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Learning from adversity: What the COVID-19 pandemic can teach us about family resiliency

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Abstract

The present study aimed to characterize the immediate impacts of the COVID-19 pandemic on families with preschool age children and to identify pre-pandemic factors that explained unique family experiences. We leveraged an ongoing longitudinal study of relatively well-resourced community families who had reported on family functioning prior to the pandemic and completed surveys 6 months after pandemic onset. Both parents of dual parenting households endorsed significant hardships as a direct result of the pandemic (e.g., disrupted family routines, challenges at work); however, families also reported aspects of flourishing (i.e., experiencing positive outcomes in response to adversity) such as spending more time together as a family. Families were prone to greater hardships and fewer opportunities for growth to the extent that parents were lower in psychological resources (i.e., greater stress and internalizing symptoms, poor well-being) and were not on the same page as a couple (i.e., interparental discord, low quality coparenting) prior to pandemic onset. Finally, greater pandemic hardships predicted poorer parental mental health, greater family dysfunction, and elevated child psychopathology, controlling for pre-pandemic levels. Parents who reported more family flourishing from the pandemic had a stronger interparental relationship. Results are intended to inform theories of family stress and family interventions that can be tailored to promote resiliency (i.e., adaptation to challenging life events) and prevent dysfunction when families face rapid change and adjustment and high degrees of uncertainty and stress.

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KEYWORDS
coparenting, COVID-19, family, interparental, mental health, pandemic, preschooler

INTRODUCTION

The coronavirus disease 2019 (COVID-19) pandemic represents an ongoing global health crisis that has had a tremendous worldwide impact. The social and economic impacts of this pandemic (i.e., job loss, financial insecurity, social distancing) have caused an unprecedented increase in daily stressors, particularly among caregivers, and especially among those parenting young children. These stressors can spill over into the family system and undermine parenting (Bakker & Demerouti, 2013; Bass et al., 2009; Bolger et al., 1989). Indeed, researchers of natural disasters have long recognized that large-scale events of this nature provide a scientifically important context for examining the consequences of adversity (Norris, 2006). What is unique about the COVID-19 pandemic, relative to more geographically isolated natural disasters, is its global impact. Most families have experienced disruption related to the pandemic, but to different degrees and in diverse ways. Accordingly, the COVID-19 pandemic provides an unprecedented occasion to examine the innumerable ways that major life events and transitions impact families and to identify key resiliency factors to prioritize in interventions (Brock & Laifer, 2020; Chen & Bonanno, 2020; Gruber et al., 2021). Emerging research has highlighted the numerous consequences of the COVID-19 pandemic for parent mental health, family relationship quality, and child mental health.

Parent mental health

Compared with adults without children, parents have been particularly susceptible to a range of mental health difficulties when adapting to the COVID-19 pandemic (Gadermann et al., 2021; Gassman-Pines et al., 2020; Westrupp et al., 2021). Parents of *young* children—especially children aged 4 or younger—appear to be at particular risk for deteriorating mental health relative to parents of older children (Gadermann et al., 2021). This elevated risk might be due to substantial caregiver burden (Gassman-Pines et al., 2020; Russell et al., 2020) resulting from unprecedented demands to balance new and evolving caregiving, work, and education routines (Prime et al., 2020). These immediate and rapid changes to family routines can compromise a parent's ability to attend to their own emotional needs, increasing the likelihood of psychological distress. In addition to caregiver burden, accumulating evidence demonstrates that pre-existing mental health and financial difficulties (Westrupp et al., 2021), as well as greater COVID-related hardships (e.g., job loss, financial insecurity, COVID-19 illness), are key risk factors for parental mental health concerns (Gassman-Pines et al., 2020; Peltz et al., 2021; Rodriguez et al., 2021; Westrupp et al., 2021).

Family relationship quality

Emerging research also points to elevated dysfunction across multiple subsystems within the family in the context of the COVID-19 pandemic. Parents have reported elevated parenting stress and increases in harsh parenting practices (Chung et al., 2020). Pandemic-related stress also poses risk for dysfunctional coparenting in dual parenting households (Giannotti et al., 2021; Lucassen et al., 2021; Peltz et al., 2021; Pruett et al., 2021). There is also evidence that the quality of the intimate relationship between parents has been impacted. For example, 28% of parents reported relationship challenges with their partner in the early months of the pandemic (Gadermann et al., 2021), and higher levels of

pandemic stress were associated with poorer intimate relationship quality during the first few months of the pandemic in an international study with participants from 57 countries (Balzarini et al., 2022).

Child mental health

A growing body of literature highlights an increased prevalence of child mental health concerns during the pandemic across developmental stages (Glynn et al., 2021; Marques de Miranda et al., 2020; Nearchou et al., 2020). Research suggests that preschoolers are experiencing elevated mental health symptoms compared with pre-pandemic norms (Glynn et al., 2021). Greater COVID-related hardships (e.g., income loss, household job loss) are associated with elevations in internalizing and externalizing problems among children up to age 7 (Gassman-Pines et al., 2020). Longitudinal research conducted with older children and adolescents documents notable increases in internalizing and externalizing symptoms from pre- to post-pandemic onset (Feinberg et al., 2022) and suggests that pandemic stressors (e.g., financial, school, physical environment) are associated with child and adolescent psychopathology when controlling for pre-pandemic symptoms (Rosen et al., 2021).

Embedding pandemic research in family models of stress

Multiple theories provide insight into why families have been adversely impacted by the COVID-19 pandemic. For example, the *ABC-X Model of Family Stress and Adaptation* (Hill, 1958; Rosino, 2016) addresses how families adapt to stressful events or transitions. Within this framework, emphasis is placed on the family's perception of a stressor, which is determined, in part, by resources available within the family unit (e.g., individual-level resources such as the mental health of family members, familial assets such as strong relationships and family integration, tangible resources such as financial assets). In the absence of adequate resources, the family is more likely to perceive the stressor as a threat, increasing the likelihood that family members feel overwhelmed and develop negative psychological states that undermine health and family functioning. A central feature of this model is consideration of sources of resiliency within the family, prior to the onset of the stressor, that play a pivotal role in how the family experiences the stressor and whether it ultimately undermines family health.

