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Stressful Life Events and Perceived Parental Control in Formerly Homeless Families: Impact on Child Internalizing Symptoms

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Abstract

Research has neglected the potential role of perceived parental control as a moderator between stressful life events (SLEs) and child internalizing symptoms. Using secondary data from the *Early Risers “Skills for Success” Program*, this study examined the impact of perceived parental control on the association between SLEs and child internalizing symptoms in formerly homeless families. The sample consisted of 137 families with 223 children between 4 and 12 years of age ($M = 8.1$, $SD = 2.3$) living in supportive housing sites in Minneapolis, Minnesota. Participants completed measures assessing the number of SLEs experienced (e.g., unemployment of parent, death of loved one, serious illness, homelessness, etc.), perceived parental control, and child internalizing symptoms. In this sample, 65% of children ($n = 144$) experienced at least one SLE with an average experience of two events ($M = 2.0$, $SD = 1.9$, Range: 0–7 SLEs). A regression analysis found that experiencing more SLEs and a perceived absence of parental control over child behavior were positively associated with child internalizing symptoms. A significant interaction between SLEs and perceived absence of parental control over child behavior in predicting child internalizing symptoms was also found. These findings suggest that children of parents who model appropriate control are more likely to experience fewer internalizing symptoms in response to SLEs.

Keywords

children; families; homelessness; internalizing symptoms; perceived parental control

In 2014, nearly 600,000 people were homeless in the United States (National Alliance to End Homelessness, 2015). This estimate includes more than 360,000 individuals and 240,000 families. The average homeless family in the United States consists of a single mother in her mid- to late-twenties with two children (HUD; Department of Housing and Urban Development, 2015). While the causes of homelessness vary, they include stressful life events (SLEs) such as unemployment, loss of a family member or friend, and personal injury (Dougherty et al., 2013; Grover, Ginsburg, & Ialongo, 2005; Zugazaga, 2004). Any incident that exceeds an individual's personal and social resources, and thus ability to cope, is considered a SLE (Fisher, 2016; Holmes & Rahe, 1967; Selye, 1973).

SLEs place tremendous strain on a family. The resulting sense of helplessness lowers perceived parental control and leads to internalizing symptoms in children. While previous research has examined the impact of SLEs on child internalizing symptoms, it has not examined the impact of perceived parental control on the relationship between SLEs and child functioning (Platt, Williams, & Ginsberg, 2016). As such, this study investigated whether or not perceived parental control influences the relationship between SLEs and child internalizing symptoms in formerly homeless families.

Understanding the relationship between SLEs and perceived parental control in this population is critical to mitigate the devastating effects of child internalizing symptoms. Merrill, Richards, and Sloan (2011), for instance, examined exposure to SLEs in more than 200,000 homeless and non-homeless mothers across the United States using secondary data from the Pregnancy Risk Assessment Monitoring System (PRAMS, Robbins et al., 2014). The PRAMS is a longitudinal project of the Centers for Disease Control and Prevention (CDC) on state-based maternal health before, during, and immediately after pregnancy. They found that the most common SLEs experienced by homeless families were moving (64%), inability to pay bills (47%), and interpersonal relationship problems (64%). The strongest correlation Merrill et al. (2011) found was between homelessness and physical abuse ($\beta = .41, p < .001$). This finding is consistent with previous estimates that over 90% of homeless mothers have experienced or witnessed severe physical and/or sexual abuse (HUD, 2015). They also found that the frequency of SLEs, which is significantly higher among homeless women than their non-homeless counterparts, is associated with negative child outcomes.

