

Patterns of Children's Coping With Life Stress: Implications for Clinicians

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In a study of children's patterns of coping with daily stressors, boys and girls 9–17 years old were asked to complete a coping checklist in response to one of four types of stressors – school, parents/family, siblings, or peer/interpersonal. Patterns of coping-strategy use were found to be similar across the various stressors, with wishful thinking, problem-solving, and emotional regulation being among those most frequently used. Older adolescents, compared to younger children, tended to use a broader range of coping strategies, regardless of stressor. Implications for clinical practice are discussed.

The role of coping in child adjustment has been the focus of research over the past decade. For example, active coping strategies, such as problem-solving and monitoring, have been found to be related to better functioning when compared to less active strategies, such as distraction (Ender & Parker, 1990; Peterson, 1989). Many studies of coping have examined the frequency with which children report using specific strategies in response to a particular stressor. For the most part, results vary as a function of the type of problem or event. For example, school-aged children report using wishful thinking more than any other coping strategy in response to problems in school or with siblings (Wertlieb, Wiegel, & Feldstein, 1987). Junior high school children report distancing/denial more than any other coping strategy in response to interpersonal conflict situations (Roeker, Dubow, & Donaldson, 1996). Adolescents coping with a boy/girlfriend problem report using cognitive restructuring, self-blame, and emotional regulation more frequently than adolescents coping with a parent or friend problem, while

those coping with a school problem report using self-criticism more frequently than those coping with a parent or friend problem (Stark, Spirito, Williams, & Guevremont, 1989).

Although much has been learned about the types of coping strategies used by children in response to typical developmental stressors (e.g., academic problems, relationship difficulties), it is unclear if these findings have affected clinical practice. One reason for this lack of transfer from research findings to clinical practice may be that clinicians cannot easily integrate these diverse findings on single coping strategies into therapy. Research on child coping indicates that children and adolescents typically utilize more than one strategy in response to stress (Forsythe & Compas, 1987; Frydenberg & Lewis, 1994). Thus, data on overall patterns of coping may be more relevant to clinicians than data regarding individual coping strategies.

To date, few investigators have examined children's coping patterns. One exception is a study by Forsythe and Compas (1987), which explored the relative use of both problem- and emotion-focused

coping (Lazarus & Folkman, 1984) by calculating the ratio of scores for these two types of coping strategies, with higher ratios reflecting relatively greater use of problem-focused, compared to emotion-focused, coping. Subsequent analyses indicated that a higher proportion of problem- to emotion-focused coping was related to lower levels of psychological distress for events perceived as controllable, whereas the opposite was true for events over which individuals perceived themselves to have low levels of control.

Roecker et al. (1996) used analyses of covariance to compare the coping patterns reported by children (ages 13–18) in response to interpersonal conflict between peers and interpersonal conflict between parents. Results indicated that the pattern of five coping responses (i.e., seeking support, problem-solving, distancing, internalizing, externalizing) was remarkably consistent across the two situations. One exception was that internalizing was reported significantly more in response to parent, compared to peer, conflict.

This paper will summarize patterns of coping-strategy use in a sample of children and adolescents for different types of situational stressors. "Coping patterns" here refers to the use of multiple coping strategies. Data were collected by means of a brief measure specifically designed for use in clinical practice. The primary hypothesis was that, similar to previous findings of cross-situational coping, the patterns of coping strategies reported by children and adolescents would vary by the type of stressor encountered. Secondarily, it was expected that differences would be found in coping patterns by age. Previous research suggests that older children use greater frequencies of coping strategies; thus, older and younger children were expected to exhibit different coping patterns. No differences were expected by gender.

A third goal of the present study was to examine children's ratings of coping efficacy, about which there have been few reports in the literature. Grych and Fincham (1993) examined 11–12-year-old children's coping efficacy in response to marital conflict by having them rate the extent to which coping responses would make them feel better and reduce the conflict; ratings of efficacy were related to the type of conflict exhibited. Stark et al. (1989) asked adolescents coping with different types of life stressors to rate the perceived efficacy of cop-

ing strategies used. The only significant finding was that males were more likely than females to perceive resignation to be an effective coping strategy. However, no differences in efficacy were reported across stressors. In the present study, no differences in the pattern of efficacy were predicted across stressors.

