Coparenting Among Families of Treatment-Seeking Adolescents: associations with Coping Behaviors and Psychological Adjustment

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ABSTRACT

COPARENTING AMONG FAMILIES OF TREATMENT-SEEKING ADOLESCENTS: ASSOCIATIONS WITH COPING BEHAVIORS AND PSYCHOLOGICAL ADJUSTMENT

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Northern Illinois University, 2021
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In recent decades, the family literature has demonstrated that the influences of coparenting spread through the entire family system and also uniquely affect child and adolescent psychosocial outcomes. For example, extant evidence shows that coparenting influences the connection between marital conflict and adolescent psychosocial outcomes. However, the period of adolescence is underscored by novel stressors, as teenagers experience biological, psychological, social, and cognitive transformations. Moreover, the median age of onset for mood, anxiety, substance use, and impulse-control disorders is before 25 years of age and most frequently during adolescence. Additionally, the manner in which adolescents cope with stressors may buffer against or exacerbate the deleterious effects of that stressor. Despite this, much of the research on coparenting has utilized non-clinical samples of youth. Therefore, the present study utilized a sample of treatment-seeking adolescents and examined the manner in which their perceptions of their parents’ coparenting practices (i.e., coparenting cooperation, coparenting conflict, and coparenting triangulation) influence the association between marital conflict and their own psychological adjustment. Potential moderating influences of teens’ coping styles (i.e., primary control coping, secondary control coping, and voluntary disengagement) were also explored.
The present study included a sample of 79 adolescents ($M_{\text{age}} = 14.97, SD = 2.20$; 62.0% female; 74.7% White, Non-Hispanic) receiving outpatient mental health services in the Chicago area completed electronic questionnaires. Initial mediation analyses demonstrated that coparenting cooperation and coparenting conflict fully mediated the link between marital conflict and adolescent psychological adjustment. Coparenting triangulation did not significantly mediate this connection. When all three coparenting constructs were considered simultaneously in a parallel mediation model, none of the three coparenting dimensions emerged as significant mediators. Additional analyses examined primary control coping, secondary control coping, and voluntary disengagement coping as moderators of the links between coparenting, marital conflict, and adolescent outcomes within the full parallel mediation model. However, none of the coping constructs significantly moderated the connections within the simultaneous mediation models. Limitations of the current study and implications of how the coparenting relationship may influence adolescents’ psychosocial adjustment are discussed.
DEDICATION

To my parents for teaching me how two individuals can make a perfect team in raising a child
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van Aken, & Deković, 2008; Teubert & Pinquart, 2010a). Despite these findings, few studies have examined the influence of coparenting within clinical samples of offspring, despite well-established patterns of increased family discord, poorer cohesion, and greater marital conflict in clinical samples of youth (e.g., Cumsille & Epstein, 1994; King, Radpour, Naylor, Segal, & Jouriles, 1995; Nomura et al., 2002). Additionally, the vast majority of coparenting research has involved families with infants, toddlers, and preschoolers (McHale, Kuersten-Hogan, & Rao, 2004). As such, the influence of coparenting on older children and adolescents has not been as widely studied. However, it is well known that adolescence is a unique developmental stage as family roles change, children become more independent, and there is greater risk for development of mental health disorders (e.g., Kessler et al., 2005; Steinberg, 2005). Thus, given the importance of coparenting there is clearly a need to study its influence on clinical samples during this significant developmental period.

Additional family processes, such as marital conflict (i.e., verbal, physical, or psychological aggression occurring within the marital relationship; Jouriles, Murphy, & O’Leary, 1989), have also shown an association with psychological maladjustment during childhood and adolescence (e.g., Davies & Cummings, 1994; Cummings, Schermerhorn, Davies, Goeke-Morey, & Cummings, 2006; Rhoades, 2008). There is a wide body of literature demonstrating associations between marital conflict and deleterious youth outcomes; however, extant evidence has indicated that more proximal processes (e.g., youth coping strategies, cognitive appraisals of self-blame, quality of parent-child relationships) may explain this connection (Compas et al., 2017; Grych, Raynor, & Fosco, 2004; Fosco & Grych, 2008; Cummings et al., 2006; Rhoades, 2008). Coparenting may be one of those explanatory mechanisms between marital conflict and youth outcomes (e.g., Dush, Kotila, &
Schoppe-Sullivan, 2011; Feinberg et al., 2007; Flannery, 2017; Fosco & Bray, 2016), but these associations have not been examined within clinical samples of adolescents. Additionally, the manner in which clinical samples of adolescents cope with these combined family processes has not been examined. It is well established that coping strategies influence the association between specific stressors (e.g., family stress, marital conflict) and youth adjustment (e.g., Compas et al., 2017); however, the outcomes related to these strategies vary due to numerous factors such as the type of stressor, type of coping strategy used, or the age of the individual (Compas et al., 2017; Zimmer-Gembeck & Skinner, 2016). Taken altogether, there is reason to believe that adolescent perceptions of their parents’ marital conflict and coparenting practices, as well as their coping responses to these potential stressors, may influence their own psychological adjustment, yet this has not been explicitly examined to date.

Coparenting

Coparenting is often succinctly defined as parental collaboration in childrearing (Teubert & Pinquart, 2010b); however, it is a complex construct. The coparenting relationship involves an interparental relational alliance that influences the prosperity and well-being of the focal child. This differs from other partnerships that two parents might share. For example, interactions within the marital relationship focus on the welfare of the marital partners, rather than on the prosperity of the child (Margolin, Gordis, & John, 2001). Further, the marital relationship is a family subsystem that requires two partners, whereas the coparenting system requires two partners in the context of a child or multiple children.
Of course, overlap between these two constructs may exist, as research has shown feelings toward the marital partner may influence the coparenting relationship, and marital conflict and coparenting-related conflict have been shown to be highly correlated \( r = .53; \) Margolin et al., 2001).

According to family systems theory, families consist of interdependent subsystems with established boundaries (Minuchin, 1985). However, the spillover hypothesis proposes that the defined subsystems often share emotions, thoughts, or behaviors that can “spill over” from one relationship to another (Easterbrooks & Emde, 1988). As such, conflict between marital partners or other family members can spread to other family subsystems, such as the coparenting relationship (Margolin & Christensen, 1996). Despite this spillover hypothesis, extant evidence suggests that the coparenting subsystem is not merely a substrate of the marital system, but the two constructs are autonomous, have distinguishable characteristics, relate to idiosyncratic processes and outcomes, and should therefore be examined as discrete components occurring in the family system (e.g., Lamela & Figueiredo, 2016; Teubert & Pinquart, 2010b; Margolin et al., 2001; Feinberg et al., 2007). For example, several investigations have revealed the coparenting relationship bears a unique influence on child and adolescent adjustment, over and above influences of marital behaviors (e.g., Feinberg, 2007; McHale & Rasmussen, 1998; Schoppe-Sullivan, Mangelsdorf, Frosch, & McHale, 2004). Moreover, at a conceptual level, couples struggling in their marital relationships may attempt to safeguard their children from subjection to interparental disagreements, and as a result demonstrate collaborative coparenting despite their negative feelings toward one another. Therefore, a positive or cooperative coparenting relationship can exist in the absence of a caring marital relationship (Margolin et al., 2001).
Research has also suggested that coparenting may serve as a more proximal mechanism influencing the effects of the marital relationship on child outcomes (e.g., Morrill, Hines, Mahmood, & Córdova, 2010; Feinberg, Kan, & Hetherington, 2007; Katz & Low, 2004). For example, a recent study demonstrated that coparenting behaviors during the preschool years mediated the longitudinal relationship between marital support and child externalizing problems from child age 3 to 9 (Parkes, Green, & Mitchell, 2019). It has also been proposed that the coparenting relationship is one of the most directly and closely related ways that the parental relationship influences child outcomes (Zemp, Johnson, & Bodenmann, 2018; Margolin et al., 2001). In sum, coparenting has been defined as the manner in which parental figures collaboratively manage their roles, responsibilities, and contributions in order to enhance the wellbeing and rearing of their child, and this construct has demonstrated pervasive associations throughout the family system (Margolin et al., 2001; McHale et al., 2004; Feinberg et al., 2007).

While some research has examined coparenting as a broad construct, it is also frequently conceptualized as being multidimensional and composed of several processes, both with direct (e.g., engaging in coparental conflict in front of the child) and indirect influences (e.g., influencing or modifying the other coparent’s behavior, thus influencing the child) on child outcomes (Lamela, Figueiredo, Bastos, & Feinberg, 2015). The most frequently cited characteristics of the coparenting relationship include cooperation or support, conflict, and triangulation (e.g., Margolin et al., 2001; Teubert & Pinquart, 2010b). Coparenting cooperation involves shared decision-making, support, and mutual communication between coparents regarding decisions and behaviors specific to the parenting roles (Margolin et al., 2001). Cooperative coparents prioritize the prosperity of their children while also maintaining
a constructive parental alliance (Lamela & Figueiredo, 2016). In turn, coparenting cooperation often eases the burden of parenting through sharing responsibilities and the provision of physical and emotional availability to both the partner and child (Margolin et al., 2001). Coparenting cooperation is largely associated with positive child adjustment; however, the other coparenting dimensions have shown associations with deleterious child outcomes (Margolin et al., 2001; Teubert & Pinquart, 2010a).

One such dimension that has been connected to ineffective parenting and poor child outcomes is coparenting conflict. This dimension of coparenting includes dissension, disagreement, and arguments between the coparents about parental decisions and child-rearing matters (Feinberg et al., 2007). Similar to this construct, some researchers have examined undermining coparenting, which includes both overt and covert actions classified by a lack of respect for the partner’s parenting decisions or by acts of criticism or belittlement (e.g., one parent briefly interrupting the other parent when interacting with the child; van Egeren & Hawkins, 2004). Coparenting conflict and undermining are often considered homogenous constructs due to links to similar outcomes (Teubert & Pinquart, 2010a) and results from factor analyses (Margolin et al., 2001; Teubert & Pinquart, 2011). Thus, undermining is frequently operationalized by being included within the dimension of coparenting conflict (e.g., Teubert & Pinquart, 2010a, 2011a). While negative correlations between coparenting cooperation and conflict have been found in the literature (e.g., $r = -0.63$, Altenburger et al., 2015; $r = -0.61$, Flannery, 2017), these constructs are conceptualized as different dimensions because they play different roles in children’s adjustment and outcomes, and parents can display conflict and cooperation behaviors simultaneously (e.g., parents can argue about child-rearing issues while also sharing responsibility in caretaking roles;
Altenburger et al., 2015; Margolin et al., 2001; Schoppe-Sullivan et al., 2009). Nonetheless, coparenting conflict is frequently connected to poor child adjustment (Teubert & Pinquart, 2010b).

The third and final coparenting dimension, coparenting triangulation, is also associated with a poor coparenting relationship and negative child outcomes. Coparenting triangulation is often described as occurrences in which a child becomes involved in parental arguments (Teubert & Pinquart, 2010b). Triangulation can occur when a child actively attempts to resolve or ease friction between two coparents, or when the child is drawn into the middle of parenting-related conflict by one or both of the parents. In other situations, triangulation manifests itself through an alliance between a parent and child, in which the parent and child unite against the other parent in current or future disagreements (Teubert & Pinquart, 2010b, 2011a). Further examples of triangulation have included the child becoming a scapegoat for parental conflict (Fosco & Bray, 2016). Triangulation can also cause the child or adolescent to experience stress due to feeling caught in the middle of parental conflict (Margolin et al., 2001). Additionally, triangulation has been shown to occur with greater frequency during late childhood and adolescence than it does during early childhood (Buehler & Welsh, 2009; Fosco & Grych, 2010; Margolin et al., 2001).

Although it is a broad and multifaceted construct, research has demonstrated that coparenting can be concisely delineated using three dimensions: coparenting cooperation, coparenting conflict, and triangulation (Margolin et al., 2001; Teubert & Pinquart, 2011). As the coparenting literature has grown, the effects of coparenting have become well documented. The subsequent sections highlight many of the influences of each coparenting dimension on child development.
Extant evidence has demonstrated that the impact of coparenting on children begins as early as infancy and toddlerhood. For example, cooperative coparenting has demonstrated a positive direct association with prosocial behavior (e.g., turn taking, sharing behaviors) of preschool children (Scrimgeour, Blandon, Stifter, & Buss, 2013). Also, findings from a recent longitudinal assessment revealed coparenting cooperation occurring in families of 3-year-old children was negatively associated with child externalizing symptoms measured one year later (Schoppe, Mangelsdorf, & Frosch, 2001). Altenburger et al. (2015) examined the longitudinal influence of coparenting cooperation on toddlers with difficult temperament and at a high risk for dysregulation (i.e., greater sleep difficulties, eating issues, and sensory sensitivity) followed from ages 9 to 27 months. Among those with high levels of negative affectivity, greater cooperative coparenting was associated with children being more well-regulated. Moreover, those toddlers whose parents demonstrated very low levels of cooperative coparenting had the highest levels of dysregulation over time (Altenburger et al., 2015). The effects of coparenting cooperation throughout childhood were also clearly demonstrated in a recent study by Choi, Parra, and Jiang (2019). Using data from the Fragile Families and Child Wellbeing study, they examined trends in coparenting and behavior problems in children at ages 1, 3, 5, and 9 years. Their findings revealed that all cooperative coparenting and child behavior pathways from one time point to the subsequent time point (i.e., years 1 to 3, 3 to 5, and 5 to 9) were significant, indicating that coparenting cooperation is likely to result in fewer child behavior problems over time (Choi et al., 2019).

Coparenting cooperation has also been shown to influence other family processes and
their impacts. For example, a recent longitudinal study demonstrated that coparenting cooperation promotes fathers’ involvement in play with their preschool-aged children (Jia, Kotila, & Schoppe-Sullivan, 2012). In this study, cooperative coparenting also served a moderating influence on the connection between father involvement in play and socioemotional adjustment of the preschool-age children. Specifically, father involvement in play that was accompanied by cooperative forms of coparenting predicted lower levels of child internalizing and externalizing behaviors and higher rates of prosocial behaviors at school. Interestingly, the interaction between father involvement in play and child internalizing and externalizing behaviors was nonsignificant when combined with lower levels of coparenting cooperation. Data from observational evaluations of triadic family play sessions (i.e., mother, father, and toddler) have also demonstrated that coparenting styles highlighted by mutual communication, encouragement, and joint decision-making are associated with greater symbolic and less aggressive play in toddlers (Keren, Feldman, Namdari-Weinbaum, Spitzer, & Tyano, 2005). Additionally, results from an observational study have demonstrated that cooperative coparenting moderates the association between preschool children’s effortful control and maternal and teacher reports of externalizing behavior problems over time (Schoppe-Sullivan, Weldon, Cook, Davis, & Buckley, 2009). Specifically, coparenting cooperation served as a buffer for children, as the typically established link between low effortful control and increased externalizing behavior problems was not present when coparenting cooperation was observed. In sum, research has demonstrated that cooperative coparenting bears a consequential impact on children and toddlers, as coparenting cooperation has consistently revealed an association with many outcomes concerning child adjustment, both directly and in combination with other family
processes.

Although there is a well-established link between coparenting cooperation and childhood outcomes, fewer have examined the effects of coparenting cooperation among families with adolescents. However, a recent longitudinal study indicated a bidirectional connection between coparenting cooperation and adolescent internalizing and externalizing behaviors (Riina & McHale, 2014). Specifically, increased depressive symptoms and risky behaviors (e.g., alcohol and drug use, vandalism, theft) occurring at age 13 predicted less cooperative coparenting by the parents three years later. Conversely, higher rates of coparenting cooperation at age 13 predicted fewer adolescent risky behaviors 3 and 4 years later, but did not show a significant longitudinal association with adolescent depressive symptoms. Nonetheless, results from other studies have been inconsistent. For example, Baril and colleagues (2007) did not find support for the longitudinal connection between coparenting cooperation and later adolescent risky behavior (e.g., substance abuse, delinquent acts). McConnell and Kerig (2001) were also unable to find a significant association between cooperative coparenting and internalizing and externalizing behaviors in school-age children. Thus, whether coparenting cooperation is linked with adolescent outcomes is still unclear.

A recent meta-analysis investigated the associations between the dimensions of coparenting and internalizing and externalizing behavioral adjustment of youth from infancy to adolescence (Teubert & Pinquart, 2010a). The meta-analysis was comprised of 59 studies of coparenting (40 cross-sectional studies and 19 longitudinal) that included youth outcome data (children’s ages ranged from 0.7 to 16.3 years). When specifically considering the influence of cooperative forms of coparenting on youth internalizing symptoms, results from the meta-analysis revealed a weighted mean effect size of \( r = -.13 \) (\( p < .0001 \)). Similarly, the
weighted mean effect size for the link between coparenting cooperation and youth externalizing problems was -.13 \( (p < .0001) \). Several sample and method characteristics (i.e., age, child sex, annual family income, percentage of separated families, mono-informant bias, clinical background, and longitudinal versus cross-sectional design) were considered as potential moderators between coparenting cooperative and internalizing and externalizing symptoms, but none were supported (Teubert & Pinquart, 2010a). However, a contemporary study examining longitudinal changes in coparenting over the course of adolescence revealed interesting findings related to coparenting and offspring age (Riina & Feinberg, 2018). Specifically, utilizing five waves of data from families with adolescents, the researchers examined changes in coparenting cooperation and conflict over a six-year period (i.e., child age 11 to 17 years). Their findings revealed that parents report less coparenting cooperation over the course of adolescence, but not necessarily higher levels of coparenting conflict (Riina & Feinberg, 2018). As such, examining the influences of coparenting cooperation on adolescent functioning is important, given evidence that the coparenting dynamic changes during adolescence. The existing research has indicated that coparenting cooperation may foster positive youth development defined by lower rates of internalizing and externalizing behaviors (Teubert & Pinquart, 2010a); however, the research on the influences of coparenting cooperation on adolescent development remains limited.

