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ORIGINAL PAPER

Working with Low-income Families: Lessons Learned from Basic and Applied Research on Coping with Poverty-related Stress

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Abstract Poverty and low socioeconomic status create tremendous amounts of physical and psychosocial stress that compromise health and well-being. This paper explores how the stressors created, exacerbated, and maintained by living in poverty lead to compromised mental health, and at the same time present significant challenges to participating in and benefitting from traditional psychotherapy. This paper summarizes the strong research evidence supporting the causal role of poverty-related stress in contributing to mental (and physical) health problems, discusses the physiology that underlies this process and how it affects clients' ability to make use of psychotherapy, and presents recommendations for incorporating a multi-faceted approach to coping in clinical work with low-income clients and families. Addressing the pernicious effects of economic stress with a multi-step approach to effective coping can serve to prepare low-income clients to better engage in and get the most out of psychotherapy.

Keywords Low-income · Socioeconomic status · Poverty · Psychotherapy · Coping · Stress

Why do therapists struggle to address the needs of low-income clients? Scholars have argued that it stems, in part, from our culture's collective denial of the continued importance of social class in our world. Denying its existence helps to keep poor and low-SES individuals marginalized by ignoring a source of serious stress and inequity in their lives. As Smith (2009) writes, "silence regarding injustice ultimately contributes to its perpetuation" (p. 89). She argues that because therapists are products of this culture, many are ill-prepared to address this "hidden" part of our culture that has such a large effect on so many lives. It is imperative, however, that we who provide psychological services to the poor possess relevant knowledge about the effects of low social class and poverty on mental health and incorporate this information into case formulations and treatment plans so that we do not unwittingly engage in what Grimes and McElwain (2008) call "discrimination by negligence."

Recognizing social inequality and the stress of living in poverty requires attention to the extremely potent external and societal conditions that contribute to a client's mental health problems. One of the (many) tasks of a therapist is to help clients achieve insight into why they are having difficulty, and in the case of low-SES clients this means that consideration of poverty-related stress must be part of that discussion. Otherwise the implicit message sent is that a therapist's job is to "make them happy in poverty" (Waldegrave 2005, p. 272). Rather than helping clients be happy living with poverty, the psychotherapeutic community can equip low-income clients with skills for coping with poverty-related stress so that they can go on to make positive changes for themselves and their families. This article summarizes the strong research evidence supporting the causal role of poverty-related stress in contributing to mental health problems, discusses the physiology that underlies this process and how it affects clients' ability to make use of psychotherapy, and presents recommendations for incorporating a multi-faceted approach to coping in clinical work with low-income clients and families.

Hence, this paper argues that explicitly focusing on the stress of poverty and facilitating the development of

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adaptive coping in the face of such stress is, in fact, necessary for conducting effective psychotherapy with poor clients. The focus on stress and coping is not meant to replace standard psychotherapeutic techniques, but rather to help with case conceptualization and to prepare a client for therapy. Armed with a better understanding of the sources of their difficulties and a bigger toolbox of skills with which to face problems, clients can then be prepared to make use of psychotherapy without engaging in self-blame and internalized oppression.

Of course, implicit in what is written above is the idea that we actually need to talk about economic stress, social class, inequality and the like. For many psychotherapists, this is likely to be unfamiliar territory, even those clinicians who are comfortable addressing other multicultural topics such as racism and heterosexism. One of the lessons learned from basic and applied research is that it is so rare for poor people to be treated with dignity and respect and for the context of their lives to be acknowledged in a non-judgmental way, that clients are extremely receptive to having these discussions. Naming the thing that is a source of many of their problems—poverty, inequality, barriers to upward mobility, lack of access—is a powerful tool of empowerment. Validation of the pervasiveness, uncontrollability, demoralizing, and damaging nature of poverty-related stress aids greatly in establishing strong rapport with low-income clients.

It is sometimes assumed that, because poor clients are often in crisis when seeking psychological services, they are not interested in traditional psychotherapy techniques. This brings up two important implications. First, the seeming lack of interest in psychotherapy may well be due to the lack of attention to self-calming and mindfulness, and client frustration with trying to learn insights and new ways of being without the skills needed for relaxation and calming. Second, Smith (2009) warns that the very assumption that poor individuals want something different from psychological treatment is in itself rooted in bias. She argues that poor clients want the same things out of psychotherapy as anyone—a safe space to explore their hopes, dreams, fears, and seek new ways to approach life's problems and challenges.

