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The Best Intentions: Does Positive Parental Religious Coping Moderate the Relationship
between Parental Perceived Control and Child Anxiety in African American Family Dyads?

By

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The Best Intentions: Does Positive Parental Religious Coping Moderate the Relationship between Parental Perceived Control and Child Anxiety in African American Family Dyads?

Anxiety is incredibly pervasive in daily life, and is unavoidable regardless of cultural background. Feelings of angst and worry will certainly occur in people's daily routines as well as during major positive and negative life events. These feelings of anxiousness can often be adaptive to individuals by means of emphasizing the importance of an external event, raising cognitive awareness to a highly receptive level, and encouraging a degree of achievement motivation (Hoen-Saric, 1979). The issue occurs when anxiety becomes excessive and chronic. Excessive and chronic anxiety is maladaptive, leading to impaired daily functioning, fatigue, and avoidance coping strategies (APA, 2000). Anxiety disorders are among the most common psychological difficulties in America today, with approximately 28.8% of Americans suffering, or having previously suffered, from an anxiety disorder (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). There is a myriad of differing distinctions ranging from Generalized Anxiety Disorder to various Specific Phobias. These disorders have been known to illicit cognitive, feelings/physiological, and behavioral symptoms related to how the body handles excessive and chronic anxiety. The hardships experienced by the individual are not the only concerns resulting from anxiety disorders, with around \$45 billion being spent on anxiety related health services and lack of productivity (Richards, Petrie, & Chapman, 2013; DuPont, Rice, Miller, Shiraki, Rowland, & Horwood, 1996; Greenburg et al., 1999).

There is a growing body of literature uncovering the etiology of anxiety. Of particular interest is the burgeoning knowledge on cognitive and psychological constructs that influence the development of anxiety. Specifically, perceived level of control over environment, situations and behavior can significantly impact their level of distress (Richards, Petrie, & Chapman, 2013;

Monaghan & Sims, 2013). Recent literature has reported that an external locus of control, low perceived control, is often associated with chronic anxiety (Monaghan & Sims, 2013; Rapee et al., 1996). This manifests in the cognitive understanding that external events and internal reactions are dictated by random external factors, not of one's own control (Richards, Petrie, & Chapman, 2013). It is this constant unpredictability and lack of perceived agency that can induce chronic anxiety. Knowing that low perceived control of environmental factors, situations and behavior can lead to chronic anxiety, it is reasonable to infer that low perceived control orientations can be risk factors to having a low resiliency to developing anxiety disorders. In fact, a study looking at children ages 9-17 found that children with anxiety disorders reported significantly lower levels of perceived control of anxiety than children without anxiety disorders (Weems, Silverman, Rapee, & Pina, 2003). Results supported that a low perceived control over external threats, negative internal emotions, and somatic reactions are important to the experience of anxiety in children, as it is in adults (Rapee et al., 1996; Weems, Silverman, Rapee, & Pina, 2003). Recent literature has emphasized the influence of parental modeling of perceived control on child anxiety, finding that female parents that exhibit low levels of perceived control most often have adolescent children with higher levels of perceived stress (Monaghan & Sims, 2013). Additionally, parents who exhibit low levels of perceived control tend to exhibit high levels of parental control (i.e. overly protective) (Weems, Silverman, Rapee, & Pina, 2003). In a longitudinal study looking at toddlers who had parents with social anxiety and no known anxiety disorders it was found that toddlers who had parents with social anxiety exhibit higher levels of fear/avoidance during social referencing episodes (Aktar, Majdandzic, Vente, & Bogels, 2014).

Resiliency and Protective Factors

Although anxiety can be modeled from parent to child, not all children who have parents with anxiety disorders develop disorders themselves. The risk of developing anxiety disorders can be determined by one's level of resiliency. One's level of resiliency, the active psychological process that safeguards individuals from stressful life events, is largely determined by protective factors utilized by the individuals (Ng, Ang, & Ho, 2012). Protective factors serve as moderators to the relationship between stressful life events and the level of anxiety experienced by the individual. By being a moderator, the protective factor can serve as a coping strategy, reducing the overall level of anxiety experienced by stressful life events. Some of the most common protective factors are positive relationships, positive environment, positive thinking, mastery, adaptive help-seeking behavior and positive religious coping (Ng, Ang, & Ho, 2012).