Similarly, Crusto et al. (2010) examined the relationship between traumatic events and parenting stress in 175 children and their parents living in an urban environment who met the federal poverty criteria (i.e., annual household income of approximately \$20,000 for a family of three). The majority of children were boys ($n = 88$) and racial minorities (i.e., $n = 49$ African-American, $n = 67$ Latino/Hispanic) with an average age of 4.4 years ($SD = 0.8$). Families experienced an average of two traumatic events, with children experiencing nearly five different types of events ($SD = 2.9$; Range: 0–13). The three most frequent traumatic events were seeing a physical assault (42.4%), parent separation from child (40.9%), and the imprisonment of a family member (34.4%). Crusto et al. (2010) found a significant positive relationship between posttraumatic stress (PTS) symptoms in children and family violence/other family-related traumatic events ($\beta = .19, p < .05$), non-family violence/traumatic events ($\beta = .18, p < .05$), and parenting stress ($\beta = .34, p < .001$). They also found a direct relationship between the number of traumatic events experienced and clinically significant distress in children (i.e., multiple events had an additive effect). These findings suggest that the cumulative effect, rather than type, of traumatic event is associated with greater negative child outcomes.

Using secondary data from the National Evaluation of Safe Start Promising Approaches (SSPA) program, which is funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Hickman et al. (2012) examined the relationship between violence, child internalizing/externalizing symptoms, and parenting stress. Children were evenly split between genders ($n = 399$ females, $n = 369$ males) with an average age of 4.9 years ($SD = 2.6$). The majority of children identified as racial minorities (i.e., $n = 215$ Hispanic, $n = 184$

African-American). Children experienced an average of 8.8 violent events ($SD = 11.59$) in their lifetime, which consisted of 16 different types separated into four categories (i.e., child physical assault, child maltreated by adult, witnessing violence, and sexual abuse). Three of the most frequent events were seeing or hearing intimate partner violence (IPV; 70%), seeing someone get attacked or hit on purpose without a weapon (41%), and being attacked by a parent/caregiver without an object or weapon (31%). Hickman et al. (2012) found that the number (i.e., frequency) of violent events predicted both negative child outcomes ($\beta = .13, p < .05$) and parenting stress ($\beta = .13, p < .05$). Again, this is consistent with previous studies that found the number of events being more predictive of negative child outcomes than the type.

Parenting Stress in Homeless Families

Experiencing SLEs and subsequently becoming homeless presents unique challenges to raising children. SLEs are associated with impaired parenting (Appleyard & Osofsky, 2003) and parenting stress (Crusto et al., 2010; Salloum, Smith Stover, Swaidan, & Storch, 2014). It is important to note, however, that impairment is not synonymous with incapacitation or disability. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (APA; American Psychiatric Publishing, 2013) defines impairment as reduced functioning. As such, impaired parenting refers to an individual's inability to perform "normal" caregiving practices.

The perceived absence of internal (i.e., personal) control further exacerbates parenting stress (Salloum et al., 2014). Locus of control (LOC) refers to the extent a parent believes that their circumstances (e.g., homelessness) are a function of their actions or factors beyond their control (Rotter, 1966; Moorhead & Griffin, 2004). As such, LOC is characterized by perceived power, autonomy, and competence. This means that parents who believe they are in control of circumstances (i.e., events) have an internal locus of control (ILOC) whereas parents who have an external locus of control (ELOC) believe they do not have control over events.

Parenting stress in homeless families also produces challenges that exacerbate existing problems (McNeal Smith, Holtrop, & Reynolds, 2015). A parent's perception of child-rearing competence and other restrictions influence the relationship between SLEs and child adjustment. Östberg and Hagekull (2013), for instance, examined the effect of parenting stress following exposure to SLEs (e.g., death of parent or sibling, conflict between parent and close family friend, unemployment, conflict at work, economic problems) on child internalizing problems in 436 children, with an average age of 7.4 ($SD = 1.5$) years. They found moderate associations between SLEs and parenting stress ($r = 0.34$), as well as, parenting stress and child internalizing symptoms ($r = 0.40$). It may be that the fear and helplessness accompanying an ELOC interferes with parents' efforts to appropriately attune and respond to children's needs. These findings further suggest that parenting stress due to SLEs influences negative child adjustment.