Low Socioeconomic Status and Health

Poverty rates in the U.S. now exceed 14% of the general population, thereby affecting more than 43 million children and adults (U.S. Census Bureau 2009). The link between low socioeconomic status (SES; here used interchangeably with low-income and poverty, though not identical constructs) and poor health is well established. For many health outcomes, there is a steady SES-health gradient, with poorer health associated with each step down the SES ladder. The SES-health gradient applies to both physical health conditions such as hypertension, heart disease, cancer, and life expectancy, as well as a wide range of mental health problems from depression to schizophrenia. The gradient is not small—the poorest white males in the US die a decade earlier than the wealthiest white men, for example. Some diseases increase ten-fold when comparing the highest rung of the SES ladder to the lowest (Sapolsky 2005) and research clearly shows that these pernicious effects begin early in life (e.g., Shonkoffet al. 2009).

Researchers have tried to understand the mechanism of the SES-health gradient—why the gradient exists. Poor lifestyle choices are often offered to explain the SES-health gradient. The incidence of smoking, drinking, obesity, poor diet, and sedentary lifestyles are higher among individuals with lower SES. However, multiple studies have shown that lifestyle risks only account for a small portion of the SES-health gradient (Sapolsky 2004). Similarly, access to healthcare is a real problem faced by many low-income families. However, healthcare access does not fully account for the SES-health gradient either. Further, the gradient exists even in countries with socialized healthcare, and for diseases that are not affected by preventative health care (Sapolsky 2004). What does explain the lion's share of the SES-health gradient then?

Chronic psychosocial stress is now recognized as a major mechanism through which poverty and low SES exert a negative toll on children and adults (Shonkoff et al. 2009). Ongoing stress borne of low SES, low-income, and poverty creates constant wear and tear on the body, dysregulating and damaging the body's physiological stress response system and reducing cognitive and psychological resources for battling adversity and stress (Kahn and Pearlin 2006; McEwen 1998). The stress of poverty and low income is much more than worries about money—it is also hunger, violence, and illness to name a few (McLoyd 1990). Referred to as poverty-related stress (PRS; Wadsworth and Berger 2006), the stressors of poverty vary widely from violence exposure to transportation problems, but it is the cumulative nature of PRS that matters more than any particular type of stress (e.g., Evans 2004). Cumulative risk studies have consistently failed to identify singularly potent stressors and instead find that it is the sum of stressors that makes the difference—risk for problems increases with each additional stressor in a step-wise fashion (Evans 2004). In addition, the context of PRS affects how well one is able to mount a response to new threats and challenges; poverty amplifies the effects of other stressors (e.g., Almeida et al. 2005). Thus, poor clients can become overwhelmed by seemingly minor issues that serve as the proverbial "straw" breaking the camel's back.

Some of the earliest research on the experience and effects of poverty-related stress came from Pearlin and colleagues who wrote of the experience of poverty from a "strain perspective." According to Kahn and Pearlin (2006), "among the array of chronic stressors that people may confront in their daily lives, there is probably none more pivotal than economic hardships and strains" (p. 18). For these authors, it is the day-to-day events and experiences brought about by major life events or chronic poverty that lead directly to negative outcomes such as depression (Kahn and Pearlin 2006), anxiety (Pearlin and Radabaugh 1976), alcohol use (Pearlin and Radabaugh 1976), and physical health conditions (Kahn and Pearlin 2006). Expanding this idea, Conger and colleagues have identified economic stress as being a particularly potent catalyst for a variety of problems within a family—problems that partially explain emotional and behavioral problems for children, primarily via the effects on parents and the interparental relationship. In a series of studies involving Iowa farm families marked by severe income loss, Conger and colleagues developed the "Family Stress Model" (e.g., Conger and Elder 1994). In this model, low family income and negative financial events lead to economic pressure (stress) in the family (Conger et al. 1999). This economic stress spawns parental distress and interparental conflict, both of which lead to parenting problems. Ultimately, it is through these parenting problems that children's psychological functioning is compromised. Of course, children's emotional and behavioral problems can create additional stress in families, further contributing to a cycle of stress and dysregulation.

