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The children's coping behavior questionnaire: development and validation

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THE CHILDREN'S COPING BEHAVIOR QUESTIONNAIRE:
DEVELOPMENT AND VALIDATION

A Thesis

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
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Master of Arts

in

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by

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Abstract

Coping is defined as the actions and cognitions used to manage stressful demands. As children develop, coping becomes more refined and situation-specific. Children's coping styles have been found to relate to distress and adjustment. Despite the importance and implications of children's coping responses, there is no accepted standard in measuring children's coping. Past research has had to utilize the few measures in existence, despite possible psychometric inadequacies. Therefore, the purpose of this study was to develop a psychometrically sound self-report measure of coping in children and adolescents. After initial item generation, pilot testing, and item elimination, the data were factor analyzed and reliability and validity data were obtained. Final analyses resulted in a 57-item coping measure with a three-factor solution (Diversion, Ameliorative Coping, and Destructive Coping). The measure showed strong reliability and good preliminary validity data. Results indicate that the Children's Coping Behavior Questionnaire presents a promising new measure of youth's coping.

Literature Review

Research has highlighted the importance of studying children's coping behavior. (e.g. Fields & Prinz, 1997; Skinner & Zimmer-Gembeck, 2007). Coping is defined as the actions and cognitions used to manage stressful demands (Lazarus & Folkman, 1984). Research examining children's coping behavior has found coping behavior to be fairly stable, remaining consistent across various situations (Donaldson, Prinstein, Danovsky, & Spirito, 2000; Spirito, Stark, & Tyc, 1994; Stallard, Velleman, Langsford, & Baldwin, 2001). For example, Donaldson et al. (2000) found that although children's coping strategies fluctuated slightly across situations, the overall pattern remained constant. In fact, some researchers suggest that children's coping behavior is more consistent and stable than that of adults (Compas, Malcarne, & Fondacaro, 1988).

Researchers vary in their conceptualization of coping. One common conceptualization is to categorize coping efforts as either focused directly on managing a stressful situation or focused on avoiding a stressor or attending to one's emotions about the situation (Compas & Epping, 1993; Stallard et al., 2001). The former is most commonly labeled approach (Altshuler & Ruble, 1989) or problem-focused (Lazarus & Folkman, 1984) coping, whereas the latter is generally referred to as avoidant or emotion-focused coping. In addition, coping strategies have been classified as either behavioral or cognitive in nature (Spirito, Francis, Overholser, & Frank, 1996) depending on whether the coping efforts are actions or thoughts.

Edgar and Skinner (2003) argue that dichotomizing coping strategies may neglect to account for the fact that people may use both avoidant and approach strategies in managing a single situation, or that some specific coping behaviors may function in both categories depending on the context. Consequently, some research has focused on delineating specific

coping strategies, such as distraction, withdrawal, blaming, problem solving, emotional regulation, and wishful thinking (Spirito, Stark, & Williams, 1988). Literature examining children's coping in a variety of situations (e.g. cancer patients, hurricane survivors) has found that the strategies most often used by children are wishful thinking, emotion regulation, and problem solving, with wishful thinking commonly being most frequent (Donaldson et al., 2000; La Greca, Silverman, Vernberg, & Prinstein, 1996; Miller et al., 2000; Spirito et al., 1994; Stallard et al., 2001; Tyc, Mulhern, Jayawardene, & Fairclough, 1995; Vernberg, La Greca, Silverman, & Prinstein, 1996). Miller et al. (2000) postulated that the high occurrence of wishful thinking in childhood might be accounted for by children's imaginative cognitions. However, Vernberg et al. (1996) found that although wishful thinking was frequently used, it did not have a distinctive effect on adjustment. The consistency of these findings support the idea of children's coping behavior being fairly stable across situations, and suggest a need to identify those children who use maladaptive coping styles. These children may tend to consistently use such styles, even if ineffective.

The developmental literature shows that coping styles may progress as children age. Donaldson et al. (2000), for example, found that younger children used a narrower range of coping behaviors than did adolescents. As children grow into adolescence, they use a wider range of coping responses, and vary their coping across situations (Brown, O'Keeffe, Sanders, & Baker, 1986; Compas et al., 1988; Tyc et al., 1995). This finding suggests that as children develop, their coping behavior becomes more refined and situation-specific.

In addition to the consistency and quantity of coping strategies, younger children and adolescents differ in the quality of coping styles employed. Although the findings are not completely consistent (see Compas & Ebbing, 1993), younger children facing a stressor appear

more likely to utilize behavioral methods of coping, whereas older children are more likely to employ cognitive methods such as problem solving (Curry & Russ, 1985; Skinner & Zimmer-Gembeck, 2007; Spirito et al., 1994). In a review of the literature, Skinner and Zimmer-Gembeck (2007) noted that cognitive coping strategies begin to appear in middle childhood. As children progress to adolescence, they are able to use more complex, meta-cognitive coping strategies. For example, they are able to take into account the effect of their coping on themselves and others. This is likely due to children's cognitive development becoming more complex and flexible by adolescence (Altshuler & Ruble, 1989).