Child Internalizing Symptoms in Homeless Families

Homeless children are four times more likely to be diagnosed with internalizing symptoms (i.e., anxiety and depression) than their non-homeless peers (for a comprehensive meta-analysis see Hodgson, Shelton, van den Bree, & Los, 2013). With regard to homelessness, McLaughlin et al., (2010) found that an environment characterized by stress and conflict is associated with an increased likelihood of developing internalizing symptoms. Similarly, Kim, Conger, Elder, and Lorenz (2003) examined the relationship between SLEs and adolescent internalizing symptoms. In a group of 451 adolescents, they found a reciprocal relationship between SLEs and internalizing symptoms (i.e., SLEs led to internalizing symptoms and internalizing symptoms increased the risk for exposure to future SLEs).

Theoretical Framework

According to the social interaction learning (SIL) model, disrupted parenting affects the relationship between child adjustment and the environment (Patterson & Reid, 1984; Patterson, 2002). In a comprehensive literature review, Gewirtz et al. (2008) examined the mechanism through which SLE-related trauma is transmitted from parents to children. This mechanism is relevant to research on the risks associated with homelessness and perceived parental control. Therefore, informed by the SIL model, this study aimed to explore the impact of perceived parental control on the association between SLEs and child internalizing symptoms in formerly homeless families. The specific aims were to: (1) examine the association between SLEs (i.e., unemployment of parent, divorce of parent, death of loved one, serious illness, victim of violent crime, accidental illness requiring hospitalization, eviction, and legal problems resulting in detention or jail time) and child internalizing symptoms; (2) investigate the association between perceived parental control and child internalizing symptoms; and (3) determine whether or not perceived parental control influences the relationship between SLEs and child internalizing symptoms.

Hypotheses

An absence of empirical studies on the relationship between SLEs, perceived parental control, and child internalizing symptoms limits the knowledge of parenting practices in homeless and formerly homeless families. SLEs are relevant to this population insofar as they not only exacerbate existing family dysfunction but also reduce positive interactions, and thereby increase the occurrence of child internalizing symptoms. As such, SLEs were operationalized as incidents that disrupt otherwise normative family processes. Within the SIL model, the impact of such incidents interrupts parenting practices and contribute to child internalizing symptoms. Applying this model, perceived parental control was hypothesized to moderate the relationship between SLEs and child internalizing symptoms. Specifically, children whose parents have an ILOC were predicted to display lower internalizing symptoms in response to SLEs than children whose parents have an ELOC.

Methods

Secondary Data

This study used secondary data from the *Early Risers “Skills for Success” Program*, a multifaceted preventative intervention developed at the University of Minnesota. This program was designed for elementary school children who experience early adjustment difficulties that may be linked to future risky behaviors such as substance use and conduct problems (August, Realmuto, Hektner, & Bloomquist, 2001; Bernat, August, Hektner, & Bloomquist, 2007). Although a detailed description of the participant recruitment process and eligibility criteria is available elsewhere (i.e., Gewirtz, DeGarmo, Plowman, August, & Realmuto, 2009), it is briefly summarized here.

Initially 152 families with 253 children living in 16 single-site supportive housing communities in Minneapolis, Minnesota were recruited. After 18 families with 40 children relocated or withdrew before the baseline assessment, an additional 8 families with 17 children were recruited. The subsequent sample consisted of 142 families with 229 children ($n = 126$ children assigned to the prevention program; $n = 103$ children assigned to services as usual). Of that sample, 5 families with 6 children could not be contacted or declined participation. The final sample comprised 137 families with 223 children ($n = 121$ children in families assigned to the prevention program; $n = 102$ children in families assigned to services as usual) residing in 1 of 16 different supportive housing sites. All families had to meet the federal homelessness criteria in order to qualify for placement in a supportive housing site. The four categories for defining homelessness were: (1) literal homelessness; (2) imminent risk of homelessness; (3) homeless under other federal status; and (4) fleeing/attempting to flee domestic violence (HUD; United States Department of Housing and Urban Development, n.d.). Because the current analyses focused only on baseline data, random assignment did not influence results.