The SES-health gradient has also been found among children and adolescents, with global ratings of health being associated with lower SES, and acute conditions such as injuries and respiratory illnesses showing a clear gradient by adolescence (Chen et al. 2006). Younger children with low SES are at increased risk for injury, asthma, and elevated blood pressure (Chen et al. 2002), suggesting that the SES-health gradient even exists among young children for some conditions. Stress resulting from unhygienic homes, disrupted family relationships, poor child-care services, more negative life events, and healthcare access are key mechanisms for the SES-health gradient for children and ultimately across the lifespan. How does poverty-related stress "get under the skin"?

Responses to Stress

How does stress lead to mental health problems and what lessons can be gleaned for psychotherapy? A stress response that is quickly activated to a present stressor, appropriate in degree for the stressor at hand, and quickly terminated provides protection for the organism while minimizing the harmful effects of chronic stress activation. Unfortunately, the human body is not well equipped to handle a chronically activated sympathetic nervous system and the resulting elevated heart rate, interrupted digestion, overactive immune response, and the like. Chronic social stress of the type associated with poverty can actually *sensitize* multiple components of the nervous system, heightening physiological reactions to even mildly stressful or threatening events (Repetti et al. 2002). Physiological responses not only occur more frequently, but also tend to increase in magnitude and duration, taking longer to recover to baseline levels (Heim and Nemeroff 2001). Over time, these repeated and exaggerated stress responses become entrenched, placing individuals at risk for developing stable patterns of high-reactivity, and leading to higher resting heart rate, higher blood pressure, and higher circulating stress hormones such as cortisol (Evans 2004).

Appropriate physiologic stress responses are critical for normal health and functioning and a balance must be maintained so that stress responses are activated only when and to the degree necessary for meeting challenges. Repeated, excessive activations and inefficient downregulation of the stress response systems (sympathetic-adrenomedullary system and hypothalamic–pituitary–adrenal axis) result in cumulative wear and tear on the body, a condition referred to as allostatic load (McEwen 1998). Allostatic load is associated with dysregulation throughout the SAM and HPA stress response systems, as well as impaired physical and mental health outcomes. An over-reactive stress response system can interfere with both the ability to learn new material as well as the ability to implement previously learned complex material. Hence, to maximize the ability of a low SES client to learn new behaviors or ways of thinking, this research suggests that it can be worth addressing a client's dysregulated stress response system and helping them learn to downregulate their reactivity.

Research has shown that there are a variety of coping strategies that are effective for coping with poverty-related stress (Wadsworth and Santiago 2008). These include problem solving, emotion regulation, active acceptance, and healthy distraction. Unfortunately, research has also found that if physiological arousal is too high, poverty-related stress interferes with the ability to engage in these helpful strategies (Santiago et al. 2011). Simply advising clients to take a new approach to a problem or think differently is going to fall short unless clients are able to first calm the physiologic products of an over-reactive stress response system. Based on this body of research, there is a need to better incorporate coping into psychotherapeutic services for this population. The coping-based approach has three steps.

The first step addresses the involuntary stress responses that are interfering with the ability to learn new information and to enact skills and utilize previously learned information. Since the involuntary responses stem from the physiologic stress response systems, techniques that help calm the body and mind such as meditation, relaxation, guided imagery, deep breathing, physical exercise and biofeedback would be the logical first step. Once the client can calm herself and think more clearly, then attention can turn to dealing with the stressful events and situations that need to be solved or coped with. Of course, managing involuntary stress responses is an ingoing process that needs to continue as the next steps are engaged.

The efficacy of different forms of coping depends somewhat on how controllable the stressful event or situation is for an individual. Hence, the second step in the process is to appraise the controllability of the situation or event and use that information to guide the selection of coping strategy or approach. Building on Folkman and Lazarus (1985), research has shown that active, approach-oriented coping such as problem solving tends to be most helpful in situations with a degree of controllability (i.e., Bento et al. 2010). Accommodative coping strategies such as cognitive reframing and active acceptance, on the other hand, are particularly well suited to stressors over which one has very little control and must instead adjust oneself to the situation or event. Clients may require assistance in judging the controllability of situations and events since there are likely to be events that they believe they "should" be able to control that they objectively cannot or cannot at the moment, and conversely events that they cannot see how to take control over, but which may indeed have ready solutions.