Coparenting Conflict

Among the extant literature, it has been hypothesized that coparenting conflict may bear more consequential influences on youth adjustment than do other dimensions of
coparenting because it is overt (Baril et al., 2007; Katz & Low, 2004). In contrast to the negative associations between coparenting cooperation and child externalizing problems, greater levels of coparenting conflict (i.e., undermining, competition, and coparental arguing) have been linked with more externalizing behavior problems in preschoolers (Schoppe et al., 2001). Research examining coparenting conflict has existed for decades, as Jouriles and colleagues (1991) published one of the earliest studies to examine coparenting conflict and child behavioral outcomes. Results from their study demonstrated a positive association between coparenting conflict and preschoolers’ internalizing and externalizing problems, even when controlling for general marital disagreements. The influences of coparenting conflict may be chronic, as conflict in the coparenting relationship has also been shown to be strongly positively associated with internalizing and externalizing behavior problems in school-aged children (McConnell & Kerig, 2001). For example, higher rates of coparenting conflict have demonstrated concurrent and longitudinal associations with increased internalizing and externalizing symptoms in school-aged children over a 15-month period (Jones, Shaffer, Forehand, Brody, & Armistead, 2003). Additionally, a recent longitudinal investigation found bidirectional associations between coparenting conflict and child outcomes, as higher levels of externalizing problems (at child ages 7 – 16 years) led to increased coparenting conflict over a 4-year period, whereas lower levels of coparenting conflict led to a reduction in youth externalizing difficulties over time (Choi et al., 2019; Zemp et al., 2018). A recent study also revealed that coparenting conflict might serve as a longitudinal mechanism contributing to the intergenerational transmission of anxiety from parent to offspring (Metz, Majdandzic, & Bögels, 2018). Specifically, their findings demonstrated parents with higher levels of anxiety showed greater levels of coparenting conflict, which in turn, was related to more fearfulness
Consistent with the literature concerning coparenting cooperation, there has been greater focus on the effects of coparenting conflict on infants and younger children. Nonetheless, extant research suggests that the influence of coparenting conflict also persists into the adolescent period (Feinberg et al., 2007). For example, parental self-reports of coparenting conflict predicted increases in adolescent self-reports of risky behavior (e.g., substance abuse, delinquent acts) over a two-year longitudinal period. Additionally, these self-reported levels of coparenting conflict mediated the link between marital quality and adolescent reports of risky behavior over a two-year period (Baril, Crouter, & McHale, 2007). There is also evidence that greater coparenting conflict predicts increased adolescent antisocial behavior over the course of a three-year period (Feinberg et al., 2007). Additionally, a study of single African American mothers with coparenting maternal grandmothers found that low levels of coparenting conflict buffer young adolescent girls from the negative effects of neighborhood violence (Forehand & Jones, 2003). Findings from an investigation of coparenting conflict trajectories from childhood through adolescence (ages 8 to 16 years) revealed levels of coparenting conflict might fluctuate throughout adolescence (Helland et al., 2017). Specifically, nearly half of the sample experienced increases in coparenting conflict for at least one time point throughout the study, and significant changes in coparenting conflict occurred more frequently than stable levels across the adolescent years (Helland et al., 2017). Furthermore, higher rates of adolescent externalizing problems were associated with higher rates of coparenting conflict at concurrent time points. Thus, given the fluctuations in levels of coparenting conflict and associated externalizing problems during adolescence, there is a greater need to understand the influences of coparenting during this developmental period. In
the meta-analysis conducted by Teubert and Pinquart (2010a), discussed above, medium effect sizes between coparenting conflict and internalizing symptoms \((r = .19, p < .0001)\) and externalizing symptoms \((r = .23, p < .0001)\) were revealed. Additionally, consistent with coparenting cooperation, offspring age did not significantly moderate the association between coparenting conflict and child outcomes (Teubert & Pinquart, 2010a). Overall, despite this and the scores of evidence illustrating that coparenting conflict holds a strong influence on younger children, these associations have not been as thoroughly examined in samples of adolescents.

Triangulation

Within the domain of coparenting, triangulation is theoretically conceptualized as situations in which the child is drawn into interparental conflicts about parenting (Margolin et al., 2001; Teubert & Pinquart, 2010b, 2011a; referred to as coparenting triangulation in this document). However, triangulation within the broader realm of interparental conflict is more widely studied and consists of situations in which the child becomes involved in more global conflict between parents, but also includes conflict about parenting (Fosco & Grych, 2010; referred to as interparental triangulation in this document). As a result of this overlap, much of the coparenting literature has actually measured and reported on interparental triangulation, rather than the more narrowly defined construct of coparenting triangulation. For example, many of the studies examined in Teubert & Pinquart’s 2010 coparenting meta-analysis investigated interparental triangulation (e.g., Buehler & Welsh, 2009), yet the authors included the results in their coparenting findings. Additionally, many studies have claimed to
examine coparenting triangulation, yet they have used measures that actually examine interparental triangulation (e.g., the triangulation subscale of the Children’s Perception of Interparental Conflict questionnaire; CPIC; Grych et al., 1992, e.g., Fosco & Grych, 2008). This is problematic, as this subscale assesses a broader range of triangulation behaviors, rather than behaviors specifically related to parenting (e.g., sample items include “When my parents argue I end up getting involved somehow,” rather than, “When my parents argue about how to raise me, I end up getting involved”).

Despite the paucity of studies explicitly examining coparenting triangulation, it has been revealed that adolescents are more likely to involve themselves in an interparental argument if they perceive the argument is about them (i.e., coparenting triangulation; Fosco & Grych, 2010). Nonetheless, it is unknown whether there are distinctions in the outcomes between the two forms of triangulation; therefore both forms of triangulation will be reviewed here. Evidence exists that demonstrates both forms of triangulation carry a strong negative influence on child and adolescent outcomes. For example, a longitudinal study found that observations of appropriately defined coparenting triangulation occurring when children were 2 years old was uniquely associated with later externalizing problems at 7 years old, even when controlling for general family conflict, low coparenting cooperation, and child negative affectivity (Murphy, Jacobvitz, & Hazen, 2016). These findings are notable, as they provide evidence indicating that coparenting triangulation is particularly detrimental to a child’s socioemotional development, regardless of the level of contention or poor family climate.

Studies examining the associations between behavioral outcomes and interparental triangulation have yielded inconsistent results, as some studies have found significant associations with externalizing problems, but not internalizing problems, and vice-versa
For example, in an assessment of young adolescents, Fosco and Grych (2008) demonstrated a unique association between interparental triangulation and youth externalizing problems, but not internalizing problems. Conversely, Franck and Buehler (2007) documented a link between interparental triangulation and internalizing problems, but not externalizing problems, in a sample of young adolescents. In a longitudinal sample of adolescents (ages 11 – 15), Buehler and Welsh (2009) also found a link between interparental triangulation and youth internalizing symptoms, but failed to demonstrate an association with externalizing problems. Despite these mixed findings regarding internalizing and externalizing outcomes, it is well established that interparental triangulation is a general risk factor for poorer socioemotional adjustment (e.g., lower self-esteem, increased aggression and risk-taking behaviors; Fosco, Xia, Lynn, & Grych, 2015). Furthermore, in their meta-analysis of the connections between coparenting and youth internalizing and externalizing problems, Teubert and Pinquart (2010a) found small to medium effect sizes between triangulation and both internalizing ($r = .21, p < .0001$) and externalizing problems ($r = .13, p < .001$), and these effect sizes were not moderated by age of the sample. As such, the results presented in previous studies indicate that interparental triangulation serves as a risk factor for numerous deleterious outcomes during childhood and adolescence, including internalizing and externalizing problems. However, there has been ambiguity in the operationalization of coparenting triangulation throughout the literature, with the majority of studies examining interparental triangulation despite labeling the construct coparenting triangulation. As such, conclusions regarding the influences of coparenting triangulation during adolescence cannot be reliably drawn.
Within the existing family literature, marital conflict has shown to be a widely studied construct that is also closely associated with child outcomes, including adjustment problems such as internalizing and externalizing disorders (e.g., Davies & Cummings, 1994). Marital conflict is often defined as verbal, physical, and/or psychological aggression occurring within the marital relationship (Jouriles et al., 1989). The effects of marital conflict are numerous, as it has been associated with depression, withdrawal, poor social competence, health problems, poor academic performance, conduct disorders, and antisocial behaviors in children (e.g., Katz & Gottman, 1996; Kelly, 2000). The nature of disagreements within the marital relationship varies widely, as all marriages include some degree of conflict and resolution. Marital conflict can be overt or covert and its characterization is vast, as it can range from relationship dissatisfaction, general marital disagreements, and inequity over division of labor to problems of marital violence, drug use, or extramarital sex (Fincham, 2003; Grych & Fincham, 1990). Conflict in the marital relationship is also associated with numerous family outcomes, including poor parenting, greater incidence of parent-child conflict, increased conflict between siblings, and child maladjustment (Fincham, 2003). Marital conflict that is child-centered, frequent and intense, hostile or aggressive, or poorly resolved has shown to be most strongly associated with negative child outcomes (Grych & Fincham, 1990; Katz & Gottman, 1996). For example, there is evidence that when couples poorly resolve their marital conflict or demonstrate hostility toward one another, their children show higher levels of externalizing problems over a three-year period (child ages 5–8 years; Katz & Gottman, 1996). Additionally, research has shown that the probability of having a child with
socioemotional or behavioral difficulties as a result of marital conflict is greater than the probability of experiencing marital conflict due to the presence of a poorly adjusted child (Grych & Fincham, 1990; O’Leary & Emery, 1984). Literature examining conflict between parents pre- and post-divorce has shown similar findings. For example, in examining longitudinal studies that include parents who divorce, evidence suggests that both marital conflict and a preponderance of the behavioral and academic problems of children with divorced parents were observed 4 to 12 years before the parental separation (Kelly, 2000). Additionally, marital conflict has been shown to predict a greater proportion of variance in child adjustment than have either marital dissolution or post-divorce conflict (Fusar Poli, Molgora, Marzotto, Facchin, & Cyr, 2017; Kelly, 2000). Thus, it is important to examine the influences of marital conflict within intact families, as well as more proximal family processes associated with marital conflict.

In studying the effects of marital conflict within intact families on child and adolescent behavior problems, various mediating and moderating processes have been suggested (Fauber, Forehand, Thomas, & Wierson, 1990; Forehand, Wierson, McCombs, Brody, & Fauber, 1989; Grych & Fincham, 1990). For example, the intensity, resolution, and child-centeredness of marital conflict shape the child’s understanding of the conflict and mediate the influence of the conflict on child internalizing and externalizing problems (Grych & Fincham, 1990). Marital conflict has also shown to have an indirect effect on children’s emotion regulation, with evidence of mediating factors such as poorer parent-child relationships, family climate, and parenting behaviors (e.g., warm, emotionally sensitive parenting; Fosco & Grych, 2012). Relevant to the present study, there is also growing evidence suggesting the coparenting relationship (including the individual dimensions of
coparenting) may mediate the associations between marital conflict and child psychological adjustment (Feinberg et al., 2007; Flannery, 2017; Grych & Fincham, 1990; Katz & Low, 2004; Lamela et al., 2015; Margolin et al., 2001; Schoppe-Sullivan et al., 2004).

Marital Conflict and Coparenting Conflict.

Coparenting conflict may mediate the supported associations between marital conflict and child outcomes. Although the constructs of coparenting conflict and marital conflict are theoretically distinct, there is reason to believe marital and coparenting conflict could be strongly associated. For example, difficulties within the coparenting relationship could influence attitudes and interactions in the marital relationship, and vice-versa (Margolin et al., 2001). However, extant research has demonstrated that the marital and coparenting relationships have unshared variance in the prediction of child outcomes when considered simultaneously (Margolin et al., 2001; Schoppe-Sullivan et al., 2004). For example, a 2007 study examined the longitudinal influences of coparenting conflict and marital conflict on adolescent antisocial behavior and symptoms of depression. Results revealed that (a) coparenting conflict was a primary source of conflict between marital partners for over 80% of the parent dyads in the study, and (b) coparenting conflict accounted for more variance in adolescent maladjustment (i.e., antisocial behavior and symptoms of depression) than did the combined influence of marital disagreement and marital quality, suggesting an important distinction between the processes and outcomes of coparenting conflict and marital conflict (Feinberg et al., 2007).

Coparenting conflict seems to serve as a mediator between marital conflict and child
outcomes. For example, there is evidence that coparenting conflict mediates the relationship between marital violence and children’s symptoms of anxiety and depression (Katz & Low, 2004). Previous research has also demonstrated a link between parent reports of marital conflict and adolescent self-reports of delinquency and symptoms of depression, with parent-reported coparenting conflict mediating this longitudinal association (Cui et al., 2007; Zemp et al., 2018). Thus, although there are conceptual similarities, extant research has demonstrated that marital conflict and coparenting conflict can be meaningfully differentiated and coparenting conflict may help explain the influence of marital conflict on child outcomes.

Marital Conflict and Triangulation

Existing evidence has demonstrated that interparental triangulation may also mediate the association between marital conflict and adolescent internalizing and externalizing problems. For example, Grych, Raynor, and Fosco (2004) found that high school-aged adolescents experiencing more frequent, intense, and poorly resolved interparental conflict were more likely to be pulled into parental disagreements. Moreover, the findings demonstrated that adolescent appraisals of interparental triangulation mediated the association between marital conflict and adolescent internalizing and externalizing problems. Fosco and Grych (2010) examined the longitudinal relationship between adolescent reports of marital conflict, interparental triangulation, and the parent-child relationship. Results from their analysis revealed more problematic forms of marital conflict (i.e., conflict characterized as persistent, hostile, or unresolved) predicted increased interparental triangulation 6 months later. Moreover, the adolescents reported greater involvement in their parents’ arguments
when they perceived the topic of the conflict was child-centered. Additionally, adolescents in their sample reported experiencing greater levels of self-blame following triangulation (Fosco & Grych, 2010), which has been linked with poorer adjustment over time (Kerig, 2005). A recent study examined the combined influences of adolescent appraisals of interparental triangulation and marital conflict on their own internalizing and externalizing behaviors (Fosco & Bray, 2016). Results demonstrated that adolescents reporting elevated interparental triangulation and marital conflict also reported higher rates of internalizing and externalizing problems. On the other hand, adolescents appraising lower levels of interparental triangulation and marital conflict reported better adjustment (i.e., lower internalizing/externalizing problems; Fosco & Bray, 2016). Although existing research has consistently shown negative outcomes associated with marital conflict and interparental triangulation for adolescents, this relationship has rarely been considered with coparenting triangulation.

However, in one recent study, coparenting triangulation was found to fully mediate the links between marital conflict and both adolescent internalizing and externalizing problems, but it did not significantly moderate the associations between marital conflict and adolescent internalizing and externalizing problems (Flannery, 2017). Thus, extant evidence has demonstrated that triangulation influences the relationship between marital conflict and adolescent adjustment; yet coparenting triangulation has not been as widely examined, and it remains to be seen whether or not this relationship remains significant when examined from clinical samples of adolescents.
Consistent with the research examining coparenting conflict and triangulation, there is also evidence that coparenting cooperation mediates the association between marital conflict and youth outcomes. For example, a recent study (Flannery, 2017) of young adolescents within intact families revealed coparenting cooperation mediated the links between marital conflict and youth internalizing and externalizing problems. In their meta-analysis, Teubert and Pinquart (2010a) found a significant association between positive coparenting (i.e., coparenting that is defined by high levels of cooperation and low levels of triangulation and conflict) and offspring internalizing (weighted mean effect size, $r = -.12, p < .001$) and externalizing (weighted mean effect size, $r = -.16, p < .001$) symptoms, even when controlling for marital conflict.

Although there is limited research examining the association between coparenting cooperation and marital conflict among intact families, there has been some literature examining this connection within samples of divorced families. Research investigating children’s adjustment following divorce has shown that frequent and intense interparental conflict predicts more problematic internalizing and externalizing behaviors (Amato, 2010; Kelly, 2000; Vareschi & Bursik, 2005). Conversely, the degree to which parents can resolve conflict and engage in coparenting cooperation may be more predictive of positive child outcomes (Polak & Saini, 2019; Vareschi & Bursik, 2005). For example, increases in coparenting cooperation following intervention programs among families who have experienced divorce have been associated with fewer youth internalizing and externalizing problems (Adamsons & Pasley, 2013; Fackrell, Hawkins, & Kay, 2011). Unsurprisingly,
parents often have difficulty establishing a cooperative coparenting relationship following marital dissolution (Dush et al., 2011; Kelly & Emery, 2003). Nonetheless, extant evidence indicates coparenting cooperation after relationship dissolution, even in the context of high interparental conflict, is associated with greater father involvement with the offspring (Waller, 2012), which buffers against the typical deleterious effects (i.e., internalizing and externalizing problems) associated with relationship dissolution (Dush et al., 2011; Kelly & Emery, 2003). Extant research has also revealed that higher levels of coparenting cooperation post-divorce are associated with greater youth social skills compared to children whose parents demonstrate low levels of post-divorce coparenting cooperation (Whiteside & Becker, 2000). Moreover, interventions emphasizing increased post-divorce coparenting cooperation have shown an association with positive youth outcomes, including greater prosocial behaviors, less aggression, and less post-divorce withdrawal (Whiteside & Becker, 2000). In sum, coparenting cooperation has been shown to have a protective influence for children against the negative effects of divorce and conflict between parents.

Despite the evidence that coparenting cooperation can buffer against the deleterious influences of interparental conflict, this relationship has been largely examined in divorced couples. Yet, research has shown that marital conflict, rather than marital dissolution or post-divorce conflict, is more predictive of child behavioral problems (Kelly, 2000). Nonetheless, there currently exists a gap in the literature regarding the influences of coparenting cooperation on the connections between marital conflict and adolescent outcomes among intact families. Furthermore, understanding the relationship between coparenting, marital conflict, and offspring outcomes in families with clinically referred high school-aged adolescents is needed, in addition to understanding how adolescents respond to or cope with
their parents’ conflict.