The findings do not suggest that adolescents always use cognitive means of coping and younger children always use behavioral means. In fact, the prevalence of wishful thinking in children could be considered a cognitive coping strategy, albeit less complex than the cognitive coping used by older adolescents. In general, however, children appear to learn to cope more adaptively with age (Brown et al., 1986). They become more able to tailor coping strategies to the particular situations and are able to fluctuate back and forth between cognitive and behavioral means as they see fit (Skinner & Zimmer-Gembeck, 2007).

In the same way that development affects coping, coping also can affect children's development. The way in which children choose to cope with distress may have lasting effects on how they cope with situations in the future. Adaptive coping can help children gain insight into and prevent future stressful situations as they get older, as well as improve their future resiliency (Skinner & Zimmer-Gembeck, 2007).

The study of coping is important to understanding children's adjustment in general and especially after experiencing a traumatic event. The consensus is that problem-focused, cognitive, or approach strategies generally are related to better adjustment (Brown et al., 1986;

Fields & Prinz, 1997). Emotion-focused or avoidant coping has been associated with more distress (Blount, Davis, Powers, & Roberts, 1991; Jones & Ollendick, 2005; Spirito et al., 1994; Tyc et al., 1995). Some authors suggest that problem-focused coping is more adaptive for controllable circumstances, but that emotion-focused is actually more appropriate for uncontrollable circumstances in which people cannot enact change on the environment, only within themselves (Altshuler & Ruble, 1989; Compas, Banaz, Malcarne, & Worsham, 1991; Donaldson et al., 2000; Stallard et al., 2001; Tyc et al., 1995).

Social withdrawal and blaming others are two maladaptive coping responses that seem to be particularly detrimental to children's adjustment after experiencing a major stressor (Spirito et al., 1996; Stallard et al., 2001). This finding suggests that after a stressful situation, children should be particularly careful about being alone and placing blame. In addition, children who catastrophize tend to display higher rates of anxiety (Brown et al., 1986).

Higher levels of coping and greater numbers of coping strategies have been associated with more distress and higher levels of anxiety and depression (Curry & Russ, 1985; La Greca et al., 1996; Spirito et al., 1994; Stallard et al., 2001; Vernberg et al., 1996). For example, Stallard et al. (2001) found that children who survived road traffic accidents and met criteria for Post-Traumatic Stress Disorder used more coping strategies than those who did not experience a traumatic stressor. Such findings suggest that as children's levels of distress increase, there is an increased need for coping and children fulfill this need by using a number of coping strategies.

One example of a traumatic stressor that can impact children is that of a natural disaster. Yule (2001) reported that children display high levels of stress, fear, and shock in the wake of traumatic experiences. Such reactions lead to higher levels of depression, anxiety, panic disorders, and PTSD in children. After Hurricane Andrew in 1992, La Greca et al. (1996) found

that almost 30% of children experienced severe levels of PTSD symptoms three months after the storm hit, and 13% continued to experience these symptoms ten months after the storm. The negative effects on adjustment following Hurricane Hugo in 1989 were seen in children as young as two years of age (Swenson et al., 1996).

After Hurricane Hugo, depressed children used an increased number of coping strategies but believed their coping to be less effective compared to those with higher depression scores (Jeney-Gammon, Daugherty, Finch, Belter, & Foster, 1993). Children endorsing fewer depressive symptoms showed higher coping efficacy scores, and were also more likely to make use of cognitive coping strategies and social support. Jones and Ollendick (2005) found that children who believe they effectively cope might be more likely to employ coping strategies that directly challenge the stressor. Those with low efficacy beliefs may be more likely to use avoidant strategies, which may, in itself, be a risk factor for the development of post-disaster psychopathology (Jones & Ollendick, 2005).

Vernberg et al. (1996) found similar results in children following Hurricane Andrew. In this sample, coping and PTSD symptomatology were positively related. In addition, maladaptive coping styles, such as blame and anger, predicted PTSD symptoms up to 10 months after the storm. These results suggest that maladaptive coping may have a greater and longer-lasting effect on preventing adjustment than adaptive coping patterns have on aiding it. In a related study, La Greca et al. (1996) found children who endorsed fewer PTSD symptoms immediately following Hurricane Andrew were more likely to adjust well, as evidenced by continued low endorsement of PTSD symptoms ten months after the storm. However, a sizeable minority with severe symptoms post-hurricane remained significantly distressed almost a year after the storm.

Coping skills consistently are included in conceptual models of factors leading to adjustment after experiencing a natural disaster. One such model, outlined by Freedy, Kilpatrick, and Resnick (1993), is called the “risk factor model of natural disaster adjustment.” This model aims to predict adjustment based on characteristics and events occurring before, during and after experiencing a natural disaster. Coping is considered a post-disaster characteristic that affects adjustment. The model proposes that certain factors associated with disaster exposure may act together with factors associated with the individual, such as coping styles, to affect adjustment.