The third step is to pick a coping method that matches the controllability of the stressor. Coping comes in many forms and current definitions of coping conceptualize it as a conscious and voluntary process that includes attempts to manage emotions and cognitions, regulate behavior and arousal, and act on the environment to alter or decrease a source of stress (Compas et al. 2001). Coping therefore includes voluntary attempts to handle stress by focusing on emotions, thoughts, or actions that one can take.

Connor-Smith et al. (2000) proposed the Responses to Stress Model, which distinguishes between coping (voluntary) responses to stress, and involuntary (automatic) stress responses. Among voluntary or coping responses, we can distinguish between responses that demonstrate engagement with or disengagement from the stressor or reactions to the stressor. Voluntary engagement responses include primary control coping strategies and secondary control coping strategies. Primary control strategies are used to directly alter the stressor or one's emotional reactions to it. For example, problem-solving, emotional expression, and emotion regulation all fall under primary control coping. Secondary control coping includes strategies that aim to adapt oneself to the stressor—cognitive coping strategies fall under this category (Connor-Smith et al. 2000). Voluntary disengagement strategies are used to avoid the stressor both behaviorally and cognitively. In addition to coping responses defined by the Responses to Stress model, researchers have identified social support and religious coping as other common methods for coping with stress.

Adult Coping

Adults engage in a variety of strategies to cope with stress, including social support, primary control, secondary control, disengagement coping, and religious coping. Research has confirmed that certain types of coping are helpful and are superior to other types in the context of PRS, especially when strategy and controllability of the stressor are matched.

Social Support

Social support may buffer against PRS by serving several functions. Often social support provides tangible help and resources such as family members helping with child-care or lending money in a time of need. Social support can also provide the opportunity for venting and expressing emotions, and for discussing ways to solve a particular problem (strategies encompassed by primary control coping). Talking with someone about financial stress can also elicit validation that times are hard and that one is doing the best they can. In these ways, social support serves as a buffer against the negative impact of poverty (Leadbeater and Linares 1992). However, poverty itself often decreases the availability of social support due to fewer available resources, dangerous neighborhoods, and increased stress (McLoyd and Wilson 1994).

Despite the decreased availability of social support for adults in poverty, those who perceive high levels of social support report lower levels of economic strain (Henly et al. 2005) and depressed mood (Ennis et al. 2000). Similarly, marital support promotes resilience. By demonstrating care, concern, and affection, marital support has a "soothing" effect on the negative effects of financial stress (Conger et al. 1999). However, some studies indicate that social support does not buffer against all types of stress, such as parenting stress for low-income mothers (Raikes and Thompson 2005). Thus social support is a positive resource for low-income families, though certainly not a panacea.

Primary Control or Active Coping

Primary control coping strategies include problem solving, emotional expression, and emotional regulation. Although primary control strategies are generally related to better psychological functioning, poverty often undermines their use. Despite reports by low-income mothers that active problem solving and thinking about the future are helpful ways of coping (Cosgrove and Flynn 2005), poverty predicts lower use of both (Klebanov et al. 1994). Regardless, when utilized, problem solving can benefit low-income adults at high risk for depression (Vinokur et al. 2002). In addition, active coping can reduce the impact of perceived discrimination on depression by fostering a sense of taking control and confronting discrimination (Noh and Kaspar 2003).

Wadsworth and colleagues (2005) examined primary control coping as a moderator of stress' negative effects. For adults, primary control weakened the impact of economic stress on depression. Parallel results were found for parents coping with family PRS. Primary control coping was related to less symptoms for a range difficulties from anxiety and depression to aggression, attention problems and social difficulties (Wadsworth and Santiago 2008). Thus primary control coping is helpful in the face of PRS and protects against a range of problems. However, because poverty undermines the use of primary control strategies, intervention should directly target teaching these skills.