Furthermore, most research concerning anxiety and its related constructs (i.e. perceived control) has been conducted using primarily Non-Hispanic White samples. The vast majority of the extant research concerning African Americans and anxiety focuses on risk factors. There is a dearth of research regarding protective factors in African Americans and multiracial populations. These limitations have proven problematic in the prevention, diagnosis, and treatment of anxiety and related disorders in these increasingly large minority populations. Not only are ethnic minority adults underserved and under-researched but ethnic minority families with children are as well. This lack of research is troubling, as ethnic minority children are likely to be 50% of the child population in the United States by 2020 (Magnus et al., 1999). The importance of this point is further coupled with the evidence that the children of non-Hispanic White anxious parents are 3-7 times more likely to meet criteria for an anxiety disorder; whereas the children of African American anxious parents are four times more likely to meet criteria for an anxiety

disorder (Chapman et al., 2012). This is evidence that the necessity to conduct such research is equal across populations. That is not to say that research findings regarding the etiology of anxiety would be equal in these populations. The extent to which anxiety and its related constructs are manifest has been shown to vary by cultural orientation. Previous research has already found that reported somatic symptoms of anxiety are less prevalent in non-Hispanic Whites than African Americans (Chapman et al., 2009). Thus, the anxiety management of parents and children in each population will be a point of exploration. The more we understand how these anxiety related constructs develop and maintain chronic anxiety, the more we will be able to study potential protective factors, able to alleviate the onset of anxiety disorders.

Positive Religious Coping

Further understanding the protective factors utilized by diverse populations will be crucial for the field of Clinical Psychology remaining well equipped to prevent and treat pathology in an ever globalizing world. In the literature available regarding positive religious coping it is one of the most prevalent protective factors among African Americans and often assists in the development of other positive coping methods, like increased perceived control (Pargament, Koenig, & Perez, 2000). Examples of using positive religious coping to help cope with stressful life events and behaviors are seeking control through partnership with God in problem solving, actively looking to God for strength, and thinking about how one's life is an active part of a larger spiritual force (Pargament, Koenig, & Perez, 2000). The significance of positive religious coping in African Americans could be due to the pervasive nature of spirituality in the upbringing of many African Americans (Pollack, Harvin, & Cramer, 2000). This could also be because of the powerful emphasis that the predominantly African American churches have placed on preserving personal heritage and social support while having acted as an

agent of social reform and justice (Frazier, Mintz, & Mobley, 2005). Predominantly, African American Churches have been viewed as a sustainer of African American culture and expression since its creation and the communal nature of congregations has shown to be a large source of social support as well (Bryant-Davis, 2005). Spirituality in African Americans has shown to be associated positively with dimensions of psychological well-being; such as positive relations with others, self-acceptance, environmental mastery, feelings of having a purposeful life, and personal development (Frazier, Mintz, & Mobley, 2005). Similarly, spirituality took on an added element of relinquishing anxious and traumatic issues to a Higher Being. This phenomenon of feeling supported by a higher being was shown to relieve the stress of racism-related stress in African American women (Lewis-Coles & Constantine, 2006). Furthermore, religious coping has been shown to protect against anxiety in a non-clinical sample of both African American and European American young adults. Although, African Americans reported significantly more positive religious coping, less negative religious coping, and lower endorsed anxiety than European Americans (Chapman & Steger, 2010). This positive religious coping strategy, based in solidarity with one's community, family and a higher being, has been found to predict a higher quality of life for African American adults more so than other traditionally researched coping strategies (Utsey et al., 2007).

Positive religious coping and its effects in children have yet to be specifically researched to the extent adults have been. Yet, it has been found that parents who utilize positive religious coping have children that are more competent when it comes to coping with anxiety (Dumas & Tsiopinis, 2006). The obvious postulation stemming from these findings, and what we know of the influence of parental modeling, is that parental use of positive religious coping may protect against higher levels of child anxiety.