A similar model, conceptualized specifically for children, was proposed by La Greca et al. (1996). This model postulates that four main factors work together in complex ways to affect adjustment. Those four factors are: severity of disaster exposure, child characteristics, post-disaster setting, and coping processes. Although disaster exposure was most predictive of PTSD symptoms, all factors in the model displayed significant predictive value. Coping was a particularly integral part of the model as it was assumed to be affected by each of the other three factors. In addition, coping’s relationship to PTSD symptoms is reciprocal in that coping affects symptom severity and symptom severity affects the type of coping strategies used. Results of studies using this model suggest that it is useful in predicting adjustment post-hurricane (La Greca et al., 1996; Vernberg et al., 1996). For example, coping processes added significant predictive value for children’s future PTSD symptom endorsement. Maladaptive coping processes, such as blame and anger, added the most value, suggesting that negative coping has an especially detrimental impact on children’s adjustment. In general, children endorsing greater levels of PTSD symptoms drew on more coping strategies.

The influence of coping on children’s well-being after a significant stressor suggests that there may be clinical implications for the study of coping in children. Costello, Erkanli,

Fairbank, and Angold (2002) found that 25% of children and adolescents in their sample experienced at least one extreme stressor by the age of 16. In a review of the literature, Davis and Siegel (2000) found that children encounter a myriad of traumatic stressors including natural and technological disasters, war and violence exposure, chronic and life-threatening illnesses, and sexual and physical abuse. Such stressors seem to be less and less rare (Davis & Siegel, 2000), showing that there may be a heightened need to teach children effective ways of coping, especially for those situations in which they have no control.

Despite the myriad of research that exists on children's coping, there is no comprehensive, psychometrically sound, measure of youth's coping. Existing assessments often are inconvenient or time consuming to administer, such as observations and interviews (Curry & Russ, 1985), whereas some survey assessments are too lengthy (Spirito et al., 1988). Because there is no accepted standard in measuring children's coping (Spirito, 1996), past research has had to utilize the few measures in existence, despite possible psychometric inadequacies.

The most widely used instrument of children's coping is the Kidcope (Spirito et al., 1988). The Kidcope has two versions, one for adolescents ages 13 to 16 and one for children ages 5 to 13. Both versions evaluate the use of ten coping strategies: social withdrawal, distraction, wishful thinking, cognitive restructuring, social support, problem-solving, self-criticism, emotional regulation, resignation, and blaming others. Children are asked to determine whether they use each strategy and its perceived effectiveness. The adolescent version contains eleven items scored on a 4-point Likert scale, whereas the child version contains 15 items scored on a dichotomous scale measuring simply whether or not the particular strategy is employed. Although initially conceptualized as a screening measure (Spirito, 1996), the Kidcope has been used to measure coping in a range of situations including natural disasters, war, traffic accidents,

and daily life stress (Donaldson et al., 2000; Pardekooper, de Jong, & Hermanns, 1999; Stallard et al., 2001, Vernberg et al., 1996).

Although the Kidcope has some advantages, such as its brief length and the number of coping strategies it measures, it has quite a few limitations. One of the biggest limitations is the inconsistent psychometrics associated with the measure. Factor analytic studies of the Kidcope are inconsistent. Factor structures found have included single-factor structures (Spirito, 1996), two-factor approach/avoidance structures (Spirito, 1996), two-factor control/escape oriented structures (Cheng & Chan, 2003), four factor structures (i.e. Positive Coping, Blame and Anger, Wishful Thinking, Social Withdrawal) (Vernberg et al., 1996), and a three factor structure (i.e. Problem-Focused Coping, Problem-Avoidant Coping, and Negative Coping) (Vigna, Hernandez, Kelley, & Gresham, 2007).

In addition to the inconsistent factor structure, the Kidcope has shown poor test-retest reliabilities over a ten-week period (Spirito et al., 1988), but acceptable over a three- to seven-day period. In addition, the brevity of the Kidcope only allows for one or two items to tap into each coping strategy, which significantly reduces the range of responses (Spirito et al., 1988). In their use of the Kidcope, Stallard et al. (2001) concluded that children may have trouble separating out coping behaviors using the Kidcope because several of the items include more than one behavior. For example, a single item assessing problem-solving includes a number of behaviors ranging from thinking about solutions to talking to others for more information. Children may have difficulty rating an item that includes many behaviors in which they did not engage but one behavior in which they did. In addition, opposing behaviors are sometimes grouped under one umbrella strategy. For example, emotional regulation can consist of aggressive behaviors meant to let out frustration, as well as calming behaviors meant to soothe

frustration. In this sense, the Kidcope's conciseness may act as a significant limitation. Stallard et al. (2001) also suggested that the Kidcope might not be sensitive to developmental issues associated with coping behavior.

The limitations of this widely used measure, as well as the importance of coping in predicting children's adjustment, highlight the need for a more appropriate and psychometrically sound way of measuring children's coping styles across ages and across situations. The purpose of the current study was to develop a psychometrically sound, self-report measure for assessing coping strategies in children and adolescents. This study hypothesized that: (1) higher levels of depression, anxiety, and internalizing problems (as measured by the BASC-SRP) would be positively related to greater endorsements of coping in general, as measured by a total score on the CCBQ; (2) adaptive coping behaviors as measured by the CCBQ would be positively related to the Personal Adjustment Composite of the BASC-SRP; (3) maladaptive coping behaviors would be inversely related to personal adjustment and positively related to anxiety, depression, and social stress scores on the BASC-SRP; (4) coping behaviors as measured by the CCBQ would predict PTSD symptomatology.