Secondary control coping

Secondary control coping strategies include acceptance—acknowledgement that circumstances are unlikely to change; distraction—engaging in other activities to get one's mind off stressful circumstances; positive thinking—trying to see the positive in stressful times; and cognitive restructuring—thinking about a situation in a way that allows one to see what he or she is gaining or learning from the problem (Connor-Smith et al. 2000). Secondary control strategies appear to be particularly helpful for problems over which there is little control. Thinking about a problem differently in order to adapt to stressors that are difficult to change is especially relevant for coping with poverty. For example, when there are few jobs available to apply for or when there is no better housing available within an affordable range, accepting the situation or thinking differently about it may be the best one can do. In addition, distraction allows an individual to "take a break" from stress by engaging in something else that is more positive, thus promoting psychological health.

Secondary control coping mediates the association between life stress and parental hostility (Wadsworth et al. 2005), suggesting that life stress undermines the ability to engage in secondary control coping strategies, though these strategies predict less hostility in the end. Secondary control strategies such as cognitive restructuring are also helpful when coping with discrimination (Yoo and Lee 2005), as these strategies can help people to think differently about the discrimination, for example attributing the discrimination to the ignorance of others (rather than to oneself). In addition, for parents coping with family PRS, secondary control coping strategies are associated with fewer problems across a range of domains including anxiety and depression, withdrawal, somatic problems, thought problems, aggression, attention problems and social difficulties (Wadsworth and Santiago 2008). Because poverty is often associated with structural barriers, feelings of powerlessness and lack of control are common (Belle and Doucet 2003). Therefore, secondary control strategies that involve adapting oneself to a stressor may be especially potent for coping with PRS, and there is evidence that these skills can be taught in a preventive intervention (Raviv and Wadsworth 2010).

Disengagement Coping

Disengagement coping consists of strategies that attempt to orient the individual away from a stressful event or away from their emotional reactions and includes avoidance, denial, and wishful thinking. Avoiding and denying stress provides temporary and welcome escape from stress, but is unlikely to promote psychological health in the long-term because such strategies do not address or solve problems. Effortful attempts to suppress unwanted thoughts, for example, eventually lead to increased frequency of unwanted thoughts (Wegner 1994) and sometimes a sense of failure and self-blame (Kelly and Kahn 1994). Thus, cognitive avoidance is likely to lead to negative long-term psychological effects. Behavioral avoidance also may provide temporary relief from stress, but is likely to have long-term negative consequences as well (Compas et al. 2001). Thus for a person avoiding or denying financial trouble, he or she is likely unable to suppress thoughts for extended amounts of time. Eventually a person will be reminded of the trouble and may feel even worse about it because they have not addressed the situation, creating feelings of incompetence and shame.

In the context of PRS, avoidance coping is related to depression (Rayburn et al. 2005). Thus, trying to forget about problems, ignoring or denying them, often prevents an individual from seeking validation and support, leaving them feeling isolated with a problem that does not get fixed. Disengagement coping exacerbates the effects of economic strain on depressive symptoms for low-income parents (Wadsworth et al. 2005). Thus, disengagement

coping may provide short-term relief from stress, but it is likely to promote negative psychological consequences when unaccompanied by engagement in more positive activities or problem-solving. Hence, equipping clients with more active strategies to use instead of or in combination with disengagement is recommended.

Religious Coping

Although religious coping is sometimes helpful when coping with acute loss such as that incurred through natural disasters and other traumas (Pargament et al. 1999), few studies have examined religious coping in the context of chronic PRS. However, there is evidence to suggest that religiosity can buffer against the negative effects of stress. Overall well-being is associated with religion that is internalized and based on a personal, secure relationship with God (Bergin et al. 1987). Religiosity may be especially helpful for socially marginalized groups who embed religion more fully into their lives and because religion offers accessible resources, alternative routes to leadership roles, and social networks provided by one's church (Pargament 1997). Indeed, we find higher levels of religiosity among several groups including African Americans (Pargament 1997), older populations (Gurin et al. 1960), and less educated people (Gallup 1994), suggesting that for these groups religion is a central and important aspect of their lives.

