An Examination of the Cascading Resilience Model and Family Resilience

by

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Abstract

The concept of resilience has been widely studied for decades. Recent streams of resilience research have focused on relational and environmental factors important for understanding risk and resilience beyond individual traits (Masten, Lucke, Nelson & Stallworthy, 2021). This systems perspective of resilience is critical when considering family resilience. Family resilience is the ability of a family, as a functional system, to withstand and overcome adversities and stress (Walsh, 2016a). Transactional processes among family members, as well as challenges faced by individual members of the family, impact the functioning of the family as a unit. Around the world, parenting programs are being developed and employed to promote positive parenting techniques and improve child well-being and family outcomes. The Cascading Resilience Model (CRM; Doty, Davis, & Arditti, 2017) is a theoretical model explaining how parenting programs can create cascades of resilience that spill over into a variety of unintended systems, including the family system. This model highlights theories such as Barbara Fredrickson's broaden and build theory (2004), and social capital theory, as mechanisms by which parental skills create cascades of resilience. Despite the CRM's strong theoretical underpinnings, it has yet to be empirically tested with a community sample. Therefore, the present study tests the CRM's proposed pathways for how parenting qualities can lead to family resilience. Self-report data from 295 self-identified parents was collected on parental self-efficacy, positive emotions, coping capacity, social supports, and family resilience. Structural equation modelling was used to test the CRM, and showed that the proposed pathways of the CRM did not fully explain the data collected. However, adding a direct pathway from parental positive emotion to family resilience significantly improved model fit, highlighting the importance of considering parental emotion in interventions to improve family resilience.

Preface

This thesis is an original work by Leah Brassard. This thesis research received research ethics approval from the University of Alberta Research Ethics Board, Project Name "An Examination of the Cascading Resilience Model", Study ID Pro00123869, on September 14th, 2022.

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Table of Contents

List of Tables

List of Figures

Introduction

Resilience has long been studied in relation to children and their families. Historically, resilience was considered a trait individuals possessed that allowed them to overcome hardship and adversity (Masten & Coatsworth, 1995). Children who overcame trauma were thought to possess innate characteristics that made them "strong" (Walsh, 2016a). This conceptualization was problematic, as it created assumptions that resilience was not something one could build or develop, but rather that it was something one was born with. In more recent years, there has been a shift in the research to consider resilience through a systems lens with the recognition that a variety of external factors influence an individual's capacity for resilience (Masten 2018). For children, the most significant external factor influencing resilience is having a close, caring relationship with an important adult who advocates for them (Ungar, 2004).

Worldwide, parenting programs have been developed and employed to support this notion that childhood resilience can be fostered through positive parenting. Targeted programs such as Triple P – Positive Parenting Program (Sanders, 1999), Bounce Back and Thrive! (BBT: Pearson & Kordich Hall, 2016), and the Incredible Years Parent Training Program (Webster-Stratton, 2006) promote resilience through teaching positive parenting skills to parents and caregivers, with the hope that these positive changes to one's parenting can subsequently impact their children's resilience. Indeed, research on these programs have shown improvements in a variety of child outcomes including social, emotional, and behavioural benefits (Sanders, Kirby, Tellegen, & Day, 2014; Gardner & Leijten, 2017). They have also shown unexpected positive impacts for biological, family, and community outcomes (Sanders & Mazzucchelli, 2017; Bywater et al., 2018). The processes by which these unintended but beneficial spillovers of resilience have come to pass has been largely unexplored.

The Cascading Resilience Model (CRM) is a theoretical model proposed by Doty, Davis, & Arditti (2017) to explain these resilience cascades. Their model highlights that parenting programs have both intended and secondary skill-building impacts, with secondary skills subsequently promoting processes through which resilience can spill over into biological, family, and community systems. The authors theorize that parental self-efficacy (the degree of confidence a parent has in their parenting decisions; Wittkowski et al., 2017), and parental positive emotion, improve a parent's coping capacity and increase their networks of social supports. Through broaden and build and social capital processes, these improvements result in cascades of resilience ranging from improved health and physiological outcomes for children, to generational family resilience, to improved emotional outcomes of peers associated resilient children (Ha & Granger, 2016; Dufur, Parcel, & McKune, 2008; Osgood et al., 2013).

This theoretical model may be beneficial for developing and assessing parenting programs, and understanding the impacts these programs have on different systems. However, to date, the CRM has not been empirically tested with a community sample. The present study tests the CRM to understand what parental qualities and processes specifically support family resilience, one of the systems proposed to be impacted through the CRM.

Literature Review

In the following sections, resilience, parenting programs, and the processes proposed by the CRM are discussed in detail. This information will lay the foundation for the importance of testing this theoretical model, and why these proposed processes were used as pathways for the structural equation models analyzed in this study.

Resilience

A Historical Background

Resilience has been defined and studied in a variety of ways. Some conceptualizations of resilience highlight that resilience is one's ability to withstand and bounce back from life challenges (Masten & Cicchetti, 2016). Others focus on resilience as a construct heavily influenced by external factors such as one's environment, political climate, social relationships, and societal pressures (Masten et al., 2021). Childhood resilience has been an area of study and scholarship for several decades. Research explicitly focusing on resilience in child development emerged in the 1970s after researchers began to note unexpected adaptive functioning in children identified as high-risk for mental health problems due to their traumatic upbringings. Since this initial discovery, thousands of scholars and researchers have explored the vast ways in which resilience can be seen in children, parents, and families.

Ann Masten, a renowned resilience scholar, and colleagues, highlighted that the trajectory of resilience research is best described by four "waves". The first wave in the early years of childhood resilience research, sought to identify factors, traits, or characteristics associated with better outcomes in children exposed to hardship. The second wave of resilience research shifted away from "what matters" toward "how it works". These researchers sought to discover what processes occurred that allowed someone to overcome trauma and hardship, and

how these processes occurred. This subsequently brought about the third wave of research: intervention. Individual, parental, and community-based interventions have all been developed to test and intervene with the processes identified to support and bolster resilience. Finally, the fourth and current wave of resilience research involves a systems perspective by which scholars are attempting to integrate findings across disciplines using a broader lens to understand how reciprocal interactions impact resilience. For example, studies of this fourth wave have examined combinations of genetic, environmental, and social factors, and how these combinations impact risk and resilience (Masten, et al., 2021).

Family Resilience

Family resilience has blossomed from this fourth wave of resilience research to go beyond understanding how contextual factors impact a child's resilience, to measure resilience within a specific context most children find themselves in: a family. Although most theory, research, and intervention has focused on dyadic relationships between a parent and child, family resilience examines resilience through a more complex interactional model that reflects the whole family as a unit. Family resilience has been defined as the ability of the family as a functional system to withstand and rebound from adversity (Walsh, 2016a). From this conceptualization, a parent or child is not alone in facing hardship, and not alone in recovering from hardship. How the family unit functions, communicates, and deals with stress will impact each individual members' outcomes.