Current Study

The purpose of the current investigation will be to examine the parental perceived control, child perceived control and overall anxiety, and the moderating influence positive parental religious coping has on the relationship between parent to child modeling. This is an important inquiry because, despite positive religious coping being regarded as a deterrent of anxiety, recent literature has suggested that an increased use of positive religious coping negatively correlates with perceived control of internal sensations and external events in African Americans with agoraphobia (Richards, Petrie, & Chapman, 2013). Conceivably, an explanation for these findings could be that individual coping strategies, like private prayer, encourage a cognitive schema of relinquishing perceived control (i.e. “giving it up to God”) and do not incorporate the social support associated with communal worship and practice (Richards, Petrie, & Chapman, 2013). A potential explanation for their findings was that those reporting high levels of positive religious coping may have been relinquishing symptoms control to a higher power and not enacting behavioral change and that the isolation behavior prevented the communal support that can come from positive religious coping (Richards, Petrie, & Chapman, 2013). Despite this finding, the majority of research supports positive religious coping as being a protective factor that moderates the relationship between perceived control and anxiety. Knowing that less perceived control often results in increased anxiety, this may indicate that increased positive religious coping may result in decreased anxiety (Zalta, 2013).

This study uses a sample of family dyads to clarify the effects of parental perceived control, parental positive religious coping, child perceived control and child anxiety with one

primary aim: To examine if parents that exhibit higher levels of perceived control and positive religious coping have children with higher perceived control and less anxiety. This aim is further explored in the following hypotheses:

Hypothesis 1. Parents with higher levels of perceived control will report higher levels of positive religious coping.

Hypothesis 2. Children with higher levels of perceived control will report lower levels of anxiety and children with lower levels of perceived control will report higher levels of anxiety.

Hypothesis 3. Parental levels of reported perceived control will significantly account for the variance in their child's reported perceived control.

Hypothesis 4. Positive parental religious coping and parental perceived control will collectively be significant predictors of their child's perceived control.

Method

Participants

The current investigation was a part of a larger study, the Multiracial Family Wellness Project (MFWP), by the Center for Mental Health Disparities at the University of Louisville. The MFWP is being led by, principal investigator, Dr. Kevin Chapman. The study, upon completion, will be comprised of 150 parent-child dyads. These dyads will include 50 African American families, 50 non-Hispanic White families, and 50 multiracial families. The study restrictions are that parents must be of biological relation, one child per family will be included in the study, child must live with a minimum of one biological parent included in the study, and the operational definition of multiracial will be having one African American parent and one

non-Hispanic White parent. The study will focus on children whose ages fall within the range of 6-17 (elementary, middle and high school).

For the purposes of the current investigation it was elucidated that only a total of six family dyads were able to be recruited and examined between the time the study was launched and this manuscript completed. Thus, this investigation is comprised of six parent-child dyads ($N=6$). These six dyads included all African American families (100%) consisting of one biological mother and one child each (mothers = 6, children = 6). The mothers were between the ages of 31 and 43 years ($M = 36.8$, $SD = 5.4$), and the children between ages 7 and 14 years ($M = 12.0$, $SD = 2.5$). Child gender had a distribution of 4 females (66.7%) and 2 males (33.3%). In each of the dyads, aspects of the household including marital status, parental education level, income level, and number of total children were accounted for. Marital statuses reported were single with boyfriend/girlfriend (2 dyads, 33.3%), divorced and remarried (2 dyads, 33.3%), and divorced and single (2 dyads, 33.3%). Parental education levels reported were some college or specialized training for at least one year (4 dyads, 66.7%) and college graduate (2 dyads, 33.3%) with a mean education level of some college or specialized training for at least one year. Income levels accounted for were \$10,000-\$19,000 (1 dyad, 16.7%), \$20,000-\$29,000 (1 dyad, 16.7%), and \$30,000-\$39,000 (4 dyads, 66.7%) with a mean income of \$20,000-\$29,000. The number of total children reported in each family was between 2 and 5 ($M = 3.6$, $SD = 1.2$).

Procedure

The MFWP utilized a semi-structured clinical interview and 21 psychometric measures to analyze stress, emotions, family functioning, ethnic identity, afrocentricity, religious involvement and collectivistic culture, in the parents. Upon the consent of their parents and their

own free will, the children were administered a semi-structured clinical interview and 7 psychometric measures analyzing stress, worry, mastery, fear and resiliency.

In the current investigation the biological parents were asked to complete the Brief Religious Coping (Brief-RCOPE) and Anxiety Control Questionnaire (ACQ) self-report measures and the children were asked to complete, the self-report measures, the Anxiety Control Questionnaire for Children (ACQ-C) and Multidimensional Anxiety Scale for Children (MASC). The children were able to play the Nintendo Wii as an incentive and to avoid test fatigue. In congruence with ethical practice and law, the study was thoroughly explained to the parents and child before consent was given. Once full competence of the study and its risks were established the parents and child signed an informed consent form. Each family was compensated by experiencing a free family assessment with detailed feedback about anxiety, depression, negative feelings, anger, coping, and family functioning, as well as a monetary amount of \$27 for full participation in the study. If any participant met diagnostic criteria for anxiety and related disorders, the Principal Investigator informed the family of resources that would assist with the treatment and care of these disorders. Recruitment for the study began in September 2013. By February of 2014 the data collection period for the current investigation had ended.