Participants

Between 1 and 34 families resided at each study site ($M = 14.87$). Families had between 1 and 5 ($M = 1.6$) children. The mean child age was 8.12 years ($SD = 2.3$) and nearly half of the children identified as female ($n = 109$). The majority of children ($n = 151$) also had siblings in the study. Families were predominantly headed by a single parent, nearly all ($n = 134$) of whom were women. The mean age of mothers was 33 years ($SD = 6$). Participants identified as Asian ($n = 5$, 2.2%), African-American, ($n = 108$, 48.8%), Hispanic ($n = 5$, 2.2%), Multiracial ($n = 46$, 20.6%), Native ($n = 11$, 4.9%), Other ($n = 5$, 2.2%), and Caucasian ($n = 43$, 19.3%). The average annual household income was \$10,347 ($SD = \$5,595$). In this sample, 65% of children ($n = 144$) experienced at least one SLE in the past year, with an average experience of two events ($M = 2.0$, $SD = 1.9$, range: 0–7 SLEs) (see Table 1 for sociodemographic composition of participants).

The top three SLEs reported by participants were: (1) moving or change of household (22.4%); (2) unemployment of parent (21.1%); and (3) the death of a loved one (16.1%) (see Table 2 for SLE types and frequencies experienced by children).

Procedure

Case managers at each housing site participated in recruitment and introduction of research assistants. Research assistants contacted families to obtain consent and schedule a two-hour administration of measures. Both parent and child were present during administration of the consent form. Separate assessments were scheduled for families with more than one child. All measures (e.g., stressful life events, perceived parental control, and child internalizing symptom) in the present study were administered to parents without their children present. The University of Minnesota Institutional Review Board (IRB) approved recruitment and data collection procedures. Parents provided informed consent while children provided assent to participate in the research. Issues regarding mandated reporting procedures were reviewed with all families as part of this consent process.

Demographics—Participant ethnicity, family composition, marital history, parent education, and occupation data were collected with the Early Risers Biographical Questionnaire. Ethnicity was coded as a single binary variable for the current analyses (i.e., “0” for Caucasian and “1” for non-Caucasian). This decision was made to control for the potential impact of minority status. Gender was also coded as a binary variable (i.e., “0” for males and “1” for females).

Stressful life events—The Early Risers Biographical Questionnaire was also used to collect the frequency and type of SLEs experienced. SLEs included: (1) unemployment of parent; (2) divorce of parents; (3) death of loved one; (4) serious illness; (5) victim of violent crime; (6) eviction from apartment; (7) legal problems (resulting in jail time or detention); (8) accidental injury (requiring hospitalization); (9) move or change of household; (10) separation of parents (from each other); (11) unexpected separation of child (from parent); (12) homelessness; and (13) child experiencing danger (of being killed or badly hurt). Participants reported “yes” or “no” to indicate whether or not they had experienced a SLE in the past year. A composite SLE score was created by adding the total number of different events experienced.

Perceived parental control—The 47-item Parental Locus of Control (PLOC) Scale ($\alpha = .92$) was developed to assess different factors related to perceived parenting control across five subscales (Campis, Lyman, & Prentice-Dunn, 1986). The PLOC is associated with parenting style (Pereira, Barros, Mendonça, & Muris, 2014) and self-regulation in the context of parenting (Sanders & Mazzucchelli, 2013). It also has good validity across different income levels, which reflects a defining characteristic of homelessness (Campis et al., 1989) and diverse cultural backgrounds (Ortega, 2001).