Froma Walsh is a leading expert in family resilience. She highlights that holding a narrow focus on individual child resilience leads many troubled families to be written off as hopeless despite their potential for adaptation if only a contextual, relational perspective was adopted. Walsh outlines three critical elements that comprise her family resilience framework:

belief systems of the family, organizational process, and communication (Walsh, 2016a). Belief systems involve the congruent sets of beliefs a family and it's members hold about the world. Successful families maintain an openness to differing viewpoints amongst family members, recognizing that each member of the family is a unique individual living in their own contextual world, therefore holding their own beliefs about that world. Respecting differences in beliefs while creating meaning through family narratives is at the core of resilient families (Beavers & Hampson, 2003). Organizational processes involve the way the family supports and connects with each other, adapts to change, and outsources social and economic resources. Families with high levels of resilience demonstrate a connectedness both within the relationships of the family, and to the broader community and social organizations present (Olson & Gorall, 2003). Finally, communication processes involve the family's ability to share, collaborate, problem-solve, and communicate effectively. Resilient families demonstrate a clear sharing of information, the ability to share emotions, and to collaborate when faced with problems or new tasks (Beavers & Hampson, 2003; Olson & Gorall, 2003). Together, these three elements of family resilience allow for involvement from a variety of family members invested in the positive development and well-being of children. Even in troubled families, siblings, step-parents, grandparents, and other caregivers can play a vital role in bolstering resilience (Walsh, 2016b; Ungar, 2004).

Through the early studies of resilience, both factors that support the overcoming of hardship, as well as stressors and risk factors related to hardship, were identified. Parental mental illness, trauma, emotional and physical abuse, and biological risk factors were highlighted as risk factors for poor social, emotional, behavioural, and mental health outcomes in children (Kumpfer & Alvarado, 2003). Likewise, a shortlist of adaptive traits was compiled, including skills such as self-regulation, motivation, self-efficacy, problem-solving capabilities, and perhaps most

notably, capable caregiving and close, positive relationships with a caregiver (Masten, 2015). From a deficit-focused, pathology lens of resilience research, blame and shame were shifted onto mothers and families for their child's challenges. Parents unable to provide stable, competent, positive parenting to their children were seen as the problem. However, positive psychologists highlighted that targeted parenting interventions could be utilized to improve parental skills shown to protect children against hardship (Walsh, 2016a). Caregivers could become a child's greatest asset in battling adversities. Indeed, studies have shown that resilience is greater in children who have at least one supportive, caring parent, caregiver, or adult in their social world (Ungar, 2004). Bolstering family resilience was one such way to shift blame away from parents and to encourage adaptive functioning for not only their children, but the family as a whole (Walsh, 2016a).

Resilience Parenting Programs

Many parenting programs have been carefully constructed to promote children's well-being and mental health outcomes. These programs specifically target parental skills and the qualities of caregivers that have been shown to improve child outcomes. Perhaps the most notable parenting program to date is the Triple P Positive Parenting Program developed by Matt Sanders and the Parenting and Family Support Centre from the University of Queensland, Australia. Backed by decades of research, Triple P is seen as one of the world's most effective parenting programs, teaching parents the skills they need to raise well-adjusted children (Sanders et al., 2014). The program teaches core parenting skills like emotion regulation, problem-solving, and parental self-efficacy; the confidence and competence a parent feels about their parenting (Sanders, 1999). Globally, Triple P has shown positive benefits both short- and long-term for children and parents (Sanders et al., 2014). The most notable strength of the Triple P program is

it's universal, flexible design said to be appropriate for parents everywhere, regardless of their circumstances. Many other universal parenting programs exist, including the Incredible Years Parent Training (Webster-Stratton, 2006), Bounce Back and Thrive! (BBT: Pearson & Kordich Hall, 2016), and Parenting Resilient Kids (PaRK: Fernando et al., 2018). These programs have also shown promise in building skills in parents that subsequently improve outcomes for their children, including conduct challenges, ADHD symptoms, and peer interactions (Leitjen et al., 2018).

Several resilience-building programs have also been developed for more specific populations with unique needs. Indigenous, Black, and Latinx parents face additional challenges including discrimination, limited access to resources, intergenerational trauma, and other barriers in their parenting (McKinley, Saltzman & Theall, 2023; Smith, Yzaguirre, Dwanyen & Wieling, 2022). These families experience disproportionate rates of anxiety, depression, suicide, post-traumatic stress disorder (PTSD) and substance use disorder (Nelson & Wilson, 2017; Bernard et al., 2021). As well, these parents have unique cultural beliefs, traditions, and customs that need to be supported and incorporated into parent programming. Programs such as the Weaving Healthy Families (WHF: McKinley et al., 2023) and Traditional Aboriginal Parents Program (TAPP: Tooms et al., 2021) have been developed from Indigenous parenting models to promote and support resilience in Indigenous children through parent training and community engagement. Similarly, programs such as the Chicago Parent Program (CPP) have been developed through collaboration with Black and Latinx parents to improve positive parenting in culturally appropriate ways (Gross et al., 2009). Many of these culturally sensitive parenting programs have yielded positive effects for parents, families, and for their children's social,

emotional, and behavioural outcomes while ensuring that the voices and unique experiences of these parents are valued.

Military families experience unique challenges to parenting as well. Frequent relocation, deployment, and challenges with stress and anxiety about military experiences can create challenges for parents to provide stable, positive relationships with their children (Manser, 2020). Programs such as After Deployment Adaptive Parenting Tools (ADAPT: Gewirtz, DeGarmo & Zamir, 2018) and the Coming Home Project (Bobrow et al., 2013) have been critically designed to support parents in building resilience, strengthening their emotion regulation, and improving family well-being while remaining sensitive to the challenges military parents face. Many of these military-specific programs have led to improvements in parental self-efficacy and co-parenting skills and decreases in parental stress (Saltzman et al., 2013; Saltzman et al., 2016). These improvements to parental functioning are thought to have subsequent benefits for child and family functioning as parents begin to create more positive environments in the home.

Cascades of Resilience

Cascades of resilience are ways by which positive outcomes experienced by one individual in one area of functioning (for example, a parent improving their parental self-efficacy), can have future benefits for other individuals and other areas of functioning (for example, children and families experiencing less stress). A parent engaged in a positive parenting program may first begin to see benefits in specifically targeted areas of functioning, however, over time these changes and learned skills can impact other domains of that parent's functioning, and even systems beyond the parent themselves (their children, their families, or their communities) (Masten & Cicchetti, 2010). Cascades of resilience are the primary driving

force behind many parenting programs that focus primarily on assisting parents with their parenting in the hopes that cascading positive impacts will reach the children and families of these parents and result in resilience. Indeed, resilience cascades have been found to flow from teachers to students (Damico, 2020), schools to students, communities to families (Masten & Motti-Stefanidi, 2020), and within individuals through epigenetic effects (Masten & Cicchetti, 2010). However, limited research has explained the processes by which these cascades occur so that more targeted intervention can be utilized (Doty et al., 2017).

The Cascading Resilience Model

The Cascading Resilience Model (CRM) developed by Doty, Davis, & Arditti (2017) highlights specific processes by which the resilience developed through parenting programs can have positive, unintended impacts on a variety of systems related to parents and their children (see their article for thorough review of the CRM). Parental experiences of positive emotion and parental self-efficacy are thought to be unintentional, secondary benefits that stem from parental involvement in parenting programs. These positive emotions and feelings of parental self-efficacy are said to generate processes by which positive outcomes spill over into other systems, such as biological, family, and community systems. For example, a trial program called Strong African American Families demonstrated that through the improvement of parenting skills and the parent-child relationship, children at-risk for epigenetic aging experienced biological buffering effects through their positive parental relationships (Brody et al., 2016). Similarly, at the community level, an evaluation of the Promoting School-University Partnerships to Enhance Resilience (PROSPER) program discovered that children who had close social ties to children of parents involved in PROSPER also experienced benefits similar to those directly linked to the intervention (Osgood et al., 2013). Family systems have also been hypothesized to be impacted

by cascading resilience, even to the extent of generational family resilience developing long after the initial family resilience was bolstered (Mueller & Elder, 2003).