Measures

Brief Religious Coping (Brief-RCOPE; Pargament, Smith, Koenig, & Perez, 1998).

The Brief RCOPE is a ten-item measure adapted from a larger measure of religious coping (RCOPE; Pargament, Koenig, & Perez, 2000). Items from the Brief RCOPE were determined through a factor analysis of the 21 original RCOPE items and yield a positive religious coping subscale (i.e., benevolent religious practice in the search for personal meaning) and a negative

religious coping subscale (i.e., personal struggle with religious coping methods). Furthermore, positive religious coping is operationalized as exhibiting behaviors of higher perceived control: seeking forgiveness of sins, stress relieving religious activities, and actively seeking spiritual support (Pargament, Koenig, & Perez, 2000). Negative religious coping is operationalized as exhibiting behaviors of lower perceived control: waiting for God to control a situation and viewing illness as divine punishment (Pargament, Koenig, & Perez, 2000). It is noticeable that a key difference between positive religious coping and negative religious coping is the level of perceived control utilized; higher perceived control being the more positive cognitive orientation. The RCOPE has been shown to have internal consistency as well as criterion and discriminant validity (see Egbert, Mickley, & Coeling, 2004). The internal consistency in the current sample was $\alpha = .66$.

Anxiety Control Questionnaire (ACQ; Rapee, Craske, Brown, & Barlow, 1996). The ACQ is a 30-item self-report questionnaire used to assess perceived control of both internal and external anxiety-related events. Questions on the ACQ are rated on a six-point likert-type scale (e.g. 0 = “strongly disagree” to 5 “strongly agree”) with respondents indicating the extent to which they agree with a particular statement. The ACQ yields three subscales related to overall perceived control over anxiety-related events (total subscale), reactions to internal stimuli (reaction subscale), and perceived control over external events (events subscale). The internal consistency of the ACQ has been reported as moderate in college samples of African American and non-Hispanic White adults (Chapman et al., 2009). The internal consistency in the current sample was $\alpha = -.31$. This negative average covariance among items reported is likely the result of the underpowered sample size.

Anxiety Control Questionnaire for Children (ACQ-C; Weems, Silverman, Rapee, & Pina, 2003). The ACQ-C is a modified version of the adult Anxiety Control Questionnaire, a measure of perceived control. The ACQ-C is a 30-item self-report questionnaire that was designed for children between the ages of 6 and 17 years of age and utilizes on a five-point scale (0=none; 4=very very much), with higher scores indicative of more perceived control. The ACQ-C yields a Total score as well as two lower-order subscales (i.e., Internal and External). The Internal subscale assesses a child's perceived ability to control anxiety-related negative "internal" emotional and bodily reactions, whereas the External subscale assesses a child's perceived control over "external" threats (Weems et al., 2003). Factor analytic studies have yielded a two-factor model consistent with the two theoretically derived scales (Weems et al., 2003). The ACQ-C will be included to assess a child's perceived competence when experiencing threats associated with anxiety. The ACQ-C Total score will be used in the proposed data analyses. The internal consistency in the current sample was $\alpha = .93$.

Multidimensional Anxiety Scale for Children (MASC; March, 1997). The MASC is a reliable measure of child anxiety. Its factor structure is comprised of four scales (somatic symptoms, social anxiety, harm avoidance, separation/panic anxiety) and three additional subscales (total anxiety rating scale, anxiety disorder rating and inconsistency scale). The inconsistency scale is designed to detect careless or random responding and the anxiety disorder rating can indicate which participants may benefit from a full evaluation. This 39 item measure uses a four-point Likert scale ("0" for "never true about me," "1" for "rarely true about me," "2" for "sometimes true about me," and "3" for "often true about me.") and has been shown to have excellent internal reliability (March et al., 1997). The MASC can be administered to from ages 8-19 and it has been rated as being at a United States education standard 4th grade reading level

(March et al., 1997). Any participants under the age of 10 are assisted in the reading process by a researcher. The scales on the MASC were designed to indicate that higher scores indicate increasing anxiety/emotional problems (March et al., 1997). Internal consistency analysis in the current sample utilized the built in Inconsistency Index. This index screened for items on the MASC that were answered in an inconsistent manner. No participants scored high on this index, indicating a reliable internal consistency.