Within this framework, COVID-related elevations in family dysfunction and mental health difficulties might be more pronounced for families who had fewer resources (e.g., financial, parental mental health) prior to the onset of the pandemic, thereby exacerbating the stress resulting from pandemic disruptions. Yet, most research to date has been cross-sectional, has focused on family functioning *after* the onset of the pandemic, and has overlooked preexisting factors that might explain individual differences in pandemic impacts. Further, most studies have relied on reports from a single parent, providing a restricted account of how the whole family has been impacted. Thus, there is a critical need for research that considers (a) individual and family-level resources available *prior to the onset of a pandemic* that forecast the family's ability to reorganize in an adaptive way that preserves the health of individual family members and relationships, and (b) the degree to which multiple family members experience the pandemic rather than focusing on reports from a single family member.

Although typically applied to understand how families navigate economic disadvantage, the *Family Stress Model* (FSM; Conger et al., 2010; Masarik & Conger, 2017) also provides insight into how families adapt to stress. Within this model, adversity is conceptualized as undermining parental mental health and escalating parenting difficulties and interparental conflict. This family disruption, in turn, may negatively impact child socioemotional functioning and adaptation. Closely aligned with this framework, *Family Systems Theory* (Cox & Paley, 2003; Minuchin, 1985) recognizes that periods of stress and transition confer significant risk for families as they are forced to reorganize and adapt to external threats. The absence of a strong family foundation—with adaptive and healthy relational dynamics—may result in further dysfunction in the family system across multiple interrelated

subsystems (e.g., parenting and coparenting). Because most research on the COVID-19 pandemic has been cross-sectional, with a few notable exceptions highlighted above, it is uncertain whether pandemic stress has contributed to *changes* in family functioning relative to pre-pandemic levels. That is, it remains unclear how families have reorganized and adapted and whether there has been a decline in individual and family health across the transition to a post-pandemic world.

The potential for growth and flourishing in the context of adversity

Models of family stress suggest that (a) resources available to families prior to the onset of a major stressor help determine how a family experiences that hardship and whether it undermines the health of the family, and (b) the change and reorganization that occur as families navigate adversity and life transitions may have far-reaching implications for subsystems across the family. Although these theories largely emphasize negative consequences of stress for families, there is also the potential for *flourishing* (i.e., experiencing positive outcomes in response to adversity), especially if families have access to resources that promote resiliency. Researchers have documented the possibility for flourishing amidst stressful events, including improved relationships with others, openness to new possibilities, greater appreciation of life, and enhanced personal strengths (Peterson et al., 2008). Although some individuals might experience greater hardship and accompanying distress, others might experience a more positive state of functioning, and these phenomena are not mutually exclusive. Indeed, it is possible for flourishing to occur in combination with dysfunction stemming from stressful events (Keyes, 2007). Thus, there is a critical need for research that not only considers the hardships that families face when adapting to adversity but also aspects of flourishing.

Though existing research on the impact of the COVID-19 pandemic on families has largely demonstrated negative outcomes, accumulating evidence suggests that some families experienced positive impacts, including improved family relationships (Ayuso et al., 2020; Wong et al., 2021) and more time spent with family (Perlman, 2020). For example, qualitative analyses with families in Spain (Günther-Bel et al., 2020) revealed that participants reported both improvement (e.g., family (re) connection, better communication) and deterioration (e.g., loneliness, conflict) during the first three weeks of government mandated lockdown. However, not all families are equally likely to experience these silver linings. For example, cross-sectional research suggests that individuals of higher socioeconomic status report more perceived benefits, suggesting economic resources play a critical role in flourishing potential (Wong et al., 2021).

The present study

Since the onset of the COVID-19 pandemic, there has been a proliferation of research aimed at understanding how families have navigated stress and adversity resulting from this global crisis. The results of this growing body of research suggest that there has been elevated risk for parental mental health difficulties, family dysfunction, and child maladjustment due to disruption and hardship. Nonetheless, much of this research has been cross-sectional in nature and precludes conclusions about directionality of effects; therefore, it is unclear if pandemic hardships are the cause or consequence of family dysfunction. Further, emerging research suggests that not all families respond to stress in the same way, and some families may be able to thrive in the face of these challenges (i.e., experience aspects of flourishing). By identifying preexisting factors present prior to the pandemic that explain why families thrive or falter in the context of adversity, interventions can be tailored to promote resiliency and prevent maladjustment when families encounter stress.

There were three primary aims to the present study. The first aim was descriptive in nature and involved implementation of a questionnaire developed to assess a wide range of COVID-19 pandemic impacts. Both parents in dual parent households of preschoolers reported on not only hardships but

also aspects of flourishing (e.g., more quality time with family, increase in physical activity) during the first 6 months of the pandemic when families were rapidly adapting to changing routines and tolerating growing uncertainty.

The second aim was to identify pre-pandemic predictors of differences in how families were impacted by the pandemic. Leveraging data collected as part of a larger longitudinal study of relatively well-resourced families with preschoolers, which was underway prior to the onset of the pandemic, we examined family characteristics and parental mental health as predictors of pandemic impacts. We predicted that the highest levels of hardships and lowest levels of flourishing would be reported by parents who were of greater socioeconomic disadvantage (i.e., lower income and less education) and who identified as a racial or ethnic minority, a proxy for marginalization stress and health inequities. Additionally, consistent with the *stress generation model of depression* (Hammen, 1991), which suggests that depressed individuals generate life stresses, we expected parents to report greater hardships (and less flourishing) to the extent that they reported greater mental health difficulties prior to the pandemic, particularly internalizing symptoms.