The CRM highlights two theories to support how resilience can cascade into these different systems from positive emotion and parental self-efficacy. The first, broaden and build theory, asserts that positive emotions are important for adaptive functioning (Fredrickson, 2004). Joy, contentment, and love, among other positive emotions, are said to promote the discovery of novel and creative problem-solving skills and increase coping capacity. When an individual holds a more positive attitude and looks at novel situations through a positive lens, their mind can broaden beyond their typical, patterned response. When a new challenge or situation presents itself, the individual can consider different ways to approach a solution. Studies have found that participants who experienced positive emotions demonstrated more open, creative, and resourceful thought patterns in response to stressful situations (Fredrickson, 2004; Garland et al., 2010). More creative coping strategies are hypothesized to be one such way for resilience to cascade into other systems in the CRM (Doty et al., 2017). Similarly, broaden and build theory also explains how parental self-efficacy can improve parental coping capacity. As individuals continue to harness their creativity and learn novel ways to approach and solve problems, they gain confidence that they can deal with challenges thrown their way. This self-efficacy that one can cope with new situations improves coping capacity over time. Again, the CRM posits that this improvement in coping capacity from parental self-efficacy results in cascades of resilience (Doty et al., 2017).

The second theoretical mechanism of the CRM, social capital theory, describes how individuals build and utilize social resources and community networks to attain positive outcomes (Lin, 2001). Although social capital theory has been applied to a variety of fields of

study, within the context of resilience, social capital theory explains how parents can build social connections to strengthen their support systems in times of hardship. In the CRM, positive emotions are hypothesized to translate into positive social interactions, building a network of social support over time. Parents who are more positive and friendly build more social relationships, are more well-liked, and have stronger social connections (Dorsey and Forehand, 2002). These social connections to friends, family, community leaders, and school and church members create a community of people the parent can rely on for childcare, social interaction, financial support, emotional support, and basic necessities (Morris et al., 2021; Ungar, 2011). The authors of the CRM also predict that parental self-efficacy will promote parents' abilities to build social capital resources such as time, social support, and even material resources, although the theoretical underpinnings for this connection are less clear (Doty et al., 2017). It is possible that as parents feel more confident in their parents, they are more comfortable reaching out to others when they feel they need support. Again, these processes for building social supports are hypothesized to lead to cascades of resilience (Doty et al., 2017).

Purpose

The CRM remains a theoretical model untested with community samples. With many parenting programs being developed to promote and improve family resilience, the CRM presents as a useful theoretical tool to explore processes by which these parenting programs may result in improved family resilience. However, it is first necessary to empirically test the CRM to determine whether the pathways and processes hypothesized to result in cascades of resilience do in fact relate to family resilience. The present study seeks to do this by using a community sample of self-identified parents who self-reported on constructs identified in the CRM. Structural equation models were then tested to determine whether the CRM was the best model

to describe the relationship between positive emotion, parental self-efficacy, and family resilience.

Methods

Procedure

Participants were recruited through two online crowdsourcing websites: Amazon Mechanical Turk (MTurk), and Prolific, to complete an online survey. To participate, individuals had to be self-identified parents with the ability to read and write English. Consent was gathered through the survey link on each crowdsourcing platform. Upon consenting to participate, participants completed basic demographic and mental health questions, followed by measures of parental self-efficacy, overall emotion, coping, social supports, and family resilience. Upon completion of these measures, participants were debriefed and received compensation for their participation.

As this survey utilized crowdsourcing websites, several steps were taken to ensure that quality data was received. Four attention check questions were placed randomly throughout the survey, asking participants to select a specific response option. Participants who failed one or more attention checks were not included in the final sample (n=64). Additionally, participants who failed to complete at least 80% of the survey were deemed "incomplete" and subsequently removed from the final sample (n=43).

Participants

The sample analyzed was comprised of 295 self-identified parents. Participants were an average of 38.9 years old (sd = 13.7), with 81.4% of the sample being married or in a common-law relationship. The sample was 37.6% male, 62.0% female, with one individual identifying as "other". The most common ethnicity in the sample was white (87.5%), with 5.8% identifying as

African, 1.7% East-Asian, and 2.4% Hispanic. The majority families had one or two children (86.1%). Approximately 29% of parents identified that they experienced mental health challenges, and 16% of their children experienced mental health or behavioural challenges. Table 1 presents all demographic information for the sample.

Measures

From the CRM, two constructs deemed "secondary outcomes" were measured in this study: parental self-efficacy and positive emotion. Additionally, broaden and build processes of creativity, problem-solving, and coping were operationalized as one construct in this study: problem-focused coping. Social capital processes of sociability, trust, and networks of social support were operationalized as one construct: networks of social support. Finally, the outcome variable for this study was family resilience.

Parental self-efficacy

Parental self-efficacy was measured using the Self-Efficacy for Parenting Tasks Index (SEPTI; Coleman & Karraker, 2000). This is a 36-item measure that uses a Likert response scale ranging from (1) strongly agree to (6) strongly disagree. The scale contains five subscales related to specific domains of parenting tasks; a) achievement (e.g., I do an adequate job helping my child with school work), b) recreation (e.g., When my child wants to play with a friend, I got out of my way to make it work), c) discipline (e.g., I have trouble deciding on appropriate rules for my child, reverse scored), d) nurturance (e.g., Being a loving parent comes easily to me), and e) heath (e.g., I work hard to encourage healthy habits in my child). Higher scores indicate higher self-efficacy on all subscales. All subscales of the SEPTI have been found to have sufficient reliability (Coleman & Karraker, 2000). With the current sample, the SEPTI subscale

Table 1

Demographic Information

Characteristic	N	%
Gender		
Female	183	62.0
Male	111	37.6
Other	1	0.3
Ethnicity		
African	17	5.8
Caucasian	258	87.5
Hispanic/Latinx	5	1.7
Indigenous	7	2.4
Other	5	1.7
Prefer not to say	2	0.7
Marital Status		
Single	27	9.2
Married/common law	240	81.9
Divorced	14	4.8
Other	12	4.1
Income		
<$20,000	22	7.5
$20,000 - $50,000	111	37.6
$50,000 - $80,000	105	35.6
$80,000 - $110,000	40	13.6
$110,000 - $140,000	12	4.1
$140,000 - $170,000	2	0.7
>$170,000	1	0.3
Number of Children		
1	141	47.8
2	113	38.3
3	27	9.2
4	10	3.4
5	2	0.7
Parent Mental Health Challenges		
Yes	86	29.2
No	209	70.8
Child Mental Health Challenges		
Yes	49	16.9
No	241	83.1

Cronbach's Alpha levels are as follows: discipline = .81 achievement = .75, recreation = .68 nurturance = .80, and health = .83. The Cronbach's Alpha level for the overall scale, which was utilized in the present study analyses was .70, which is considered to be an acceptable reliability rate.

Emotion

Parental emotion was measured using the Positive and Negative Affect Schedule (PANAS; Watson & Clark, 1988). The PANAS is a 20-item measure of positive and negative emotions that uses a Likert response scale ranging from (1) very slightly/not at all to (5) extremely. Three additional positive emotions were included at the end of the PANAS for this current study; content, joyful, and loving. These were added as they map onto broaden and build theory of positive emotions (Fredrickson, 2004), a theory central to the CRM. The positive affect subscale Cronbach's Alpha level was .91 with the addition of the three CRM emotions. The negative affect subscale had a Cronbach's Alpha level of .94.