Coping

The manner in which an individual responds and adapts to stress and adversity is often conceptualized as coping. The literature on coping is extensive, as it is believed the manner in which people regulate their emotions and behavior, think constructively, and control autonomic physiological processes provides a critical influence on development. Coping is comprised of innumerable interactions with stressors, including—but not limited to—problem solving, rumination, avoidance, confrontation, support seeking, and distraction (Compas et al., 2001; Zimmer-Gembeck & Skinner, 2016). However, operationalizing coping behaviors is complex, as it is a multidimensional construct with various levels of classification (Compas et al., 2001).

Much of the extant theories on coping have relied on dichotomous models of the construct (see Zimmer-Gembeck & Skinner, 2016 for review). For example, one of the commonly cited typologies of coping includes problem-focused and emotion-focused coping (e.g., Appleton et al., 2013; Losoya, Eisenberg, & Fabes, 1998). Problem-focused coping is frequently distinguished as “taking action,” as this process includes strategies used to directly influence or confront a stressor (e.g., problem solving). Conversely, emotion-focused coping includes responses aimed at mitigating emotional responses to stress (e.g., distraction, withdrawal; Kerig, 2001; Zimmer-Gembeck & Skinner, 2016). A second model of coping includes engagement (sometimes called active or approach) coping and disengagement (sometimes called avoidance) coping (Zimmer-Gembeck & Skinner, 2016). Engagement
coping shares similarities to problem-focused coping, as it is characterized by active responses to a stressor (e.g., problem solving, cognitive reappraisal or challenging, support seeking). On the other hand, disengagement coping includes responses aimed at avoiding a specific stressor (e.g., withdrawal, escape, minimization, distraction, denial; Kerig, 2001; Zimmer-Gembeck & Skinner, 2016). In general, studies with children and adolescents have demonstrated that engagement coping is most frequently associated with fewer internalizing and externalizing problems and greater social and academic competence (Compas et al., 2017; Zimmer-Gembeck & Skinner, 2016). Conversely, disengagement coping and emotion-focused coping (when characterized by expressions of denial or negative affect) are consistently associated with elevated internalizing and externalizing problems (Compas et al., 2017; Zimmer-Gembeck & Skinner, 2016; Santiago & Wadsworth, 2009; Compas et al., 2001; Kerig, 2001).

However, extant evidence has indicated weaknesses for both of the aforementioned models, as certain coping responses may be congruous with both categories of the dichotomy, and coping behaviors within a specific dichotomized group may be vaguely connected and result in a variety of outcomes (Compas et al., 2001; Connor-Smith et al., 2000). For example, deep breathing or pausing to count to 10 may promote a feeling of relaxation (i.e., disengagement/emotion-focused coping), but it may also provide an opportunity to reframe or problem-solve (i.e., engagement/problem-focused coping). Additionally, specific behaviors such as emotional suppression or relaxation are forms of disengagement coping, but they are loosely associated and may result in different outcomes (Compas et al., 2001). As such, reviews by Compas et al. (2001) and Connor-Smith et al. (2000) suggest a multidimensional, rather than dichotomous, model of coping. Their proposed model includes broad levels of
voluntary (i.e., coping that includes conscious awareness and application) and involuntary (i.e., automatic responses) coping. Voluntary forms of coping include active and conscious efforts to regulate one’s cognitive, behavioral, emotional, or physiological responses to a stressor, or toward the stressor itself (e.g., processes such as reframing, challenging, accepting, distracting, avoiding, etc.; Connor-Smith et al., 2000). Conversely, involuntary coping includes automatic, temperamentally based, and/or conditioned reactions to a stressor that may not necessarily occur within conscious awareness (e.g., physiological arousal, intrusive thoughts, dissociation; Connor-Smith et al., 2000).

The proposed model suggested by Compas et al. (2001) and Connor-Smith et al. (2000) divides voluntary and involuntary forms of coping into further subgroups of disengagement and engagement coping. Voluntary disengagement coping includes responses directed away from a stressor or stress-response (e.g., avoidance, denial, distraction; Compas et al., 2001; Connor-Smith, 2000). Voluntary engagement responses include responses directed toward a stressor or toward one’s reactions to a stressor (e.g., goal-oriented actions with the aim of changing or adapting to a stressor; Compas et al., 2001; Connor-Smith et al., 2000). Voluntary engagement (sometimes referred to as voluntary approach) coping is divided into primary control coping and secondary control coping. Primary control coping is conceptualized as active, problem-focused strategies aimed at directly confronting or changing a stressor. Secondary control coping refers to strategies aimed at adapting to a stressor, rather than trying to directly change it (e.g., cognitive reappraisal, acceptance).

Taken altogether, this multidimensional model of coping consists of involuntary coping (i.e., automatic responses), primary control coping (i.e., modifying a stressor), secondary control coping (i.e., adapting to a stressor), and disengagement coping (i.e., avoiding a stressor;

However, the present study only examined voluntary forms of coping rather than involuntary coping, as the automatic processes within this category do not always occur within conscious awareness, can be confounded with internalizing and externalizing behaviors (e.g., automatic anger responses can be highly correlated with externalizing symptoms; Compas et al., 2017), and can be difficult to self-report (Compas et al., 2014; 2017). Additionally, confirmatory factor analyses (CFAs) of the three-factor structure of voluntary forms of coping (i.e., primary control coping, secondary control coping, and disengagement coping) have revealed good fit in diverse samples of adolescents (e.g., Benson et al., 2011; Compas et al., 2017; Xiao et al., 2010). Recent literature has also listed the dichotomous models of coping as limitations of previous research, and has therefore called for improved conceptualization of coping by using the three-factor model when examining responses to stress and psychological adjustment (e.g., Compas et al., 2017).

A recent meta-analysis (Compas et al., 2017) examined the relationship between the three-factor model of coping and internalizing and externalizing symptoms in childhood and adolescence, while controlling for potential moderating influences of age. Results indicated both primary and secondary control coping were significantly negatively associated with both internalizing and externalizing symptoms (weighted effect sizes ranged from $r = -.14$ to -.30). Conversely, disengagement coping was significantly positively associated with internalizing and externalizing symptoms (weighted effect sizes $r = .18$ and .13, respectively). Analyses of age as a moderator did not yield a significant effect size for associations between these factors of coping and internalizing and externalizing outcomes. Thus, the results of the meta-analysis illustrated that youth engagement in primary and secondary control coping show lower levels
of internalizing and externalizing problems, whereas disengagement coping is associated with higher rates of internalizing and externalizing problems (Compas et al., 2017). Although the findings indicate generally negative outcomes for disengagement coping and positive outcomes for primary and secondary control coping, the authors urged caution with this broad interpretation, as several studies found that the type of stressor might actually interact with the type of coping and adjustment outcomes (Compas et al., 2017).

Coping has been investigated in response to a wide range of stressors for youth, including personal/parental illness, pain, parent/family conflict, parental divorce, family economic strain, social stress, sexual abuse, natural disasters, academic stress, and more. However, the effects of coping vary by the stressor and coping form (e.g., primary control coping; Compas et al., 2001; 2017). For example, primary control coping has been associated with better adjustment (i.e., lower rates of internalizing and externalizing problems, greater social competence) when dealing with stressors within the adolescent’s control (e.g., academic stress, peer stress), whereas secondary control coping has been largely associated with poorer adjustment when used in response to controllable stressors (Compas et al., 2001; 2017; Zimmer-Gembeck & Skinner, 2016). However, when considering stressors that are outside of an adolescent’s control (e.g., chronic illness, parental conflict, parental depression), primary control coping is often associated with poorer adjustment than secondary coping (Compas et al., 2001; 2012; 2017). Regardless of the perceived controllability of the stressor, disengagement coping is most frequently associated with higher rates of internalizing and externalizing problems (Compas et al., 2001; 2017; Fear et al., 2009; Wadsworth & Compas, 2002; Zimmer-Gembeck & Skinner, 2016).

Marital conflict, as well as other parental and family factors, is not an event that
adolescents can control; therefore, youth outcomes vary according to the type of coping used in response to these stressors. For example, adolescents’ use of secondary control coping in response to parent-related stress (i.e., parental irritability, withdrawal, and marital conflict) has shown to be associated with fewer symptoms of anxiety, depression, and aggression than when primary control coping is used (Jaser et al., 2007). In an examination of youth coping with stress related to parental depression, children (ages 7 to 17 years old) engaging in secondary control coping demonstrated fewer symptoms of anxiety and depression; however, primary control coping was not significantly associated with these forms of maladjustment (Langrock et al., 2002). Further, a study examining adolescent coping with family conflict revealed secondary control coping was associated with lower internalizing symptoms, whereas disengagement coping exacerbated internalizing symptoms over a one-year period (Santiago & Wadsworth, 2009). Similarly, adolescents engaged in secondary control coping in response to family conflict (e.g., verbal interparental conflict) reported lower rates of anxiety, depression, and aggression than those engaging in primary control coping (Wadsworth & Compas, 2002). Additionally, adolescents who utilized disengagement coping in this study demonstrated higher levels of anxiety, depression, and aggression (Wadsworth & Compas, 2002). Taken altogether, the extant research has demonstrated that when adolescents face uncontrollable family-related stressors, secondary control coping is linked to better psychological outcomes, disengagement coping is associated with more detrimental outcomes, and primary control coping has not shown a consistent significant association with psychological outcomes.

In addition to direct associations between coping and youth outcomes, some studies have also examined coping as a moderator between parent-related stress and offspring
outcomes. For example, a recent study examined primary and secondary control coping responses to marital conflict during late childhood ($M$ age $= 10.28$ years) and later ($M$ age $= 15.26$ years) adjustment (Tu, Erath, & El-Sheikh, 2016). Results revealed higher levels of secondary control coping protected against later externalizing problems in the context of higher marital conflict, whereas lower levels of secondary control coping increased risk for externalizing problems. Additionally, primary control coping did not significantly moderate the association between marital conflict and adolescent externalizing problems. Further, higher levels of disengagement exacerbated the influence of marital conflict on externalizing problems, whereas lower levels of disengagement protected against later externalizing problems (Tu et al., 2016). Higher levels of disengagement coping have also shown to increase the influence of marital conflict on internalizing and externalizing problems during late childhood and early adolescence (Nicolotti, El-Sheikh, & Whitson, 2003). Negative forms of coping (i.e., the combined influence of low primary and secondary control coping and high disengagement coping) have also shown to exacerbate the influence of marital conflict on young adolescents’ internalizing and externalizing problems (Rogers & Holmbeck, 1997). Thus, adolescent coping responses have shown to moderate the association between marital conflict and adolescent adjustment, yet the manner in which coping may moderate the association between coparenting and adolescent outcomes has not been examined.

In sum, youth coping strategies have consistently demonstrated an influence on the associations between stressor and adjustment. However, the strength of these associations and the severity of the outcomes vary by the perceived controllability of the stressor and the type of coping utilized. As such, when interpreting associations between adolescent perceptions of marital conflict, coparenting, and their own adjustment, consideration of how coping may
interact is needed. That is, extant research has demonstrated that adolescent perceptions of coparenting mediate the influence of marital conflict on their own psychological adjustment (Flannery, 2017). Yet, given the stated evidence, there is reason to believe that the manner in which an adolescent copes with these uncontrollable stressors (i.e., marital conflict and coparenting) might influence their own adjustment. However, this has not been examined to date.

Adolescence

Understanding how family and coping processes influence adolescents’ psychological functioning is needed, as there is an increase in the incidence and prevalence of psychopathology, including increased rates of internalizing and externalizing disorders, during adolescence (e.g., Patton et al., 2016). Moreover, research on lifetime prevalence and age-of-onset rates of mental health disorders has suggested that median age of onset for mood disorders, anxiety disorders, substance use disorders, and impulse-control disorders is before 25 years of age, and most frequently between ages 11 and 18 years (Kessler et al., 2005). There are numerous theoretical explanations for the high onset rates of mental health disorders during adolescence; however, it is widely understood that the developmental transition to adolescence is marked by novel stressors related to transformations of biological (e.g., puberty, hormonal changes), cognitive (e.g., greater capacity for abstract reasoning), psychological (e.g., identity development and exploration), and social (e.g., increased peer interactions; emergence of romantic relationships) functions (Arnett, 1999; Compas, Hinden & Gerhardt, 1995; Helland et al., 2017; Steinberg & Morris, 2001).
Specifically, during this developmental stage, changes in cognitive processes, hormonal changes of puberty, and increased reliance on peer relationships interact in a manner that uniquely shapes stress and coping responses (Compas et al., 2017). Specifically, during the transition to middle and late adolescence, stronger executive functions emerge, allowing for greater efficiency of problem solving, planning, logic, reasoning, and understanding of consequences (Thompson & Goodman, 2010; Zimmer-Gembeck & Skinner, 2016). Additionally, there is increased ability to think about one’s own and other’s emotions, which coincides with greater use of peers for emotional support and to learn further coping strategies (Compas et al., 2017; Grych & Fincham, 1990). Coping during adolescence is also highlighted by greater self-direction in coping efforts, whereas coping during childhood is largely dependent on caregivers guiding coping or regulatory efforts (Compas et al., 2017). Taken altogether, extant evidence suggests adolescents engage in primary and secondary control coping more frequently than in earlier stages of development. However, it is unknown whether the use of these strategies is more adaptive in adolescence, and coping may therefore act as a source of risk or resilience during this developmental period (Compas et al., 2017; Zimmer-Gembeck & Skinner, 2016).

In addition to these changes related to coping, there is evidence that this developmental period is also associated with changes in the family system, as the aforementioned transformations create new demands for parents, siblings, and the identified adolescent (e.g., Helland et al., 2017; McElhaney, Allen, Stephenson, & Hare, 2009). Moreover, the deleterious associations between marital conflict and child outcomes have been well documented in families with adolescents (e.g., Buehler & Gerard, 2013; Davies & Cummings, 1994; Fosco & Bray, 2016; Grych & Fincham, 1990). Further these associations
have been found to be stronger during adolescence (Helland et al., 2017). Yet, the amount of literature dedicated to investigating coparenting processes during adolescence is lacking.

Given the paucity of research examining coparenting processes and influences during adolescence, there is also a particular scarcity of studies examining adolescent appraisals of coparenting. Notably, older children and adolescents are capable of providing an accurate report on family processes (Kuppens, Grietens, Onghena, & Michiels, 2009). Further, adolescent perceptions of family processes and events within the home have shown to more closely predict their emotional, psychosocial, and behavioral outcomes than do parent or observational report of the same processes (Glasgow et al., 1997; Grych et al., 1992; Neiderhiser, Pike, Hetherington, & Reiss, 1998; Paulson, 1994; Spera, 2006). For example, adolescent perceptions of marital conflict have shown greater predictive utility of adolescent externalizing problems than do parent reports (Latendresse et al., 2009; Forehand et al., 1989). Adolescent views of marital conflict have also been shown to explain the link between parent-report of marital conflict and adolescent report of distress, adolescent report of internalizing symptoms, and teacher report of adolescent externalizing symptoms (Harold, Fincham, Osborne, & Conger, 1997). Specific to marital conflict, negative outcomes are largely influenced by the adolescent’s own processing of the conflict; namely, perceptions of intensity, threat of becoming involved in the conflict, feeling as though they are the source of the conflict, or fearing the conflict may lead to marital dissolution or corrupt the parent-child relationship (DeBoard-Lucas, Fosco, Raynor, & Grych, 2010; Fosco & Bray, 2016; Fosco & Grych, 2008; Grych & Fincham, 1990).

Taken altogether, there is a dearth of research examining adolescent appraisals of coparenting, yet it is known that adolescent perceptions of family processes (e.g., marital
conflict) carry substantial weight on their own psychological functioning. Additionally, Compas et al. (2017) have called for greater examination of disengagement and primary and secondary control coping during this developmental period, as it is unknown whether or not adolescents adaptively use these strategies. As such, the present study examined adolescent appraisals of coparenting practices and marital conflict and self-report of coping behaviors and psychological adjustment.

Clinical Samples

Much of the research on coparenting, marital conflict and coping have focused on non-clinical samples. Yet, it is important to specifically examine the associations between these constructs within a clinical sample, rather than generalize the findings from studies of non-clinical populations. Specifically, data sampled within a single homogenous source may have parameter values that differ from other samples, thus limiting the generalizability of results across different populations (Hoffman et al., 2019; Xie, 2013). For example, longitudinal research has found that the factor structure of depression symptoms on common rating scales differ for those whose depression symptoms have lessened over time compared to those whose symptoms of depression continued (Fried et al., 2016). Thus, researchers should exercise caution when generalizing between clinical and nonclinical samples (Fried et al., 2016; Hoffman et al., 2019).

Few studies have considered coparenting among clinically referred samples of children or adolescents. For example, in their meta-analysis, Teubert & Pinquart (2010a) examined whether studies from clinical samples moderated any of their examined effect sizes.
However, their analysis included only 7 studies with clinical samples, and they were largely clinically referred parents rather than children. Only two studies examined coparenting within a clinically referred sample of youth. Mahoney, Jouriles, & Scavone (1997) found coparenting conflict was positively associated both mothers’ and fathers’ reports of child externalizing problems, even when controlling for general marital adjustment, in a sample of two-parent families receiving services for their child’s conduct problems (ages 4 to 9 years). Additionally, Harvey (2000) found coparenting cooperation demonstrated a negative association with parent ratings of child internalizing and externalizing behaviors in a sample of two-parent families receiving clinical services for a child diagnosed with attention-deficit/hyperactivity disorder (ADHD; ages 7 to 12 years; Harvey, 2000). Thus, the results from these studies extend findings from nonclinical samples by illustrating that coparenting conflict and cooperation are unique elements of the family system associated with behavioral problems in clinically referred children (Harvey, 2000; Mahoney et al., 1997). Despite these findings, a gap in the coparenting literature remains, as other dimensions of coparenting (i.e., cooperation, triangulation) have not been examined for clinical samples. Additionally, clinically referred samples of adolescents have not been studied within the coparenting literature.