The first subscale measures parental efficacy ($\alpha = .75$). A sample item is, “What I do has little effect on my child’s behavior.” A high score indicates perception of ineffective parenting. The second subscale measures parental responsibility ($\alpha = .77$). A sample item is, “There is no such thing as good or bad children – just good or bad parents.” Since all items on this subscale are reverse scored, a low score reflects perceived absence of parental responsibility. The third subscale is child control of parents’ life ($\alpha = .67$). A sample item is, “My life is chiefly controlled by my child.” A high score on this subscale reflects the

perception that a child's needs and demands are dominating (including some reverse scored items). The fourth subscale measures parental belief in fate or chance ($\alpha = .75$). A sample item is, "Being a good parent often depends on being lucky enough to have a good child." A high score indicates the perception that external factors influence parenting and child behaviors. The final subscale measures parental control of child's behavior ($\alpha = .65$). A sample item is, "My child's behavior is sometimes more than I can handle. Similar to the third subscale, a high score reflects the perception of low control over a child's behavior with some items reverse scored.

Child internalizing symptoms—The Behavior Assessment System for Children, Second Edition (BASC-2; Reynolds & Kamphaus, 2004) ($\alpha = .81-.96$) was developed to evaluate the behavioral and emotional status of children. Strong reliability and validity of these subscales has been demonstrated with youth (i.e., children and adolescents) in the United States (Reynolds et al., 2004). The Parent Report Scale (PRS), which contains 150 items that measure the parent's perspective ($\alpha = .88-.90$), was examined for this study. Responses are scored on a four-point scale, from "0" for never to "3" for almost always.

The internalizing problems composite ($\alpha = .90$) consists of anxiety, depression, and somatization scales (Rescorla, 2009). The anxiety scale ($\alpha = .83$) measures the tendency to be nervous about real or imagined problems. The depression scale ($\alpha = .87$) measures the tendency to have feelings of unhappiness and sadness that may result in being unable to engage in everyday activities. The somatization scale ($\alpha = .83$) examines the tendency to be overly sensitive to relatively minor physical problems or discomfort. The internalizing composite score was examined due to the strong clinical association between anxiety and depression and other internalizing symptoms (Axelson & Birmaher, 2001; Beekman, de Beurs, van Balkom, Deeg, Dyck, & van Tilburg, 2000). The BASC-2 also has good validity across different income levels and cultural backgrounds (Reynolds et al., 2004; Lapointe, Celia Garcia, Taubert, & Sleet, 2010).

Data Analysis

Data were analyzed with Mplus 7 (Muthén & Muthén, 2012). Participants were nested, and not independent from each other, in two primary levels. The first level consisted of children and the second level consisted of children nested within families. The COMPLEX analysis feature of Mplus was used in order to prevent an inflated chi-square and root-mean square error by accounting for non-independence (i.e., multi-collinearity) among data (Muthén et al., 2012). Independent variables consisted of the number of SLEs experienced and perceived parental control whereas the dependent variable consisted of child internalizing symptoms (see Table 4 for bivariate correlations, means, and standard deviations of the main variables).

In addition to looking at main effects of perceived parental control on child internalizing symptoms, perceived parental control was examined as a potential moderator between SLEs and child internalizing symptoms. An interaction model was estimated by adding interaction terms between each of the five PLOC scores and SLEs to the main effects model. All variables used in interaction terms were centered around their means. Simple slopes were

plotted and interpreted for significant interaction effects. Missing data was handled with full information maximum likelihood (FIML) because it provides more statistically reliable standard errors when compared to mean-imputation, list-wise deletion, or pair-wise deletion (Muthén et al., 2012; Wothke, 2000).

A multiple linear regression model was tested to address the following research questions: (1) are SLEs associated with child internalizing symptoms; (2) is perceived parental control associated with child internalizing symptoms; and (3) does perceived parental control influence the association between SLEs and child internalizing symptoms? A stepwise approach was used to examine predictors after checking for linearity, normality, independence, and homoscedasticity (Cohen, 1968).