Coping

Parental coping capacity was measured using the Carver Brief COPE, a 28-item scale with responses ranked from (1) I haven't been doing this at all to (4) I've been doing this a lot (Carver, 1997). The Brief-COPE is a self-report questionnaire designed to measure effective and ineffective ways to cope with a stressful life event through three subscales; a) problem-focused coping (e.g., I've been taking action to try to make the situation better), b) emotion-focused coping (e.g., I've been getting emotional support from others), and c) avoidant coping (e.g., I've been saying to myself "this isn't real"). The Brief-COPE was initially validated on a community sample who had been impacted by a hurricane and has since been deemed reliable in numerous other samples (Carver, 1997). With the current sample, the COPE subscale Cronbach's Alpha

levels are as follows: problem-focused = .82, emotion-focused = .86, and avoidant = .92. For the purposes of this study, only problem-focused coping was utilized in analyses, as it is said to represent psychological strength, grit, positive outcomes, and matches with the broaden and build theoretical perspective that more positive emotion creates greater problem-solving capacities (Dias et al., 2012). Emotion-focused and avoidant coping contain some more negative elements of coping not desirable for the CRM, such as self-blame, denial, and behavioural disengagement.

Social capital

Social capital was measured using the Personal Social Capital Scale (PSCS) developed by Wang et al. (2014). The PSCS contains 42 items measuring 10 sub-constructs. Five sub-constructs measure bonding social capital and five measure bridging social capital. Bonding social capital refers to how well a person is embedded within their various networks of different types of people (e.g., among people in each category, how many can you trust? Family members, friends, former colleagues), and bridging social capital refers to how well a person is embedded within different types of social organizations (e.g., how many groups or organizations represent your rights and interests? Government, economic, cultural, leisure, etc.). Psychometric assessment, including confirmative factor analysis (CFA), indicated that the PSCS had excellent reliability, clear structure validity, and adequate predictive validity (Chen et al. 2009). The Cronbach's Alpha levels for the bonding (.93) and building (.93) subscales show excellent internal consistency in the sample.

Resilience

Family resilience was measured using the Walsh Family Resilience Questionnaire (WFRQ; Walsh, 2016a). Participants rate how often their family engages in specific behaviours

to deal with challenges with responses ranging from (1) rarely/never to (5) almost always. The WFRQ displays acceptable psychometrics across its three subscales: a) belief systems (e.g., We view distress with our situation as common/understandable), b) organization patterns (e.g., Our family respects our individuals needs and differences), and c) communication and problem-solving (e.g., We can express our options and be truthful to each other). The overall Cronbach's Alpha level of the WFRQ is .96, with the subscales having levels of .89, .86, and .91 respectively.

Results

Descriptive Statistics

For each of the constructs measured in the present study, means, standard deviations, minimum and maximum values, as well as skewness and kurtosis statistics were calculated to describe normality of the data. For parental self-efficacy, total scores ranged from 3 to 5.92 on a Likert scale from 1 to 6, with a mean response score of 4.28 (SD=0.67). For positive emotion, scores ranged from 1.23 to 5 on a Likert scale from 1 to 5, with the mean score being 3.62 (SD=0.74). For social supports, total scores ranged from 1.5 to 5 on a Likert scale of 1 to 5, with the mean response being 3.30 (SD=0.61). For problem-focused coping, scores ranged from 1 to 4 on a Likert scale of 1 to 4, with the mean score being 2.67 (SD=0.59). Finally, family resilience scores ranged from 1 to 5 on a Likert scale from 1 to 5, with the mean score being 3.57 (SD=0.66). Family resilience and positive emotion were both slightly negatively skewed (-0.578 and -.0531 respectively), however, this skewness was minimal given appropriate symmetry falls between -0.5 and 0.5. There were no issues with kurtosis, and given the minimal negative skewness of family resilience and positive emotion, analyses were carried out without any changes to the data.

Correlations

Bivariate correlations were run for all variables: parental self-efficacy, positive emotion, problem-focused coping, networks of social support, and family resilience. Correlations are shown in Table 2. Significant positive correlations were found between positive emotion and networks of social support (r=.233), as well as parental self-efficacy and problem-focused coping (r=.129). All other correlations were not significant.

Table 2

Bivariate Correlations

Measure	1	2	3	4	5
1. Parental Self-Efficacy	1.00	-	-	-	-
2. Positive Emotion	.054	1.00	-	-	-
3. Coping	.129*	.072	1.00	-	-
4. Social Supports	.097	.233**	.057	1.00	-
5. Family Resilience	.049	-.035	-.050	.080	1.00

** indicates significance at >.001, * indicates significance at >.05.

Path Analysis

A recursive path analysis was conducted in MPlus 8 (Muthén & Muthén, 2017) to test the Cascading Resilience Model (CRM). Data were first screened to ensure maximum likelihood assumptions were met. Missing data was low (7%) and Full Information Maximum Likelihood (FIML) was used to deal with missing data. The CRM contained two independent variables:

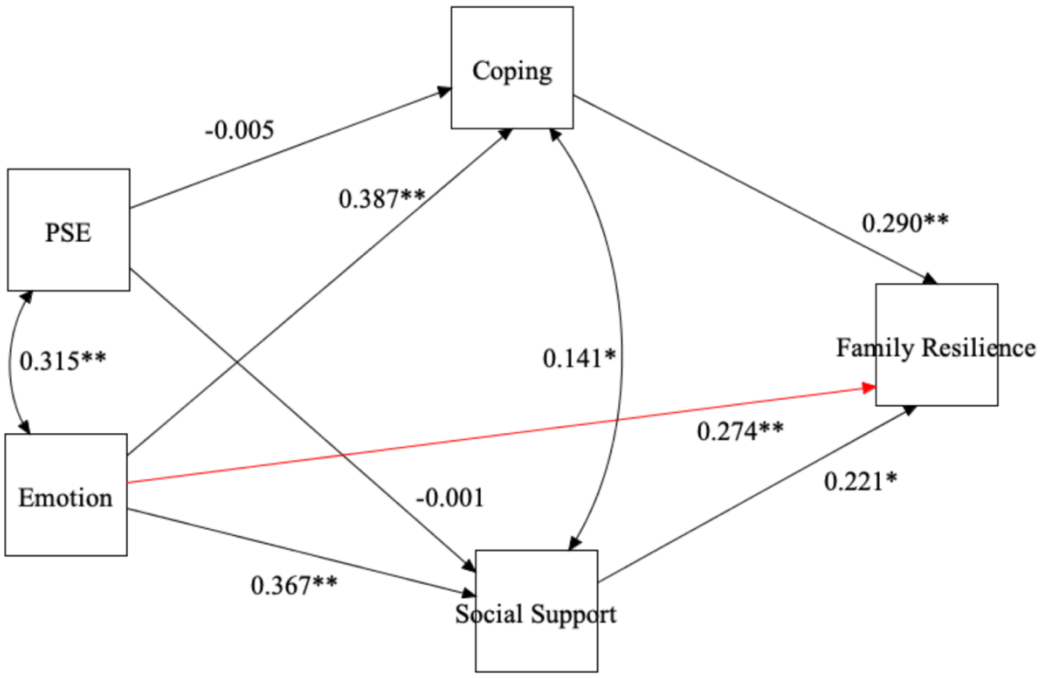
parental self-efficacy and parental positive emotion. These variables were hypothesized to be positively associated with both networks of social support and problem-focused coping. Networks of social support and problem-focused coping were hypothesized to be subsequently positively associated with family resilience. Parental self-efficacy and parental positive emotion were hypothesized to covary, as were networks of social support and problem-focused coping. Overall, the model fit for the CRM with two degrees of freedom was poor ($\chi^2 = 21.75$, $p<.001$; RMSEA=0.183; CFI=0.895; TLI=0.527). In examining the local fit indices, the relationship between positive emotion and family resilience had a standard residual greater than 1.96, warranting investigation.