Unlike coparenting, marital conflict has been more frequently examined within clinical samples. In fact, marital conflict is a risk factor for deleterious psychological adjustment in youth, especially in families of clinically referred youth (King et al., 1995; Emery, 1982; Grych & Cardoza-Fernandes, 2001). For example, a study examining marital conflict and adolescent psychopathology in psychiatrically hospitalized adolescents (ages ranged from 13 to 19 years) revealed parents of adolescent inpatients reported more marital
conflict compared to matched-control samples. Additionally, marital conflict was associated with more severe behavior problems at school, with peers, and during spare time for the clinically referred sample, but not the control group (King et al., 1995). However, no research has looked at the indirect pathways from marital conflict to adolescent outcomes through coparenting in a clinical sample. Therefore, the present study aimed to extend these findings to a clinically referred sample of adolescents to determine whether or not teen appraisals of coparenting also mediate the known connection between marital conflict and psychological maladjustment in clinical samples, as has been supported in nonclinical samples (Flannery, 2017).

Additionally, the study extended these associations by investigating whether adolescent forms of coping interact with the relationship between marital conflict, coparenting, and adjustment. As stated above, there is a need to examine whether or not the use of disengagement or primary or secondary control coping is adaptive during adolescence (Compas et al., 2017). There is evidence that clinically referred adolescents develop and utilize poorer forms of coping (e.g., inflexible coping responses, less reliance on primary or secondary control coping, greater avoidance or disengagement; Wadsworth, 2015), which is associated with greater risk for psychopathology across the lifespan (Seiffge-Krenke & Klessinger, 2000; Wadsworth, 2015; Zimmer-Gembeck & Skinner, 2011). Nonetheless, there is a need to examine this further with respect to family factors of marital conflict and coparenting.
The Present Study

The primary aim of the present study was to examine whether the indirect pathways through three dimensions of coparenting explain the links between marital conflict and psychological symptoms among a clinically referred sample of youth from two-parent households. In addition, three dimensions of coping (i.e., primary control coping, secondary control coping, and disengagement coping) were examined as potential moderators of these associations. Although the connections between marital conflict, coparenting, and youth outcomes have been previously examined, few studies have examined adolescent appraisals of coparenting. Further, this association had yet to be examined within clinically referred samples of adolescents, where stronger associations have been found when examining other family process constructs (e.g., Grych & Fincham, 2001; Yap, Pilkington, Ryan, & Jorm, 2014). Further, given recent findings demonstrating that the relationship between marital conflict and adolescent internalizing and externalizing problems is mediated by coparenting (Flannery, 2017), it is important to assess whether these patterns hold true for clinical samples of adolescents, as findings may be more relevant for treatment recommendations. Therefore, the goal of the present study was to assess whether or not the previously demonstrated findings (i.e., youth appraisals of the three dimensions of coparenting mediate the relationship between marital conflict and internalizing and externalizing problems) are replicated within clinically referred samples of middle and high school-aged adolescents.

Additionally, youth coping responses to marital conflict had not been examined while simultaneously considering coparenting. Specifically, the present study examined how primary control coping, secondary control coping, and disengagement in response to these
uncontrollable parent stressors may moderate the links to psychological adjustment. Additionally, as a more rigorous test of these relationships, demographic variables that are significantly linked to the dependent variables were controlled in all study analyses. Namely, child gender (e.g., Steinberg & Morris, 2001), ethnicity (e.g., Cabrera, Shannon, & Jolley-Mitchell, 2013), and family standard of living (e.g., Shaw, Vondra, Hommerding, Keenan, & Dunn, 1994) were examined.

Hypotheses and Research Questions

Adolescents’ exposure to marital conflict is associated with numerous adjustment problems in nonclinical (e.g., Grych & Fincham, 2001) and clinical (e.g., King et al., 1995) samples of adolescents. Additionally, Flannery (2017) demonstrated adolescent appraisals of coparenting significantly mediate the association between their reports of their parents’ marital conflict and their own internalizing and externalizing problems. As such, similar findings were expected for the current study examining clinically referred adolescents’ reports of marital conflict, coparenting, and adjustment (i.e., internalizing and externalizing problems). The following hypotheses were made:

1a. Adolescents’ reports of marital conflict would be indirectly associated with psychological adjustment through appraisals of coparenting cooperation (See Figure 1).
Figure 1: Proposed indirect effects model of marital conflict predicting adolescent maladjustment via coparenting conflict.
1b. Adolescents’ reports of marital conflict would be indirectly associated with psychological adjustment through appraisals of coparenting conflict (See Figure 1).

1c. Adolescents’ reports of marital conflict would be indirectly associated with psychological adjustment through appraisals of coparenting triangulation (See Figure 1).

Using hierarchical regression analyses, Flannery (2017) simultaneously considered coparenting cooperation, coparenting conflict, and coparenting triangulation to examine which construct would most strongly predict adolescent maladjustment, while controlling for marital conflict. Results revealed coparenting triangulation maintained the strongest association with adolescent maladjustment. Moreover, the associations between coparenting cooperation and coparenting conflict reduced to nonsignificance when each dimension was considered simultaneously (Flannery, 2017). However, all three constructs have not been examined as simultaneous mediators of the link between marital conflict and adolescent maladjustment. Therefore, the following research question was examined:

1. Which, if any, of the three coparenting constructs (i.e., cooperation, conflict, or triangulation) when considered simultaneously in a parallel mediation model would significantly explain the association between marital conflict and adolescent maladjustment (see Figure 2)?
Figure 2: Proposed parallel mediation model demonstrating all three forms of coparenting partially explain the association between marital conflict and adolescent maladjustment when considered simultaneously.

Extant research has demonstrated that secondary control coping is associated with better adjustment for adolescents when responding to stressors that are outside of their control, such as parent-related stress (e.g., Compas et al., 2001; 2017; Jaser et al., 2007; Langrock et al., 2002). Additionally, secondary control coping has shown to moderate the link between marital conflict and adolescent psychological maladjustment, such that the association between marital conflict and maladjustment is less positive when secondary control coping is higher (Tu et al., 2016). However, given extant research revealing coparenting explains the association between marital conflict and adolescent maladjustment (Flannery, 2017), it is unknown how secondary control coping will influence this connection when coparenting is also considered. Therefore, the following research question was explored:
2. Within the parallel coparenting mediation model, would secondary control coping moderate the association between marital conflict and psychological maladjustment directly and indirectly (via coparenting cooperation, coparenting conflict, and coparenting triangulation) when considered simultaneously (see Figure 3)?

Figure 3: Proposed parallel model indicating secondary control coping directly moderates the association between marital conflict and adolescent maladjustment and indirectly via individual interactions with coparenting cooperation, conflict, and triangulation and maladjustment.
The coping literature has revealed that primary control coping is associated with poorer outcomes for adolescents when used in responses to stressors that are outside of their control (e.g., Compas et al., 2001; 2017; Jaser et al., 2007). However, literature examining moderating effects of primary control coping has illustrated inconsistent findings, as primary control coping has not consistently shown a significant interaction with the association between marital conflict and adolescent outcomes (Tu et al., 2016). Nonetheless, it is unknown whether the same will hold true for a clinical sample of adolescents or whether this moderating influence will remain nonsignificant when coparenting is also considered. Therefore, the following research question was asked:

3. Within the parallel coparenting mediation model, would primary control coping moderate the association between marital conflict and psychological maladjustment directly and indirectly via coparenting cooperation, coparenting conflict, and coparenting triangulation) when considered simultaneously (see Figure 4)?

It is well established within the coping literature that disengagement coping is associated with poor outcomes for children and adolescents, regardless of the controllability of the stressor (Compas et al., 2017; Wadsworth & Compas, 2002). Additionally, higher levels of disengagement coping have shown to moderate the association between marital conflict and adolescent maladjustment, such that this association is more positive when disengagement is higher (Nicolotti et al., 2003). However, consistent with the previous research questions, it is unknown whether this moderating influence will be maintained when coparenting is also considered within a clinically referred sample of adolescents. Thus, the following research question was proposed:
Figure 4: Proposed parallel model indicating primary control coping directly moderates the association between marital conflict and adolescent maladjustment and indirectly via individual interactions with coparenting cooperation, conflict, and triangulation and maladjustment.

4. Within the parallel coparenting mediation model, would disengagement coping moderate the association between marital conflict and psychological maladjustment directly and indirectly (via coparenting cooperation, coparenting conflict, and coparenting triangulation) when considered simultaneously (see Figure 5)?
Figure 5: Proposed parallel model indicating disengagement coping directly moderates the association between marital conflict and adolescent maladjustment and indirectly via individual interactions with coparenting cooperation, conflict, and triangulation and maladjustment.
CHAPTER 2

METHOD

Participants and Procedure

Middle and high school-aged (i.e., ages 11 – 18 years) participants were recruited from outpatient clinical psychology private practices providing therapeutic services in the Chicago area and surrounding suburbs. Participants included middle- and high school-aged adolescents receiving outpatient mental health services without a history of intellectual disability, autism spectrum disorder, or significant developmental disability. Additionally, it was required that the adolescents lived with two cohabitating coparental figures (e.g., mother, father, stepparent, grandparent, etc.) to be eligible to participate in the study.

Participants were recruited from a total of 16 outpatient clinical psychology practices in the Chicago area. A total of 79 adolescents participated in the study. The present study included participants in 6th (11.4%), 7th (7.6%), 8th (7.6%), 9th (12.7%), 10th (16.5%), 11th (17.7%), and 12th (26.6%) grade, with ages ranging from 11 through 18 (M = 14.97, SD = 2.20). The sample included more females (62.0%) than males (35.4%), with two participants self-identifying as nonbinary. The majority of the participants in the study identified as Non-Hispanic White (74.7%; 2.5% Hispanic White, 1.2% American Indian or Alaska Native, 8.9% Asian, 8.9% Biracial/Multiracial, 3.8% Black or African American). Although all forms of dyadic coparenting relationships were eligible for the study, none of the participants reported
on same-sex coparents. Moreover, every participant in the present sample reported on their biological mother as one coparent and a paternal figure (i.e., biological father or stepfather) as the other coparent (i.e., none of the participants reported on grandparents or extended family members as coparents). The vast majority (94.9%) of the coparenting relationships included biological mother-father dyads (5.1% of the sample included biological mother-stepfather dyads). The majority of the sample included highly educated parents, as 86.1% of the sample reported at least one parent had a college degree or higher. A large majority of the sample also reported that their family had more than enough money or had a comfortable standard of living (87.3%). A smaller number reported having enough money for the basics or living under meager conditions (12.7%). The adolescents in the study also reported on the amount of time they have spent in treatment and the amount of involvement their parents have in their treatment sessions. Among the participants, 7.6% of the sample reported they have been in therapy for 1 month or less, 17.8% reported receiving therapy for 2-5 months, 27.9% reported receiving therapy for 6-11 months, and 46.8% reported receiving therapy for 12 months or longer. The majority of participants reported receiving solely individual therapy with occasional parent check-ins with their therapist (92.4%). A smaller number reported their parents check-in with their therapist for a few minutes of every single session (8.9%). None of the participants in the current sample reported receiving family therapy, occasional parent-child joint sessions, or occasional parent-only sessions. In sum, the present sample was largely White/Non-Hispanic, of higher socioeconomic and educational status, and accessed individual outpatient therapy services for a longer duration of time.

As a result of the mandatory shelter-in-place due to coronavirus disease 2019 (COVID-19), all recruitment efforts, screening processes, consent procedures, and data
collection were conducted remotely. The Institutional Review Board approved all study procedures. Clinical practices were recruited through e-mail correspondence, phone calls, video calls, and secure messaging via groups for therapy practitioners on social media platforms. Clinicians that expressed interest in participating in the study administered electronic flyers to their clients that were eligible to participate in the study. Parents of interested participants then emailed the primary researcher. Parents of eligible participants completed an electronic consent form (see Appendix A). The adolescent participants were then emailed a link to the electronic assent form (see Appendix B) and electronic questionnaire. Participants that were 18 years old at the time of survey completion provided their own individual consent to participate (see Appendix C) and did not require parental consent. Study consent forms included information regarding the study aims and procedure, a statement that participation is voluntary and will not influence the treatment services being received, and a space for parents to sign, scan, and send back to the primary researcher. Parents were also permitted to email the primary researcher a statement indicating they had read the consent document and consent to their child participating in the study, rather than providing a scanned signature. Adolescent participants that were 18 years old did not require parental consent to participate. After completing the electronic questionnaire, the adolescent participants received a $10 electronic Amazon gift card as compensation for their participation in the study. The electronic survey was completed via Qualtrics and consisted of measures inquiring about participants’ basic demographic information and appraisals of their parents’ coparenting practices, marital conflict between their coparents, their coping practices in response to interparental conflict, and their own psychological functioning. Participants were permitted to skip questions when completing the electronic questionnaire. However,
they did receive a prompt if an item was skipped to ensure responses were not unintentionally left blank. As a result, there were no missing data for the present study. While data collection was attempted through December of 2020, all of the participants’ data were collected between March 12, 2020 and September 8, 2020.

Measures

Demographic Information

Participants completed a demographic questionnaire inquiring about the following information: age, grade level, gender, race, parents’ educational attainment, and approximate family standard of living (i.e., single item asking, “What best describes your family’s standard of living?” with responses of “more than enough money,” “comfortable,” “enough money for the basics,” etc.; higher numbers indicate a higher standard of living). The participants also indicated the two most prominent parental figures involved in their life as well as their relationship to the stated individuals (e.g., mother, father, grandmother, father’s girlfriend, stepfather, etc.). This relationship was then automatically embedded in the following study measures. Additionally, the participants defined the relationship between their identified parental figures (e.g., married, divorced, never married but living together, etc.), indicated if they lived together at the time of survey completion, whom the participant lived with (i.e., Parental Figure 1, Parental Figure 2, both, or neither), and how long all three individuals had resided together. This was to make certain that all adolescents with diverse two-parent
backgrounds (e.g., stepparents, same-sex parents) would be included in the study analyses (see Appendix D for all demographic items).

**Coparenting**

Consistent with previous research (e.g., Flannery, 2017; Teubert & Pinquart, 2010b), participants completed 12 items from the 38-item Coparenting Inventory for Parents and Adolescents (CI-PA; Teubert & Pinquart, 2011, see Appendix E) to assess their parents’ coparenting practices at the dyadic level (e.g., “If there is a problem that concerns me, my parents find a solution together”). The remaining 26 items of the full CI-PA report on each parent’s individual coparenting contributions, and have not been found to be correlated with the dyadic subscales (Teubert & Pinquart, 2011). These 12 items of the CI-PA assess coparenting cooperation, coparenting conflict, and coparenting triangulation (4 items each) using a 5-point scale (0 = *completely true*, 4 = *not at all true*). The CI-PA subscales were scored by calculating averages of the responses for each domain (i.e., cooperation, conflict, and triangulation). All items on the CI-PA were automatically reworded such that the parental figures identified on the demographic form (e.g., mother, father, stepfather, etc.) were embedded in the text. Additionally, the final item on the CI-PA (i.e., “I get involved in my parents’ arguments”) was reworded to more accurately represent coparenting triangulation (i.e., “I get involved in my parents’ arguments about raising me”).

The CI-PA was developed using two independent samples of German families (i.e., mother, father, and adolescent participants; Teubert & Pinquart, 2011). Adolescent participants for the original measurement development were between the ages of 10 and 18.
Confirmatory factor analyses (CFAs) have shown reasonable fit for the three-factor model of coparenting (i.e., cooperation, conflict, and triangulation; Flannery, 2017), as well as acceptable to good internal consistencies for the coparenting cooperation, conflict, and triangulation scales ($\alpha$’s = .71, .81, and .86, respectively; Flannery, 2017). Previous findings have also shown moderate correlations between adolescent ratings of the three dimensions in the expected directions (i.e., $r$ for cooperation and conflict = -.60; $r$ for cooperation and triangulation = -.32; $r$ for conflict and triangulation = .33; Teubert & Pinquart, 2011). Consistent with extant research that adolescents and parents report slight differences in their appraisals of family processes (e.g., Paulson, 1994; Schwarz et al., 1985; Spera, 2006), the CI-PA has revealed moderate correlations between parent and adolescent ratings ($r$’s ranged from .26 to .39, all $p$’s < .01; Teubert & Pinquart, 2011). The CI-PA has demonstrated good test-retest reliability over a 6-week period and good concurrent validity as evidenced by high correlations between adolescent ratings on the CI-PA and related parent reports on the Coparenting Questionnaire (CQ; Margolin, 1992; Teubert & Pinquart, 2011). The CI-PA demonstrated good internal consistencies for the coparenting cooperation, conflict, and triangulation scales for the present study ($\alpha$’s = .82, .80, and .85, respectively). Notably, the coparenting triangulation subscale demonstrated good internal consistency with the reworded coparenting triangulation item, as the $\alpha$ value reduced to .84 if this item were removed from the analysis.

Marital Conflict

Adolescents’ report of marital conflict was assessed by the Conflict Properties
subscale of the Children’s Perception of Interparental Conflict Scale (CPIC; Grych et al., 1992; see Appendix F). The Conflict Properties subscale includes 19 items and evaluates youth perceptions of the frequency and intensity of interparental conflict, as well as the manner in which conflict is resolved (e.g., “When my parents argue, they usually make up right away”). The items of the CPIC are answered on a 3-point scale (0 = False, 1 = Sort of true, 2 = True). The composite score for the Conflict Properties subscale was calculated by taking the average of the respective item responses. Higher scores reflect conflict that occurs more frequently, is more poorly resolved, or involves greater hostility and aggression (Grych et al., 1992).