Phase I: Item Generation

Methods

Procedure

The purpose of this phase was to create a pool of items relating to youth's coping behaviors. A pool of 83 items was generated based on theoretically driven logic, past literature identifying common coping styles, and revisions to existing adult and child coping measure items. Based on the above criteria, items were generated to include the following coping responses: routines, distraction, emotional expression, social support, hopefulness/wishful thinking, problem-focused coping, anger/blame, and miscellaneous (e.g. humor). Items were reviewed and added by an expert child clinical psychologist for clarity and theoretical relevance.

Phase II: Item Selection

The purpose of Phase 2 was to retain items that would comprise an internally consistent measure of coping with a stable factor structure.

Methods

Participants

Participants included 450 youth, ages 10-16 ($M = 12.58$) from New Orleans and Baton Rouge. The overall sample was racially diverse (53% African American, 39% Caucasian, 5% Asian, 2 % Hispanic, 1% other). Females comprised 55% of the sample.

A majority of the participants (348) were recruited from New Orleans and Baton Rouge schools after Hurricane Katrina as part of longitudinal grant research. Ages ranged from 10-16 ($M = 12.61$) and 54% of the sample were female. This sample was primarily African American (25% Caucasian, 5% Asian, 2 % Hispanic, 1% other), and low-income ($M = \$23,000$). New Orleans residents made up 66.1% of the sample.

The remaining 102 participants were recruited from a primarily Caucasian and middle- to upper-income school in Baton Rouge. These subjects were collected in order to balance the sample with regards to race and income. The participants' ages ranged from 11-15 ($M = 12.47$), and females comprised 57% and males comprised 43% of the sample. The sample was primarily Caucasian (6% African American, 3% Asian, 2% Hispanic, 2% other). School statistics (National Center for Education Statistics, 2006) show that only 2% of students at the school meet eligibility requirements for free or reduced lunch (state average = 61%). Demographic information is presented in Table 1. Both the grant and the Baton Rouge balance sample were equivalent in terms of age and gender statistics, but were significantly different with regards to race.

Table 1: Demographic Information

Demographic Variables	Sample			Comparison Statistic	Significance Level
	Entire	Grant	Balance (B.R. only)		
<i>N</i>	450	348	102		
Age	<i>M</i> =12.58(1.38)	<i>M</i> =12.61(1.48)	<i>M</i> =12.47(.98)	<i>t</i> (448)=.87	<i>p</i> =.38
Gender				<i>t</i> (448)=.51	<i>p</i> =.61
Female	246	188	58		
Male	240	160	44		
Race				<i>t</i> (444)=6.10	<i>p</i> =.00
African American	237	231	6		
Asian	20	17	3		
Caucasian	175	87	88		
Hispanic	8	6	2		
Other	6	4	2		

Measures

Demographic Questionnaire. For the grant sample, a demographic questionnaire was completed by parents of participating children to gather descriptive data on the sample. This study used information regarding child age, grade, gender, and race, as well as mother and father levels of education, occupation, and income. The children from the second sample completed a brief demographic sheet including the above information except for income (see Appendix A).

Children's Coping Behavior Questionnaire (Pilot Version). The pilot version of the coping measure consisted of 83 items assessing a broad range of coping behaviors. Coping strategies were rated on a 4-point scale, ranging from "never" to "almost always," indicating frequency of use (see Appendix B).

Procedure

After parent consent and child assent were obtained, the pilot version of the CCBQ was administered to children and adolescents. The grant participants were recruited shortly after Hurricane Katrina and the pilot version of the coping questionnaire was included in a packet of

questionnaires that was administered to these participants approximately 19 months post-hurricane. The demographic questionnaire was sent home in a packet of materials for the parents to complete. For the remaining Baton Rouge participants the demographic and coping questionnaires were administered in their school.

Results

Initial Item Selection

Criteria for initial item elimination included low item frequencies and means. Items that were endorsed less than 35% of the time (i.e. 65% or greater of the responses were “never”) were considered for elimination. DeVellis (2003) suggests that item means should generally approach the median response value (i.e. 2.5 for this study), and should not be too near the extreme values. Items were eliminated based on substantially low means (less than or equal to 1.55), indicating that the average response for that item was between “never” and “sometimes.” No item means approached the upper extreme response value. Based on the above criteria, five items were eliminated. All five displayed both low endorsement frequencies and means.

Exploratory Factor Analyses

Preliminary principle axis factoring (PAF) exploratory factor analyses on the remaining 78 items indicated that a varimax orthogonal rotation produced the cleanest factor structure. Factor solutions were based on the following criteria: eigenvalues of 1.0 or greater, factors loadings of .40 or greater, simple structure, and theoretical logic (Comrey & Lee, 1992). The scree plot indicated that three factors accounted for the most variance. A final analysis forcing three factors produced the clearest factor structure. Based on the above criteria, 19 items were eliminated. Additional items were eliminated based upon an increase in alpha if item deleted (2 items), high inter-item correlations greater than .80 (0 items), and low item-total correlations

below .20 (0 items; Floyd & Widaman, 1995) within each factor. The results of the final factor analysis with the remaining 57 items are presented below. Table 2 presents items and loadings for Factor I, Table 3 for Factor II, and Table 4 for Factor III.