As the original CRM model did not contain any direct relationship of positive emotion to family resilience, a second model was generated with the addition of this direct pathway from positive emotion to family resilience. This model, with one degree of freedom, had excellent fit ($\chi^2 = 0.992$, $p = 0.319$; RMSEA=0.000; CFI=1.000; TLI=1.000). Figure 2 displays the final model with standardized coefficients for each path. Positive emotion was significantly positively associated with problem-focused coping, such that a one standard deviation unit increase in parental positive emotion was associated with a 0.387 increase in coping ($p<.001$). Positive emotion was also significantly positively associated with social support ($\beta=.367$; $p<.001$) and family resilience ($\beta=.274$, $p<.001$). Positive emotion covaried significantly with parental self-efficacy ($\beta=.315$, $p<.001$). Parental self-efficacy was interestingly not significantly associated with problem-focused coping ($\beta=-0.005$, $p=.937$), or social support ($\beta=-0.001$, $p=.986$) and a direct link from parental self-efficacy to family resilience was not added to the model. Problem-focused coping was significantly associated with greater family resilience ($\beta=.290$, $p<.001$) and

covaried significantly with social supports (β=.141, p=.025). Social support was also significantly positively associated with greater family resilience (β=.221, p=.002).

Figure 1

Results of Final Path Analysis



Standardized estimates presented for each path. ** indicates significance at >.001, * indicates significance at >.005. Emotion = parental positive emotion, PSE = parental self-efficacy, Coping = problem-focused coping. The red arrow indicates a pathway added to the model that was not a part of the original CRM model.

Discussion

Summary of Findings

The present study was intended as an exploration of the Cascading Resilience Model (CRM) outlined by Doty and colleagues (2017), and found that the CRM did not fully explain

the relationships between parental self-efficacy, positive emotions, coping, social support, and family resilience. The CRM theorized that parental self-efficacy and parental positive emotion would improve parental coping capacity and increase networks of social support for parents. These improvements were thought to subsequently improve family resilience. Positive emotion in parents was found to be associated with better problem-focused coping and perceptions of greater networks of social supports. The results indicate that the more positive emotions a parent holds in general (such as joy, contentment, and love), the greater the parent's ability to problem-solve and cope, and the more social support the parent perceives themselves to have. However, parental self-efficacy was not associated with networks of social support or problem-focused coping, as the authors of the CRM originally hypothesized (Doty et al., 2017).

As the CRM theorized, parental coping capacity and perceived networks of social support were associated with greater levels of family resilience. In this study, contrary to the CRM, parental positive emotion was found to also have a strong direct relationship to family resilience, such that parents who felt more positive emotions also had higher levels of family resilience. However, the CRM does not contain a direct link between positive emotion and family resilience. The CRM focuses on how these coping capacities and social supports are the mechanisms that lead to improvements in resilience rather than considering any direct impacts that positive emotion may have on resilience overall. Adding this direct pathway from positive emotion to family resilience greatly improved model fit. Interestingly, when designing the second model with this additional pathway from positive emotion to family resilience added, creating a direct pathway from parental self-efficacy to family resilience was not prioritized. Parental self-efficacy did not have significant relationships with other pathways in the model and was therefore not utilized for other direct pathways.

Overall, the results of this study partially support the Cascading Resilience Model, but also highlight how parental positive emotion may have direct impacts for family resilience, and the parental self-efficacy may not be as involved in these pathways as originally theorized.

Research and Practical Implications

The results from the present study have several research and practical implications for family resilience work. Doty et al. (2017) theorized that the more confidence a parent had in their parenting practices and decisions, the more social supports they would perceive themselves to have, and the greater their problem-solving and coping would be. However, the present study found no significant relationships between parental self-efficacy and social supports or coping. It is possible that parents who feel greater self-efficacy over their parenting decisions do not feel as strong of a need to prioritize social supports, as they believe they can handle difficult parenting decisions on their own. A parent with high parental self-efficacy may not reach out to friends, community leaders, or others in the networks of social supports in times of need, relying on their own parenting skills to get them through difficult times. Alternatively, in households with two parents, parents may rely on one another as supports when they feel greater parental self-efficacy and may not have reported this as social supports in this study as the measure used noted friends, work colleagues, and neighbours as social supports, but not co-parents. Leahy-Warren and colleagues (2012) found that greater social support increased parental self-efficacy, indicating that perhaps the directionality of the relationship between these constructs is in the opposite direction of what was proposed in the CRM. Likewise, a study by Izzo and colleagues (2008) found that for Mexican immigrant parents, those who felt greater social supports felt more efficacious as parents (Izzo et al., 2008). Further research in this area is warranted, as there are

few studies highlighting relationships between parental self-efficacy and social support, and it is unclear the directionality of potential relationships between these constructs.

As well, parental self-efficacy was not significantly related to problem-focused coping in this study. It is possible that parents with higher parental self-efficacy may not find themselves needing to cope with challenging parental situations as often, therefore not reporting higher levels of coping. Parental self-efficacy and coping capacity were positively correlated in this study, indicating that there is a positive relationship between these two variables on their own. However, when put into the model, their relationship became non-significant. One study on parents of children with disabilities found that improving parental self-efficacy and supports led to significantly improved active coping (conceptualized as problem-focused coping in our study) (Whiting et al., 2019). Other research broadly examining parental self-efficacy and coping-related outcomes have shown that strengthening parental self-efficacy has positive effects for immigrant parents facing migration stressors (Eltanamly et al., 2023), decreases distress in parents of children with complex health needs (Whiting et al., 2019), and improves parental warmth in fathers with depression (Trahan & Shafer, 2019). These outcomes may be related to coping capacities, however, direct relationships between parental self-efficacy and coping were not reported. Given these findings, it is odd that parental self-efficacy was not significantly related to problem-focused coping in the present study.

Parental self-efficacy appears to have many benefits for parents and their children, however, in the context of the cascading resilience model, these pathways were not a significant factor. Positive emotion emerged as a more impactful pathway for improving problem-focused coping, social supports, as well as family resilience directly. It is possible that given the present study's single time measurement, relationships between parental self-efficacy and these

secondary benefits of social support and coping were not yet established. In the theoretical explanations given in the CRM, parental self-efficacy appeared to relate to coping and social supports in the longer-term. For example, the CRM proposed that parents who feel more self-efficacy in their parenting decisions will begin to feel they can cope better when new adversities and challenges arise (Doty et al., 2017). This sense of security that parents can cope happens over time, as they experience more challenges and find themselves competent and self-efficacious. Perhaps the relationship between parental self-efficacy and coping is one that builds slowly as self-efficacy increases, something not captured in our study. Likewise, parents who feel greater self-efficacy were said to build greater networks of social support, however this may take time as well. As this study merely measures these constructs in parents rather than attempting to increase or strengthen parental self-efficacy and measure subsequent impacts, it is difficult to know whether improving parental self-efficacy would indeed improve coping and social support networks over time. Again, as this study used a single time point to measure these constructs, changes over time could not be captured, and may explain why relationships between parental self-efficacy and coping and social supports did not emerge.