The Conflict Properties subscale has shown good validity and good test-retest reliability over a 2-week period (Grych et al., 1992). Two independent samples of 9- to 12-year-old children and their parents were used to develop the CPIC. Both samples demonstrated good internal consistency (α’s > .89). The internal consistency has been comparable for studies utilizing adolescent samples (ages 14 to 19; α = .93; Fosco & Grych, 2010). The Conflict Properties subscale has shown good concurrent validity, as scores have revealed significant correlations (r = .30) with parent reports of marital conflict and inter-spousal aggression on other well-established measures (i.e., the O’Leary-Porter Scale; Porter & O’Leary, 1980, and the Conflict Tactics Scale; Straus, 1979; Grych et al., 1992). Scores on the CPIC have also indicated good criterion validity due to significant correlations with child internalizing and externalizing behaviors as indicated by parent report on the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983; Grych et al., 1992). The Conflict Properties subscale of the CPIC demonstrated excellent internal consistency for the present study (α = .94).
Coping

Participants completed the parental conflict version of the Responses to Stress Questionnaire (RSQ) to assess adolescent coping responses to conflict between parents (Connor-Smith et al., 2000; see Appendix G). The RSQ is adapted to measure coping behaviors in response to specific stressors (e.g., parental depression, peer stress, childhood cancer). As such, the item framework is consistent across versions of the RSQ, albeit with slight rewordings to capture responses to a specific stressor. For example, the family stress version of the RSQ includes the item; “I get really jumpy when I have problems with my family.” On the parental cancer form, the item is phrased, “I get really jumpy when I am dealing with having a parent with cancer.” The parental conflict version used for the proposed study words this same item; “I get really jumpy when my parents argue.”

The RSQ is composed of 57 items that include three subscales measuring voluntary coping responses and two subscales assessing involuntary coping; however, only the voluntary coping items were administered for the proposed study. The voluntary coping subscale is composed of three further subscales: Primary Control Coping (9 items), Secondary Control Coping (12 items), and Voluntary Disengagement (9 items). Primary control coping on the RSQ is comprised of problem solving, emotional expression, and emotional regulation. Secondary control coping includes acceptance, cognitive restructuring, distraction, and positive thinking. Finally, disengagement included avoidance, denial, and wishful thinking. Items are scored on a 4-point scale (i.e., Not at all, A little, Some, A lot) to indicate how frequently each coping behavior is used in response to conflict between parents. Subscale scores were calculated by taking the mean score for the items corresponding to each subscale.
Extant research has indicated mixed results regarding intercorrelations across subscales for various stressors. For example, primary and secondary control coping were significantly correlated on the original study utilizing the family stress form ($r = .34$; Connor-Smith et al., 2000), but not with disengagement coping ($r$'s = .06 and .07 for Primary Control and Secondary Control, respectively). Conversely, primary and secondary coping were not correlated on the parental depression form ($r = .14$), but disengagement coping was significantly associated with primary control coping ($r = -.66$) and marginally significantly associated with secondary control coping ($r = -.18$; Fear et al., 2009). Primary and secondary control coping did not show a significant correlation in a recent study utilizing the interparental conflict version of the RSQ ($r = .09$; Keeports, 2017), and disengagement coping data were not collected. As such, extant evidence suggests the intercorrelations across subscales of the RSQ may vary by the type of stressor in question.

The social stress form of the RSQ has been largely used for establishing reliability and validity. However, the interparental conflict version of the RSQ has previously shown strong reliability ($\alpha$'s = .84 and .92 for primary and secondary control, respectively; disengagement coping has not been collected for this specific scale, Keeports, 2017). The social stress form of the RSQ has demonstrated adequate test-retest reliability following a 2-week period ($r$’s = .81, .74, and .69 for primary, secondary, and disengagement coping, respectively; Connor-Smith et al., 2000). The social stress form of the RSQ has also shown good validity, as the primary control scale has been significantly associated with corresponding scales on the COPE (e.g., instrumental support; active coping) and not related to theoretically unrelated scales (e.g., denial, acceptance; Connor-Smith et al., 2000). Good predictive validity has also been demonstrated using the social stress form of the RSQ, as correlations between primary
control and secondary control have shown negative correlations with internalizing symptoms, whereas disengagement coping was positively associated with internalizing symptoms (Connor-Smith et al., 2000). Additionally, primary and secondary control coping as measured by the interparental conflict version of the RSQ showed negative correlations with internalizing symptoms (Keeports, 2017). For the present study, the parental conflict version of the RSQ demonstrated acceptable to good internal consistencies for the primary engagement, secondary engagement, and voluntary disengagement subscales (α’s = .77, .80, and .84, respectively).

Psychological Adjustment

The Brief Problem Monitor (BPM; Achenbach, McConaughy, Ivanova, & Rescorla, 2011; Achenbach & Rescorla, 2001) was completed to assess adolescent participants’ psychological adjustment (see Appendix H). The BPM is a 19-item self-report measure that maps onto three broadband scales of attention, internalizing, and externalizing problems. All three scales were summed to yield a total composite score of psychological maladjustment. The internalizing scale is comprised of 6 items reflecting how true a statement has been in the past week (e.g., “I am unhappy, sad, or depressed”). The externalizing scale includes 7 items that reflect how true a statement has been in the past week (e.g., “I am disobedient at home”). The attention problems scale consists of 6 items reflecting how true a statement has been in the past week (e.g., “I act without stopping to think”). All items on the BPM are rated on a 3-point scale (0 = not true, 1 = somewhat true, 2 = very true). The present study utilized a raw score for total maladjustment, which was calculated by summing across all 19 items.
Factor analysis was used to select items from the Youth Self Report (YSR) to develop the BPM (Chorpita et al., 2010). The YSR is a widely utilized measure of youth functioning, as it has demonstrated strong psychometric properties, including good test-retest reliability, internal consistency, and convergent validity with corresponding subscales from the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992) and the parent and teacher scales of the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001). Specifically, data from a sample of 2,332 youths revealed significant correlations with the parallel subscales and overall composite scores of the CBCL, YSR, and with diagnoses from structured diagnostic interviews (e.g., total score $r = .56$; Chorpita et al., 2010). The total composite score has also revealed good internal consistency ($\alpha = .86$) and test-retest reliability over an eight-day period ($r = .88$; Achenbach & Rescorla, 2001). Cross-informant correlations for the BPM raw scores have also been good (e.g., $r$’s for total scale correlations between parent and youth responses = .42; teacher and youth responses = .22). The BPM revealed good internal consistency for the total composite score of psychological maladjustment for the present study ($\alpha = .84$).
CHAPTER 3

RESULTS

Preliminary Analyses

To examine the distribution of the data, frequencies and descriptive statistics of coparenting cooperation, coparenting conflict, coparenting triangulation, marital conflict, primary control coping, secondary control coping, voluntary disengagement coping, and psychological maladjustment were run (see Table 1 for the descriptive statistics of the composite variables). Of note, reported levels of marital conflict, coparenting cooperation, coparenting conflict, and coparenting triangulation were comparable to a sample of 11-14 year old adolescents in a recent study (Flannery, 2017). Additionally, scores on the BPM were consistent with those of a recent study utilizing a sample of youth (ages 10-18) diagnosed with ADHD, depression, an anxiety disorder, bipolar disorder, or an attachment disorder (Piper, Gray, Raber, & Birkett, 2014). The current sample had a mean score of 17.46 (standard deviation = 6.45; see Table 1) on the BPM, indicating participants endorsed an average of 17 of the 19 symptoms as “somewhat true” (or 8 of the 19 symptoms as “very true”) within the past week. Data normality was assessed for the independent and dependent variables. For small samples (i.e., $n < 200$), it is suggested that transformations be performed
if the quotient of the skew and the standard error of skew is greater than 2.58, or if the quotient of the kurtosis and standard error of kurtosis is greater than 2.58 (Ghasemi & Zahediasl, 2012; Smith, 2017; Tabachnick & Fidell, 2013). Given these parameters, the composite variables for marital conflict, coparenting conflict, and coparenting triangulation revealed non-normal distributions due to positively skewed data. Coparenting cooperation revealed a non-normal distribution due to negatively skewed data. Additionally, coparenting cooperation and triangulation revealed non-normal distributions due to leptokurtic data. Therefore, transformations were applied to Marital Conflict (square root transformed), Coparenting Cooperation (reciprocally transformed), Coparenting Conflict (logarithmically transformed), and Coparenting Triangulation (logarithmically transformed). All subsequent analyses were conducted using the transformed composite variables. Additionally, no issues with multicollinearity were detected for the present study analyses (all regression VIF scores ranged from 1.24 to 1.89).
Table 1

Descriptive Statistics of Independent and Dependent Variables for Participants (N= 79)

<table>
<thead>
<tr>
<th>Variable</th>
<th>M (SD)</th>
<th>Range</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>14.97 (2.20)</td>
<td>11 – 18</td>
<td>-0.45</td>
<td>-0.99</td>
</tr>
<tr>
<td>Grade</td>
<td>9.75 (2.04)</td>
<td>6 – 12</td>
<td>-0.57</td>
<td>-0.93</td>
</tr>
<tr>
<td>Family Standard of Living</td>
<td>4.09 (0.62)</td>
<td>2 – 5</td>
<td>-0.39</td>
<td>0.91</td>
</tr>
<tr>
<td>Coparent Configuration (Mother-Father Dyad vs. Mother-Stepfather Dyad)</td>
<td>0.05 (0.22)</td>
<td>0 – 1</td>
<td>4.18</td>
<td>15.87</td>
</tr>
<tr>
<td>Marital Conflict (Untransformed)</td>
<td>0.63 (0.48)</td>
<td>0 – 1.89</td>
<td>0.72</td>
<td>-0.60</td>
</tr>
<tr>
<td>Marital Conflict (Square Root Transformed)</td>
<td>0.73 (0.32)</td>
<td>0 – 1.38</td>
<td>0.04</td>
<td>-0.76</td>
</tr>
<tr>
<td>Coparenting Cooperation (Untransformed)</td>
<td>3.29 (0.78)</td>
<td>0.50 – 4</td>
<td>-1.55</td>
<td>2.02</td>
</tr>
<tr>
<td>Coparenting Cooperation (Reciprocally Transformed)</td>
<td>0.68 (0.23)</td>
<td>0.22 – 1</td>
<td>-0.19</td>
<td>-0.99</td>
</tr>
<tr>
<td>Coparenting Conflict (Untransformed)</td>
<td>0.97 (0.81)</td>
<td>0 – 4</td>
<td>1.38</td>
<td>2.15</td>
</tr>
<tr>
<td>Coparenting Conflict (Logarithmically Transformed)</td>
<td>0.26 (0.16)</td>
<td>0 – 0.70</td>
<td>0.38</td>
<td>-0.13</td>
</tr>
<tr>
<td>Coparenting Triangulation</td>
<td>0.90 (1.06)</td>
<td>0 – 3.75</td>
<td>1.15</td>
<td>0.14</td>
</tr>
<tr>
<td>Coparenting Triangulation (Logarithmically Transformed)</td>
<td>0.22 (0.22)</td>
<td>0 – 0.68</td>
<td>0.60</td>
<td>-0.92</td>
</tr>
<tr>
<td>Adolescent Maladjustment (BPM Total)</td>
<td>17.46 (6.45)</td>
<td>3 – 32</td>
<td>-0.07</td>
<td>0.06</td>
</tr>
<tr>
<td>Primary Engagement Coping</td>
<td>2.29 (0.58)</td>
<td>1.22 – 3.44</td>
<td>0.02</td>
<td>-0.84</td>
</tr>
<tr>
<td>Secondary Engagement Coping</td>
<td>2.34 (0.55)</td>
<td>1 – 3.58</td>
<td>0.71</td>
<td>0.00</td>
</tr>
<tr>
<td>Voluntary Disengagement Coping</td>
<td>1.98 (0.67)</td>
<td>1 – 3.44</td>
<td>0.38</td>
<td>-0.93</td>
</tr>
</tbody>
</table>

*Note: M = Mean, SD = Standard Deviation. Skewness standard error = 0.27. Kurtosis standard error = 0.54.*
Demographic variables (i.e., participant age, grade, gender, ethnicity, family standard of living, and parental education level) were assessed via correlations and t-tests to determine whether any were significantly associated with the dependent variables. T-tests (see Table 2) were conducted to assess for differences across mean values for the dichotomous demographic variables including gender, racial/ethnic minority status (White, Non-Hispanic or Non-White), coparenting configuration (mother-father dyad or mother-stepfather dyad), participant education level (middle school student or high school student), parent educational level (non-college degree or college degree/higher), and parent involvement in treatment (only individual treatment or parents regularly check-in). A significant difference was found for parent educational level, as adolescents whose parents were non-college educated reported higher levels of voluntary disengagement coping than did adolescents with at least one college-educated parent. No additional significant differences were found for the dichotomous demographic variables. Thus, parent educational attainment was included as a demographic control variable in the subsequent analyses.
Table 2
Independent T-Tests of Demographic Variables, Adolescent Psychological Symptoms, Appraisals of Parenting, and Coping Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Male</th>
<th>Female</th>
<th>t-value</th>
<th>White, Non-Hispanic</th>
<th>Minority</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 28)</td>
<td>(n = 49)</td>
<td></td>
<td></td>
<td>(n = 59)</td>
<td>(n = 20)</td>
<td></td>
</tr>
<tr>
<td>Marital Conflict</td>
<td>0.69 (0.25)</td>
<td>0.76 (0.35)</td>
<td>-1.06</td>
<td>0.71 (0.32)</td>
<td>0.77 (0.32)</td>
<td>-0.76</td>
</tr>
<tr>
<td>Coparenting Cooperation</td>
<td>0.71 (0.22)</td>
<td>0.66 (0.24)</td>
<td>0.95</td>
<td>0.69 (0.22)</td>
<td>0.66 (0.26)</td>
<td>0.39</td>
</tr>
<tr>
<td>Coparenting Conflict</td>
<td>0.23 (0.14)</td>
<td>0.29 (0.17)</td>
<td>-1.53</td>
<td>0.25 (0.15)</td>
<td>0.29 (0.19)</td>
<td>-0.73</td>
</tr>
<tr>
<td>Coparenting Triangulation</td>
<td>0.17 (0.19)</td>
<td>0.26 (0.23)</td>
<td>-1.64</td>
<td>0.20 (0.20)</td>
<td>0.28 (0.25)</td>
<td>-1.45</td>
</tr>
<tr>
<td>Adolescent Maladjustment</td>
<td>16.11 (6.97)</td>
<td>18.24 (6.21)</td>
<td>-1.39</td>
<td>17.41 (6.35)</td>
<td>17.60 (6.89)</td>
<td>-0.12</td>
</tr>
<tr>
<td>Primary Coping</td>
<td>2.28 (0.63)</td>
<td>2.28 (0.57)</td>
<td>0.04</td>
<td>2.23 (0.58)</td>
<td>2.46 (0.57)</td>
<td>-1.57</td>
</tr>
<tr>
<td>Secondary Coping</td>
<td>2.46 (0.60)</td>
<td>2.29 (0.52)</td>
<td>1.33</td>
<td>2.28 (0.56)</td>
<td>2.50 (0.49)</td>
<td>-1.55</td>
</tr>
<tr>
<td>Disengagement Coping</td>
<td>1.87 (0.61)</td>
<td>2.06 (0.71)</td>
<td>-1.19</td>
<td>1.94 (0.71)</td>
<td>2.08 (0.57)</td>
<td>-0.88</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coparenting Configuration</th>
<th>Mother-Father</th>
<th>Stepparent</th>
<th>t-value</th>
<th>Middle School</th>
<th>High School</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 75)</td>
<td>(n = 4)</td>
<td></td>
<td></td>
<td>(n = 21)</td>
<td>(n = 58)</td>
<td></td>
</tr>
<tr>
<td>Marital Conflict</td>
<td>0.73 (0.33)</td>
<td>0.75 (0.16)</td>
<td>-0.13</td>
<td>0.74 (0.24)</td>
<td>0.72 (0.35)</td>
<td>0.17</td>
</tr>
<tr>
<td>Coparenting Cooperation</td>
<td>0.69 (0.23)</td>
<td>0.59 (0.30)</td>
<td>0.89</td>
<td>0.71 (0.21)</td>
<td>0.67 (0.24)</td>
<td>0.50</td>
</tr>
<tr>
<td>Coparenting Conflict</td>
<td>0.26 (0.16)</td>
<td>0.35 (0.18)</td>
<td>-1.08</td>
<td>0.20 (0.13)</td>
<td>0.28 (0.17)</td>
<td>-1.98</td>
</tr>
<tr>
<td>Coparenting Triangulation</td>
<td>0.23 (0.22)</td>
<td>0.10 (0.14)</td>
<td>1.15</td>
<td>0.23 (0.22)</td>
<td>0.22 (0.22)</td>
<td>0.19</td>
</tr>
<tr>
<td>Adolescent Maladjustment</td>
<td>17.68 (6.30)</td>
<td>13.25 (8.77)</td>
<td>1.35</td>
<td>16.00 (7.04)</td>
<td>17.98 (6.20)</td>
<td>-1.21</td>
</tr>
<tr>
<td>Primary Coping</td>
<td>2.31 (0.56)</td>
<td>1.86 (0.94)</td>
<td>1.51</td>
<td>2.31 (0.58)</td>
<td>2.28 (0.59)</td>
<td>0.20</td>
</tr>
<tr>
<td>Secondary Coping</td>
<td>2.34 (0.55)</td>
<td>2.27 (0.52)</td>
<td>0.24</td>
<td>2.48 (0.58)</td>
<td>2.28 (0.53)</td>
<td>1.41</td>
</tr>
<tr>
<td>Disengagement Coping</td>
<td>1.99 (0.68)</td>
<td>1.69 (0.39)</td>
<td>0.85</td>
<td>2.08 (0.62)</td>
<td>1.93 (0.69)</td>
<td>0.87</td>
</tr>
</tbody>
</table>

(Continued on following page)
Table 2 (continued)

<table>
<thead>
<tr>
<th>Highest Parental Education Level</th>
<th></th>
<th>Parent Involvement In Treatment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>t-value</td>
<td></td>
</tr>
<tr>
<td>Non-College Educated</td>
<td>College Educated</td>
<td>(n = 5)</td>
<td>(n = 74)</td>
</tr>
<tr>
<td>Marital Conflict</td>
<td>0.85 (0.41)</td>
<td>0.72 (0.31)</td>
<td>0.86</td>
</tr>
<tr>
<td>Coparenting Cooperation</td>
<td>0.60 (0.22)</td>
<td>0.69 (0.23)</td>
<td>-0.79</td>
</tr>
<tr>
<td>Coparenting Conflict</td>
<td>0.29 (0.18)</td>
<td>0.26 (0.16)</td>
<td>0.37</td>
</tr>
<tr>
<td>Coparenting Triangulation</td>
<td>0.27 (0.32)</td>
<td>0.22 (0.21)</td>
<td>0.36</td>
</tr>
<tr>
<td>Adolescent Maladjustment</td>
<td>17.80 (6.87)</td>
<td>17.43 (6.47)</td>
<td>0.12</td>
</tr>
<tr>
<td>Primary Coping</td>
<td>2.42 (0.59)</td>
<td>2.28 (0.59)</td>
<td>0.54</td>
</tr>
<tr>
<td>Secondary Coping</td>
<td>2.35 (0.37)</td>
<td>2.34 (0.56)</td>
<td>0.06</td>
</tr>
<tr>
<td>Disengagement Coping</td>
<td>2.56 (0.73)</td>
<td>1.93 (0.66)</td>
<td>2.03*</td>
</tr>
</tbody>
</table>

*Note. Means and standard deviations provided in the table. Standard deviation values are in parentheses.

