 2 times per week) were coded as “symptom present” and item scores of 0 or 1 were coded as “symptom absent.” We then summed these scores within syndrome clusters and followed DSM criteria to generate diagnoses. Clinical risk status for PTSD was inferred for youth who reported at least one symptom of re-experiencing, at least three symptoms of avoidance, and at least two symptoms of hyperarousal.

Externalizing and internalizing behavior problems—We obtained indicators of youths' internalizing (anxiety, depression) and externalizing (aggression, rule-breaking behavior) problems via youth reports on the *Youth Self Report (YSR)* and caregiver reports on the *Child Behavior Checklist (CBCL)* (Achenbach & Rescorla, 2001). These are rater-specific versions of a well-established standardized clinical rating measure of psychopathology that discriminates clinical from non-clinical samples and is normed for use with youth in our sample age range. The YSR and CBCL provide internally reliable broad-band syndrome scores for both externalizing behavior (YSR $\alpha = .86$; CBCL $\alpha = .94$) and internalizing behavior (YSR $\alpha = .90$; CBCL $\alpha = .90$). Raw mean scores on the YSR/CBCL typically are used for inferential analyses, but we also utilized T-scores to generate estimates of clinical status on externalizing and internalizing behavior. T scores greater than 63 indicate that a youth's symptom levels fall in the clinical range of functioning (Achenbach & Rescorla, 2001).

Competent behavior—Also via the CBCL and YSR measures, we obtained indicators of youths' general competent behavior across three domains: activity involvement, social relationships, and school performance. Again, we incorporated caregiver as well as youth reports. The YSR and CBCL provide internally reliable indicators of competence integrating all three domains (YSR $\alpha = .75$, CBCL $\alpha = .79$). As with the externalizing and internalizing problem scores, we used raw mean scores on the total competence index for inferential analysis. Clinically significant levels on the total competence index are indicated by corresponding T scores less than 37 (Achenbach & Rescorla, 2001).

Procedures

All procedures were conducted following approval by our university's Institutional Review Board. As noted above, participants were recruited via a number of community outreach strategies. The data presented here were collected in the context of a larger project on

youths' experiences in the urban community. Parents/caregivers interested in participating were directed to contact our offices to determine their eligibility. In order to participate, the family had to be residents of the city where data collection occurred, the parent/caregiver had to have legal custody or guardianship of the youth, and the target youth had to be between the ages of 11 and 14 inclusive. Eligible families were invited to schedule an appointment for data collection. At appointed times families (youth and at least one parent/caregiver) came to our university campus office and were guided through an informed consent procedure. Once parents/caregivers provided consent and youth provided assent, formal data collection began. One parent/caregiver was interviewed along with the youth, and interviews were conducted individually in separate private office spaces. The YSR and CBCL were administered by interviewers, whereas the measures of PTSD and coping were presented via desktop computers using the MediaLab program (Empirisoft, 2008). At the end of the procedure, participants received \$80 (\$40 youth, \$40 parent/caregiver) for their time.

Results

Descriptive analyses of coping measures

Table 1 shows descriptive data and intercorrelations among the coping subscales. Paired *t*-tests revealed that despite significant correlations within coping style category, youth reported significantly more distancing coping for stress than for violence, $t(130) = 9.22, p < .001$.

Cluster analysis of coping measures

As shown in Table 1, although most pairwise correlations were large and statistically significant, distancing coping – with stress and with violence – was uncorrelated with most other subscales and only modestly correlated (at $p < .10$) with externalized coping on the coping with violence measure. Because all subscales showed good variability this suggests that youth might have been responding in a manner suggestive of person-level patterns. To explore this possibility we applied k-means clustering via the QUICK CLUSTER procedure in SPSS version 19 to the coping scores after first standardizing them per procedural recommendations. This method utilizes an iterative clustering technique that maximizes distances between cluster centers while minimizing distances between cases within clusters (Aldenderfer & Blashfield, 1984; Boxer, Edwards-Leeper, Goldstein, Dubow, & Heretick, 2003). We computed two sets of cluster solutions, separately for the coping with stress and coping with violence measures. Informed by the correlational analysis, we expected that youth could be characterized as primarily distancing, primarily externalizing-internalizing, or neither of those patterns. We accepted a three-cluster solution due to the coherence of the clustering in accordance with our expectation and an interest in ensuring the relative evenness of the resulting cell sizes for subsequent analysis.