METHOD

Participants

The sample included 768 children and adolescents, 404 of whom (50.7%) were boys and 393 (49.3%) girls. Age range was 9–17 years ($M=12.35$, $SD=2.33$). For the purpose of data analysis, participants were divided into early (ages 9–11 yrs), middle (12–14 yrs) and late (15–18 yrs) adolescence (Petersen, Susman, & Beard, 1989). The sample was primarily white (75%). Participants were drawn from two samples reported in previous studies (Spirito, Stark, Grace, & Stamoulis, 1991; Stark et al., 1989). The first sample was composed of 599 (298 males, 301 females) elementary and middle school children from a suburban middle-income neighborhood with a median income of approximately \$35,000, and an age range of 9–14 years ($M=11.3$, $SD=1.6$). The second sample consisted of 169 high school students (69 males, 100 females) from ten rural and urban schools and a range of socioeconomic classes (median incomes ranged from \$15,000 to \$30,000 in each of the ten schools) between the ages of 14 and 17 years ($M=14.8$, $SD=0.8$).

Procedure

Both samples were administered surveys in the school setting; the surveys were anonymous and approved by the investigator's institutional review board and the separate school district superintendents. Measures were completed in the classroom. Each child was asked to pick a problem experienced within the past month and describe it in writing. Participants were then asked to complete the Kidcope (described below) and rate how often they used a particular coping strategy to deal with their self-selected problem and the efficacy of those coping strategies endorsed.

Each problem was sorted into categories (school, siblings, family, peers) based on a response system developed by two raters. The reviewers independently rated the responses and achieved 85%

agreement on problems. Disagreements were resolved via a discussion between raters. School stressors included problems related to extracurricular activities or school; family stressors included problems related to parents or family; sibling stressors included problems related to siblings; and interpersonal stressors included problems related to friends or boyfriend/girlfriend.

Measure

The Kidcope (Spirito, Stark, & Williams, 1988) is a checklist designed to assess ten cognitive and behavioral coping strategies: distraction, social withdrawal, wishful thinking, resignation, self-criticism, blaming others, problem-solving, emotional regulation, cognitive restructuring, and social support. The adolescent version of the Kidcope, for those 13 years and older, is comprised of one item per ten coping categories; the younger version (for 7–12-year-olds) is comprised of 15 items that are collapsed into the same ten scoring categories as the older version. Two total scores can be obtained: frequency (i.e., "How often did you do this?") and efficacy (i.e., "How helpful was it?").

On the younger version, children endorse frequency of strategy use on a dichotomous (yes/no) scale; the adolescent version uses a five-point Likert scale ranging from not at all (0) to almost all the time (4). In order to present coping patterns graphically, frequency items were converted to dichotomous scores, reflecting whether a coping strategy was used (1) or not (0). On the efficacy scale, younger children respond on a three-point scale (not at all, a little, a lot), older children on a five-

point scale ranging from "not at all" to "very much."

In order to compare older and younger versions of the Kidcope in this study, all responses were standardized. Moderate test-retest reliability correlation coefficients have been reported for the frequency and efficacy scales of the Kidcope across short periods of time ranging from three days to two weeks (Spirito et al., 1988, 1991). Concurrent validity has been supported by moderate to high correlations of the Kidcope items with other commonly used coping scales (Spirito et al., 1988).

RESULTS

The mean percentage and standard deviation scores for adolescents who reported the use of each coping strategy are shown in TABLE 1 for four stressor categories (school, family, sibling, and interpersonal). The results for stressor category, gender, and age group (early, middle, and late adolescence) are presented graphically in FIGURES 1–3. Significant multivariate and univariate between-group effects for individual coping-strategy use across stressors, gender, and age groups have been reported elsewhere (Spirito et al., 1991; Stark et al., 1989), and thus are not presented in this study, where the focus is on coping patterns.