Table 2: Factor I Items and Factor Loadings

Item Description	Factor I: Diversion	
Returned to doing things with family	.67	
Returned to doing fun family activities	.67	
Spent time with family	.65	
Returned to regular daytime activities	.64	
Returned to helping around the house	.61	
Received comfort from family	.61	
Tried to see the good side	.60	
Received comfort from place of worship	.58	
Returned to after-school activities	.57	
Focused on what is good in my life	.57	
Asked adults for advice	.54	
Returned to completing homework	.53	
Knew the problem was in God's hands	.52	
Made the most of my life	.51	
Received comfort from other adults (not family)	.51	
Spent time with friends	.51	
Prayed	.50	
Returned to helping with chores	.50	
Did a physical activity	.50	
Spent time with a friend	.50	
Returned to doing things with friends	.49	
Focused on something other than the problem	.48	
Tried to think of positive things	.48	
Played a game to forget	.47	
Watched TV, played on the computer, or read	.46	
Played sports to forget	.46	
Tried to relax or calm down	.45	
Got control of things	.45	
Thought about a better time or place	.40	
	Eigenvalue	13.25
	% Variance	23.25
	α	.93

Table 3: Factor II Items and Factor Loadings

Item Description	Factor II: Ameliorative Coping
Received comfort from friends	.64
Tried to understand the situation	.60
Focused on how to solve the problem	.58
Expressed my feelings to someone	.58
Came up with several different solutions	.57
Talked with a friend about the problem	.53
Told myself things to make me feel better	.52
Cried to let my feelings out	.50
Looked for people who could help	.47
Wished I could change how I felt	.45
Focused on the cause of the problem	.44
Did something just to do something	.44
Wrote about the situation in a diary	.43
Took things one day at a time	.42
	Eigenvalue 6.08
	% Variance 10.66
	α .88

Table 4: Factor III Items and Factor Loadings

Item Description	Factor III: Destructive Coping
Took it out on others	.69
Destroyed things	.69
Blamed someone else	.63
Refused to obey adults	.61
Ate more than usual	.57
Yelled, screamed, or got angry	.56
Expected the worst outcome	.54
Took it out on myself	.53
Made fun of the situation	.53
Made jokes about it	.51
Stayed by myself	.47
Kept quiet about the problem	.47
Imagined I was in the situation again	.42
Told myself it was not really happening	.42
	Eigenvalue 2.65
	% Variance 4.64
	α .87

Factor I, *Diversion through Routines, Family, and Positivity*, includes 29 items that measure numerous coping behaviors that may be interpreted as serving to divert the individual's attention from his or her current problems. Items on this scale center on home and school routines, family support, and positive thinking, including spirituality. Factor II, *Ameliorative Coping*, includes 14 items that assess the individual's use of problem-solving approaches or emotional expression to ameliorate distress caused by a problem. Factor III, *Destructive Coping*, includes 14 items that measure both physical and self destruction in response to a stressor.

Readability Analysis

The final version of the Children's Coping Behavior Questionnaire produced a Flesch-Kincaid reading level of seventh grade.

Phase III: Reliability and Validation

The purpose of Phase 3 was to assess the initial psychometric properties of the CCBQ, including internal consistency, construct validity, and predictive validity.

Methods

Participants

The full sample of 450 participants described above was included in reliability analyses. For the validity analyses, participants included the 348 youth recruited in conjunction with grant research.

Measures

Behavioral Assessment System for Children, Second Edition (BASC-2; Reynolds & Kamphaus, 2004). The BASC-2 Self-Report-Child (SRP-C), for use with children ages 8 to 11, and the Self-Report-Adolescent (SRP-A), for use with adolescents ages 12 to 21, was administered to the grant participants. The child form consists of 139 items and the adolescent form consists of 176 items. The SRP-C form consists of 14 subscales: Attitude to School, Attitude to Teacher, Atypicality, Locus of Control, Social Stress, Anxiety, Depression, Sense of Inadequacy, Attention Problems, Hyperactivity, Relations with Parents, Interpersonal Relations, Self-Esteem, and Self-Reliance. The SRP-A form consists of the same 14 subscales. In addition, the SRP-A form includes a Sensation Seeking and a Somatization subscale. The SRP-C and the SRP-A both also include four composite scores: Personal Adjustment, School Problems, Internalizing Problems, and Inattention/Hyperactivity. The present study used the Anxiety, Depression, and Social Stress subscales, as well as the Personal Adjustment and Internalizing Problems Composite scores.

UCLA PTSD Reaction Index (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998). The UCLA PTSD Index assesses PTSD symptoms in children. The measure consists of 22 items assessing the major criteria of PTSD outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, including scores for re-experiencing, avoidance, and heightened arousal symptoms. Diagnosis and Index Summary scores can also be obtained. Acceptable reliability (Cronbach's $\alpha = .82$) and validity data have been reported, as well as appropriate levels of sensitivity and specificity (Roussos, Goenjian, & Steinberg, 1999; Steinberg, Brymer, Decker, & Pynoos, 2004). The measure displayed high reliability ($\alpha = .94$) in the current sample. The present study used the Index Summary Score.

Procedure

After parent consent and child assent were obtained, the measures were administered to the participants as part of a packet of questionnaires associated with the larger grant study. Measures were administered at the children's schools. Items were read aloud by researchers while children circled their answers individually.