Youth in Cluster 1 reported the lowest levels of engagement in all coping strategies (*low negative coping*; n [stress] = 40, n [violence] = 55); youth in Cluster 2 reported high levels of externalizing and internalizing coping but low levels of distancing coping (*high externalizing/internalizing coping*; n [stress] = 42, n [violence] = 44); and youth in Cluster 3 reported high levels of distancing coping but low levels of externalizing and internalizing coping (*high distancing coping*; n [stress] = 49, n [violence] = 32). Although assignment to the two sets of clusters was not perfectly overlapping, the contingency coefficient of the two cluster groupings was moderate (.438) and significant ($p < .001$) suggesting, similarly to the correlations presented earlier, a meaningful degree of consistency in children's responses to stress and violence. Per nonparametric testing, there was no significant relation between gender and cluster assignment for either stress or violence. Following Aldenderfer and

Blashfield (1984), external criteria were utilized to validate the cluster solution. These are described below.

Coping and mental health indicators

Table 2 presents descriptive data and correlations for the CPSS, CBCL, and YSR scores. Along with continuous scores we include information on the proportion of youth reaching clinical status levels on each of the three indicators. Correlations between mental health indicators and the coping scores (continuous scores, not cluster groupings) were generally modest to moderate in size, ranging from $r = .004$, $p = .966$ (parent-reported externalizing problems and distancing coping with stress) to $r = .628$, $p < .001$ (self-reported externalizing problems and externalized coping with stress), with most in the range of .20–.40. Tests of relations between coping styles and mental health outcomes focused on the coping cluster groups and were conducted separately for coping with stress and coping with violence.

Prior to inferential testing we screened all outcome variables for gender differences. Independent-samples t-tests revealed significant gender differences in four variables: caregiver-rated competence (females > males, $p = .044$), youth-reported competence (males > females, $p = .002$), youth-reported internalizing problems (females > males, $p = .004$) and PTSD-re-experiencing symptoms (females > males, $p = .006$). Differences in outcome score means by cluster group were tested via one-way analysis of variance (ANOVA) procedures, except for the two outcomes that yielded gender differences. For tests of cluster group effects on variables that showed mean-level gender differences, we used analysis of covariance (ANCOVA) with gender fixed as a covariate. We used a significance criterion of .05 to reject the null hypothesis of no cluster group differences. Although we computed a number of inferential tests, increasing the chances for Type I error, we wanted to protect against Type II error in reporting significant results. We include exact p values and estimated effect sizes (η^2 for one-way ANOVA, partial η^2 for ANCOVA) in the presentation of results. We also used nonparametric tests to examine relations between coping clusters and dichotomized indicators of clinical status on externalizing problems, internalizing problems, competence, and PTSD.

Coping with stress—With respect to coping with stress, significant coping-cluster group differences were observed at $p < .05$ for four outcome variables: youth-reported externalizing problems ($F[2,130] = 28.65$, $p < .001$, $\eta^2 = .309$), youth-reported internalizing problems ($F[2,130] = 7.83$, $p = .001$, partial $\eta^2 = .110$), total PTSD symptoms ($F[2,130] = 5.03$, $p = .008$, $\eta^2 = .073$), and youth-reported competence ($F[2,130] = 3.63$, $p = .029$, partial $\eta^2 = .055$). In the first three cases, post-hoc testing showed that youth in the high externalizing-internalizing coping cluster were significantly more emotionally/behaviorally distressed than were youth in either the low negative coping or high distancing coping cluster. Outcome scores on those three variables did not differ significantly between the low negative and high distancing cluster groups. In the case of youth-reported competence, post-hoc testing indicated that youth in the low negative coping cluster reported significantly higher levels of competence than did youth in the other two clusters, with no difference in competence between the high externalized-internalized and high distancing cluster groups.