Religiosity and religious coping likely serve several functions to buffer against stress. For those highly involved in religious communities, religiosity provides a social support network, a place for people to get validation and respect, and be accepted. In addition, certain forms of religious coping promote cognitive strategies, such as acceptance, hope or positive thinking, as well as making meaning out of stressful times, which is similar to cognitive restructuring. Although research is needed to examine religiosity and religious coping in the context of PRS, research suggests that religious coping may be particularly relevant to the lives of marginalized and ethnic minority clients (Pargament 1997).

Child Coping

Unfortunately children are not immune to poverty's pernicious effects. Chronic stress affects children across many areas of their lives. Shonkoff and colleagues (2009) describe poverty's stress as toxic for children—although some stress is necessary and desirable to motivate and foster the ability to adapt to stress in the future, chronic and uncontrollable stress resulting from poverty leads to serious adverse consequences. Hence, targeting how children cope with PRS is also an important psychotherapeutic consideration.

Social Support

Social support for young children often comes in the form of support-seeking from parents, caregivers, or other family members. Poor children often receive less social support and have parents that are less responsive and more authoritarian (Evans 2004). A strong social support network does promote resiliency in the face of adversity for children (Masten et al. 1990), suggesting that when poor children do have a network of support they often fare better. Social support is related to higher self-esteem for children, though it does not always buffer the impact of stress on child adjustment (e.g., Guest & Biasini 2001). Seeking support as a coping strategy may be helpful in some contexts and not others. This is because sometimes seeking support for children reflects distress or anxiety and not simply a positive attempt to cope with stress. For example, seeking social support when coping with discrimination is related to lower levels of distress (Scott and House 2005), but seeking support when coping with family conflict is often associated with distress or depression (e.g. Sandler et al. 1994). Thus, in some contexts, seeking social support can help to buffer the impact of stress, especially for a stressor external to the family, like an incident of discrimination, and in other contexts, seeking social support likely reflects distress. In addition, when a source of stress is within the family such as family conflict, seeking support from caregivers to cope with the conflict may be impossible or ineffective. However, primary control strategies that overlap with social support, such as emotional expression, are often associated with fewer mental health problems across contexts (Wadsworth and Compas 2002).

Primary Control Coping

Primary control strategies such as emotional expression, emotion regulation, and problem solving predict less anxious/depressed symptoms and aggressive problems for poor youths (Wadsworth and Compas 2002). Directly approaching the problem tends to predict fewer symptoms for young people coping with general stress (Compas et al. 2001). Similarly, directly altering the stressful situation or one's emotional reactions to the stressor is effective in coping with economic stress. In addition, primary control coping strategies are related to fewer problems across multiple psychological domains ranging from anxiety and depression to aggression and attention problems (Wadsworth and Santiago 2008).

In addition, as with adults, while primary control coping strategies are helpful in the face of PRS, PRS undermines

the use of these strategies (Wadsworth and Compas 2002). Poor children and teens may be using less primary control strategies under high conditions of stress due to the uncontrollable nature of PRS for children and teens who have little power over their family's financial situation. Primary control strategies should be aimed at daily stressors that arise in the context of PRS for which children might have more ability to affect such as difficulties with peers so that they build solid skills for overcoming challenges in the future.

Secondary Control Coping

Secondary control coping strategies, such as positive thinking, acceptance, cognitive restructuring and distraction, appear to be particularly helpful for children coping with PRS. Youths who use high levels of secondary control coping tend to have fewer aggressive behaviors and suffer from less anxiety and depression (e.g., Wadsworth et al. 2005). Still, children who live in poverty are less able to make use of secondary control coping, highlighting to the need for intervention to target these skills. Secondary control coping protects children and teens across many domains of psychological functioning including anxiety and depression, somatic complaints, aggression, and social difficulties (Wadsworth and Santiago 2008). Children coping with PRS are in a position of little control—their actual ability to problem solve or create change is very small. Thus, intervention should target secondary control coping strategies that focus on adapting to a stressor that is not likely to change or dissipate.