Results

Reliability

Cronbach's alpha was calculated for each factor, as well as for the composite scale, to determine the level of internal consistency. Alphas for the three factors and the composite were all strong: *Diversion* (.93), *Ameliorative Coping* (.88), *Destructive Coping* (.87), and Composite (.94).

Construct Validity

Construct validity was estimated through the calculation of correlations between the three factors and the Depression, Anxiety, Social Stress, Personal Adjustment, and Internalizing

Problems scores from the BASC-2 SRP (see Table 5). A Bonferroni correction was applied to adjust for the number of correlations being calculated. Using the corrected p -value of .003, *Diversion* was significantly correlated with the Personal Adjustment score ($r = .44$). *Ameliorative Coping* was significantly correlated with the Social Stress (.26), Anxiety (.44), Depression (.29), and Internalizing Problems (.37) scores. *Destructive Coping* was significantly correlated with the Social Stress (.52), Anxiety (.59), Depression (.50), Internalizing Problems (.63), and Personal Adjustment (-.27) scores. Finally the composite score was significantly correlated with the Anxiety (.25) and Personal Adjustment (.29) scores.

Table 5: Validity Correlations for CCBQ and BASC Scores

	BASC Scores				
	Social Stress	Anxiety	Depression	Internalizing Problems	Personal Adjustment
Diversion	-.13*	.00	-.14*	-.08	.44**
Ameliorative Coping	.26**	.44**	.29**	.37**	.08
Destructive Coping	.52**	.59**	.50**	.63**	-.27**
Composite Score	.10	.25**	.09	.19*	.29**

* $p < .05$

** $p < .003$

Predictive Value

A regression analysis was conducted to explore if the factors could predict levels of symptomatology. The three coping factors were entered into the model simultaneously. The overall model was significant, $F(3,217) = 29.79, p < .001$, and accounted for 29% of the

variance. In addition, each of the three factors made a significant contribution to the model as a whole: *Diversion* ($t = -3.33, p = .001$), *Ameliorative Coping* ($t = 3.89, p < .001$), and *Destructive Coping* ($t = 4.56, p < .001$).

Confirmatory Factor Analysis

A CFA was conducted to assess the fit of the data to the three-factor model obtained in the EFA. Adequate fit was assessed through a non-significant chi-square statistic and a root mean square error of approximation (RMSEA) between .05-.08 (Storch et al., 2005). According to the chi-square statistic, the model showed a poor fit ($\chi^2 = 4491.12, p < .001$). However, the chi-square statistic is easily influenced by sample size and therefore may not be the truest measure of fit (Loehlin, 1998). The RMSEA (.065), which is not as easily influenced, indicated that the model shows a reasonable fit with the data.

Discussion

The current study aimed to develop and validate a new measure of coping for youth. The analyses revealed a strong three-factor structure with high factor loadings and simple structure for the scale. Factor I, *Diversion*, includes items that assess family routines and support, positive thinking, spirituality, and distraction. It appears that most coping strategies on this factor may be used by youth to divert their attention from the current problem. Distraction items (e.g. “played sports to forget”) are clearly used as a means to ignore or forget about the problem. Family routines and support are more subtle means of changing the focus from the problem to a return to regular family activities and interactions (i.e. a return to normalcy). Positive thinking and drawing on one’s religious beliefs may also be a subtle form of diversion in that focusing on the positive or believing that God will solve the problem takes the pressure off of the individual.

Factor II, *Ameliorative Coping*, includes coping mechanisms that attempt to ameliorate the problem either through focusing on and trying to find a solution to the problem itself, or through attempts to express one’s emotions about the problem. Both problem-solving and emotional expression may be useful for successful coping when used in moderation. The fact that these two mechanisms were grouped together under one factor is somewhat surprising in that the literature generally separates problem-focused and emotion-focused coping. However, Vernberg et al. (1996) also found that these two coping styles grouped together in their analysis of the Kidcope. They postulated that these methods represent productive and practical attempts to address distress. Perhaps, this factor may simply tap youth’s attempt to better their situation in some way, regardless of what the specific method of change might be. For example, the literature suggests that problem-focused coping is more ameliorative when the stressor is controllable whereas emotion-focused coping is more ameliorative when the stressor is uncontrollable

(Altshuler & Ruble, 1989). Perhaps this scale taps both mechanisms, with the overarching focus being on methods used to actively decrease distress in some way.

Factor III, *Destructive Coping*, assesses the most maladaptive coping responses. Methods address both self-destructive coping (e.g. “took it out on myself”) as well as physically destructive coping (e.g. “destroyed things”). Literature suggests that such negative coping may have the greatest impact on adjustment, especially after major life stressors (La Greca et al, 1996; Vernberg et al, 1996). Such results may indicate that a decrease in destructive coping may be more beneficial than an increase in the methods contained in either of the first factors.

Internal consistency analyses indicated that all three factors, as well as the composite score, show high levels of reliability. These results indicate that the CCBQ can be used as a total score to obtain a quantitative measure of coping in general, or as a set of three subscales to get a more qualitative picture of which mechanisms youth are actually using to cope. The reliability of the composite score of the CCBQ is quite large, and to be expected because of the large number of items and because the individual coping behaviors, in general, are likely to be related to one another given that they are all behaviors that may be done in response to a stressor. The high alpha of this score should not be taken to indicate that a total score is necessarily the best use of the measure.