In terms of clinical or practical significance of coping cluster differences, we found that clinical levels of youth-reported externalizing behavior ($\chi^2 [2] = 14.47$, $p = .001$) and youth-reported internalizing behavior ($\chi^2 [2] = 9.57$, $p = .008$) were associated with coping cluster group. In the externalized-internalized cluster group, 19.0% of youth (8/42) were in the clinical range of externalizing behavior problems (compared to 7.5% for the low negative group and 4.1% for this high distancing group) and 23.8% (10/42) were in the clinical range

of internalizing behavior problems (compared to 0% in the low negative group and 2% in the high distancing group).

Coping with violence—With respect to coping with violence, significant coping-cluster group differences were observed at $p < .01$ for three youth-reported outcome variables: externalizing problems ($F[2,130] = 7.16, p = .001, \eta^2 = .101$), internalizing problems ($F[2,130] = 8.73, p < .001, \text{partial } \eta^2 = .121$), and total PTSD symptoms ($F[2,130] = 11.14, p < .001, \eta^2 = .148$). In all cases, post-hoc tests revealed that youth in the high externalizing-internalizing coping cluster were uniformly the most emotionally/behaviorally distressed, with no differences in outcome scores between youth in the low negative coping and high distancing cluster groups.

In terms of clinical or practical significance, we observed clinical levels of youth-reported internalizing behavior ($\chi^2 [2] = 6.87, p = .032$) and post-traumatic stress symptoms ($\chi^2 [2] = 10.56, p = .005$) by coping cluster group. In the externalized-internalized cluster group, 20.5% of youth (9/44) were in the clinical range of internalizing behavior problems (compared to 3.6% for the low negative group and 12.5% for the high distancing group) and 13.1% (8/44) were in the clinical range of PTS symptoms (compared to 0% for the low negative group and 9.3% for the high distancing group).

Table 3 displays descriptive statistics for the outcome measures by coping-cluster groups, with superscripts added to means in order to denote significant coping-cluster group differences.

Discussion

In this study, we sampled 131 early adolescents from a large metropolitan community in the northeast to examine relations among coping with stress and violence and several important indicators of behavioral and mental health. Using a person-centered approach to understanding our data, we discovered that youth whose principal negative coping styles in response to stress and violence represented externalized (e.g., aggression) and internalized (e.g., social withdrawal) reactions also reported significantly higher and/or clinically meaningful levels of problem behavior and post-traumatic stress reactions. In contrast, youth whose principal negative coping styles represented distancing strategies (e.g., distraction) did not show elevated problem behavior or post-traumatic stress. Youth who tended not to endorse engagement in either externalized-internalized or distancing coping reported the highest levels of overall competence. These results have implications for the measurement of youths' coping reactions to stress and violence in accordance with key theoretical views as well as the tailoring of targeted interventions for youth exposed to chronic stress and/or violence.

Coping is a broad construct that has received a great deal of attention from scientists and clinicians working with child as well as adult populations. Fundamentally, coping consists of behavioral, cognitive, and/or emotional reactions in response to some stressor (Dubow & Rubinlicht, 2011). Stressors have been conceptualized elegantly by Lazarus and Cohen (1977) as demands made by internal or external environment that upset one's "balance" and affecting physical and psychological well-being to the extent that some form of action is required to restore that balance. Many studies have shown that when youth engage in coping strategies (i.e., approach or engagement coping) that can meaningfully change the stressors to which they are responding, or modify their emotional reactions to those stressors, their outcomes are optimized. The sorts of stressors that enable these kinds of responses are likely to be fairly controllable, unstable, and specific.