Disengagement Coping

Disengagement strategies such as avoidance, denial, and wishful thinking are generally not beneficial for children coping with poverty. Such strategies either have no effect or actually worsen symptoms for poor children (e.g., Wadsworth and Compas 2002). A natural response for overwhelming burdens of stress would be to try to "get away" or escape. However, these strategies do little to actually change the situation or adapt to the stress.

Research has suggested that disengagement coping may actually be helpful for children in some circumstances such as family conflict (O'Brian et al. 1995). In such instances, avoiding potentially dangerous conflict situations is helpful for children and teens. Recent findings suggest that disengagement coping is not related to worse outcomes for low-income youths coping with family conflict in the short-term, but is detrimental in the long-term. Because disengagement coping does little to fix or change the problem, the negative effects of the stress are likely to catch up to youths later on. In addition, unlike secondary control strategies, disengagement coping does not allow them to adapt themselves to the stressor in any positive way. Disengagement coping was unrelated to internalizing symptoms for low-income teens coping with family conflict within a single time point, but moderated the effect of family coping across time, such that more use of disengagement coping predicted more internalizing symptoms a year later (Santiago and Wadsworth 2009). Thus, although disengagement may be functional in the short-term, the long-term effects of using disengagement strategies, uncoupled with any more positive strategies such as distraction or problem-solving, are harmful.

Helping children cope with PRS can come in two forms: (1) by improving the functioning of their parents and (2) by helping them develop coping skills on their own and directly improve functioning. With this in mind, two new interventions have been developed in which low SES clients are taught how to cope effectively with PRS—one that works directly with parents and one that works with children and parents. First, a large randomized control trial of a family strengthening program (FRAME) has been conducted with low SES parents that teaches parents skills and principles of the three steps: (1) relaxation and guided imagery, (2) stress appraisal, and (3) primary control coping, secondary control coping, and problem solving. Relative to couples assigned to the no-intervention condition, parents who received the 14 h intervention showed reduced financial stress, reduced disengagement coping, and improved problem solving. These improvements predicted improvements in depressive symptoms for both men and women (Wadsworth et al. 2011a, b) as well as internalizing and externalizing symptoms in their children (Etter et al. 2011).

The second program involves teaching coping skills directly to children facing poverty-related stress. Raviv and Wadsworth (2010) used a multiple baseline design to evaluate the feasibility and efficacy of the Families Coping with Economic Strain (FaCES) program. In this program, children and their parents learn about stress and its effect on their health. They learn skills for emotion regulation and efficacious coping skills. Parents are taught the same skills and are encouraged to serve as coaches and models for their children. Youths who participated in the intervention showed improvement in acquisition of the targeted secondary control coping skills, which were accompanied by decreases in involuntary engagement responses (e.g., intrusive thoughts, rumination) and internalizing and externalizing symptoms. Finally, FaCES was very accessible to participating families, which is important since program accessibility is very much interlinked with participation rates and overall program effectiveness. Attrition rates were low and parent-reported levels of satisfaction with the program were high. Hence, interventions focused

on increasing an individual's repertoire of strategies for coping with PRS appear to be beneficial to low-income adults and children. While these interventions were both designed as preventive in nature, both evaluations actually showed treatment effects (i.e., reductions in symptoms over time) as opposed to preventive effects (i.e., stable symptoms over time for intervention versus control families, whose symptoms increase). Hence these studies further support the potential utility of addressing PRS and coping as intervention targets.

Conclusion

Working with individuals and families with low SES requires extra attention to the social context in which behaviors and psychological problems are rooted. The nature of SES-related stress is that it is often chronic and cumulative, and affects every arena of one's life. Hence, as Smith (2009) recommends, we must support flexible approaches to treatment which recognize that sometimes before a client can engage effectively in therapy we may have to act as coping coaches, case managers, life coaches, and the like.

Effective coping is probably not going to alter a family's economic situation. However, having the ability to cope effectively with PRS could prevent the development of depression and other psychological problems that interfere with success in occupational, academic, and interpersonal realms. In addition, we propose that an explicit focus on and naming of external stress as a key contributor to the mental health problems faced by clients living in poverty is a useful strategy for combating self-blame and helplessness, as it encourages agency and action in addition to self reflection. We also offer that teaching effective appraisal and coping skills is essential for empowering low-income clients to take steps to improve life for themselves and their families.

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