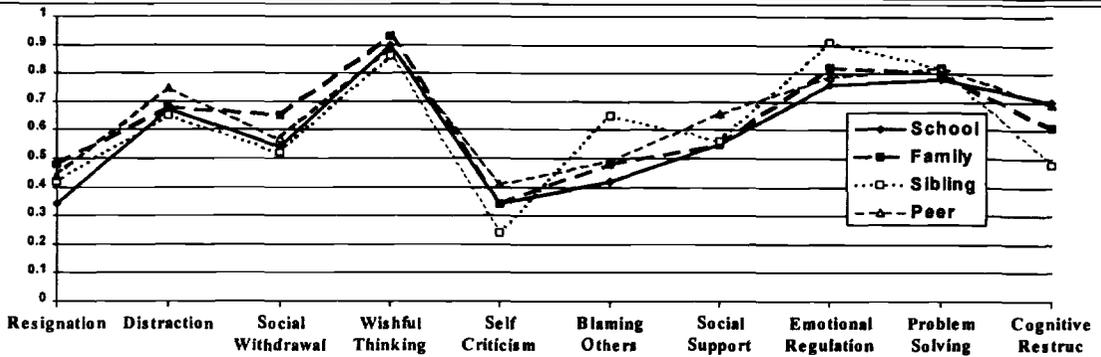
A split-plot MANOVA was conducted with the four stressor categories as the between-groups factor, and the ten coping strategies as the within-groups factor to examine differences in coping frequency patterns across the ten coping strategies, and to examine whether these frequency patterns varied as a function of stressor. The interaction effect for the between-groups factor (i.e., stressor

Table 1
MEANS (AND STANDARD DEVIATIONS) OF COPING STRATEGY USE ON THE KIDCOPE
FOR CHILDREN AND ADOLESCENTS BY STRESSOR CATEGORY

| STRATEGY | STRESSOR | | | | | | | | F | POST HOC |
|-------------------------|----------------|--------|----------------|--------|-----------------|--------|---------------|--------|--------|------------------------|
| | SCHOOL (N=260) | | FAMILY (N=242) | | SIBLINGS (N=85) | | PEERS (N=169) | | | |
| | M | SD | M | SD | M | SD | M | SD | | |
| Resignation | 0.34 | (0.47) | 0.48 | (0.50) | 0.42 | (0.50) | 0.44 | (0.50) | 3.53** | Family>School |
| Distraction | 0.67 | (0.47) | 0.68 | (0.47) | 0.65 | (0.48) | 0.75 | (0.43) | 1.52 | |
| Social Withdrawal | 0.54 | (0.50) | 0.65 | (0.48) | 0.52 | (0.50) | 0.57 | (0.50) | 2.74* | (None) |
| Wishful Thinking | 0.90 | (0.30) | 0.93 | (0.25) | 0.86 | (0.75) | 0.89 | (0.31) | 1.60 | |
| Self Criticism | 0.34 | (0.47) | 0.34 | (0.48) | 0.24 | (0.43) | 0.41 | (0.49) | 2.54 | |
| Blaming Others | 0.42 | (0.49) | 0.48 | (0.50) | 0.65 | (0.48) | 0.49 | (0.50) | 4.71** | Sibling>School, Family |
| Social Support | 0.55 | (0.50) | 0.55 | (0.50) | 0.56 | (0.50) | 0.66 | (0.48) | 1.93 | |
| Emotional Regulation | 0.76 | (0.43) | 0.82 | (0.38) | 0.91 | (0.29) | 0.79 | (0.41) | 3.10* | Sibling>School |
| Problem Solving | 0.78 | (0.41) | 0.80 | (0.40) | 0.82 | (0.38) | 0.82 | (0.38) | 0.40 | |
| Cognitive Restructuring | 0.70 | (0.46) | 0.61 | (0.49) | 0.48 | (0.50) | 0.69 | (0.47) | 5.49** | School, Peers>Sibling |

Note. For ease of presentation, each mean above represents the percentage of the population that endorsed using the strategy.
* $p < .05$; ** $p < .01$.