In the present study, we focused on negative coping responses and associated stresses – avoidant or disengaged coping behaviors that typically have been associated with poorer outcomes, and violence in addition to stress in general. Definitions of “stress” for respondents are probably idiosyncratic and most likely construed a number of different ways by participants in our study. Yet violence is very commonly viewed as a stressor that is uncontrollable, stable, and global. This might especially be the case for violence in the community. Our finding of differences in mean levels of coping strategy endorsement across the stress in general and violence measures, but otherwise significant relations between the two measures in terms of coping subscale correlations as well as coping cluster contingency coefficients, suggests an important degree of generalized cross-situational coping style in our sample with respect to those sources of stress. In other words, how youth cope with “stress” appears to be related meaningfully to how they cope with violence. Of course, it might be the case that for some youth in our sample – particularly those living in higher-violence contexts – “stress in general” might accrue primarily through violence exposure.

Still, the finding that youth from a generally socioeconomically distressed metropolitan community seem to cope in similar ways with violence as well as more general stress and distress is an important contribution with respect to recent observations concerning the context of youths' coping with violence, and the coping strategies of youth – particularly ethnic minority youth – from economically disadvantaged areas. For example, Tolan and Grant (2009) described the broader community socialization context around the development of children's coping styles; Kliever and colleagues (e.g., Kliever et al., 2006) have similarly identified the critical importance of parental socialization of children's coping. It might be the case that overarching socioeconomic and family contextual influences under distressed conditions promote similar patterns of coping across different stressors.

As noted, we focused on coping strategies most typically associated with poorer behavioral and mental health outcomes – negative coping responses including externalizing, internalizing, and distancing strategies. Although variable-centered principal components analysis generally supported the independence of these three strategies in our sample, across both types of stressor, person-centered cluster analysis joined the externalizing and internalizing strategies in a single cluster group of youth high in both, and isolated the distancing strategy in a different group high just in that strategy, while also creating a group of youth who were relatively low endorsers of all three strategies. This analysis, in conjunction with our observations from subscale correlations, revealed the surprising finding that, at least in this particular sample of youth, distancing coping was not associated with symptoms. The only instance of distancing showing any relation to less optimal outcomes was in regard to youth-reported overall competence: youth in the distancing cluster group for coping with stress in general had competence scores equivalent to youth in the externalized-internalized group, and both were significantly less competent than were youth in the low negative coping group.

We share Gaylord-Harden et al's (2010) recent acknowledgement of the need for more research on coping among low-income, ethnic minority youth in order to promote the development of effective interventions in this population, and we believe the current study represents an important move in that direction. In this sample, contrary to prior studies suggesting an aggregation of externalized, internalized, and distancing coping styles as uniformly negative, we found that distancing coping was largely unrelated to problem outcomes. Though not necessarily promotive of positive outcomes, it might be that distancing coping acts at least to inhibit the development of behavioral and mental health symptoms in response to stress and violence. Future studies utilizing longitudinal methodology should investigate this proposition, especially with the addition of positive

coping strategies for comparison; our work is limited in this regard by the cross-sectional design of the study and the absence of positive coping items.

From the standpoint of effective prevention and intervention, additional studies could explore whether teaching distancing coping strategies could be useful in the context of short-term cognitive-behavioral interventions for children exposed to stress or violence in which the goal is to defuse negative emotions before they trigger adverse behavioral reactions. Also, given recent observations about important differences between how youth cope with different types of violence exposure – i.e., witnessed violence versus victimization by violence (e.g., Reid-Quinones et al., 2011) – future work should investigate whether those differences ultimately translate to different outcomes, and whether distancing coping in particular represents an “effective” or “adaptive” (Brady, Gorman-Smith, Henry, & Tolan, 2008) form of coping for witnessing or victimization by violence. This information, especially in the context of person-centered analysis of coping styles, could be particularly useful for selected interventions aimed at helping witnesses and/or victims of violence more efficiently.