Results

A basic main effects model was estimated using demographic variables (i.e., ethnicity, mother's level of education, age, and gender). In this model, neither ethnicity, the mother's level of education, nor the child's gender significantly predicted internalizing. The child's age, however, significantly predicted internalizing symptoms ($b = .76$, $\beta = .14$; $p < .05$) insofar as older children experienced more internalizing symptoms. SLEs were then added to the main effects model. SLEs also significantly predicted child internalizing symptoms ($b = 1.45$, $\beta = .22$; $p < .01$). That is, more SLEs were associated with higher levels of child internalizing symptoms.

The subsequent multiple linear regression models added five perceived parental controls. In these models, neither parental efficacy, parental responsibility, child control of parent life, nor parent belief in fate or chance significantly predicted child internalizing symptoms. Parent control of child behavior, however, significantly predicted child internalizing symptoms ($b = .42$, $\beta = .25$; $p < .01$); parents who perceived an absence of control over their child's behavior had children with more internalizing symptoms. An interaction model was then tested by adding interaction terms between SLEs and each of the five perceived parental controls: (1) SLEs $\times$ Parental Efficacy; (2) SLEs $\times$ Parental Responsibility; (3) SLEs $\times$ Child Control of Parent Life; (4) SLEs $\times$ Parent Belief in Fate or Chance; and (5) SLEs $\times$ Parent Control of Child Behavior. In this model, the interaction between SLEs and child control of parent life was a significant predictor of child internalizing symptoms ($b = .36$; $\beta = .24$; $p < .01$). Other significant predictors from the previous perceived parenting control model retained their significance in the interaction model.

To achieve a more parsimonious model and reduce potential multicollinearity, non-significant interaction terms were dropped from the model. In this final model, the interaction between SLEs and child control of parent life remained a significant predictor of child internalizing symptoms ($b = .28$, $\beta = .18$; $p < .05$). This interaction effect indicated that SLEs do not have a strong impact on internalizing symptoms when parents perceive their children as having less control over their life (see Figure 1 for interaction between SLEs and parent perception of child control on parent life on child internalizing symptoms).

However, more SLEs were reliably associated with an increase in child internalizing symptoms for parents who perceive their children as having a high level of control over their lives (see Table 3 for factor loadings, standard errors, and p-values for each predictor included in the final model).

Discussion

Although existing evidence suggests an association between SLEs and child internalizing symptoms, it is unclear to what extent perceived parental control influences this association. In this study, we examined whether perceived parental control moderates the relationship between SLEs and child internalizing symptoms in formerly homeless families. Several interesting findings emerged. Children who experienced more SLEs had higher rates of internalizing symptoms. This finding is particularly relevant to homeless families because they often face additional challenges (e.g., discrimination and prejudice) that contribute to a high frequency of SLEs, which could in part account for the high rates child internalizing symptoms observed in this population (e.g., Phelan, Link, Moore, & Stueve, 1997).

Perceived parental control of child behavior, a specific aspect of LOC, was negatively associated with child internalizing symptoms. Parents who did not feel in control over their child's behavior were more likely to have children with internalizing symptoms. Surprisingly, other perceived parental control factors (i.e., efficacy, responsibility, belief in fate or chance, and child control of parents' life) were not associated with child internalizing symptoms. It may be that children learn emotion regulation through modeling (e.g., Bariola, Gullone, & Hughes, 2011), which is consistent with the SIL model assumption that parenting practices are a predictor of child adjustment (e.g., Forgatch & DeGarmo, 1999). That is, parents who perceive themselves in control of their children's behavior project calm and competence. This may help children trust that their parents are in control and feel more secure in response.