Figure 1
CHILD/ADOLESCENT COPING PATTERNS FOR FOUR DIFFERENT STRESSORS



category) was significant, Wilks's $F(27, 2174)=2.39$, $p<.001$; however, this was likely due to abundant power, and not a substantial effect ($\eta^2=.03$), suggesting that the differences in the patterns of the ten coping strategies did not vary considerably by stressor. Nonetheless, post-hoc testing revealed significant differences on the coping strategies, as noted in TABLE 1 (resignation, blaming others, emotional regulation, and cognitive restructuring).

To further examine similarities in the coping frequency patterns across the four stressors, a series of intraclass correlations was computed. An overall intraclass correlation coefficient of .88 ($p<.05$) was obtained for the relationship among the patterns of coping for these stressor categories (i.e., school, family, sibling, interpersonal). Correlations among combinations of the four stressors ranged from .87 to .93. Correlations between each pair of stressor categories were comparable, ranging from school and sibling (.94) to peers and siblings (.81).

A significant multivariate effect for the within-groups factor, Wilks's $F(9, 744)=127.88$, $p<.0001$, $\eta^2=.61$, as well as significant effects at a univariate level for each of the four stressors, suggested overall differences in the frequencies of the ten coping strategies compared to one another, as depicted in FIGURE 1 and TABLE 1. As shown in FIGURE 1, wishful thinking, problem-solving, and emotional regulation were used most frequently across stressors, whereas blaming others, self-criticism, and resignation were least frequently reported.

A similar analytic strategy was utilized for the examination of coping patterns by gender (see TABLE 2). A split-plot MANOVA was conducted to examine main and interaction effects between the ten coping strategies (within-groups) and gender (between-groups). No significant (between-groups \times within-groups) interaction effect between gender and the ten coping strategies was found, Wilks's $F(9, 746)=1.69$, NS, $\eta^2=.02$, suggesting that coping frequency patterns did not vary significantly

Figure 2
CHILD ADOLESCENT COPING PATTERNS FOR ALL STRESSORS BY GENDER

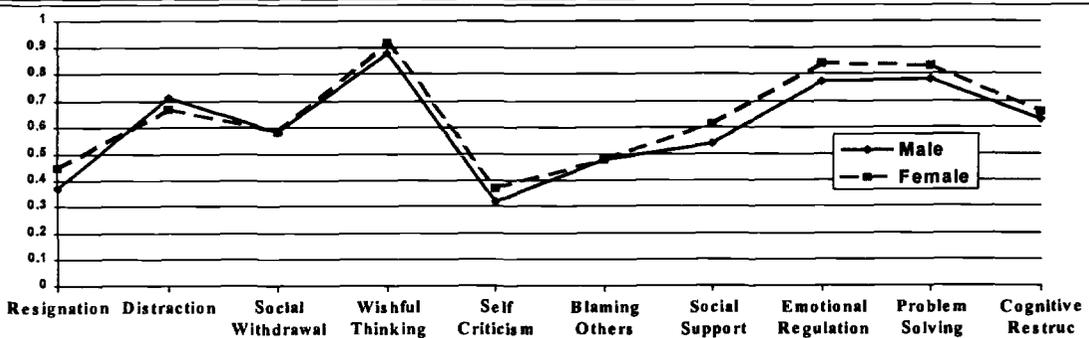
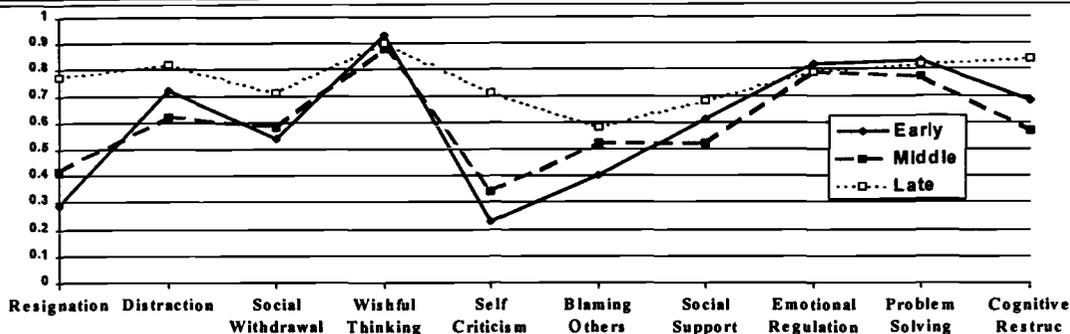