The third aim was to examine the acute consequences of hardships on the health and well-being of the family during the first 6 months after pandemic onset. Using well-established, validated measures of constructs, we focused on three primary outcomes: parental mental health (i.e., depression and anxiety, alcohol abuse, well-being), family relationship quality (i.e., interparental relationship satisfaction, coparenting quality, parenting sense of competence), and child mental health (i.e., internalizing and externalizing problems). We leveraged pre-pandemic data as controls to determine whether acute hardships explained change variance in each of the outcomes. As an exploratory step, we also accounted for the potential that family flourishing during the pandemic would not only predict better mental health of parents and child and higher quality family relationships but would also mitigate risk arising from hardship.

METHODS

On March 13, 2020, the United States declared a national state of emergency in response to the COVID-19 disease outbreak. Approximately 6 months after the state of emergency was declared (September, 2020), parents of preschool age children, largely residing in the Midwest region of the United States, were invited to complete a series of questionnaires. These families were already enrolled in a large-scale longitudinal study of child development (N = 159 families) and had completed assessments prior to the onset of the pandemic (March 31, 2018 to March 10, 2020). In the absence of a designated response period as part of the instructions (e.g., "past 2 weeks"), participants were instructed to consider each item *since March 13, 2020* to capture functioning *after* the start of the pandemic. This applied to measures of parental alcohol use and family functioning. Each parent received $50 for completing the survey (up to $100 per family). Parents had completed largely identical questionnaires prior to pandemic onset when the child was 2 years of age (M = 24.50 months, SD = 0.66), providing pre-pandemic measures of most variables of interest. This assessment took place, on average, 19 months (M = 19.46, SD = 5.99 for fathers; M = 19.45, SD = 5.95 for mothers) prior to participants completing the pandemic surveys and, therefore, approximately 1 year prior to the start of the pandemic. Compensation for this assessment was $100 per parent. All procedures were approved by the University of Nebraska-Lincoln's. See Table S1 for demographic characteristics of this sample.

Measures

Pandemic impacts

We administered the *Epidemic-Pandemic Impacts Inventory* (EPII; Grasso et al., 2020), which was developed to assess a range of potential impacts of the COVID-19 pandemic on various aspects of

personal and family life. In addition to hardships from the pandemic (e.g., increase in work responsibilities), items assess positive change directly resulting from the pandemic (i.e., flourishing) such as more quality time with family and more time in nature or outdoors. Participants were asked to indicate whether the pandemic had impacted anyone in the household across 92 items. Both parents of dual parenting households completed the EPII; thus, we used a multi-informant approach and scored an item as having occurred for that family if at least one parent endorsed the item (rate of agreement between parents was 79%). A complete list of items is shown in Tables S2 and S3 along with the percent of the sample endorsing each impact. We computed four scores reflecting the number of negative impacts experienced by families across four key domains: (1) *disease-specific* (i.e., distancing, quarantine, and infection; 16 items), (2) *economic hardship* (5 items), (3) *work, education, and home disruptions* (36 items), and (4) *health behaviors and consequences* (16 items). We also created an overall negative impacts scale across those four domains (73 items). A *positive pandemic impacts* score was computed by summing the number of 19 items that were endorsed. Given these scores reflect cumulative counts of experiences that are not necessarily expected to co-occur, estimates of internal consistency were not calculated.

Parent mental health

Inventory of Depression and Anxiety Symptoms (IDAS-II; Watson et al., 2012). Participants rated their feelings and experiences during the past 2 weeks on a scale from 1 (*not at all*) to 5 (*extremely*). We used the 10-item dysphoria subscale assessing the nonspecific emotional and cognitive symptoms underlying depression and anxiety disorders (Cronbach's $\alpha = 0.85$ pre-pandemic and 0.91 post-onset). We also used the 8-item well-being subscale, which reflects positive emotionality and energy (Cronbach's $\alpha = 0.72$ pre-pandemic and 0.88 post-onset). *Alcohol Use Disorders Identification Test* (AUDIT; Saunders et al., 1993). Participants responded to 10 items assessing problematic drinking since pandemic onset (e.g., not able to stop drinking; needing a drink first thing in the morning to get going, failed to do what was normally expected; $\alpha = 0.89$). The AUDIT was not administered prior to the pandemic; however, participants had completed the *Short Michigan Alcohol Screening Test* (SMAST; Selzer et al., 1975), which was used as a baseline measure in Aim 3 analyses.

Family functioning

Parenting Sense of Competence Scale (PSOC; Johnston & Mash, 1989). Participants were asked to rate the extent to which they agreed or disagreed with 17 items assessing parenting efficacy (e.g., "I meet my own personal expectations for expertise in caring for my child") and satisfaction (e.g., "Being a parent makes me tense and anxious"). Scores range from 17 to 102, with lower scores reflecting less self-efficacy ($\alpha = 0.87$). We did not administer a pre-pandemic measure of parenting sense of competence. *Coparenting Relationship Scale* (CRS; Feinberg et al., 2012). Participants completed the CRS, a 35-item survey self-report measure of the coparenting relationship in dual-parent families (e.g., agreement, conflict, support). Composite (average) scores range from 0–6, with higher scores reflecting more positive coparenting ($\omega = 0.92$ pre-pandemic and 0.95 post-onset). *Quality of Marriage Index* (QMI; Norton, 1983). The QMI is a self-report questionnaire designed to assess global happiness with the intimate relationship. Participants indicated the extent to which they agreed or disagreed with five items (e.g., "Our relationship is strong"). Participants also rated their global relationship "happiness". Items were summed ($\alpha = 0.96$ pre-pandemic and 0.97 post-onset).

Child mental health

Child Behavior Checklist for Ages 1.5–5 (CBCL; Achenbach & Rescorla, 2000). The CBCL assesses child behavioral and emotional problems. Caregivers were asked to rate child behaviors on a scale of 0

(*not true*) to 2 (*very true/often true*) thinking about the past 2 months. Scores were computed for internalizing (36 items; α = 0.71 pre-pandemic and 0.85 post-onset) and externalizing (24 items; α = 0.87 pre and 0.91 post). As expected, correlations between maternal and paternal reports were small to moderate (*r*s ranged from 0.14 to 0.30). Scores were averaged across reporters at each timepoint to produce a less biased and more reliable estimate of child psychopathology (Achenbach et al., 1987; Lengua et al., 2008).