As the CRM theorized, parental coping capacity and perceived networks of social support were associated with greater levels of family resilience. This is important for intervention and community work. At the individual intervention level, working with parents on adaptive coping methods and increasing coping capacity may be important for improving resilience across the family unit. When the family experiences times of stress, parental coping capacity may act as a buffer for the entire family, supporting them during those times of struggle. Additionally, given that positive emotion had a significant positive relationship with parental coping capacity, interventions highlighting both the skill-building aspects of these coping strategies, *and* parental

positive emotion toward these skills may be critical. For example, a parent who feels anxious to learn new parenting and coping skills may not generate positive feelings toward the intervention they are taking part in. Targeting a parent's emotional reactions toward a skill-building intervention may help to broaden the parent's mind to new possibilities (Fredrickson, 2004), leading to a more effective intervention. Presently, many parenting interventions focus on skill-building to teach and train parents on skills such as positive, active, problem-focused coping strategies (Pearson & Kordich Hall, 2016; Sanders, 1999; Webster-Stratton, 2006). However, it remains unclear whether parental feelings of positive (or negative) emotion toward these interventions impacts the efficacy of said interventions.

At the community level, parent perceptions of social supports appear to impact family resilience. Social supports are not limited to an individual's immediate family, friends, and social circle. From Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1979), social supports can come from meso-, exo-, and macro-systems that include access to resources, relationships with community members, and the community culture. If parents feel they have limited access to direct supports from their immediate social circle, improving community access to resources and positive culture may be one way to bolster family resilience through social supports. Indeed, Walsh (2012) highlights how community-based intervention is critical in her family resilience framework, particularly for families facing adversity related to community vulnerability. Although the studies highlighted by Walsh (2012) do not explore the impact social supports have directly on family resilience, one can reasonably expect that improving community resources in vulnerable spaces would help families to generate resilience. Additional research on resource access and resilience has shown that increasing community resources and supports for families reduces the risk of childhood mental health challenges (Place et al., 2002) and improve academic

outcomes for children (Murray Nettles et al., 2000). Parental positive emotion may also be a factor in how social supports are accessed by parents and families. A parent who feels overwhelmed and anxious may be less likely to reach out for help or access social supports (Boyden et al., 2020; Ren et al., 2020). Interventions that support parental well-being and foster feelings of positivity and hope may lead parents to perceive that they have access to social supports, and to subsequently utilize those supports (Horton & Wallander, 2001). Interventions focused on improving resource access and fostering positive emotions may be beneficial for family resilience when parents do not have access to individualized parenting programs for skill-building.

One of the biggest findings from this study that may be useful from a parenting intervention perspective, is that parental positive emotions appear to have a direct relationship with family resilience. Direct coaching on parental emotional expression, emotional attunement, and emotion regulation may be one way to improve resilience across an entire family unit. Indeed, parent emotion regulation and emotional expression have been the target of more recent parenting intervention programs as a means of improving parental emotion socialization practices (Hajal & Paley, 2020; Havighurts & Kehoe, 2017). The present study supports these parent emotion intervention practices, showing how important they may be for the entire family. Although the CRM posits that improvements in family resilience can come from indirect pathways of improved coping and increased social supports, directly targeting parental emotions through parenting interventions may be just as impactful for family resilience. For example, if parents are holding negative emotions toward their children, families, or themselves as they struggle with adversity, they may have challenges with appropriate communication (Theiss, 2018), self-regulation, and modeling appropriate emotional responses to stress (Vernon &

Moretti, 2022). These may impact child outcomes, as well as family-wide outcomes. Improving a parent's outlook and fostering more positive emotional expression can improve parenting skills, communication, problem-solving, and potentially, family outcomes as a result (Walsh, 2016a; Fredrickson 2004).

Limitations and Future Directions

One of the biggest limitations of this study is its cross-sectional design. Longitudinal data collection is important to better understand how parental self-efficacy and positive emotion may be linked with social supports across time. In the CRM, it is hypothesized that networks of social support may build gradually over time from parents growing their self-efficacy and increasing their positive emotions. The present study has no way of determining whether social supports would increase over time if parental self-efficacy or positive emotion improved over time. As previously mentioned, parental self-efficacy may have stronger relationships with coping and social support in the long-term, so perhaps those pathways would become significant if longitudinal data was used. Similarly, the CRM is intended to examine cascades of resilience from one area of resilience (for example, family resilience) to another area of resilience (for example, community-level resilience) over time. These cascades are theorized to occur over longer periods of time, like months or even years. The CRM even hypothesizes generational cascades by which resilience continues into future generations. The present study does not contain separate timepoints to analyze these cascades. Future longitudinal research is needed to examine how different lengths of time may impact these cascades, and the pathways hypothesized by the CRM in general.

Additionally, although data was screened using attention checks and measures of incompleteness to rule out participants faking data, it is possible, given the online platforms

used, that the sample was not truly comprised of real parents. Participants were asked a series of demographic information about themselves and their children, however there is no definitive way of knowing whether this data was true. Additionally, the sample consisted of predominantly white participants and who were generally middle-class. The sample greatly lacked diversity in ethnic and racial backgrounds and is therefore not generalizable to the overall population. Future research should explore testing the CRM with more diverse samples to understand how these constructs and their pathways relate to all parents.

Another important limitation when interpreting these findings has to do with the measures utilized to operationalize constructs from the CRM. Firstly, the measure used for parental self-efficacy had a reliability rate of .70, which is just on the cusp of an "acceptable" reliability rating. It is possible that using a different measure of parental self-efficacy may result in significant pathways from parental self-efficacy to coping or social supports, which were not found in the present study. Additionally, the measure used to operationalize social supports, although having a strong reliability level, was not a perfect measure to capture all of the possible social supports' parents may rely on when struggling with their children. As noted, co-parenting was not captured as a potential social support in this measure. Family and closer social circle supports were captured by this measure (e.g., friends, coworkers, people in your neighbourhood), however broader community and societal supports such as a church group, pastor, parenting group, as well as political party policies, economic resources, and access to care, were not. It appears that a measure that captures both microsystem (school, church, parenting group) supports and exosystem (social services, media, government policy) supports has not yet been validated in parenting literature. Finally, the PANAS was used as the measure of parental positive emotion, however the PANAS only captures state levels of emotion rather than overall

traits of positive emotion that parents may hold. It is possible that parents may have been feeling overly positive or overly negative at the time that they completed the survey, and that this may have differed from their natural, more regular experiences of emotion.

Another area for future research on the CRM is to explore the manipulation of parental self-efficacy and/or positive emotion through parenting interventions. Actively improving parental self-efficacy or positive emotions in a clinical intervention trial with two or more time points would provide rich data on how each of the CRM proposed pathways improves family resilience. The present study does not manipulate parental self-efficacy or positive emotion, and therefore, the directionality of these pathways for cascading resilience cannot be determined. It may be the case that parental self-efficacy improves when social supports are increased, or when coping capacities are the target of an intervention, rather than the inverse directional relationship proposed by the CRM, which did not yield significant results in this study. As well, a study that directly targets and improves positive emotion would also provide insight into whether the direct effect of parental positive emotion is a greater influence on family resilience than the pathways through coping capacity and social supports. This could help inform targeted interventions for families struggling with resilience by understanding which mechanisms to prioritize for intervention. For example, it may be more advantageous to focus on improving parent's positive emotions to directly improve family resilience rather than intervening with the coping capacity pathway overall.

Finally, future research could explore other avenues for resilience to cascade from these secondary parental outcomes. The CRM hypothesizes that these pathways of parental self-efficacy and positive emotion into coping and social supports may impact a child's biological or social functioning, increasing resilience at the individual child level. Likewise, the CRM

hypothesizes that these pathways have community-wide resilience outcomes as well. The purpose of the present study was to specifically explore the CRM's impact on family resilience, but future research should explore these other areas for cascading resilience. Research on how parental self-efficacy and positive emotion impact individual and community resilience can have implications for public health and government policy.