* p < .05, ** p < .01, *** p < .001.
Bivariate correlations (see Table 3) were conducted to assess whether participant age, grade, or family standard of living were significantly associated with the dependent variables. Family standard of living was the only demographic variable significantly correlated with the study variables. Specifically, family standard of living was associated with marital conflict, coparenting cooperation, and coparenting conflict. Higher standards of living were associated with lower levels of marital conflict and coparenting conflict and higher levels of coparenting cooperation. Broadly, the independent and dependent variables were significantly correlated with one another in the expected directions (e.g., coparenting cooperation and marital conflict were significantly negatively correlated; marital conflict and adolescent maladjustment were significantly positively correlated). However, primary and secondary engagement coping were not significantly correlated with marital conflict, adolescent maladjustment, or any of the coparenting variables. Following the collective findings from the preliminary analyses, the only demographic variables controlled in the subsequent analyses included parent educational attainment and family standard of living.
Table 3

Bivariate Correlations among Continuous Demographic, Independent, and Dependent Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Grade</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.94***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Family Standard of Living</td>
<td></td>
<td>.06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Marital Conflict</td>
<td></td>
<td></td>
<td>-.03</td>
<td></td>
<td>-.07</td>
<td>-.28*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Coparenting Cooperation</td>
<td></td>
<td>-.02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Coparenting Conflict</td>
<td></td>
<td>.18</td>
<td></td>
<td></td>
<td>.20</td>
<td>-.24*</td>
<td>.42***</td>
<td></td>
<td>-.69***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Coparenting Triangulation</td>
<td>.03</td>
<td>.02</td>
<td>-.19</td>
<td></td>
<td></td>
<td></td>
<td>.57***</td>
<td>-.52***</td>
<td>.39***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Adolescent Maladjustment</td>
<td>.08</td>
<td>.12</td>
<td>.21</td>
<td>.33**</td>
<td></td>
<td>-.42***</td>
<td>.39**</td>
<td>.35**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Primary Coping</td>
<td></td>
<td>.04</td>
<td>.06</td>
<td>.09</td>
<td>-.02</td>
<td>-.14</td>
<td>.12</td>
<td>.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Secondary Coping</td>
<td>-.07</td>
<td>-.10</td>
<td>.06</td>
<td>.06</td>
<td>-.00</td>
<td>-.04</td>
<td>.06</td>
<td>-.02</td>
<td>.61***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Disengagement Coping</td>
<td>-.05</td>
<td>-.07</td>
<td>-.16</td>
<td>.45***</td>
<td>-.34**</td>
<td>.30**</td>
<td>.45***</td>
<td>.29**</td>
<td>.35**</td>
<td>.49**</td>
<td></td>
</tr>
</tbody>
</table>

*Note. N = 79, * p < .05, ** p < .01, *** p < .001.*
Mediation Analyses

Hypothesis 1 proposed that the three dimensions of coparenting would mediate the association between marital conflict and psychological adjustment. To test this hypothesis, the PROCESS macro (Hayes, 2013) was used for three identical regression analyses. To derive direct, indirect, and total effects in a mediation model, PROCESS conducts a sequence of linear regressions to examine the effect of the independent variable on the mediator (i.e., the \( a \) pathway), the effect of the mediator on the dependent variable (i.e., the \( b \) pathway), the effect of the independent variable on the dependent variable while holding the mediator constant (i.e., the direct effect), the product of \( a \) and \( b \) (i.e., the indirect effect of the independent variable on the dependent variable through the mediator), and the sum of the direct and indirect effects of the independent variable (i.e., the total effect). For the current analyses, the PROCESS macro utilized bias-corrected bootstrapped estimates of the confidence intervals for the indirect effects (hereby referred to as “associations” rather than “effects” given the cross-sectional design of the present study cannot determine causality as is suggested by the term “effect”). Bootstrapping in a mediation analysis is a resampling method that constructs a confidence interval around the indirect association. The present analyses utilized a bootstrap sample of 10,000 replications with replacement. Linear regression analyses were then run on each bootstrap sample via PROCESS to compute 10,000 indirect associations. The indirect associations were then arranged in ascending order to determine the lower and upper bounds of the confidence interval. The 95% confidence intervals for these analyses are considered significant if they do not contain zero (Hayes, 2018).
All three mediation analyses controlled for parent educational attainment and family standard of living. The first analysis (i.e., Hypothesis 1a) included coparenting cooperation as the mediating variable of the association between marital conflict (the independent variable) and adolescent psychological maladjustment (the dependent variable). As shown in Figure 6, results from this first mediation analysis indicated the link between marital conflict and teen maladjustment was fully mediated by coparenting cooperation, as the direct pathway between marital conflict and adolescent maladjustment was nonsignificant. Additionally, there was a significant indirect association between marital conflict and adolescent maladjustment via coparenting cooperation, as the 95% confidence interval did not include zero (0.56 to 7.67; see Table 4).

![Figure 6: Indirect effects model of Marital Conflict predicting Adolescent Maladjustment via Coparenting Cooperation (N = 79). Unstandardized coefficients are shown. Standard errors are in parentheses. Analysis controlled for Family Standard of Living and Parent Educational Attainment. *p < .05. **p < .01. ***p < .001.](image-url)
Table 4
Indirect Associations between Marital Conflict and Adolescent Outcomes through Coparenting

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Dependent Variable</th>
<th>Mediator</th>
<th>Unstandardized Indirect Effect</th>
<th>Standard Error</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Conflict</td>
<td>Adolescent Maladjustment</td>
<td>Coparenting Cooperation</td>
<td>3.91*</td>
<td>1.76</td>
<td>0.56 to 7.67</td>
</tr>
<tr>
<td>Marital Conflict</td>
<td>Adolescent Maladjustment</td>
<td>Coparenting Conflict</td>
<td>2.22*</td>
<td>1.23</td>
<td>0.43 to 5.23</td>
</tr>
<tr>
<td>Marital Conflict</td>
<td>Adolescent Maladjustment</td>
<td>Coparenting Triangulation</td>
<td>2.57</td>
<td>1.68</td>
<td>-0.30 to 6.27</td>
</tr>
<tr>
<td>Marital Conflict</td>
<td>Adolescent Maladjustment</td>
<td>Coparenting Cooperation</td>
<td>2.15</td>
<td>2.18</td>
<td>-2.53 to 6.10</td>
</tr>
<tr>
<td>Marital Conflict</td>
<td>Adolescent Maladjustment</td>
<td>Coparenting Conflict</td>
<td>1.26</td>
<td>1.30</td>
<td>-0.56 to 4.59</td>
</tr>
<tr>
<td>Marital Conflict</td>
<td>Adolescent Maladjustment</td>
<td>Coparenting Triangulation</td>
<td>1.69</td>
<td>1.70</td>
<td>-1.17 to 5.56</td>
</tr>
</tbody>
</table>
The next mediation analysis included coparenting conflict as the mediating variable, while marital conflict and adolescent maladjustment remained as the independent and dependent variables, respectively (i.e., Hypothesis 1b). Consistent with the previous mediation analysis, the direct association between marital conflict and adolescent psychological maladjustment was nonsignificant, thus indicating that coparenting conflict fully mediated this association (see Figure 7). As shown in Table 4, a significant indirect association emerged for the connection between marital conflict and adolescent maladjustment via coparenting conflict, as the 95% confidence interval for the indirect association did not include zero (0.43 to 5.23).

Figure 7: Indirect effects model of Marital Conflict predicting Adolescent Maladjustment via Coparenting Conflict (N = 79). Unstandardized coefficients are shown. Standard errors are in parentheses. Analysis controlled for Standard of Living and Parent Educational Attainment.
*p < .05. **p < .01. ***p < .001.
To test Hypothesis 1c, the PROCESS macro (Hayes, 2013) was utilized with coparenting triangulation as the mediating variable. However, the direct associations between marital conflict and adolescent maladjustment as well as coparenting triangulation and adolescent maladjustment (i.e., the $b$ pathway) remained nonsignificant for the full mediation analysis (see Figure 8). Moreover, unlike the previous mediation analyses, the indirect association between marital conflict and adolescent psychological maladjustment was nonsignificant via coparenting triangulation, as the 95% confidence interval included zero (-0.30 to 6.27; see Table 4). In sum, the mediation analyses partially support Hypothesis 1, as the association between marital conflict and adolescent psychological maladjustment was fully mediated by coparenting cooperation (i.e., supporting Hypothesis 1a) and coparenting conflict (i.e., supporting Hypothesis 1b), but not coparenting triangulation (i.e., Hypothesis 1c was unsupported).

Figure 8: Indirect effects model of Marital Conflict predicting Adolescent Maladjustment via Coparenting Triangulation (N = 79). Unstandardized coefficients are shown. Standard errors are in parentheses. Analysis controlled for Family Standard of Living and Parent Educational Attainment.

*p < .05. **p < .01. ***p < .001
Research Question 1 asked which of the three coparenting constructs would significantly predict adolescent maladjustment when considered simultaneously in a parallel mediation analysis (see Figure 2). To address this question, the PROCESS macro (Hayes, 2018) was used. Unlike serial mediation, parallel mediation allows for multiple mediators to be correlated, but not causally associated with one another (Hayes, 2018). As such, the PROCESS macro computes several linear regression equations similar to those outlined above for simple mediation. However, for the current analysis, three mediator variables were entered into the equation (i.e., coparenting cooperation, coparenting conflict, and coparenting triangulation); thus, there were three \( a \) pathways (i.e., the direct pathways from the independent variable, marital conflict, to each mediating variable) and three \( b \) pathways (i.e., the pathways from each mediator to the dependent variable, adolescent maladjustment). When computing the regressions for the \( a \) pathways, PROCESS estimates the associations between the independent variable (marital conflict) and each mediator. However, when computing the regressions for each \( b \) pathway, PROCESS estimates the association between each mediator (e.g., \( b_1 \): coparenting cooperation) and the dependent variable (adolescent maladjustment), while controlling for the direct associations of the independent variable (marital conflict) and the associations of the other mediators (e.g., \( b_2 \): coparenting conflict, and \( b_3 \): coparenting triangulation). Next, the direct association of the independent variable (i.e., marital conflict) and the dependent variable (i.e., adolescent maladjustment) is estimated by holding the associations of each mediator constant. Additionally, given that the current parallel model has three mediators, PROCESS also computed three separate indirect associations by multiplying the respective \( a \) and \( b \) pathways. PROCESS computed the total indirect association between
marital conflict and adolescent maladjustment through all three coparenting variables by taking the sum of the three indirect associations. Finally, consistent with the simple mediation models, bias-corrected bootstrapped estimates of the confidence intervals for the indirect associations were calculated (n = 10,000 replications). The 95% confidence intervals for these analyses are considered significant if they do not contain zero (Hayes, 2018). In addition, consistent with the analyses utilized to address Hypothesis 1, family standard of living and parent educational attainment were included as demographic control variables.

As shown on Figure 9, the direct pathway between marital conflict and adolescent maladjustment was nonsignificant. Additionally, as shown in Table 4, the indirect pathways for each coparenting variable were nonsignificant, as the 95% confidence intervals for all three indirect associations included zero. Therefore, none of the three coparenting variables demonstrated significant mediation on the link between marital conflict and adolescent maladjustment when considered simultaneously.
Figure 9: Indirect effects model of Marital Conflict predicting Adolescent Maladjustment via Coparenting Cooperation, Coparenting Conflict, and Coparenting Triangulation (N = 79). Unstandardized coefficients are shown. Standard errors are in parentheses. Analysis controlled for Family Standard of Living and Parent Educational Attainment. Total unstandardized indirect effect = 4.99 (standard error = 2.04, 95% CI = 1.26, 9.30).
*p < .05. **p < .01. ***p < .001
Moderated Mediation Analyses

Research Questions 2, 3, and 4 assessed whether the three forms of coping (i.e., primary engagement coping, secondary engagement coping, and voluntary disengagement coping) would moderate the direct association between marital conflict and adolescent maladjustment and the indirect connections via each coparenting dimension (see Figures 3, 4, and 5). To address each research question, model 15 from the PROCESS macro (Hayes, 2013) was used to test moderated mediation of the $b$ and $c$ pathways for the parallel mediation model that included all three coparenting variables as mediators. Using the PROCESS macro, hierarchical multiple regression analyses were conducted. The independent variables (i.e., marital conflict, coparenting cooperation, coparenting conflict, and coparenting triangulation) and moderator variables (i.e., secondary control coping, primary control coping, and voluntary disengagement coping) were mean-centered by the program to avoid issues of multicollinearity between the original variables and interaction terms. The mean-centered independent variables were then multiplied with each mean-centered moderator variable to create four interaction terms. The mean-centered variables, interaction terms, and demographic control variables (i.e., family standard of living and parent educational attainment) were then utilized by the PROCESS macro. Model 15 of the PROCESS macro yielded indices of moderated mediation for each conditional indirect association between marital conflict and adolescent maladjustment via coparenting. Indices of moderated mediation are considered statistically significant if their bias-corrected bootstrapped estimates of the confidence intervals do not contain zero.

Research Question 2 asked whether secondary control coping would moderate the
direct and indirect associations between marital conflict and adolescent maladjustment. As shown on Figure 10, the direct pathway between marital conflict and adolescent maladjustment was not significantly moderated by secondary control coping. Additionally, the indices of moderated mediation were nonsignificant for all three coparenting pathways with secondary control coping as the moderator (see Table 5).

Research Question 3 assessed whether primary control coping would moderate the direct association between marital conflict and adolescent maladjustment and the indirect associations via coparenting cooperation, coparenting conflict, and coparenting triangulation (see Figure 4). Consistent with the previous analysis, model 15 of the PROCESS macro was used (Hayes, 2013). Results from this analysis demonstrated similar findings, as the direct association between marital conflict and adolescent maladjustment was not significantly moderated by primary control coping (see Figure 11). Additionally, all three indices of moderated mediation were nonsignificant (see Table 6).