Pre-pandemic sociodemographic characteristics and stress

At the time of study enrollment, each parent was asked to report their ethnicity and race, and it was determined whether at least one family member identified as a *racial or ethnic minority* (1 = *yes*, 0 = *no*) to serve as a proxy measure of marginalization stress and health inequities. Each parent was also asked to report their *highest level of education* (1 = *did not complete high school*; 2 = *GED*; 3 = *high school diploma*; 4 = *vocational, technical, associate's degree*; 5 = *some college*; 6 = *bachelor's degree*; 7 = *master's degree*; 8 = *doctorate*). *Family joint income* was measured as a continuous score prior to the pandemic (when target child was age 2 years): 1 = *less than $9999*; 2 = *$10,000–$19,999*; 3 = *$20,000–$29,999*; 4 = *$30,000–$39,999*; 5 = *$40,000–$49,999*; 6 = *$50,000–$59,999*; 7 = *$60,000–$69,999*; 8 = *$70,000–$79,999*; 9 = *$80,000–$89,999*; 10 = *more than $90,000*. *Chronic Strains Inventory* (CSI; Hammen et al., 1987). The CSI covers multiple life domains (e.g., school, work, health, relationships) in which stress can arise. Participants were provided with a list of behavioral indicators for each area and asked to choose the rating that best represented their experiences in each area over the past 6 months. An average score was calculated because not all domains apply to every participant (e.g., school), with higher scores reflecting greater reported chronic stress. Given stress is a formative construct, estimates of internal consistency were not calculated.

Data analytic plan

Of the 159 families who originally enrolled in the study during pregnancy, one couple miscarried, one child was diagnosed with trisomy 21 and did not participate beyond pregnancy, and 11 parents separated. Consequently, these families were excluded from analyses for a final sample of 146 families in dual parenting households at the time of the pandemic onset. This approach enhanced the internal validity of the study. We computed descriptive statistics for the EPII (Aim 1) and estimated correlations between pre-pandemic variables and EPII scores (Aim 2). For Aim 3, we ran three sets of predictive models corresponding to each type of outcome: parent mental health, family functioning, and child mental health. In each model, outcome measures were regressed on pandemic hardships, flourishing, and an interaction between hardships and flourishing, as well as control variables (i.e., pre-pandemic levels of each outcome, joint family income, and family ethnic/racial minority status). In models with both maternal and paternal outcome variables modeled simultaneously (e.g., maternal and paternal well-being), steps were taken to address interdependence across family members. Specifically, residual variances were covaried. Further, to test for indistinguishability of paths (e.g., whether pandemic hardships had an equal effect on maternal and paternal well-being), we conducted a series of nested model comparisons evaluating the relative fit of a model with equality constraints to one with effects freely estimated. If a chi-square test was not significant, we retained the equality constraints and concluded indistinguishability between partners. When appropriate (i.e., when a model was overidentified), we applied the following criteria to establish adequate global model fit: CFI above 0.95; RMSEA and SRMR under 0.08. Most families (69%, n = 100) completed the pandemic survey; however, analyses were conducted with the full sample using all available data (i.e., pre-pandemic scores) with full information maximum likelihood estimation (Enders, 2010). Families who participated in the pandemic survey did not differ significantly from those who declined

participation regarding scores on pre-pandemic variables, with one exception; families of higher socioeconomic status were, on average, more likely to participate ($p < .05$) which was accounted for in the analyses (i.e., income status was a covariate). The model was estimated using the MLR estimator which provides robust standard errors to address non-normality.

RESULTS

Aim 1: Hardships and flourishing during the first 6 months of the pandemic

Table S2 summarizes rates of hardships reported by families across four domains. *Disease-specific* consequences (e.g., distancing, quarantine, and infection) were relatively rare ($M = 1.54$ out of 16 items, SD = 1.65, Min = 0 Max = 7). Few families had adverse experiences with the disease, which was expected given the geographic location of the study. No families reported hospital stays or death of someone living in the home from COVID-19, and few families reported death of a close friend or family member (3%). There were higher rates of isolation and quarantine (19%–27%), and almost a third of families reported limited physical closeness with child or loved ones due to concerns of infection (29%). *Economic hardship* was also relatively rare, with 20% of families endorsing *any* hardship. No families endorsed lack of access to clean water, although 7% reported difficulties accessing enough food or healthy food. The most common economic hardship was difficulty getting places due to less access to public transportation or concerns about safety (13%).

In contrast, *work, education, and home disruptions* were much more frequent ($M = 7.58$ out of 36 items, SD = 3.66, Min = 0, Max = 20). The most common disruptions were in family activities such as celebrations (98%), vacations (85%), spiritual activities (76%), and hobbies (87%–88%). Three out of 4 families (74%) reported separation from family or close friends. In terms of work disruptions, 50% reported reduced hours or furlough, and 15% reported being laid off form a job or closing a business. More than half of families reported increased work responsibilities (63%) and indicated that at least one parent continued to work even though they were in close contact with people who might be infected (56%). Almost half of families (44%) reported a difficult transition to working from home. There were also disruptions in childcare, with 63% of families having a child in the home who could not go to preschool (or childcare center). Parents of nearly half of the families (45%) reported difficulty taking care of children who were now in the home, and 61% reported taking over teaching the child. Relatively rare items included homelessness (2%) or relocation (7%). Family dynamics were disrupted, with 45% of families reporting increases in verbal interparental arguments (4% reporting increased *physical* conflict), and 7% of families reported increased *physical* conflict with children.

Families also reported *health behaviors and consequences* that were already noticeable within the first 6 months ($M = 6.17$ out of 16 items, SD = 2.92, Min = 0, Max = 13). The most common disruption was more time spent on screens and devices (89% of families). There were also notable increases in parent mental health symptoms (71% endorsed mood disturbances and stress; 66% reported sleep disruptions; 34% reported increased substance use). Similarly, children exhibited declines in health, with 51% of families endorsing increased child behavioral or emotional problems and 32% reporting child sleep difficulties. Physical health also suffered. Approximately 3 out of 4 families experienced a decrease in healthy behaviors (62% less physical activity or exercise; 65% overeating or eating more unhealthy foods; 70% more time being sedentary). One in 4 families reported a noticeable increase in health problems not related to the COVID-19 disease (23%) and engaging in less routine medical care (30%).