Figure 3
CHILD/ADOLESCENT COPING PATTERNS FOR ALL STRESSORS BY AGE GROUP



by gender. An intraclass correlation was computed to examine further the similarities in the patterns of coping-strategy use across gender. A coefficient of .96 ($p < .05$) suggested a strong correspondence between the patterns of coping use across males and females.

A significant within-groups main effect was revealed at a multivariate level for the ten coping strategies, Wilks's $F(9,746)=156.99, p < .0001, \eta^2 = .66$, which was also significant within each gender. Post-hoc analyses suggested greatest use of wishful thinking, problem-solving, and emotional regulation, and least use of blaming others, self-criticism, and resignation; these results are displayed in FIGURE 2.

Patterns of coping-strategy use were also examined across the three age groups (i.e., early, middle, and late adolescence), using the same analytic strategy. Means and standard deviations by age

group are presented in TABLE 2. The results of a split-plot MANOVA revealed a significant interaction effect between coping-strategy use and age group, Wilks's $F(18, 1490)=8.71, p < .0001, \eta^2 = .10$, suggesting that differences in the patterns of coping use varied somewhat across the three age groups. The results of univariate and post-hoc analyses suggested that, although a pattern of coping similar to that described above was present for early and middle adolescents, late adolescents reported a significantly different pattern of coping use (see FIGURE 3). Specifically, early and middle adolescents again reported the greatest use of strategies such as wishful thinking, problem-solving, and emotional regulation, and least use of blaming others, self-criticism, and resignation. However, late adolescents' coping use was less differentiated across the ten strategies. In other words, late adolescents endorsed using more of the

Table 2

MEANS (AND STANDARD DEVIATIONS) OF COPING STRATEGY USE ON THE KIDCOPE FOR CHILDREN AND ADOLESCENTS BY GENDER AND BY AGE GROUP

| STRATEGY | GENDER | | | | F | AGE GROUP | | | | | | | |
|-------------------------|--------------|--------|----------------|--------|-------|-------------------|--------|--------------------|--------|-----------------|--------|----------|----------|
| | MALE (N=361) | | FEMALE (N=395) | | | EARLY (1) (N=302) | | MIDDLE (2) (N=355) | | LATE (3) (N=99) | | POST HOC | |
| | M | SD | M | SD | | M | SD | M | SD | M | SD | | |
| Resignation | 0.37 | (0.48) | 0.45 | (0.50) | 4.89* | 0.29 | (0.46) | 0.42 | (0.49) | 0.77 | (0.42) | | 37.66*** |
| Distraction | 0.71 | (0.46) | 0.67 | (0.47) | 1.27 | 0.72 | (0.45) | 0.62 | (0.49) | 0.82 | (0.39) | 8.23 | 2<1, 3 |
| Social Withdrawal | 0.58 | (0.49) | 0.58 | (0.49) | 0.02 | 0.54 | (0.50) | 0.58 | (0.49) | 0.71 | (0.46) | 4.33* | 1<3 |
| Wishful Thinking | 0.88 | (0.32) | 0.92 | (0.27) | 3.58 | 0.93 | (0.25) | 0.88 | (0.32) | 0.90 | (0.30) | 2.60 | |
| Self Criticism | 0.32 | (0.47) | 0.37 | (0.48) | 2.42 | 0.23 | (0.42) | 0.34 | (0.48) | 0.71 | (0.46) | 42.53*** | 1<2<3 |
| Blaming Others | 0.48 | (0.50) | 0.48 | (0.50) | 0.06 | 0.40 | (0.49) | 0.52 | (0.50) | 0.58 | (0.50) | 6.44** | 1<2, 3 |
| Social Support | 0.54 | (0.50) | 0.61 | (0.49) | 4.39* | 0.81 | (0.49) | 0.52 | (0.50) | 0.68 | (0.47) | 5.36** | 2<1, 3 |
| Emotional Regulation | 0.77 | (0.42) | 0.84 | (0.37) | 5.14* | 0.82 | (0.38) | 0.79 | (0.41) | 0.79 | (0.41) | 0.66 | |
| Problem Solving | 0.78 | (0.42) | 0.83 | (0.38) | 3.93 | 0.83 | (0.38) | 0.77 | (0.42) | 0.82 | (0.39) | 1.55 | |
| Cognitive Restructuring | 0.63 | (0.48) | 0.66 | (0.48) | 0.38 | 0.68 | (0.47) | 0.57 | (0.50) | 0.84 | (0.37) | 13.97*** | 2<1<3 |