Validity analyses were conducted both to establish the construct validity and predicative value of the measure. A number of hypotheses, which were only partially supported, were stated regarding the outcomes of these measures. The first hypothesis stated that higher levels of depression, anxiety, and internalizing problems would be positively related to greater endorsements of coping in general. This hypothesis was only partially supported in that total coping was positively related both anxiety and personal adjustment only. These results highlight

the complex nature of coping, in that higher levels of anxiety may relate to higher levels of coping, but coping may also relate to higher levels of personal adjustment. It is likely that coping responses are both influenced by and influence levels of distress.

The second hypothesis stated that adaptive coping behaviors as measured by the CCBQ would be positively related to the personal adjustment. This hypothesis was only partially supported. Specifically, the *Diversion* factor was positively related to personal adjustment, which was to be expected, but the *Ameliorative Coping* factor was not. Most items on the *Diversion* factor are likely to be considered adaptive due to the inclusion of social support, routines, positive thinking, and spirituality, which have been shown to relate to decreased levels of distress or increased levels of adjustment (Jeney-Gammon et al., 1993; La Greca et al., 1996; Salsman et al., 2005). *Ameliorative Coping*, which assesses problem-solving and emotional-expression, also seems more likely to include adaptive coping responses (Vernberg et al., 1996). However, this factor was not related to personal adjustment, and instead showed weak to moderate positive relationships with social stress, anxiety, depression, and internalizing problems. These results could simply indicate that increased levels of distress are related to an increased attempt to better the situation. Conversely, perhaps the methods assessed by the *Ameliorative Coping* factor have the potential to be maladaptive when used in excess. At extreme levels, an obsession with solving a problem that is uncontrollable or an exaggerated focus on one's negative emotions may in fact be maladaptive. The CCBQ does not record the stressful situation with which the participants are coping, and therefore this suggestion cannot be tested with the current data.

The third hypothesis stated that maladaptive coping behaviors would be inversely related to personal adjustment and positively related to anxiety, depression, and social stress scores. This hypothesis was fully supported. *Destructive Coping*, which is clearly maladaptive due to the

inclusion of methods such as social withdrawal, blame, and anger (Jeney-Gammon et al., 1993; La Greca et al., 1996; Spirito et al., 1996; Stallard et al., 2001; Vernberg et al., 1996), showed strong positive relationships with anxiety, depression, and social stress, as well as internalizing problems. As levels of *Destructive Coping* increase, so do levels of these constructs. In addition, *Destructive Coping* was negatively related to personal adjustment.

Finally, the fourth hypothesis stated that the CCBQ would be useful in predicting PTSD symptomatology. This hypothesis generally was supported. The regression analysis indicated that the factors were useful in predicting levels of PTSD symptom severity.

The combined results of the analyses suggest that the CCBQ is a reliable and valid measure of coping for youth. The CCBQ appears to have a clear and stable factor structure that is useful for providing quantitative and qualitative information about the nature of the coping mechanisms used.

This study has a number of limitations. First, although the sample was relatively diverse with regard to race and income-level, the majority was still minority, low-SES, which may affect the generalizability of the results. In addition, the measures used for the validity analyses were only administered to the sample participating in the grant research. The newer sample of predominantly Caucasian, high-SES participants was not included in the validity analyses. This sample was also obtained approximately 6 months after the initial sample.

Future development and refinement of the CCBQ should focus on establishing psychometrics based on a larger, more balanced sample. This sample may include a wider range of ages, races, and income-levels. Because of the slightly high readability rating, the more difficult items could be reworded or eliminated to make the questionnaire more useful with younger children. Coping in clinical samples should also be explored as well as the examination

of coping in the context of specific stressors to make connections between type of stressor and the utility of different coping responses. Coping may also be related to parent and teacher reports of child outcomes following a major stressor, as well as child resiliency. In addition, test-retest reliability should be explored and future confirmatory factor analyses using a new sample of youths should be conducted.

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Appendix A: Demographic Questionnaire

DEMOGRAPHIC INFORMATION

Child Name _____

Child Sex _____

Child Age/Grade _____ / _____

Child Race _____

Parent Name _____

What is the highest level of education completed?

Father/Male Guardian

- ___ 6th grade or less
- ___ Junior High School (7th, 8th, 9th)
- ___ Partial High School (10th, 11th)
- ___ High School Graduate
- ___ Partial College (at least 1 year)
or specialized training
- ___ Standard College/University
Graduate
- ___ Graduate/Professional Degree
(Master's, Doctorate)

Mother/Female Guardian

- ___ 6th grade or less
- ___ Junior High School (7th, 8th, 9th)
- ___ Partial High School (10th, 11th)
- ___ High School Graduate
- ___ Partial College (at least 1 year)
or specialized training
- ___ Standard College/University
Graduate
- ___ Graduate/Professional Degree
(Master's, Doctorate)

Father/Male Guardian Occupation:

Mother/Female Occupation:

Appendix B: Pilot Version of the Children's Coping Behavior Questionnaire

Directions: People do different things when they are very upset or bothered by a problem or situation. Indicate how often you did each of the following things when you experienced a serious problem or situation. Circle 1 for Never, 2 for Sometimes, 3 for Often, and 4 for Almost Always.