Data Analysis

The current investigation set out to examine the moderating relationship that positive parental religious coping may have on the relationship between parental perceived control and child perceived control and overall anxiety. Knowing that parental perceived control can influence the anxiety control of the child, does positive parental religious coping change this relationship. In other words, is there a different relationship between parental perceived control and child perceived control and overall anxiety based on whether the parents exhibit high or low positive religious coping. The goal was to establish whether or not perceived anxiety control of the parent, influenced by positive religious coping, accounts for increased variance in the perceived control and overall anxiety experienced by the child. Due to the small number of family dyads, in relation to the amount needed for statistical power, in this study, we could not move forward with our , regression analyses, and expect definitive results. These analyses, specifically the regression analysis, are integral in producing a proper moderation analysis. This being said, we conducted preliminary correlation analyses and two regression analyses in an attempt to identify any significant findings that may still exist and notable trends within the data. Responses from the self-report measures will serve as model indicators quantifying the

relationships among perceived control of parental anxiety, positive parental religious coping, anxiety control of the child and anxiety experienced by the child.

Results

Descriptive Statistics and Bivariate Pearson Correlations

Scale means, standard deviations, skewness, and kurtosis are presented in Table 1. Bivariate Pearson Correlations were conducted with all of the study variables. The ACQ, Brief-RCOPE, ACQ-C, and MASC were used to evaluate the relationship between parental perceived control, positive parental religious coping, child perceived control and child overall anxiety. Parental perceived control as measured by the ACQ Total scale was not significantly correlated with the Brief-RCOPE positive coping subscale, $r = .618$, $p = .191$. Child perceived control as measured by the ACQ-C Total scale was not significantly correlated with the Brief-RCOPE positive coping subscale, $r = .488$, $p = .326$. Parental perceived control as measured by the ACQ Total scale was not significantly correlated with the ACQ-C Total scale, $r = .215$, $p = .683$. Child perceived control as measured by the ACQ-C was significantly correlated with child anxiety as measured by the MASC, $r = -.812$, $p < .05$.

The normality of each model indicator was also examined by converting skewness and kurtosis raw scores into standard scores. This was conducted by taking the skewness raw score as the numerator and the standard error of skewness as the denominator and dividing for the standard skewness. This was conducted for kurtosis in the same fashion. The threshold for normality is standard skewness and kurtosis values less than 1.5. After establishing normality for the variables included in the regression analysis, Pearson correlation coefficients and scatter plots were used to test for linearity. Two scatter plots, one accounting for the relationship

between the ACQ-C and the ACQ (see Figure 1) and the other accounting for the relationship between the ACQ-C and the Brief-RCOPE (see Figure 2), did seemingly have a linear relationship but these linear relationships were not significant as evidenced by the correlation values. The reason for these seemingly linear relationships being insignificant could be due to a lack of power.

Regression Analyses

Despite a linearity violation not warranting the continued use of linear regression, two regression analyses were conducted to observe potential trends in the data that could be of interest to future research. In particular, a linear regression model and a multiple regression model was conducted to determine whether parental perceived control (as measured by the ACQ Total scale) predicts child perceived control (as measured by the ACQ-C Total scale), and if parental perceived control and parental positive religious coping (as measured by the Brief-RCOPE) predict child perceived control.

The results of the linear regression model indicated that the ACQ Total scale did not significantly predict the ACQ-C Total scale, $b = .215$, $t(4) = .440$, $F(1, 4) = .194$, $p = .683$, and explained 4.6% of the variance.

The results of the multiple regression model indicated that the ACQ Total scale and Brief-RCOPE together did not significantly predict the ACQ-C Total scale, $F(2, 3) = .502$, $p = .649$, and together they accounted for 25.1% of the variance. In this model it was found that the Brief-RCOPE explained 20.5% of the variance in child perceived control as measured by the ACQ-C. Individually the ACQ Total scale did not significantly predict the ACQ-C Total scale, b

= -.141, $p = .839$, and the Brief-RCOPE did not significantly predict the ACQ-C Total scale, $b = .575$, $p = .432$.