Note. For ease of presentation, each mean above represents the percentage of the population that endorsed using that strategy. * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 3
ADJUSTED STANDARDIZED MEANS (AND STANDARD ERRORS)
OF COPING STRATEGY EFFICACY ON THE KIDCOPE

| STRATEGY | STRESSOR | | | | | | | | F | POST HOC |
|-------------------------|----------------|--------|----------------|--------|-----------------|--------|---------------|--------|-------|--------------------|
| | SCHOOL (N=280) | | FAMILY (N=242) | | SIBLINGS (N=85) | | PEERS (N=189) | | | |
| | M | SE | M | SE | M | SE | M | SE | | |
| Resignation | 0.12 | (0.11) | -0.15 | (0.09) | 0.11 | (0.18) | -0.23 | (0.12) | 1.98 | |
| Distraction | 0.22 | (0.08) | -0.01 | (0.08) | 0.01 | (0.13) | -0.29 | (0.09) | 5.34* | Peer<School,Family |
| Social Withdrawal | 0.02 | (0.09) | 0.10 | (0.08) | 0.03 | (0.15) | -0.01 | (0.10) | 0.68 | |
| Wishful Thinking | 0.05 | (0.07) | 0.11 | (0.07) | -0.05(0.12) | 0.04 | (0.09) | 0.45 | | |
| Self Criticism | 0.16 | (0.11) | 0.08 | (0.11) | -0.06 | (0.23) | -0.29 | (0.12) | 2.70 | |
| Blaming Others | 0.06 | (0.10) | -0.07 | (0.10) | 0.30 | (0.14) | 0.03 | (0.11) | 1.60 | |
| Social Support | 0.13 | (0.09) | 0.05 | (0.09) | 0.07 | (0.15) | -0.08 | (0.10) | 0.79 | |
| Emotional Regulation | 0.15 | (0.08) | -0.12 | (0.07) | 0.06 | (0.12) | -0.03 | (0.09) | 2.19 | |
| Problem Solving | 0.12 | (0.07) | -0.09 | (0.07) | -0.05 | (0.12) | 0.05 | (0.09) | 1.48 | |
| Cognitive Restructuring | 0.15 | (0.08) | -0.13 | (0.09) | -0.22 | (0.16) | -0.02 | (0.10) | 2.59 | |

a Bonferonni correction (0.05/10 analyses)=0.005

* $p < .05$.

ten coping strategies than the younger children, as evidenced by a flatter profile for late adolescents in FIGURE 3. A within-groups significant multivariate main effect for coping-strategy use, Wilks's $F(9, 745)=102.11$, $p < .0001$, $\eta^2=.55$ was also observed, and should be interpreted in light of the above interaction.