Conclusion

This study examined the CRM outlined by Doty and colleagues (2017) to understand how parental self-efficacy and parental positive emotion may impact family resilience. The results of this study indicate that proposed pathways by which parental positive emotion increases coping capacity and perceptions of social support are associated with greater family resilience to a degree, however positive emotions may also have a direct impact on family resilience not accounted for in the original CRM. Future research is needed to examine longitudinal relationships within the model, as well as more causal, directional links between constructs. Overall, this preliminary research has implications for community practice and policy makers. Parents who perceive themselves as having greater levels of social support have higher levels of family resilience overall. Improving community supports such as increasing access to parenting resources, safer communities, and parenting groups may be one way to bolster families against hardship. As well, this research has implications for family and parent intervention work, providing information on specific areas that should be targeted to increase family resilience. Educating parents on coping strategies and how to hold more positive emotions may improve family resilience.

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Appendix A: Survey

Demographics

1. What is your age (in years)?
2. What is your preferred gender identity?
    a. Male
    b. Female
    c. Non-binary
    d. Trans-male
    e. Trans-female
    f. Other – text box "please list"
    g. Prefer not to say
3. What is your self-identified ethnicity?
    a. Caucasian
    b. African
    c. Hispanic/Latinx
    d. Indigenous
    e. East-Asian
    f. West-Asian
    g. Other – text box "please list"
    h. Prefer not to say
4. What is your current relationship status?
    a. Single
    b. Married/common law
    c. Divorced
    d. Widowed
    e. Other – text box "please list"
    f. Prefer not to say
5. What is your net family income?
    a. <$20,000
    b. $20,000 - $50,000
    c. $50,000 - $80,000
    d. $80,000 - $110,000
    e. $110,000 - $140,000
    f. $140,000 - $170,000
    g. > $170,000
    h. Prefer not to say
6. How many children do you have?
7. What are their ages (in years / months)?
8. Do you experience difficulties with your mental health (i.e., anxiety, depression, etc.)?
    a. If yes, please describe.
9. Have you ever been diagnosed with a mental disorder?
    a. If yes, please describe.
10. Do any of your children experience mental health challenges?
    a. If yes, please describe.

11. Do any of your children experience difficulties with learning or school?
    a. If yes, please describe.
12. Do any of your children experience behavioural challenges (outbursts, inattention, etc.)?
    a. If yes, please describe.
13. Have you and/or your family faced any of the following challenges (check all that may apply):
    a. Homelessness
    b. Racism
    c. Sexism
    d. Homophobia
    e. Ableism
    f. Displacement/immigration from previous home
    g. Unstable or insufficient income
    h. Lack of social supports
    i. Dangerous living environment/neighbourhood
    j. Single parenthood
    k. Family or extended family conflict
14. Is your family directly associated with the military (i.e., a parent or guardian currently or previously in service)? If so, how?
    a. I am a military member or veteran.
    b. My spouse is a military member or veteran
    c. An extended family member is a military member or veteran.

SEPTI - Parent Self-Efficacy

Please rate your level of agreement with each item on the following scale:
1- strongly agree
2-
3-
4-
5-
6- strongly disagree

Discipline
1. I am a good enough disciplinarian for my child.
R2. I have trouble deciding on appropriate rules for my child.
R3. My child never seems to listen to me when I want him/her to do something.
R4. I have more trouble with discipline than any other aspect of parenting.
5. My disciplinary skills are at least as good as an average parent.
R6. I spend too much time with ineffective attempts to discipline my child.
7. I really don't have much trouble disciplining my child.
R8. I thought I was a good parent until I started struggling so much with discipline.

Achievement
9. I do an adequate job helping my child with school work.
10. I am probably more helpful to my child when it comes to homework than other parents. .

11. I am involved with my child's schooling as much as possible.
R12. Helping my child with school work is very frustrating.
13. I am sure my child knows I am interested in his/her life at school.
R14. I am not as involved in my child's education as I think I should be.
15. I am good at helping my child work through school problems.

Recreation
16. I am a good parent when it comes to arranging for my child to play with friends.
R17. I don't do enough to make sure my child has fun.
18. I am satisfied with my ability to provide recreation for my child.
R19. I know I should care more about my child's social life.
20. When my child wants to play with a friend, I go out of my way to work it out.
21. I do a good job in the area of seeing to it that my child has a variety of recreational experiences.
R22. I don't get involved in my child's recreation.

Nurturance
23. I meet my own expectations in terms of providing emotional support for my child.
24. I am definitely an adequately nurturing parent.
R25. I have trouble expressing my affection for my child.
R26. I know I'm just not there enough emotionally for my child.
27. Being a loving parent comes easily to me.
28. I try very hard to put my child's emotional needs before my own.
29. I consistently encourage my child to express his/her emotions.

Health
30. I am a good parent when it comes to taking care of my child's physical health.
R31. I know I am not concerned enough about my child's health.
32. I work hard to encourage healthy habits in my child.
33. I always see to it that my child receives prompt medical attention as needed.
R34. I tend to be a little lax about my child's physical health.
R35. I am not very good at caring for my child when he/she is sick.
R36. I find myself ignoring my child's early signs of illness, hoping that whatever it is, it will just go away.

Parental Emotion Regulation
Revised Parental Emotion Regulation Inventory (PERI2)

The questions below describe some different things that parents do to manage their emotions when their children misbehave, or do things that the parent does not like.

- Parents do things to change how they *feel on the inside* (emotional experience).
- Parents also do things to change the emotion they *show on the outside* (emotional expression).

We want to know what you actually do to change the emotions you *feel* and *show* when your child does something you don't like (when he/she misbehaves). Although *some of the following questions may seem similar to one another*, they differ in important ways.
For each item, please answer using the following scale:

1----------2----------3----------4----------5----------6----------7

I Never Do This | I Sometimes Do This | I Very Often Do This

The scale is repeated on both pages for your reference.
When my child (the child in focus) misbehaves or does something that I don't like…

1 ___ I change how I'm thinking about my child's behavior to *feel* less negative emotion (e.g., anger, sadness).

2 ___ I do something to make myself *look* less upset.

3 ___ I try doing something like walking away or talking to someone else to *look* less upset.

4 ___ I have to get away (e.g., leave the room, take a walk) to keep *showing* positive emotion (such as joy or amusement).

5 ___ I control how I *feel* by changing the way I think about my child's behavior.

6 ___ I try to get away from my child to calm myself down *on the inside*.

7 ___ I give in to my child so that I can keep from *showing* how upset I am.

8 ___ I try doing something like walking away or talking to someone else to *feel* less upset.

9 ___ I control the emotion I *show* by changing the way I think about my child's behavior.

10 ___ I change how I'm thinking about my child's behavior to *show* more positive emotion.

11 ___ I try to get away from my child so that I can *feel* better.

For each item, please answer using the following scale:

1----------2----------3----------4----------5----------6----------7

I Never Do This — I Sometimes Do This — I Very Often Do This

When my child (the child in focus) misbehaves or does something that I don't like…

12 ___ I control my emotions by not *showing* them.

13 ___ I give in to my child so that I can *feel* less upset.

14 ___ I keep my emotions to myself.

15 ___ I make myself think differently about my child's behavior to help me stay calm *on the inside*.

16 ___ I get away (e.g., leave the room, take a walk) to keep from *showing* that I'm upset.

17 ___ I let my child have what he/she wants so I can *show* more positive emotions.

18 ___ I change how I'm thinking about my child's behavior to *feel* more positive emotion.

19 ___ I try not to *show* my negative emotions.

20 ___ I change how I'm thinking about my child's behavior to *show* less negative emotion.

21 ___ If I start *feeling* upset, I try to bury or push down that *feeling*.

22 ___ I make myself think differently about my child's behavior to help me *look* calm on the outside.