Table S3 summarizes aspects of flourishing reported by families. On average, families reported 10.80 (SD = 3.42, Min = 3, Max = 17) out of 19 possible positive impacts. The most widely endorsed items were having more time to spend with family members (84%–94%), feeling more appreciative of things usually taken for granted (93%), and spending more time in nature or doing enjoyable activities such as reading books (73%–86%). A large proportion of the sample reported improved relationships

with family and friends (63%) and new connections with supportive people (48%). In contrast, few families endorsed positive changes in health behaviors such as using less alcohol (19%) and spending less time on screens or devices (14%), although 55% reported an increase in physical activity. Some families reported time spent volunteering (21%–32%). The correlation between positive impacts and total hardships was relatively low and not significant ($r = 0.18$, $p > 0.05$), suggesting families experiencing more hardships did not necessarily experience fewer positive impacts.

Aim 2: Pre-pandemic predictors of pandemic hardships and flourishing

Refer to Table S4. Families endorsed more hardships to the extent that parents reported more internalizing symptoms (father $r = 0.32$; mother $r = 0.22$) and fathers reported more chronic stress ($r = 0.22$) prior to the onset of the pandemic. In contrast, greater positive impacts (i.e., aspects of flourishing from the pandemic) were endorsed if parents reported higher levels of well-being pre-pandemic (father $r = 0.22$; mother $r = 0.23$) and if mothers reported a higher quality interparental relationship (global satisfaction $r = 0.25$; coparenting quality $r = 0.24$).

Regarding specific types of hardships, parents who identified as a racial or ethnic minority were more likely to experience *economic hardship* (father $r = 0.25$; mother $r = 0.34$). Further, pre-pandemic socioeconomic status (i.e., parent education and family income) was associated with pandemic-related economic strain (rs ranged from −0.36 to −0.25). Families also endorsed more economic hardships if fathers had lower well-being ($r = -0.22$), perceived more discord in the interparental relationship ($r = -0.33$ for global satisfaction and $r = -0.35$ for coparenting quality), and reported higher levels of stress ($r = 0.31$) prior to pandemic. Families experienced more *disruptions in work, education, and home* to the extent that fathers reported more internalizing symptoms ($r = 0.21$) and chronic stress ($r = 0.23$) pre-pandemic. Multiple pre-pandemic factors were associated with increased health problems of family members including mother report of coparenting quality ($r = -0.27$); maternal well-being ($r = -0.22$), internalizing symptoms ($r = 0.32$), and stress ($r = 0.30$); and father internalizing symptoms ($r = 0.40$) and stress ($r = 0.30$). *Disease-specific problems* (e.g., need to quarantine or likelihood of infection) were not significantly correlated with any of the pre-pandemic factors under investigation.

As a final, supplemental analysis, we also examined whether family structure explained differences in pandemic impacts when data were available (not all families provided this information). There were no significant differences between families with multiple children living in the home at the start of the pandemic ($n = 52$) relative to those with only the target child living in the home ($n = 20$) with regard to hardships, $t = -1.89$, $p = 0.067$, and flourishing, $t = -0.49$, $p = 0.630$. There were no significant differences between families with both parents working (at least 15 h per week; $n = 46$) and those with only one parent employed ($n = 27$) in terms of hardships, $t = 0.40$, $p = 0.693$, and flourishing, $t = 0.14$, $p = 0.893$.

Aim 3: Pandemic impacts on parental and child mental health and family functioning

To increase the rigor of Aim 3 analyses, we removed items from the EPII scales that had significant overlap with key outcome variables to avoid artificially inflating associations due to redundant content. For example, "increases in child emotional problems" was removed from the hardship scale given child internalizing (emotional) problems was an outcome variable in Aim 3 analyses. Refer to Tables S2 and S3 to identify items that were omitted. Given family income status is a robust correlate of relationship quality and mental health (Chen et al., 2007), and socioeconomic status was associated with greater economic hardships from the pandemic, we also controlled for family income status in all analyses. A summary of model results is provided in Figure 1 and detailed model results are reported