Intraclass correlations were computed to examine further the patterns of coping across age groups. An overall coefficient of .50 (NS), obtained when comparing coping profiles across all three age groups, suggests a low correspondence in the three coping profiles. However, subsequent analyses confirmed that this was mostly due to differences between late adolescents and the other two age groups. Indeed, the intraclass correlation coefficients between late and middle adolescents ($r=.15$, NS), and between late and early adolescents ($r=.26$, NS), were much lower than the coefficient between early and middle adolescents ($r=.90$, $p < .05$).

Because children only reported the efficacy for those coping strategies that they had used, a MANCOVA, which uses only the lowest common denominator of subjects, would eliminate too many subjects. Consequently, ten ANCOVA analyses, corresponding to the ten coping strategies included in the Kidcope, were conducted to investigate differences in children's reports of coping efficacy across the stressor categories. Age and gender were included as covariates, and children's ratings of efficacy were standardized across age groups (see Method section, above). To correct for the number of analyses, the Bonferonni correction

procedure was used and a p level of .005 was set for statistical significance. As shown in TABLE 3, the only significant difference on efficacy between stressor categories was on distraction, with post-hoc testing revealing that the children found distraction less helpful for problems with peers than for problems with school or family.

DISCUSSION

This study examined children's reported use of several coping strategies in response to four different stressors. It was hypothesized that, consistent with the available literature on individual coping strategies, children and adolescents faced with different types of stress would exhibit different patterns in the reported use of several coping strategies. It was not known what actual coping pattern would be reported, since most studies of coping to date have examined individual coping strategies in isolation from one another.

Contrary to hypotheses regarding cross-situational coping patterns, the present results suggest striking similarity across four different stressors in the reported use of the ten different coping strategies. When pairs of strategies were compared, individuals encountering a school stressor exhibited virtually the same pattern of use for ten coping strategies as did individuals faced with sibling stress or family stress. These results are not intuitive, given previous findings that children alter their use of a particular coping strategy across situations (Band & Weisz, 1988). Indeed, individual coping strategies are typically only moderately intercorrelated across situations (Compas, Malcarne,

& Fondacoro, 1988; Roecker et al., 1996), indicating significantly less than perfect cross-situational coping consistency. The present study, however, differs methodologically from previous studies in that four different groups of children (those encountering each of the three different types of stressors) completed the measure, in contrast to correlations of the same children's use of strategies across stressors. The patterns differed most when comparing sibling stressors and peer stressors, suggesting interpersonal stressors inside and outside the family are handled most differently.

The present results suggest that examining several different coping strategies in relation to one another—rather than children's use of one strategy in isolation from others—yields unique and useful information about how children cope with life stress. Whereas the level of use of one particular strategy may vary somewhat across different stressors, these variations do not alter the overall pattern reported by children across different stressors. The pattern of strategies as a whole remains the same, as indicated in FIGURE 1. Thus, it may be possible to derive normative coping patterns that have clinical utility in addressing how children cope regardless of the type of stress encountered.

This finding has implications for clinical practice. Much research has examined the role of coping in child adjustment. However, it is unclear to what extent these findings have contributed to practice. Clinicians may find it useful to know about children's use of a range of strategies (i.e., coping patterns) in response to different stressors, instead of attempting to assimilate research regarding wide variations in individual coping strategies across situations. As depicted in FIGURES 1–3, the children in the present study reported using wishful thinking, problem-solving, and emotional regulation significantly more than the other seven coping strategies examined, regardless of gender, type of stressor encountered, or whether they were in early or middle adolescence. Therefore, in practice settings, it would be important to screen for a child's use of these three coping strategies. Clinicians could then further assess the coping of children who do not report that they use these strategies frequently.