23 ___ I let my child have what he/she wants so I can *feel* better.

Positive Emotions (PANAS)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then list the number from the scale below next to each word.
Please indicate the extent to which you feel this way right now, in this moment.

	Very slightly/ Not at all	A Little	Moderately	Quite a bit	Extremely
1. Interested	1	2	3	4	5
2. Distressed	1	2	3	4	5
3. Excited	1	2	3	4	5
4. Upset	1	2	3	4	5
5. Strong	1	2	3	4	5
6. Guilty	1	2	3	4	5
7. Scared	1	2	3	4	5
8. Hostile	1	2	3	4	5
9. Enthusiastic	1	2	3	4	5
10. Proud	1	2	3	4	5
11. Irritable	1	2	3	4	5
12. Alert	1	2	3	4	5
13. Ashamed	1	2	3	4	5
14. Inspired	1	2	3	4	5
15. Nervous	1	2	3	4	5
16. Determined	1	2	3	4	5
17. Attentive	1	2	3	4	5
18. Jittery	1	2	3	4	5
19. Active	1	2	3	4	5
20. Afraid	1	2	3	4	5
21. Content	1	2	3	4	5
22. Joyful	1	2	3	4	5
23. Loving	1	2	3	4	5

Coping Capacity
Carver Brief COPE Scale

	I haven't been doing this at all	I've been doing this a little bit	I've been doing a medium amount	I've been doing this a lot
1. I've been turning to work or other activities to take my mind off things				

2. I've been concentrating my efforts on doing something about the situation I'm in
3. I've been saying to myself "this isn't real".
4. I've been using alcohol or other drugs to myself feel better.
5. I've been getting emotional support from others.
6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feeling escape.
10. I've been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.
14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.

20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I've been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

Networks of Social Support

Personal Social Capital Scale PSCS-E

Cap1. How much do you like the people in each of the following six categories?	A lot	More than average	Average	Less than average	A few
Your family members	5	4	3	2	1
Your relatives	5	4	3	2	1
People in your neighborhood	5	4	3	2	1
Your friends	5	4	3	2	1
Your coworkers/fellows	5	4	3	2	1
Your country fellows/old classmates	5	4	3	2	1

Cap2. With how many of people in each of the following categories do you keep a routine contact?	All	Most	Some	A few	None
Your family members	5	4	3	2	1
Your relatives	5	4	3	2	1
People in your neighborhood	5	4	3	2	1
Your friends	5	4	3	2	1
Your coworkers/fellows	5	4	3	2	1
Your old classmates/childhood friends	5	4	3	2	1

Cap3. Among the people in each of the following six categories, how many can you trust?	All	Most	Some	A few	None
Your family members	5	4	3	2	1
Your relatives	5	4	3	2	1
People in your neighborhood	5	4	3	2	1
Your friends	5	4	3	2	1
Your coworkers/fellows	5	4	3	2	1
Your old classmates/childhood friends	5	4	3	2	1

Cap4. Among people in each of the following six categories, how many will definitely help you upon your request?	All	Most	Some	A few	None

Your family members	5	4	3	2	1
Your relatives	5	4	3	2	1
People in your neighborhood	5	4	3	2	1
Your friends	5	4	3	2	1
Your coworkers/fellows	5	4	3	2	1
Your old classmates/childhood friends	5	4	3	2	1

Cap5. When people in all the six categories are considered, how many possess the following assets/resources?	All	Most	Some	A few	None
Certain political power	5	4	3	2	1
Wealth or owners of an enterprise or a company	5	4	3	2	1
Broad connections with others	5	4	3	2	1
High reputation/influential	5	4	3	2	1
With high school or more education	5	4	3	2	1
With a professional job	5	4	3	2	1

Cap6. How do you rate the number of the following two types of groups/organizations in your community?	A lot	More than average	Average	Less than average	A few

Governmental, political, economic and social groups/organizations (political parties, women's groups, village committees, trade union, cooperate associations, volunteer groups, etc)	5	4	3	2	1
Cultural, recreational and leisure groups/organizations (religious, country fellows, alumni, sport, music, dances, crafts, games, etc)	5	4	3	2	1

Cap7. Do you participate in activities for how many of each of these two types of groups and organizations?	All	Most	Some	A few	None
Governmental, political, economic and social groups/organizations (political parties, women's groups, village committees, trade union, cooperate associations, volunteer groups, etc)	5	4	3	2	1
Cultural, recreational and leisure groups/organizations (religious, country fellows, alumni, sport, music, dances, crafts, games, etc)	5	4	3	2	1

Cap8. Among each of the two types of groups and organizations, how many represent your rights and interests?	All	Most	Some	A few	None
Governmental, political, economic and social groups/organizations (political parties, women's groups, village committees, trade union, cooperate associations, volunteer groups, etc)	5	4	3	2	1
Cultural, recreational and leisure groups/organizations (religious, country fellows, alumni, sport, music, dances, crafts, games, etc)	5	4	3	2	1

Cap9. Among each of the two types of groups and organizations, how many will help you upon your request?	All	Most	Some	A few	None

Governmental, political, economic and social groups/organizations (political parties, women's groups, village committees, trade union, cooperate associations, volunteer groups, etc)	5	4	3	2	1
Cultural, recreational and leisure groups/organizations (religious, country fellows, alumni, sport, music, dances, crafts, games, etc)	5	4	3	2	1

Cap10. When all groups and organizations in the two categories are considered, how many possess the following assets/resources?	All	Most	Some	A few	None
Significant power for decision making	5	4	3	2	1
Solid financial basis	5	4	3	2	1
Broad social connections	5	4	3	2	1
Great social influence	5	4	3	2	1

Walsh Family Resilience Questionnaire

How does your family deal with crises and ongoing challenges?

1 - rarely/never
2 -
3 -
4 -
5 - almost always

1. Our family faces difficulties together as a team, rather than individually.
2. We view distress with our situation as common, understandable.
3. We approach a crisis as a challenge we can manage and master with shared efforts.
4 We try to make sense of stressful situation and focus on our options.
5. We keep hopeful and confident that we will overcome difficulties.
6. We encourage each other and build on our strengths.
7. We seize opportunities, take action, and persist in our efforts.
8. We focus on possibilities and try to accept what we cannot change.
9. We share important values and life purpose that help us rise above difficulties.
10. We draw on spiritual resources (religious or non-religious) to help us cope well.
11. Our challenges inspire creativity, more meaningful priorities, and stronger bonds.

12. Our hardship has increased our compassion and desire to help others.
13. We believe we can learn and become stronger from our challenges.
14. We are flexible in adapting to new challenges
15. We provide stability and reliability to buffer stresses for family members.
16. Strong leadership by parents/caregivers provides warm nurturing, guidance, and security.
17. We can count on family members to help each other in difficulty.
18. Our family respects our individual needs and differences.
19. In our immediate and extended family, we have positive role models and mentors.
20. We can rely on the support of friends and our community.
21. We have economic security to be able to get through hard times.
22. We can access community resources to help our family through difficult times.
23. We try to clarify information about our stressful situation and our options.
24. In our family, we are clear and consistent in what we say and do.
25. We can express our opinions and be truthful with each other.
26. We can share difficult negative feelings (e.g., sadness, anger, fears).
27. We show each other understanding and avoid blame.
28. We can share positive feelings, appreciation, humor, and fun and find relief from difficulties.
29. We collaborate in discussing and making decisions, and we handle disagreements fairly.
30. We focus on our goals and take steps to reach them.
31. We celebrate successes and learn from mistakes.
32. We plan and prepare for the future and try to prevent crises.