A new finding that emerged from this study was the interaction between SLEs and perceived parental control in predicting child internalizing symptoms. SLEs had a stronger impact on child internalizing symptoms when parents believed children had control over their (i.e., parents') lives. A perceived absence of parental control (i.e., ELOC) was associated with more child internalizing symptoms in response to SLEs. This finding suggests that formerly homeless children are more susceptible to internalizing symptoms following exposure to SLEs if their parents feel overwhelmed. In other words, formerly homeless parents who perceive and presumably model appropriate control moderate (i.e., weaken) the impact of SLEs on their children and thereby reduce the associated risk for internalizing symptoms in their children. While it is important to note that only child outcomes were assessed in the current study, this finding is notable because it suggests that perceived parental control may be an indicator of resilience among recently homeless families who are considered an extremely high-risk population (e.g., Ganong & Coleman, 2002). Indeed, other outcome analyses of this study indicate that the *Early Risers "Skills for Success" Program* improved mothers' perceived parental control, leading to stronger observed parenting and improvement in child adjustment (e.g., Gewirtz et al., 2015).

Limitations

There are a number of important limitations to note when considering the findings from this study. Causal inferences cannot be made from non-experimental and cross-sectional data because they capture associations only at one point in time. Data also relied exclusively on parent report. This may have inflated some associations due to shared measurement error. Moreover, data was obtained from families who were recently given access to resources (i.e., supportive housing) that many homeless and highly mobile families lack. The parents in this study were thus arguably in a better situation than families who lacked access to similar resources. Participants may also have responded to measures with socially desirable answers. This is further complicated due to shame and other negative feelings related to social comparison often accompanying homelessness. Measures also did not assess the severity of SLEs. It may be that certain events have a more devastating impact on perceived parental control, and thus, child internalizing symptoms.

Despite these limitations, the findings from this study have heuristic value in terms of elucidating potential mechanisms by which SLEs affect children's adjustment and mental health. While previous research has consistently documented the role of ineffective and non-contingent parenting practices with child externalizing behavior problems (e.g., Costa et al., 2006) there is less understanding of how parenting is related to child internalizing symptoms. The present findings suggest that how parents perceive control over their lives and the lives of their children may have explanatory impact for their children's internalizing problems. Parents who feel they have little control may model behaviors of "learned helplessness." Such exposure may in-turn influence children's attributions of responsibility for their parents' functioning. Children who believe they are overly responsible in some way for their parents' status may internalize feelings of helplessness in the face of SLEs, leading to sadness, despair or anxiety.

The findings from this study also have implications for service delivery and public policy. Concerning service delivery, interventions that promote an ILOC may help mitigate the some of the negative effects of the SLEs associated with homelessness on children. The current findings lend support to intervention research demonstrating the value of building parenting practices and associated ILOC. Parent Management Training – Oregon Model (PMTO), for instance, is an evidence-based intervention that not only improves parenting practices but also reduces and prevents internalizing symptoms in children. Perlman, Gewirtz, Cowan, Haskett, and Stokes (2012) reviewed findings of studies that targeted child internalizing symptoms through parenting practices with PMTO. They found this intervention improved parenting practices, particularly for high-risk mothers, and significantly reduced internalizing symptoms in children. Regarding public policy, it is advisable for transitional housing agencies to collaborate with partners to address the parenting needs of homeless families. This is critical insofar as these agencies understandably often have a primary focus on meeting families' more immediate needs. Additional efforts to address the underlying factors associated with families' successful coping with the stressors associated with homelessness may be particularly impactful.

Future Directions

A number of future research directions will increase the understanding of how exposure to SLEs and perceived parental control are associated with child internalizing symptoms. Since causal inferences cannot be made from cross-sectional data, the longitudinal interaction between SLEs, perceived parental control, and child internalizing symptoms should be examined. It may be that cross-sectional data, especially in formerly homeless families, does not accurately capture the influence of perceived parental control on the relationship between SLEs and child internalizing symptoms over time. The role of race and ethnicity should also be examined in more detail in the context of the current findings. While the current sample was consistent with national populations of families confronting homelessness with a preponderance of minority families, the current sample size lacked power to more carefully examine the unique experiences of different ethnic and racial groups.