Discussion

This study is unique, in that it is one of the first to examine the influence of positive parental religious coping on the relationship between parental perceived control and child perceived control and anxiety. Previous literature indicates that children often learn or develop their level of perceived control or anxiety through the parents' modeling (Monaghan & Sims, 2013; Aktar, Majdandzic, Vente, & Bogels, 2014; Chapman et al., 2012). Knowing the literature specifies that perceived control and anxiety correlate negatively, we postulated that parents who model high levels of perceived control will have children that exhibit high perceived control and lower levels of anxiety. Positive religious coping has been found to be positively correlated with elements of perceived control (Pargament et al., 1998). Thus, we postulated that positive parental religious coping may play a significant role in the relationship between parent to child perceived control transference. In our examination we were not able to conduct a moderation analysis to examine these constructs and the significance of their interplay but we were able to test for significance and variance between constructs.

Among the variables assessed we found perceived control of the child to be significantly negatively correlated with child anxiety. This indicated that for our families assessed, children that reported higher levels of perceived control reported lower levels of anxiety and children that reported lower levels of perceived control reported higher levels of anxiety. The current study's findings replicate the majority of literature, demonstrating a negatively correlated relationship

between perceived control and anxiety. Furthermore, statistical significance was not found between any of our other variables. This could have been due to our sample being too small to reach statistical power.

These regression analyses suggest that, despite lack of statistical significance, there is seemingly a positive relationship between the perceived control of the child and the perceived control of the parent and parental positive religious coping. This means that as the perceived control of the parent increases, the perceived control of the child also increases. Approximately 5% of the variance in the perceived control of the child (ACQ-C) was accounted for by the perceived control of the parent. Similarly, as the positive religious coping of the parent increases, the perceived control of the child also increases. Thus, as parents report higher levels of positive religious coping we can expect that their children will report higher levels of perceived control. The variance accounted for by positive parental religious coping (Brief-RCOPE) exceeds 20% in the perceived control of the child (ACQ-C). The relevance of positive parental religious coping to understand child control was further demonstrated by the beta weights, which indicated that despite not having statistical significance, a far larger relationship between perceived control of the child and positive parental religious coping may exist than between perceived control of the parent and child. This finding is promising because this presumed protective factor more significantly contributed to the child's outcome (anxiety) than a known risk factor for anxiety. Due to a small sample size in the current study, this finding can only bring to attention this potentially moderating relationship and implore further investigation of similar variables in a larger sample.

Although the current investigation poses a pertinent question and limited results indicate potential significance of further findings, there are several limitations worth noting. First, in the

current study the sample was limited by small size (N=6) and parent gender (i.e. 100% female). One potential explanation for the small sample size is stigma associated with mental illness and a history of misunderstanding and malpractice in medical research with ethnic minorities. In the public health arena it is well known that there is generally a stigma associated with mental illness in (Corrigan, 2005). With African Americans this stigma associated with mental illness is not always a case of avoiding diagnosis, but a distrust in the standards of western research and medicine (Whaley, 2001). This distrust in western medical practice, rooted in historical legitimacy (i.e. the Tuskegee syphilis study), can be used as a defense mechanism inhibiting valuable help-seeking behavior. This underutilization of health services, not limited to mental health, is due to fear of such things as involuntary hospital admissions and practitioner's lack of cultural competence leading to an uncomfortable/hostile environment and even diagnostic error (Whaley, 2001).

Because of the small sample size and female parent only composition, findings may not generalize to the greater population or account for male parent dyads. Future studies should elaborate on the findings of this investigation by including a sample size large enough to establish statistical power. In addition, all family dyads were African American so any comparison to Non-Hispanic White, or multiracial families could not be conducted. Second, the current study utilized the Total Scale scores for the ACQ, ACQ-C, and MASC. Each of these measures has multiple subscales that specify internal and external control and variations of anxiety experienced. Further studies should aim to investigate the roles of each construct represented within the subscales. Finally, more research is needed to fully understand the role that positive religious coping has in perceived control. The literature supporting their positive correlation is limited and further investigation is needed to better understand this relationship.

Future research with a larger sample size should incorporate a preliminary investigation of the relationship between positive religious coping and perceived control to investigate significance.

The current study served to initiate investigation into the significance of positive religious coping in anxiety transference in the family. Knowing that there is a dearth of literature examining protective factors in African Americans, examining the significance of a sociocultural protective factor in anxiety transference in the family was seen as a potential addition to the body of knowledge supporting psychological understanding and treatment. Given the findings of this study, further research into the significance of sociocultural protective factors of anxiety is needed.