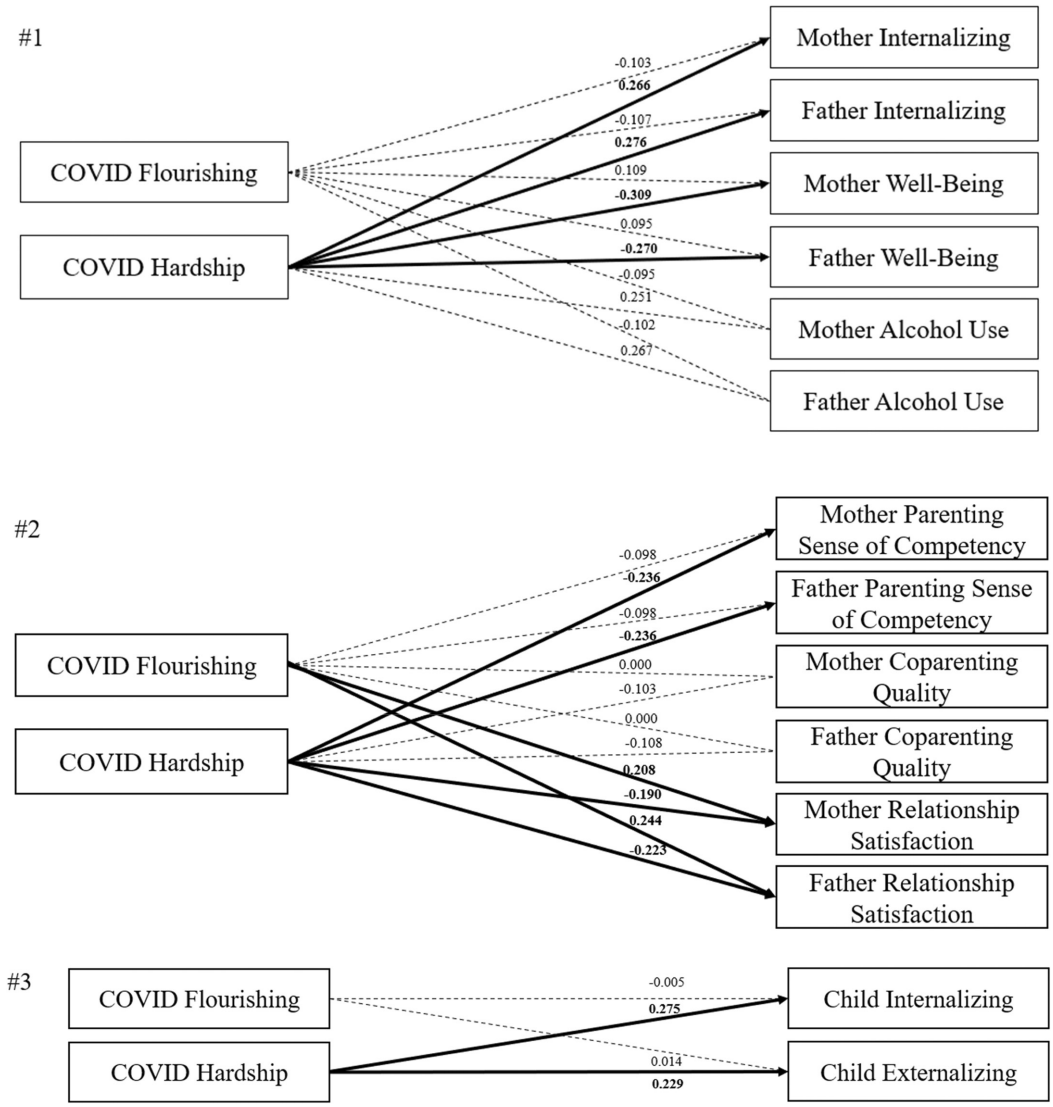

FIGURE 1 Summary of results for primary paths in Aim 3 models. Solid lines represent significant effects ($p < 0.05$). Dashed lines represent non-significant effects. Standardized estimates are reported. Exogenous variables were covaried. Residuals of endogenous variables were covaried. Pre-pandemic levels of each construct were controlled for except for parenting sense of competency given this was not administered prior to the onset of the pandemic. Additionally, we controlled for racial or ethnic minority status (at least one parent) and low-income status. Unstandardized estimates and effects of control variables are reported in Tables S5–S7.

in Tables S5–S7. Notably, there was a small, positive correlation between pandemic hardships and flourishing, $r = 0.20$, $p = 0.031$.

Model #1: Parent mental health

Parallel paths across partners (e.g., hardships → *maternal* well-being and hardships → *paternal* well-being) were all deemed indistinguishable based on nested model comparisons imposing equality constraints with one exception: pre-pandemic dysphoria → pandemic dysphoria was larger for actor

pathways for fathers than mothers ($\chi^2(1, N = 146) = 3.856$, $p = 0.0496$). This pathway was allowed to vary across parents; all other paths were modeled as equal across partners. The interaction between hardships and flourishing was not significantly associated with the outcomes (B ranged from −0.537 to 0.995, $p > 0.05$); thus, for the sake of parsimony, these paths were excluded from the model. The model had excellent global fit, $\chi^2(41) = 32.68$, $p = 0.820$, CFI = 1.000, RMSEA = 0.000, 90% CI [0.000, 0.036], SRMR = 0.057. A higher number of pandemic hardships were associated with higher levels of parental dysphoria ($B = 1.86$, $SE = 0.70$, $p = 0.008$) and lower levels of parental well-being ($B = -1.85$, $SE = 0.49$, $p < 0.001$), controlling for baseline levels of outcomes. Additionally, there was a trend toward more hardship predicting more hazardous alcohol use ($B = 1.11$, $SE = 0.61$, $p = 0.069$) controlling for previous alcohol use. Of note, the present sample had relatively low rates of hazardous alcohol use (6.67% of fathers and 4.60% of mothers).

Model #2: Family relationship quality

Paths across partners were indistinguishable and equality constraints were retained with one exception: pre-pandemic coparenting quality → pandemic coparenting quality was larger for mothers than fathers for both actor, $X^2(1, N = 146) = 8.59$, $p = 0.003$, and partner, $X^2(1, N = 146) = 4.46$, $p = 0.035$, paths. These pathways were allowed to vary across parents; all other paths were modeled as equal across partners. The interaction between hardships and flourishing was not significantly associated with any outcomes (B ranged from −0.234 to 0.984, ps > 0.05), so these paths were excluded. The model demonstrated excellent fit, $\chi^2(22) = 23.73$, $p = 0.362$, CFI = 0.993, RMSEA = 0.023, 90% CI [0.000, 0.074], SRMR = 0.073. A higher number of pandemic hardships were associated with less parenting sense of competency ($B = -2.60$, $SE = 0.89$, $p = 0.003$) and lower interparental relationship satisfaction ($B = -1.34$, $SE = 0.52$, $p = 0.010$) controlling for pre-pandemic levels of each variable (with the exception of sense of competency). Hardships were not associated with coparenting quality ($B = -0.07$, $SE = 0.04$, $p = 0.104$) controlling for pre-pandemic levels. More positive impacts from the pandemic were associated with greater satisfaction with the interparental relationship ($B = 1.47$, $SE = 0.55$, $p = 0.007$), controlling for baseline satisfaction.

Model #3: Child mental health

This model did not require tests of indistinguishability, and the model was just identified; therefore, there were no global fit statistics to evaluate. The interaction between hardships and flourishing was not significantly associated with any of the outcomes ($B = -0.383$ and 0.235, ps > 0.05), so these paths were excluded from the final model. A higher number of pandemic hardships was associated with higher levels of child internalizing ($B = 1.16$, $SE = 0.29$, $p < 0.001$) and externalizing symptoms ($B = 1.33$, $SE = 0.50$, $p = 0.008$), controlling for pre-pandemic levels. Positive impacts from the pandemic were not significantly associated with child internalizing or externalizing outcomes (ps > 0.05).