Similarly, examining a population of families experiencing stable housing with a homeless comparison group may clarify the influence of homelessness. Such a comparison is important because findings from this study cannot ascertain whether the influence of perceived parental control is unique to homeless families. An increased focus on perceived parental control may provide insight into the utility of different clinical interventions. Instead of addressing and treating the immediate symptoms of SLEs in parents, such as depression and anxiety, interventions may target perceived control. Thus, it may be possible to help parents develop a stronger sense of control in order to mitigate the deleterious effects of SLEs and, as a result, improve child adjustment.

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Figure 1. Interaction between stressful life events and parent perception of child control on parent life on child internalizing symptoms.

Table 1

Sociodemographic Composition of Children in the Sample (N = 223)

Characteristic	n	%	M	SD
Sex				
Male	114	51.1		
Female	109	48.1		
Race/Ethnicity				
Asian	5	2.2		
African-American	108	48.8		
Hispanic	5	2.2		
Multiracial	46	20.6		
Native	11	4.9		
Other	5	2.2		
Caucasian	43	19.3		
Age			8.12	2.3

Table 2

Frequencies of Major Stressful Life Event Types Experienced by Children

Major Stressful Life Event	<i>n</i>	Percent
Unemployment of Parent	47	21.1
Divorce of Parents	15	6.7
Death of Loved One	36	16.1
Serious Illness	23	10.3
Victim of Violent Crime	16	7.2
Eviction	11	4.9
Legal Problem Resulting in Jail Time or Detention	17	7.6
Accidental Injury Requiring Hospitalization	15	6.7
Move or Change of Households	50	22.4
Separation of Parents from Each Other	33	14.8
Unexpected Separation from Parents	24	10.8
Child Experienced Danger of Being Killed or Badly Hurt	15	6.7

Table 3

Multiple Linear Regression Output of Variables in the Final Model

Variable(s)	<i>b</i>	β	S.E.	P-Value
Child Internalizing Symptoms On				
Child's Ethnicity	−1.470	−.046	.070	.515
Mother's Years of Education	.647	.084	.079	.287
Child's Gender	−3.170	−.125	.062	.044
Child's Age	.738	.134	.063	.032
Stressful Life Events	1.198	.183	.086	.033
Parental Efficacy	.143	.060	.090	.507
Parental Responsibility	−.146	−.085	.064	.187
Child Control of Parents Life	.243	.082	.090	.362
Parent Belief in Fate or Chance	.109	.055	.070	.431
Parent Control of Child Behavior	.443	.260	.087	.003
Stressful Life Events $\times$ Child Control of Parents Life	.276	.180	.073	.013

Table 4

Bivariate Correlations and Demographic Statistics

Measure	1	2	3	4	5	6	7	8	9	10	11
1. Child Internalizing Symptoms	–										
2. Ethnicity	–.067	–									
3. Mother's Years of Education	.141 *	.059	–								
4. Child's Gender	–.123	–.064	.059	–							
5. Child's Age	.143 *	–.092	.014	.026	–						
6. Stressful Life Events	.263 ***	.90	.115	–.091	.080	–					
7. Parental Efficacy	.153 *	.061	–.216 ***	.075	–.006	.013	–				
8. Parental Responsibility	–.133	–.106	–.084	–.022	.110	–.126	–.060	–			
9. Child Control of Parent's Life	.242 ***	.097	.134	–.035	.060	.037	.208 ***	–.010	–		
10. Parental Belief in Fate or Chance	.070	.029	–.021	.038	–.040	–.016	.393 ***	–.039	.091	–	
11. Parental Control of Child's Behavior	.358 ***	.067	.042	–.052	–.093	.237 ***	.278 ***	–.114	.381 ***	.086	–
Mean	167.51		12		8.12	2.04	17.30	27.87	13.71	26.05	24.84
SD	30.76		1.66		2.32	1.94	5.35	7.39	4.28	6.45	7.49
Range	117–272		7–16		4–12	0–7	10–36	12–46	7–30	12–44	3–46

Note:

*
 $p < .05$,**
 $p < .01$