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Table 1

Descriptive statistics for coping measures

Scale	M	SD	Range	1	2	3	4	5	6
Coping with stress									
1 Externalized	1.80	.85	1-4.4	--					
2 Internalized	2.14	.91	1-5	.49**	--				
3 Distancing	2.77	.78	1-5	-.01	-.01	--			
Coping with violence									
4 Externalized	1.84	.89	1-4.4	.58**	.41**	.12	--		
5 Internalized	2.04	.92	1-4.7	.37**	.50**	.01	.43**	--	
6 Distancing	2.03	.81	1-5	.05	-.06	.32**	.15 ⁺	-.01	--

⁺ $p < .10$ * $p < .05$ ** $p < .01$

Table 2

Descriptive statistics for mental health measures

Scale	M	SD	Range	% c/n	1	2	3	4	5	6	7
CBCL (caregiver reports)											
1 Externalizing problems	7.73	7.50	0–43	11.4	--						
2 Internalizing problems	7.14	6.89	0–32	13.6	.64**	--					
3 Competence	21.75	4.44	7.5–32	25.8	-.38**	-.30**	--				
YSR (self-reports)											
4 Externalizing problems	9.34	6.76	0–31	7.6	.26**	.08	-.00	--			
5 Internalizing problems	11.73	7.61	1–39	12.1	.19*	.28**	.07	.53**	--		
6 Competence	20.45	3.99	11–29	22.0	-.11	-.13	.31**	-.11	-.17 ⁺	--	
CPSS (self-reports)											
7 Total	.58	.52	0–3	8.4	.31**	.27**	.00	.38**	.61**	-.16 ⁺	--

⁺
 $p < .10$ *
 $p < .05$ **
 $p < .01$

Table 3

Mental health outcomes across coping cluster groups

	CBC-EXT		CBC-INT		CBC-COMP		YSR-EXT		YSR-INT		YSR-COMP		CPSS	
	M(SD)	%clin	M(SD)	%clin	M(SD)	%clin	M(SD)	%clin	M(SD)	%clin	M(SD)	%clin	M(SD)	%clin
Coping with stress														
Hi ext-int	8.38 (7.23)	14.3	8.14 (7.84)	14.3	21.85 (4.48)	23.8	14.81 ^a (6.65)	19	15.71 ^a (8.37)	23.8	19.59 ^a (3.64)	31	.79 ^a (.53)	11.9
Hi distancing	7.94 (6.82)	10.2	6.67 (5.84)	12.2	20.97 (4.28)	32.7	7.06 ^b (5.19)	2	9.92 ^b (6.42)	4.1	19.99 ^a (3.81)	22.4	.49 ^b (.39)	6.1
Low negative	6.88 (8.67)	10	6.75 (7.15)	15	22.58 (4.57)	20	6.43 ^b (5.14)	0	9.95 ^b (6.64)	7.5	22.06 ^b (4.10)	10	.48 ^b (.60)	7.5
Coping with violence														
Hi ext-int	9.27 (8.13)	13.6	8.70 (8.26)	20.5	22.68 (4.08)	22.7	11.89 ^a (6.86)	11.4	15.50 ^a (9.03)	20.5	19.81 (3.12)	18.2	.85 ^a (.66)	18.2
Hi distancing	6.81 (6.08)	15.6	6.13 (6.19)	12.5	21.31 (3.45)	25	9.94 ^b (6.17)	3.1	11.56 ^b (6.20)	12.5	20.58 (4.15)	25	.55 ^b (.46)	9.4
Low negative	7.09 (7.71)	7.3	6.55 (5.97)	9.1	21.24 (5.15)	29.1	6.98 ^b (6.35)	5.5	8.95 ^b (5.74)	3.6	21.02 (4.43)	21.8	.39 ^b (.31)	0

Note. Variables with means denoted by superscripts showed significant differences by cluster group. Means with different superscripts within columns are significantly different.