Finally, the PROCESS macro (Hayes, 2013) was again used to address Research Question 4, which similarly examined moderated mediation of the full coparenting model with voluntary disengagement coping as the moderator. Similar to the previous analyses, voluntary disengagement coping did not significantly moderate the direct pathway between marital conflict and adolescent maladjustment (see Figure 12) and the indices of moderated mediation were nonsignificant (see Table 7). Collectively, all three research questions received similar findings, as none of the coping variables significantly moderated the direct associations between marital conflict and adolescent maladjustment or the indirect associations via coparenting.
Figure 10: Indirect effects model of moderated mediation with Secondary Engagement Coping moderating the indirect pathways between Coparenting and Adolescent Maladjustment as well as the direct pathway between Marital Conflict and Adolescent Maladjustment (N = 79). Unstandardized coefficients are shown on the a pathways. Unstandardized coefficients for the interaction terms are shown on the b pathways. Standard errors are in parentheses. Analysis controlled for Family Standard of Living and Parent Educational Attainment. *p < .05. **p < .01. ***p < .001.
<table>
<thead>
<tr>
<th>Moderated Mediation Pathway: Secondary Engagement Coping</th>
<th>Index of Moderated Mediation</th>
<th>Standard Error</th>
<th>Boot LLCI</th>
<th>Boot ULCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Conflict → Coparenting Cooperation → Adolescent Maladjustment</td>
<td>0.51</td>
<td>5.14</td>
<td>-10.28</td>
<td>10.13</td>
</tr>
<tr>
<td>Marital Conflict → Coparenting Conflict → Adolescent Maladjustment</td>
<td>-2.88</td>
<td>3.61</td>
<td>-10.87</td>
<td>3.69</td>
</tr>
<tr>
<td>Marital Conflict → Coparenting Triangulation → Adolescent Maladjustment</td>
<td>-0.77</td>
<td>3.56</td>
<td>-7.05</td>
<td>7.05</td>
</tr>
</tbody>
</table>
Figure 11: Indirect effects model of moderated mediation with Primary Engagement Coping moderating the indirect pathways between Coparenting and Adolescent Maladjustment as well as the direct pathway between Marital Conflict and Adolescent Maladjustment (N = 79). Unstandardized coefficients are shown on the a pathways. Unstandardized coefficients for the interaction terms are shown on the b pathways. Standard errors are in parentheses. Analysis controlled for Family Standard of Living and Parent Educational Attainment. *p < .05. **p < .01. ***p < .001.
Table 6
Indices of Moderated Mediation: Primary Engagement Coping as a Moderator

<table>
<thead>
<tr>
<th>Moderated Mediation Pathway: Primary Engagement Coping</th>
<th>Index of Moderated Mediation</th>
<th>Standard Error</th>
<th>Boot LLCI</th>
<th>Boot ULCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Conflict → Coparenting Cooperation → Adolescent Maladjustment</td>
<td>0.30</td>
<td>4.39</td>
<td>-9.92</td>
<td>7.36</td>
</tr>
<tr>
<td>Marital Conflict → Coparenting Conflict → Adolescent Maladjustment</td>
<td>-1.21</td>
<td>2.51</td>
<td>-6.77</td>
<td>3.42</td>
</tr>
<tr>
<td>Marital Conflict → Coparenting Triangulation → Adolescent Maladjustment</td>
<td>-2.72</td>
<td>3.81</td>
<td>-9.15</td>
<td>6.51</td>
</tr>
</tbody>
</table>
Figure 12: Indirect effects model of moderated mediation with Voluntary Disengagement Coping moderating the indirect pathways between Coparenting and Adolescent Maladjustment as well as the direct pathway between Marital Conflict and Adolescent Maladjustment (N = 79). Unstandardized coefficients are shown on the a pathways. Unstandardized coefficients for the interaction terms are shown on the b pathways. Standard errors are in parentheses. Analysis controlled for Family Standard of Living and Parent Educational Attainment. *p < .05. **p < .01. ***p < .001.
<table>
<thead>
<tr>
<th>Moderated Mediation Pathway: Voluntary Disengagement Coping</th>
<th>Index of Moderated Mediation</th>
<th>Standard Error</th>
<th>Boot LLCI</th>
<th>Boot ULCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Conflict → Coparenting Cooperation → Adolescent Maladjustment</td>
<td>-1.83</td>
<td>3.51</td>
<td>-8.84</td>
<td>5.19</td>
</tr>
<tr>
<td>Marital Conflict → Coparenting Conflict → Adolescent Maladjustment</td>
<td>0.77</td>
<td>2.08</td>
<td>-2.94</td>
<td>5.52</td>
</tr>
<tr>
<td>Marital Conflict → Coparenting Triangulation → Adolescent Maladjustment</td>
<td>-1.39</td>
<td>2.68</td>
<td>-7.91</td>
<td>3.00</td>
</tr>
</tbody>
</table>
The current study examined the associations between marital conflict, coparenting, adolescent psychological adjustment, and coping behaviors among a sample of treatment-seeking adolescents. The link between marital conflict and adolescent psychological adjustment was significantly mediated by coparenting conflict and coparenting cooperation, but not coparenting triangulation. When considering all three coparenting variables together, none of the coparenting dimensions significantly mediated the link between marital conflict and adolescent psychological adjustment. Furthermore, teen coping behaviors did not significantly moderate the full mediation model. These findings and their implications are discussed below.

Mediating Influences of Coparenting

Consistent with previous research demonstrating that marital conflict is associated with youth maladjustment (e.g., Fincham, 2003; Grych & Fincham, 1990), the current
findings demonstrated a significant association between marital conflict and adolescent maladjustment. However, there is growing evidence that the coparenting relationship may influence the association between marital conflict and youth adjustment (e.g., Feinberg, 2007; Flannery, 2017; Lamela et al., 2015; Margolin et al., 2001). Thus, the present study hypothesized that the three dimensions of coparenting would mediate the association between marital conflict and adolescent psychological adjustment. This hypothesis was partially supported, as coparenting cooperation and coparenting conflict each significantly mediated the link between marital conflict and adolescent adjustment. However, contrary to the study hypotheses, coparenting triangulation did not significantly mediate the connection between marital conflict and overall adolescent psychological maladjustment.

As shown in Figure 6, the data from the current study indicate that coparenting cooperation fully explains the association between marital conflict and adolescent maladjustment. Moreover, lower levels of marital conflict were linked with greater levels of coparenting cooperation, which in turn was associated with lower levels of adolescent psychological maladjustment. The connections between coparenting cooperation and outcomes of early childhood are well established (e.g., Choi et al., 2019; Scrimgeour et al., 2013), but the present investigation adds to the small body of literature examining coparenting cooperation and adolescent outcomes.

The influence of coparenting cooperation on adolescent outcomes has not been widely studied and the findings have been inconsistent. For example, higher rates of cooperative coparenting at child age 13 have been associated with fewer adolescent risky behaviors 3 and 4 years later, but not associated with adolescent depressive symptoms (Riina & McHale,
Conversely, Baril and colleagues (2007) did not find evidence for a longitudinal influence of coparenting cooperation on adolescent risky behavior. However, results from the present study extend the 2017 findings from Flannery, by demonstrating that adolescent appraisals of coparenting cooperation fully mediate the link between marital conflict and adolescent psychological adjustment for treatment-seeking middle and high school-aged teenagers. Cooperative coparenting has been shown to be connected with greater support of adolescent autonomy, less psychological control regarding achievement, and more collaborative with and accepting of their teenagers (Sznitman et al., 2019). Cooperative coparenting is also associated with increased emotional and physical availability to the offspring (Margolin et al., 2001). Collectively, this might explain why adolescents show better psychological adjustment when coparenting cooperation is present, even when receiving outpatient mental health services. Additionally, adolescents exposed to more cooperative coparenting experience less interparental conflict (Ahrons, 2011). However, the lower rates of marital conflict may not fully explain better adolescent adjustment. Rather, findings from the present study suggest that cooperative coparenting explains this link, as cooperative coparents model mutual support and more prosocial behaviors in their caregiving roles, thus, leading to better adolescent outcomes.

The current study also demonstrated that coparenting conflict fully mediates the link between marital conflict and adolescent psychological maladjustment (see Figure 7). Previous literature has demonstrated that conflict within the coparenting relationship may influence interactions within the marital relationship, and vice-versa, thus indicating that coparenting conflict and marital conflict are highly associated constructs (Margolin et al., 2001).
However, extant research has also shown that both of these constructs have unshared variance when predicting child and adolescent outcomes (Feinberg et al., 2007; Flannery, 2017; Margolin et al., 2001; Schoppe-Sullivan et al., 2004). Further, results from the present study extend previous research by further demonstrating that coparenting conflict mediates the relationship between marital conflict and youth outcomes. Parent reports of coparenting and marital conflict have shown that coparenting conflict mediates the relationship between marital violence and child symptoms of anxiety and depression (Katz & Low, 2004), and mediates the link between parent reports of marital conflict and adolescent self-reports of delinquency and symptoms of depression (Cui et al., 2007; Zemp et al., 2018). A recent study also demonstrated that adolescent reports of coparenting conflict partially mediate the link between marital conflict and their own externalizing problems (Flannery, 2017).

As such, results from the present analysis have extended the literature by further demonstrating that coparenting conflict mediates the link between marital conflict and adolescent psychological maladjustment. The current findings are also unique, in that they demonstrate these results utilizing adolescent report, whereas the bulk of the coparenting literature has relied on parent report of these processes. Additionally, data for the present study utilized a sample of treatment-seeking adolescents, thus indicating that this association remains significant for youth receiving outpatient mental health services. It is plausible that coparenting conflict may have a greater degree of personalization for an adolescent, whereas teenagers may feel more removed from marital conflict. In definition, coparenting conflict includes dissension, disagreement, undermining behaviors, and arguments specifically about parenting decisions and child rearing (Feinberg et al., 2007). Conversely, marital conflict is
broader, as it includes verbal, physical, and/or psychological aggression, relationship dissatisfaction, general marital disagreements, and more (Fincham, 2003; Grych & Fincham, 1990; Jouriles et al., 1989). However, difficulties within the marital relationship could spillover to the coparenting relationship by influencing attitudes and behaviors within this childrearing dynamic (Katz & Gottman, 1996; Margolin et al., 2001). However, given that coparenting directly concerns decisions about the child, adolescents may feel a greater sense of shame, responsibility, distress, or frustration when there is conflict in this relationship. As such, this may potentially explain why coparenting conflict has shown to mediate the connection between marital conflict and adolescent psychological maladjustment.

Unlike coparenting cooperation and conflict, coparenting triangulation did not significantly mediate the association between marital conflict and adolescent psychological maladjustment in the present study. This was surprising, as coparenting triangulation was found to fully mediate the links between marital conflict and adolescent internalizing and externalizing problems in a sample of middle school students in a recent study (Flannery, 2017). Additionally, Grych and colleagues (2004) found that adolescents experiencing higher levels of marital conflict were more likely to be pulled into interparental disagreements. Moreover, this interparental triangulation mediated the association between marital conflict and adolescent maladjustment (Grych et al., 2004). However, the present analysis made an adjustment to one of the 4 triangulation items on the CI-PA (i.e., the item, “I get involved in my parents’ arguments” was reworded to “I get involved in my parents’ arguments about raising me”) to more accurately represent coparenting triangulation than interparental triangulation. Reliability analyses indicated this item slightly improved the internal
consistency of the triangulation subscale. The previous study by Flannery (2017) did not include this change on the CI-PA, and it is therefore possible that the previous research did not as accurately measure coparenting triangulation. As such, the 2017 study by Flannery may have been more consistent with the extant literature that has shown interparental triangulation as a mediator of the association between marital conflict and youth outcomes because it overlapped with the construct of marital conflict more so than it does in the current study. Additionally, the study by Flannery (2017) separately examined internalizing and externalizing outcomes for a sample of middle school students. It is possible that youth experiencing triangulation may have higher rates of internalizing and externalizing problems, but not attention problems, which is also measured on the full scale of the BPM.

The present research also asked which coparenting construct, if any, would mediate the link between marital conflict and adolescent maladjustment when all three coparenting constructs are considered simultaneously. The answer to that question, according to the current findings, is that none of the coparenting variables significantly mediated this link when considered in a parallel model. Flannery (2017) simultaneously considered all three coparenting variables within a hierarchical regression analysis, controlling for marital conflict. Within this analysis, triangulation maintained the strongest connection with adolescent internalizing and externalizing problems, while the associations between coparenting cooperation and coparenting conflict reduced to nonsignificance. However, as previously stated, the measure utilized for this 2017 study may have partially examined interparental triangulation rather than solely measuring coparenting triangulation. Additionally, coparenting triangulation was not a significant mediator in the current study,
and previous research has shown that the connections between coparenting conflict and cooperation reduce to nonsignificance when all three are considered simultaneously. Therefore, the nonsignificant findings are not as surprising when examined in retrospect.

Coping with Coparenting Practices

Given extant connections between marital conflict, coparenting, and adolescent outcomes (e.g., Flannery, 2017), understanding the influence of adolescents’ coping styles in response to these processes was also explored in the current study. Namely, the present study examined whether secondary control, primary control, or voluntary disengagement coping would moderate the direct association between marital conflict and adolescent maladjustment, as well as the indirect associations via all three forms of coping. However, the results from this study did not support moderating influences of coping for any of the pathways. This was a novel research question, as the parallel mediation model for coparenting had not been previously examined, and the coping literature had not examined the effects of adolescents’ coping responses to coparenting within intact families. Yet, the results are surprising.

Secondary control coping tends to be associated with better outcomes for youth when used in response to stressors that are outside of their control, such as parent- and family-related stress (e.g., Compas et al., 2017; Jaser et al., 2007; Langrock et al., 2002). Secondary control coping has also shown to moderate the association between marital conflict and adolescent psychological maladjustment, with higher rates of secondary control coping leading to better outcomes for youth in this context (Tu et al., 2016). As such, it was
reasonable to explore whether or not secondary control coping would moderate the connections between all three forms of coparenting (i.e., stressors that are outside of the participants’ control), marital conflict, and adolescent psychological adjustment. However, secondary control coping was not significantly correlated with marital conflict, adolescent maladjustment, or any of the coparenting variables. In turn, secondary control coping also did not moderate the stated associations.

Unlike secondary control coping, primary control coping tends to be associated with poorer outcomes for youth when used in response to uncontrollable stressors (e.g., Compas et al., 2017). However, findings in the extant literature have been mixed, particularly with respect to the connections between primary control coping, marital conflict, and adolescent outcomes. For example, a recent study examining the longitudinal influences of marital conflict on youth outcomes found that primary control coping moderated the link between marital conflict and youth internalizing problems, but not externalizing problems (Tu et al., 2016). It was therefore worth considering the potential moderating influence of primary control coping on marital conflict and coparenting for the present study. However, consistent with the findings for secondary control coping, primary control coping was not significantly correlated with marital conflict, adolescent maladjustment, or any of the coparenting variables. Further, primary control coping did not moderate the direct or indirect (via coparenting) links between marital conflict and adolescent maladjustment.

Finally, voluntary disengagement coping has consistently shown to be associated with deleterious outcomes for youth, regardless of the degree of controllability of the stressor (Compas et al., 2017; Wadsworth & Compas, 2002). Moreover, disengagement coping has
previously shown to moderate the connection between marital conflict and adolescent maladjustment (Nicolotti et al., 2003). Despite the extant evidence, for the current study, disengagement coping revealed significant correlations with marital conflict, coparenting, and adolescent maladjustment, but did not moderate any of the proposed pathways.

Collectively, results from the present study did not provide evidence to support coping as a moderator of the association between marital conflict and adolescent psychological maladjustment, directly or indirectly (via coparenting cooperation, coparenting conflict, and coparenting triangulation). As such, it is possible that primary, secondary, and disengagement coping strategies are not associated with adolescents’ appraisals of coparenting. However, given the abundance of extant research demonstrating connections between coping and marital conflict, as well as coping and adolescent maladjustment, it is potentially more likely that the nonsignificant findings from the present study can be attributed to limitations of the sample and study procedure.

Age of the Present Sample

It is important to note that the present study is unique, as the sample includes data from adolescents with ages ranging from 11 through 18 ($M = 14.97, SD = 2.20$). The bulk of the coparenting literature to date has utilized parents of infants, toddlers, and school-age children, and more recently, parents of middle school children (see Teubert & Pinquart, 2010a for review). As such, the findings of the present study could potentially be explained by the age of the participants in the sample. Specifically, this sample trended toward older
adolescents, as 26.6% of the sample was in 12th grade, compared to a total of 26.6% of the sample being in 6-8th grade. Thus, it is possible that coparents interact with one another differently when their offspring are 17 or 18 years old compared to when they are 11, 12, or 13 years old. For example, older adolescents likely experience greater independence than younger adolescents. As a result, older adolescents could potentially feel more removed from their parents’ coparenting practices. Additionally, older adolescents likely utilize their own coping skills differently than younger adolescents, given that youth begin exploring their own self-directed coping behaviors when they enter young adolescence (Compas et al., 2017; Thompson & Goodman, 2010; Zimmer-Gembeck & Skinner, 2016). Given older adolescents’ greater independence and use of self-directed coping skills, it is also possible that older adolescents feel more comfortable triangulating when their parents engage in coparenting-related disagreements, unlike younger adolescents who experience discomfort when triangulated (e.g., Flannery, 2017). Taken altogether, the older age of the present sample could potentially explain the nonsignificant coping and triangulation findings.

Limitations and Future Directions

The findings from this study should be interpreted with consideration of several limitations. First, one influential limitation of the present study is the potentially confounding influence of COVID-19 on the data collection, procedure, results, and generalizability of the current study. Of note, the state of Illinois issued a shelter-in-place order on March 21, 2020 and began a process of slowly reopening on June 4, 2020. During the shelter-in-place, 38
participants completed the survey. Moreover, the final participant completed the survey in September of 2020, and the RSQ asks participants to report on stress from the past 6 months. Thus, all 79 participants reported during or reported on experiences they had while under mandatory shelter-in-place orders during the global COVID-19 pandemic.

The current research regarding the impact of COVID-19 on parent- and family-related stressors and youth outcomes is limited due to the unprecedented nature of this global pandemic. However, it is clear that COVID-19 caused unexpected challenges including disrupted family routines, new demands for parents and children, sweeping financial and job losses, and excess mortality rates. For example, in May of 2020, a poll of US adults showed that parents were experiencing higher levels of stress during the pandemic than were adults without children (APA, 2020). Contributing to this increased stress included many burdens of parenting. First, parenting roles shifted to include managing the challenges of homeschooling while also working from home. Second, there was less structure due to pauses of extracurricular activities. Third, there were concerns about their children missing out on major developmental milestones. Fourth, parents had to manage their own stress and their children’s stress related to self-isolation, access to healthcare services, and contracting COVID-19 (APA, 2020). Thus, the participants in this study were experiencing new stressors that were not anticipated by the study design.

A recent study examining changes in stress for parents during the COVID-19 pandemic found that parenting-specific stress increased from pre-pandemic ratings to May of 2020 and continued to increase by September of 2020. Additionally, the majority of the parents in the study reported it was difficult to continue to parent similarly to the way they did
before the pandemic (Adams et al., 2021). Consistent with these findings, parents with children with a physical or mental illness reported more negative emotional responses in their children (e.g., poorer concentration) and increased negative parenting (e.g., increased verbal hostility, higher levels of parental burnout) during the COVID-19 pandemic compared to parents of children who do not have physical or mental illnesses (Fontanesi et al., 2020). However, a recent systematic review of published literature regarding marital conflict during COVID-19 revealed mixed findings. Specifically, the review demonstrated evidence for reduced intimacy, increases in domestic violence, unfair distributions of domestic responsibilities, and general increases in marital conflict, particularly for couples with children compared to childless couples. However, there was also evidence that some family relationships were improved during the lockdown, as other couples experienced better communication, emotional expression, and balance between individual and family needs (Wisyaningrum, et al., 2021). The influences of the pandemic on coparenting also appear to be mixed. Using a sample of parents with children ages 8 – 10 years old, Feinberg and colleagues (2021) found that parental depression, child internalizing and externalizing problems, and coparenting conflict all increased from before the pandemic to the first 3 months of the pandemic. Conversely, Bentenuto et al., (2021) and Giannotti et al. (2021) did not find changes in coparenting practices pre-pandemic to the early months of the pandemic for parents of children aged 3 – 17. Altogether, there is evidence that the pandemic led to extensive changes to parenting stress and responsibilities, and mixed evidence that the pandemic led to changes in marital conflict and coparenting practices. Additionally, children and adolescents’ adjustment and ability to cope with these changes may have been influenced
by the pandemic.