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Table 1

Scale Means, Standard Deviations, Standard Skewness, and Standard Kurtosis (N=6)

Variable	M	SD	Standard Skewness	Standard Kurtosis
Anxiety Control Questionnaire Total Score	108.83	31.79	0.098	-0.969
Positive Religious Coping Subscale Total	17.83	1.94	-0.247	0.395
Anxiety Control Questionnaire for Children Total Score	64.66	18.08	-0.173	-0.487
Multidimensional Anxiety Scale for Children Total Score	54.16	16.5	-1.075	0.489

Note. Threshold for significant violations to normality was determined by a standard skewness/kurtosis

value greater than 1.5.

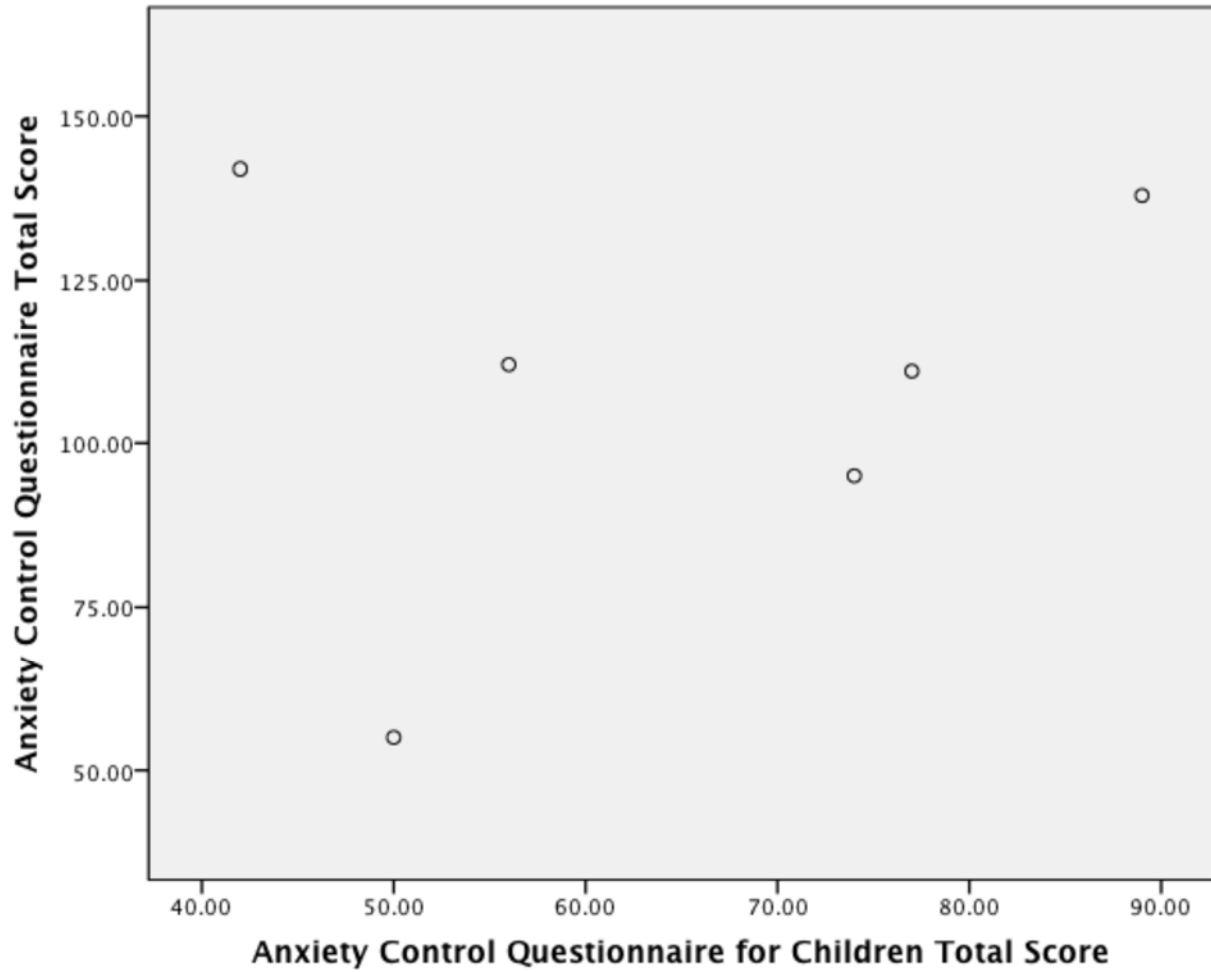


Figure 1. The linearity of the relationship between the perceived control of the child (ACQ-C) and the perceived control of the parent (ACQ).