Another way of looking at the present findings is that evidence regarding cross-situational coping specificity alone isn't sufficient in seeking to un-

derstand children's coping. Depending on how coping is examined, coping responses may inherently be both situation-specific (i.e., when individual coping strategies are examined) and consistent (i.e., when coping patterns are examined). As reported in previous studies (Stark et al., 1989), cognitive restructuring may be used more frequently in response to a boyfriend or girlfriend problem than with a parent or friend problem. However, the present data suggest that, regardless of the stressor confronted, the pattern of strategies an individual employs would look very similar in rank and frequency. If, as this study suggests, the pattern (see FIGURE 1) is actually consistent across situations, then deviations from this pattern may have clinical implications for an individual. For example, if a clinician monitors coping patterns consistently across treatment and encounters a situation in which a child or adolescent uses a different pattern of coping strategies, further inquiry into the characteristics of the situation that dictate a change in coping response is indicated. Alternatively, if the situation's features are comparable to other stressors, then the therapeutic strategy might be to investigate factors in the child and family that led to these changes, or to assist the child in the use of his or her typical pattern of coping strategies.

The patterns of coping with different stressors were also consistent for males and females. However, differences in coping patterns existed by age group. Specifically, late adolescents reported greater frequency of use for many more strategies than did early and middle adolescents. This is consistent with previous coping research. A positive correlation with age/developmental level has been well established (Compas, Banez, Malcarne, & Worsham, 1991), indicating that a wider range of coping behavior becomes available to children over the course of development.

Coping efficacy has received relatively little attention in the coping literature. In this study, only one difference in coping efficacy distinguished the children. Specifically, children coping with family stressors reported significantly lower ratings of efficacy for wishful thinking, compared to children encountering other types of stress. In general, it appears that the coping strategies used are perceived by children as moderately helpful.

Little is known about the actual utility of the coping pattern reported by most children in the

present study. Coping patterns were not compared to child outcomes. A great deal of research has sought to identify individual coping strategies that are adaptive and maladaptive in nature. Previous research suggests that strategies categorized as approach- or problem-focused coping strategies (e.g., problem-solving) are more highly correlated with positive child outcomes than those categorized as avoidant or emotion-focused (e.g., emotional regulation) (Compas *et al.*, 1988). However, these studies have not typically included the examination of coping patterns, or the use of several coping strategies. If the examination of coping patterns yields useful information about coping behavior, then it would be important to know how patterns are related to child outcomes as well.

A great deal of attention has been paid to coping behavior in middle-class, Caucasian families. The sample of participants in the present study, albeit large, did not yield additional information regarding the coping behavior of children from diverse backgrounds and cultural contexts. Future research should examine cross-cultural coping responses in children from a range of backgrounds. Another limitation of the present study is the lack of information regarding the temporal nature of the coping patterns reported. It is unknown whether children utilized the four most commonly reported strategies simultaneously or at different times in the coping process. In addition, the results are based on child reports only. Although child self-reports are a valuable source of knowledge in child research, they do not provide complete information regarding actual behavior and are known to differ from data obtained via behavioral observations (Altshuler & Ruble, 1989). Thus, clinicians must keep the context of children's perceptions in mind when utilizing the information presented. Finally, this study did not assess perception of controllability, a moderator variable that might lead to different patterns of coping than is evident when coping is examined across stressors.

CONCLUSION

The present study provides data regarding coping patterns collected from a large number of children in response to four frequently encountered types of life stress. The results indicate that the examination of several coping strategies or coping patterns in response to different types of stress

yields unique information regarding children's use of individual coping strategies across different stressors. In particular, children report consistencies in coping across situations when patterns of coping are examined. These patterns did not vary by gender; however, older adolescents reported a coping pattern that included a wider variety of strategies than did the younger participants.

Information regarding use of several coping strategies, or coping patterns, can be collected relatively easily by means of brief coping measures or focused interviews. Clinicians may find it most useful to compare such information with the typical coping pattern reported by children in the present study, as illustrated in FIGURE 1. Future research should generate improved methods of examining coping patterns, as this may yield information about children's coping that is distinct from that obtained from the examination of individual strategies. Methodological improvements should be made to address the temporal use of coping strategies and examine the role of coping patterns in determining child outcomes.

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