DISCUSSION

The primary goals of the present study were to characterize the immediate impacts of the COVID-19 pandemic on families with young children, as they rapidly adapted to new routines and demands, and to identify pre-pandemic factors that explained why some families experienced fewer hardships and more growth. We leveraged an ongoing, long-term longitudinal study of community families who had reported on family functioning prior to the pandemic and collected new data from these families 6 months after pandemic onset. Results of the present study can inform theories of family

stress and family interventions that can be tailored to promote resiliency and prevent maladjustment when families encounter stress and face significant and rapid adjustment. Further, results can inform more efficient mobilization of resources in the face of future global events of a similar nature to the COVID-19 pandemic.

Results of Aim 1 suggest that, despite relatively low rates of COVID-19 illness in our sample during the first 6 months of the pandemic, families endorsed significant hardships, largely in the form of disrupted family routines, challenges at work, and concerns about health and safety of family members. This is consistent with research suggesting that parents have been navigating unprecedented change to caregiving roles and work and education routines, increasing risk for mental health difficulties (Gadermann et al., 2021; Prime et al., 2020; Westrupp et al., 2021). Nonetheless, families also reported aspects of flourishing during the acute phase of the pandemic, such as spending more time together as a family, slowing down and nurturing a grateful perspective, and finding time to spend on healthy and enjoyable activities (e.g., new hobbies). Some families also reported increased attention to personal health during this time, along with improvements in social relationships. This converges with accumulating evidence that some families have benefited during the pandemic (Ayuso et al., 2020; Perlman, 2020; Wong et al., 2021). However, it is notable that our sample was a relatively high functioning community sample of families who likely had greater access to resources that made flourishing possible.

Aim 2 identified pre-pandemic family factors associated with positive and negative impacts of the pandemic. Pre-pandemic levels of parental psychopathology and reported levels of stress emerged as the most robust predictors of the overall number of negative pandemic impacts. This is consistent with models of family stress, such as the *ABC-X Model of Family Stress and Adaptation* (Rosino, 2016), that emphasize the importance of familial resources prior to the onset of negative life events, especially psychological resources, in determining how families will respond to adversity. Further, greater parental well-being and higher quality interparental relationships were associated with greater flourishing. It appears that when parents have greater psychological resources, feel more grateful and engaged in their lives (i.e., high well-being), and have strong and supportive interparental relationships prior to the onset of a major stressor or transition, this creates a context within which families can minimize hardships and even find positive meaning and growth when faced with adversity. This finding aligns with the *broaden-and-build theory of positive emotions*, which posits that those who have historically experienced greater emotional well-being might be more likely to place life events in a broader context, lessening the adverse impact of any particular negative event (Fredrickson, 2001). Supplemental analyses suggest that certain indicators of family structure (i.e., number of children in the home; parent employment) do not explain differences in pandemic impacts.

In Aim 3, we investigated whether pandemic hardships predicted family health and functioning controlling for pre-pandemic levels of outcomes and flourishing (e.g., more time together as a family). Results of *Model #1* demonstrated that greater pandemic hardships predicted increases in parental internalizing symptoms and decreases in parental well-being. This adds to growing literature suggesting that the mental health of parents of young children has suffered during the pandemic (e.g., Feinberg et al., 2022). Although the link between hardships and alcohol abuse did not reach significance ($p = 0.069$), it could strengthen as time passes and families transition to the more chronic stage of the pandemic, developing more reliance on substances to cope with unrelenting uncertainty and family disruptions (Alexander & Ward, 2018). Notably, when interpreting these results, attention should be paid to the nature of pandemic hardships that were reported in this community sample of families largely living in the Midwest during the first 6 months of the pandemic. For example, some hardships were rarely reported (e.g., infection, canceled medical procedures, need to move or relocate). It is also possible that specific events had more of an impact on family health and functioning than others.

Also converging with recent research (Gadermann et al., 2021), *Model #2* demonstrated that more pandemic hardships were associated with decreases in interparental relationship satisfaction, as reported by both parents. In contrast, when controlling for pre-pandemic coparenting (and flourishing),

hardships were not associated with coparenting quality, which was surprising given research suggesting coparenting quality has suffered during the pandemic (Feinberg et al., 2022; Lucassen et al., 2021; Peltz et al., 2021). Finally, greater pandemic hardships were associated with less parenting sense of competency reported by both mothers and fathers; however, in the absence of a baseline control, this result should be interpreted with caution given parents who feel less competent with childrearing might have perceived more family disruption from the pandemic.

Finally, results of *Model #3* suggest that preschoolers of parents who reported more pandemic hardships had increased internalizing and externalizing problems. Because younger children are more dependent on caregivers to help regulate their emotions (Thompson, 2011), they may be more sensitive to family disruptions, including parental stress resulting from the pandemic. Our results add to other longitudinal research focused on older children and adolescents suggesting increases in symptoms (Feinberg et al., 2022; Rosen et al., 2021). Further, results are consistent with the *Family Stress Model* (FSM; Conger et al., 2010; Masarik & Conger, 2017) suggesting that adversity undermines parental functioning (e.g., reporting more hardships in response to stress) which, in turn, poses significant risk to child adaptation.

Although pandemic hardships emerged as a consistent predictor of family dysfunction and mental health problems, *positive impacts* from the pandemic (e.g., more quality time together as a family) were only uniquely associated with higher levels of interparental relationship satisfaction. Perhaps hardships have more immediate detrimental effects on family functioning and health, whereas flourishing sets the family on a healthier long-term trajectory with gains observed much later after the onset of the negative event. Further, positive impacts did not mitigate the effect of pandemic hardships on any of the outcomes suggesting that adversity during the acute phase of the pandemic had unique, independent effects on the family regardless of opportunities for growth. Finally, there was a small positive correlation between hardships and flourishing from the pandemic suggesting that families likely experienced aspects of both, but to different degrees. This is consistent with research suggesting that it is possible for flourishing to occur in combination with dysfunction stemming from stressful events (Keyes, 2007).