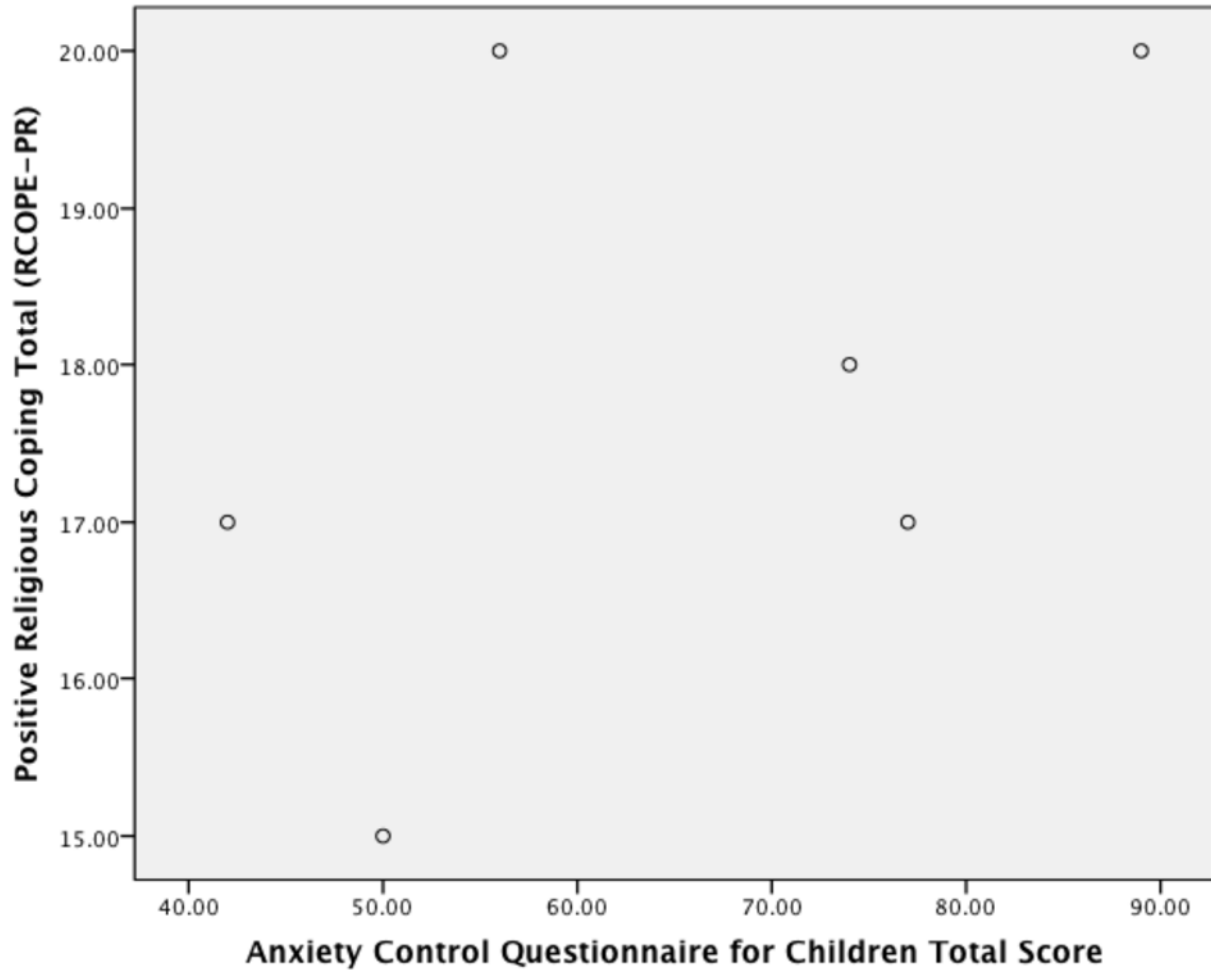


Figure 2. The linearity of the relationship between the perceived control of the child (ACQ-C) and the positive religious coping of the parent (Brief-RCOPE).