TO HELP MYSELF DEAL WITH THE PROBLEM, I ...

HOW OFTEN DID YOU DO THIS?

	Never	Sometimes	Often	Almost Always
1. Returned to doing things with friends.	1	2	3	4
2. Tried to forget.	1	2	3	4
3. Tried to relax or calm down.	1	2	3	4
4. Spent time with my family.	1	2	3	4
5. Tried to see the good side of things.	1	2	3	4
6. Tried to fix the problem by doing something.	1	2	3	4
7. Yelled, screamed, or got angry.	1	2	3	4
8. Stayed by myself.	1	2	3	4
9. Returned to doing things with my family.	1	2	3	4
10. Did something quiet like watch TV, _____ play on the computer, or read a book.	1	2	3	4
11. Prayed.	1	2	3	4
12. Spent time with my friends.	1	2	3	4
13. Wished the problem had never happened.	1	2	3	4
14. Tried to fix the problem by thinking of solutions.	1	2	3	4
15. Blamed someone for causing the problem.	1	2	3	4
16. Kept quiet about the problem.	1	2	3	4
17. Returned to my old routines.	1	2	3	4
18. Played a game to forget my problems.	1	2	3	4
19. Imagined I was in the situation again.	1	2	3	4
20. Talked with a friend about the problem.	1	2	3	4
21. Knew the problem was in God's hands.	1	2	3	4
22. Focused on the cause of the problem.	1	2	3	4
23. Took it out on others.	1	2	3	4
24. Just accepted my problems.	1	2	3	4
25. Returned to helping around the house.	1	2	3	4
26. Played sports to forget my problems.	1	2	3	4
27. Drew or colored pictures about the situation.	1	2	3	4

HOW OFTEN DID YOU DO THIS?

	Never	Sometimes	Often	Almost Always
28. Tried to be there for others who have problems.	1	2	3	4
29. Wished for a miracle.	1	2	3	4
30. Asked adults for advice.	1	2	3	4
31. Cried to let my feelings out.	1	2	3	4
32. Worried about the problem.	1	2	3	4
33. Acted as if the problem never happened.	1	2	3	4
34. Thought about a better time or place.	1	2	3	4
35. Wrote about the situation for myself only (like in a diary).	1	2	3	4
36. Played with my pet.	1	2	3	4
37. Hoped everything would be okay.	1	2	3	4
38. Made a plan of action.	1	2	3	4
39. Destroyed things.	1	2	3	4
40. Ate more than usual.	1	2	3	4
41. Returned to helping with chores.	1	2	3	4
42. Told myself my problems are not that bad.	1	2	3	4
43. Wrote a letter or email to someone about the situation.	1	2	3	4
44. Looked for people who could help me.	1	2	3	4
45. Wished that I could change the way that I felt.	1	2	3	4
46. Focused on how to solve the problem.	1	2	3	4
47. Took things from others.	1	2	3	4
48. Told myself things to make me feel better.	1	2	3	4
49. Returned to after-school activities like sports, dance, or clubs.	1	2	3	4
50. Told myself this was not really happening to me.	1	2	3	4
51. Expressed my feelings to someone.	1	2	3	4
52. Received comfort from friends.	1	2	3	4
53. Came up with several different solutions to the problem.	1	2	3	4
54. Refused to obey adults.	1	2	3	4
55. Took things one day at a time, one step at a time.	1	2	3	4
56. Returned to doing fun family activities.	1	2	3	4
57. Stopped thoughts about my problems right away when they came into my head.	1	2	3	4

HOW OFTEN DID YOU DO THIS?

	Never	Sometimes	Often	Almost Always
58. Received comfort from family.	1	2	3	4
59. Got control of things.	1	2	3	4
60. Gave up trying in school.	1	2	3	4
61. Expected the worst possible outcome.	1	2	3	4
62. Returned to my regular daytime activities like church or school.	1	2	3	4
63. Did a physical activity like riding my bike or walking.	1	2	3	4
64. Received comfort from my place of worship.	1	2	3	4
65. Tried to understand the situation.	1	2	3	4
66. Did something that I didn't think would work, but at least I was doing something.	1	2	3	4
67. Returned to completing homework.	1	2	3	4
68. Went to sleep.	1	2	3	4
69. Received comfort from neighbors, teachers, or other adults.	1	2	3	4
70. Felt anxious about not being able to cope.	1	2	3	4
71. Spent time with a friend.	1	2	3	4
72. Received gifts or needed items from others.	1	2	3	4
73. Told myself that it was not really happening to me.	1	2	3	4
74. Listened to music.	1	2	3	4
75. Stopped doing my schoolwork.	1	2	3	4
76. Focused on what I was doing instead of the problem.	1	2	3	4
77. Took it out on myself.	1	2	3	4
78. Made jokes about it.	1	2	3	4
79. Made fun of the situation.	1	2	3	4
80. Focused on how bad my problems were.	1	2	3	4
81. Tried to think of positive things.	1	2	3	4
82. Made the most of my life.	1	2	3	4
83. Focused on what is good in my life.	1	2	3	4

Vita

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