Implications and future directions

Before we turn to implications, we summarize limitations. First, the sample consisted of cohabiting couples in mixed-gender relationships who primarily identified as White and were from middle-class backgrounds, thereby limiting the generalizability of the results. Research examining similar processes among more diverse populations (e.g., among sexual, gender, and racial minorities) is needed, especially given these populations have been disproportionately impacted by the pandemic. We also lacked direct measures of marginalization stress and health inequities attributed to race and ethnicity and differences in cultural norms that might play a role in how families adapt to stressors. Further, because our sample was comprised of dual parenting households, it is unclear whether results generalize to single parents. Results were also obtained from a community sample, and additional research is needed to understand how results might differ for parents experiencing clinically significant levels of psychopathology—and with restricted access to resources that promote flourishing—prior to and during the pandemic.

Second, all data were collected using questionnaires completed by parents, and future research should also use observational measures to reduce biases that can arise from self-report measures. Further, parental reports of child psychopathology provide a limited perspective and could be enhanced with teacher reports. (Note that there are no validated self-report measures of child psychopathology at this age.) Nonetheless, we obtained reports from both parents in dual parenting households, which increases the reliability of measures. The potential for each parent within a household to have unique views of the pandemic, and its impacts, was also not addressed in the present study. Future research could investigate the extent to which parents were on the same page about their experience of the

pandemic and whether discrepancies in perspectives (e.g., different opinions about risk mitigation such as masking or social distancing) had an impact on family function. It also was unclear whether events we characterized as flourishing (e.g., increased exercise, new hobbies) were viewed as such by parents.

Third, our study was focused on the acute phase of the pandemic—the first 6 months after onset—to investigate how families adapted to rapid change and uncertainty; however, longer-term investigations of mental health trajectories and family functioning throughout the course of the pandemic are needed to understand how families cope with chronic stressors and strains. Data were also collected prior to access to vaccines and before the emergence of COVID-19 variants which represented meaningful shifts in the course of the pandemic.

Finally, it is important to recognize that "resiliency" and "flourishing" have been operationalized in multiple ways, and this should be considered when interpreting the results of the present study in the context of the larger literature on these topics. In the present study, we defined *resiliency* as adaptation to challenging life events, resulting in more positive and/or less negative outcomes, and *flourishing* as positive change in response to adversity.

Despite these limitations, our results add to a growing body of literature investigating how families adapted to the onset of the COVID-19 pandemic. Several key themes emerged that inform family stress models and point toward steps to help families encountering major life events of an unpredictable nature. First, we found that hardships from the pandemic were associated with significant decrements in mental health and family functioning, controlling for pre-pandemic levels, and this was already apparent within the first 6 months of pandemic onset. These results demonstrate how rapid changes in family routines and elevated levels of stress can have broad and immediate impacts on the health of the family, including increased parental psychopathology, interparental discord, and child internalizing and externalizing problems. Pandemic hardships were also associated with lower levels of parenting sense of competency. Yet, not all families experienced hardships to the same degree. To the extent that families had greater resources prior to pandemic onset—largely in the form of psychological resources of parents—families reported fewer disruptions from the pandemic. In contrast, higher levels of parental psychopathology predicted worse pandemic stress, consistent with *stress generation model* (Hammen, 1991). This highlights the critical importance of preventative interventions that build healthy family foundations and start with support for parent mental health. Further, our results suggested that if parents had a strong coparenting relationship prior to pandemic onset, those families adapted better to the rapid change and stress arising during the acute phase of the pandemic, pointing to a potentially critical intervention target in dual parenting households.

Second, although families faced challenges and adversity, some families also reported aspects of flourishing and growth during the first 6 months of the pandemic; however, this was most apparent for families who had more resources to begin with (e.g., parents with higher emotional well-being and a stronger and more supportive interparental relationship). Further, more positive pandemic impacts experienced by families (e.g., spending more time together as a family, finding time to spend on healthy and enjoyable activities), were associated with increased interparental relationship satisfaction. Family systems theory highlights how the interparental relationship serves as an executive subsystem in the family with top-down influences on other subsystems such as coparenting and parenting relationships (Cox & Paley, 2003). Thus, when couples experience growth in the context of adversity (Brock & Lawrence, 2008), this might serve to strengthen a critical subsystem within the family that could have long-term implications for how families adjust and reorganize after encountering adversity. This provides further support for the importance of building a strong interparental relationship in dual parenting households to prevent dysfunction when families inevitably encounter challenges and adversity.

Finally, results highlight that disparities exist with regard to how families were impacted by the pandemic. Some families—largely those with fewer psychological resources—experienced more adversity (i.e., economic hardship; work, education, and home disruptions) during the acute phase of the pandemic than others. However, it was notable that families in which one parent identified as

a racial or ethnic minority experienced greater economic hardships, which we attribute to societal inequities (McKnight-Eily et al., 2021). Further, families who had fewer economic resources prior to the onset of the pandemic also experienced more economic hardship during the first 6 months of the pandemic. Thus, family-based interventions that promote resources in the form of psychological well-being of parents and strong interparental and coparenting relationships have the potential to build resiliency in families; however, addressing systemic racism, and other inequalities such as economic disadvantage, is of critical importance for supporting the health of families. For example, increased funding should be directed toward programs with home-based intervention options for families who face significant barriers to accessing mental health services (e.g., federal programs such as *Head Start* and *Healthy Start*).

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DATA AVAILABILITY STATEMENT

This study complied with Transparency and Openness Promotion (TOP) Guidelines. The study PI, Rebecca L. Brock (rebecca.brock@unl.edu), should be contacted to request access to research materials, analysis code, and data. Data management and analysis procedures for this project were registered (https://osf.io/hprk8), and we made no deviations from that plan. Because we had prior knowledge of data from this longitudinal study, we did not preregister our hypotheses. Portions of this article were presented at the Association for Behavioral and Cognitive Therapies convention, November 2022.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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