As a result of the COVID-19 pandemic, children and adolescents were also faced with a lack of socialization from friends and structure provided by school and extracurricular activities. Consistent with this notion is the fact that, for many of the participants in the present study, stressors related to missing graduation, prom, spring and summer sports, art presentations, music and theater performances, college and high school orientations, summer jobs, summer socialization with friends, and concerns related to the virus itself may have been more salient at the time of survey completion than were stressors related to their parents’ interactions with one another. In fact, according to Adams et al. (2021), the most commonly cited strategy in decreasing parents’ stress for their sample included doing more family activities together. Consistent with this finding, Twenge et al. (2020) surveyed 1,523 adolescents from May – July of 2020. The authors found that 56% of their sample reported spending more time talking to their parents than they had pre-pandemic and 68% reported they had grown closer to their families. As such, it is possible that participants in the present study were spending more time engaging in positive activities with their parents as a result of COVID-19, and potentially influencing the outcomes of the current study. Notably, all 79 youth in this study participated during or reported on their coping behaviors and family processes occurring during the early months of the pandemic. As such, it is reasonable to believe that the patterns observed with the present findings would be different if the data were collected later in the pandemic. In sum, it is particularly challenging to generalize conclusions from the current study, as the data were collected during an unprecedented time period. Parent and family interactions, adolescent coping responses, and youth outcomes looked vastly
different during COVID-19 compared to life before or after the outbreak. Moreover, the measures used for this study had not been developed for the conditions of a pandemic-related lockdown. Thus, the influence of COVID-19 likely serves as a key limitation to the current study, and may also explain many of the nonsignificant findings.

Limitations specific to the sample size might have also influenced the present study. First, the sample size of 79 is small, limiting the study’s statistical power and increasing the likelihood of a type II error. This was smaller than the intended goal of 138 participants based on \( a \ priori \) G*Power analyses (Faul et al., 2009). Post hoc G*Power analyses revealed the current study achieved a power of 0.73 given the sample size of 79 and number of predictors in the full moderated mediation analyses for Research Questions 2-4. For the basic mediation analyses used to address Hypothesis 1, the sample size of 79 had an achieved power of 0.87. Thus, the achieved power for the present study fell short of the desired 0.95 power value. If the intended sample size had been reached, smaller effect sizes might have been significant.

The demographics of the current sample also present a limitation, as the sample was largely non-Hispanic white (74.7%), female (62.0%), older adolescents (73.4% in high school, with 26.6% of the sample in 12\textsuperscript{th} grade) with well-educated (86.1% with at least one college-educated parent) affluent parents (87.3% reported their family had more than enough money or a comfortable standard of living). Furthermore, the vast majority of the coparenting relationships included biological mother-father dyads (94.9%). As such, the findings from this study may not be representative of all adolescents or of adolescents with demographic backgrounds that are not as well represented by the current sample. Additionally, the present findings may not be as representative of other samples of treatment-seeking adolescents, as
46.8% of the current sample reported receiving therapy for 12 months or longer. It is possible these participants had received intervention addressing poor coping strategies, thus influencing the current coping findings. It is also possible that these youth might have been facing greater challenges given that they had been in therapy for an extended period of time. Therefore, replication of this study with a larger sample size, greater representation across demographic variables, and greater variation in time in treatment should be considered before generalizing the present findings.

The present study only included a sample of cohabitating coparents, with 95% of the sample reporting on their biological parent dyads. As such, the current findings cannot be generalized to non-cohabitating parents. Future research may specifically consider investigating the current findings within the context of same-sex coparents, divorced coparents, or nontraditional coparenting dynamics (e.g., grandparents, extended relatives, neighbors, close family friends). Possible coparenting configurations are numerous and family structures are often changing and vary widely. Therefore, in an effort to generalize findings from the current study, future research should consider examining similar processes across more diverse coparental configurations.

The cross-sectional design of this study also represents a limitation of the findings, as this prevents drawing causal conclusions. Future studies may consider using a longitudinal design to examine the ordering and potential bidirectional associations between constructs (e.g., adolescent maladjustment, particularly for youth receiving treatment for mental health concerns, could influence marital conflict or coparenting and vice-versa). For example, a longitudinal study could examine the manner in which adolescent maladjustment and coping
behaviors, marital conflict, and coparenting practices develop over time and whether any of these constructs emerge first and influence the others, directly or bidirectionally, at later time points. Additionally, experimental designs could be considered in the future to fully address causality of any of the associations examined in the current study. Namely, an experimental design could manipulate the coparenting variable by increasing cooperation and decreasing conflict and triangulation through intervention to more conclusively understand whether the coparenting relationship causally influences adolescent maladjustment. Using a cross-sequential design, one would be able to examine scenarios in which the coparenting relationship naturally became more negative to better understand how this influences adolescent outcomes (or vice-versa) over time. Future studies of this nature would allow for increased understanding of the developmental trends and directional influences of coparenting and adolescent maladjustment and coping behaviors.

The use of adolescent report for this study is necessary and unique, as few studies have examined adolescent perceptions of their parents’ coparenting practices. Moreover, self-report data are often ideal indicators of individual, internal, and emotional experiences (e.g., internalizing symptoms, internalized coping processes such as cognitive restructuring, etc.). There is also extant evidence that adolescent outcomes are more closely related to their own appraisals of family processes than to parent or observational report (e.g., Glasgow et al., 1997; Grych et al., 1992; Neiderhiser et al., 1998; Paulson et al., 1994; Spera, 2006). Despite these strengths of adolescent self-report, the use of single-informant data for the present study is a limitation. Future research could utilize multiple raters and observational reports to more fully examine the manner in which coparenting might influence adolescent outcomes and to
also eliminate potential issues of informant bias.

The present study did not collect data regarding participant diagnoses, but future research might consider collecting diagnostic impressions, symptom profiles, or co-occurring health concerns if utilizing a sample of treatment-seeking youth. Of note, it is possible that adolescents with different clinical presentations might engage in different coping patterns, respond differently on measures of psychological adjustment, or even have more variable appraisals of their parents’ coparenting. The present study collected a broad sample of treatment-seeking adolescents and utilized a broad measure of psychological adjustment. However, future research collecting diagnostic information and disentangling the broad measures of adjustment might better identify more specific clinical demographics, outcomes (e.g., aggression), and coping behaviors associated with coparenting.

Summary and Clinical Impressions

The present study contributed to the burgeoning coparenting literature by examining coparenting as a mediator of the influences of marital conflict on youth psychological adjustment, as well as moderating effects of coping behaviors, within a sample of treatment-seeking adolescents. Although not all of the hypotheses were supported, initial results demonstrated that coparenting cooperation and coparenting conflict both mediated the link between marital conflict and adolescent maladjustment. Despite these nonsignificant findings, conclusions can be drawn from the present study, as adolescent perceptions of coparenting practices (especially coparenting conflict and coparenting cooperation) were shown to be
related to their own psychological adjustment. It may therefore be important to recognize the coparenting relationship as a point of intervention for healthier youth outcomes, particularly given that these findings were represented by a sample of treatment-seeking youth.

In addressing the coparenting relationship as a point of intervention, family- or parent-level intervention that aims to reduce marital and coparenting conflict and offers strategies to increase behaviors that are aligned with coparenting cooperation might have positive influences on adolescent psychological adjustment. Clinicians working with couples in relationship counseling might also consider highlighting the coparenting relationship as a target for intervention. Parents receiving this type of intervention might knowingly or unknowingly have a child challenged with psychological difficulties (e.g., internalizing symptoms related to anxiety or depression) that could benefit from this treatment. For example, the web-based OurRelationship intervention program (an online 4- to 6-week integrative behavioral couple therapy program) has shown to decrease coparenting conflict over the course of 1 year, which in-turn has been associated with reduced child internalizing and externalizing problems (Doss et al., 2020). Moreover, parents might benefit from improved coparenting practices because the marital and coparenting relationships are often associated with one another. For example, Nunes et al. (2021) identified a six-step process to achieving greater coparenting satisfaction through marital therapy, which resulted in an improved marital satisfaction due to spillover effects between the marital and coparenting relationships. Finally, the majority of participants in the present study (92.4%) reported receiving solely individual therapy with occasional parent check-ins with their therapist. None
of the participants reported receiving family therapy, occasional parent-child joint sessions, or occasional parent-only sessions. The present findings indicate that adolescent perceptions of their parents’ coparenting practices are associated with their own psychological adjustment. As such, including parents in treatment by increasing the frequency of family sessions, parent-child sessions, or parent-only sessions to provide psychoeducation on coparenting could prove beneficial to the child and broader family system.
REFERENCES


APPENDICES
Title of Study: Adolescents and Family Processes

Key Information
- This is a voluntary research study on adolescent perceptions of family processes.
- This 15-minute study involves the completion of an electronic survey.
- The benefits include contributing to the growing field of research regarding adolescent perceptions of family processes, which may have implications for the development of future clinical treatments; direct benefits to your child may include gaining insight into family processes, which may be informative for treatment; the only reasonably foreseeable risk involved in completing this study is that your child might experience mild discomfort when reflecting on potentially negative events or difficult relationships.

Description of the Study
The purpose of the study is to examine how adolescents view family processes and how these views influence their psychological health. If you agree to allow your child to be in this study, your child will be asked to complete an electronic questionnaire. Questionnaires will include items about their mood, behavior, and perceptions of their family processes. Completing these questionnaires should take between 15 and 20 minutes. The study will not interfere with their clinical treatment.

Risks and Benefits
The study has the following risks. First, your child might experience mild discomfort when reflecting on potentially difficult relationships or negative events. There are no additional reasonably foreseeable (or expected) risks.

The benefits of participation include contributing to the growing field of research regarding family processes. Important gaps in the field will be addressed by this study, which may have implications for future forms of clinical and family interventions. Additionally, your child may directly benefit from the study, as thinking about their family processes can build insight that might be helpful in their own therapeutic intervention(s).

Anonymity
- This study is anonymous. We will not be collecting or retaining any information about your child’s identity. This study will utilize Qualtrics, a computer-based survey tool, to collect questionnaire responses. During the data collection phase, all data will be stored on the Qualtrics servers. Qualtrics protects the privacy of survey data. You can see their online documentation at http://www.qualtrics.com/security-statement/ and http://www.qualtrics.com/privacy-statement/.
- The records of this study will be kept strictly confidential. Once the data are transferred off of Qualtrics, they will be stored on password-protected computers in a locked research lab, which only research staff can access. We will not include any information in any report we may publish that would make it possible to identify your child.
Compensation
Your child will receive a $10 Amazon gift card in compensation for participating. This will be administered electronically by the primary researcher within one week of study participation.

Your Rights
The decision to allow your child to participate in this study is entirely up to you. You may refuse to have your child take part in the study at any time. Your decision will not affect your child’s clinical services being received at this agency and will not result in any loss of benefits to which you are otherwise entitled. Your child has the right to skip any question or research activity, as well as to withdraw completely from participation at any point during the process. You have the right to ask questions about this research study and to have those questions answered before, during, or after the research. If you have any further questions about the study, at any time feel free to contact the researcher, Andrew Flannery, at teencopingstudy@gmail.com, or the faculty advisor, Dr. Laura Pittman, at lpittman@niu.edu or by telephone at (815) 753-2485. If you have any questions about your child’s rights as a research participant that have not been answered by the investigators or if you have any problems or concerns that occur as a result of your child’s participation, you may contact the Office of Research Compliance, Integrity, and Safety at (815) 753-8588. If you have any problems or concerns that occur as a result of your child’s participation, you can report them to the Office of Research Compliance at the number above.
Your signature below indicates that you have agreed to allow your child to volunteer as a research participant for Adolescents and Family Processes Study, and that you have read and understood the information provided above. Please detach this signed page and email it to the primary researcher, Andrew Flannery, at teencopingstudy@gmail.com. Mr. Flannery will then email the survey link to your child at the email address you indicate below. You may keep the remaining portion of this document for your own records. 

**Alternatively**, if you do not have access to a printer, you may provide an electronic signature **OR** you may send a message to Mr. Flannery at teencopingstudy@gmail.com indicating your consent and the best email address to reach your child.

__________________________________________

Child’s Name

__________________________________________

Child’s Email Address

__________________________________________

Parent’s Signature

__________________________________________

Date
APPENDIX B

INFORMED ASSENT FORM
You are being asked to participate in a study that focuses on your parents’ interactions with one another and how they work together to raise you. The study will also focus on how you typically think and feel.

If you decide you would like to help out with this study, you will be asked to fill out some surveys about yourself, your mood, your behaviors, and your parents’ interactions with one another. The survey should take between 15 and 20 minutes to complete. These questions may take some participants longer than others to finish, but there is no rush to complete all the questions. This is not a test.

There are some things about the study you should know. Some questions ask about your parents and ask about how you feel. Sometimes thinking about these things may make you feel a little uncomfortable. If this happens, you can skip any questions you want.

If you do not want to be in this study, you do not have to participate. No one will be upset if you decide not to participate or if you decide to stop filling out the questionnaires after you have already started. If you want to stop participating in the middle of the study or skip an item, that is also okay.

All of your answers will be kept anonymous. This means that no one will know whom the responses came from. No one except the researchers running the study will be able to see the responses from the survey. When we are finished with this study we will write a report about what was learned about the children and teenagers at this office as a group. This report may be shared with your clinician; however, s/he will not be able to identify your individual answers. This report will not include your name or that you were in the study. Within one week, you will receive a $10 Amazon gift card for participating in this study.

If you decide you would like to be in this research study, please click the arrow below to proceed.
APPENDIX C

INFORMED CONSENT FORM FOR 18-YEAR-OLD PARTICIPANTS
Northern Illinois University
Consent to Participate in a Research Study

Title of Study: Adolescents and Family Processes

Investigators
Name: Andrew J. Flannery, M.A. Dept: Psychology Phone: (815) 753-2485
Name: Laura D. Pittman, Ph.D. Dept: Psychology Phone: (815) 753-2485

Key Information
• This is a voluntary research study on adolescent perceptions of family processes.
• This 15-minute study involves the completion of an electronic survey.
• The benefits include contributing to the growing field of research regarding adolescent perceptions of family processes, which may have implications for the development of future clinical treatments; direct benefits to you may include gaining insight into family processes, which may be informative for treatment; the only reasonably foreseeable risk involved in completing this study is that you might experience mild discomfort when reflecting on potentially negative events or difficult relationships.

Description of the Study
The purpose of the study is to examine how adolescents view family processes and how these views influence their psychological health. If you agree to be in this study, you will be asked to complete an electronic questionnaire. Questionnaires will include items about your mood, behavior, and family processes. Completing these questionnaires should take between 15 and 20 minutes. The study will not interfere with your clinical treatment.

Risks and Benefits
The study has the following risks. First, you might experience mild discomfort when reflecting on potentially difficult relationships or negative events. There are no additional reasonably foreseeable (or expected) risks.
The benefits of participation include contributing to the growing field of research regarding family processes. Important gaps in the field will be addressed by this study, which may have implications for future forms of clinical and family interventions. Additionally, you may directly benefit from the study, as thinking about your family processes can build insight that might be helpful in your own therapeutic intervention(s).

Anonymity
• This study is anonymous. We will not be collecting or retaining any information about your identity. This study will utilize Qualtrics, a computer-based survey tool, to collect questionnaire responses. During the data collection phase, all data will be stored on the Qualtrics servers. Qualtrics protects the privacy of survey data. You can see their online documentation at http://www.qualtrics.com/security-statement/ and http://www.qualtrics.com/privacy-statement/.
• The records of this study will be kept strictly confidential. Once the data are transferred off of Qualtrics, they will be stored on password-protected computers in a locked research lab, which only research staff can access. We will not include any information in any report we may publish that would make it possible to identify you.

Compensation
You will receive a $10 Amazon gift card in compensation for your time, which will be administered electronically by the primary researcher within one week of study participation.

Your Rights
The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time. Your decision will not affect the clinical services you are receiving at this agency and will not result in any loss of benefits to which you are otherwise entitled. You have the right to skip any question or research activity, as well as to withdraw completely from participation at any point during the process.

You have the right to ask questions about this research study and to have those questions answered before, during, or after the research. If you have any further questions about the study, at any time feel free to contact the researcher, Andrew Flannery, at teencopingstudy@gmail.com, or the faculty advisor, Dr. Laura Pittman, at lpittman@niu.edu or by telephone at (815) 753-2485. If you have any questions about your rights as a research participant that have not been answered by the investigators or if you have any problems or concerns that occur as a result of your participation, you may contact the Office of Research Compliance, Integrity, and Safety at (815) 753-8588.
Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. Please detach this signed page and email it to the primary researcher, Andrew Flannery, at teencopingstudy@gmail.com. Mr. Flannery will then email you the survey link. You may keep the remaining portion of this document for your own records.

**Alternatively**, if you do not have access to a printer, you may provide an electronic signature **OR** you may send a message to Mr. Flannery at teencopingstudy@gmail.com indicating your consent and willingness to participate.

________________________________________________
Name

________________________________________________
Participant’s Signature  Date
Please answer the following questions about you and your family.

Please circle your gender:   Male          Female

How old are you? ______   What grade are you in? ______

Race:
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ Black or African American
☐ White
☐ Biracial/Multiracial

Ethnicity:
☐ Not Hispanic or Latino
☐ Hispanic or Latino

Most people have two adults that are parental figures involved in their life. These individuals could be your mom, dad, stepparent, grandparent, or another adult. Please think of the 2 most important parental figures in your life and indicate who they are below.

Parental Figure 1:
___ Mother
___ Father
___ Stepmother
___ Stepfather
___ Grandmother
___ Grandfather
___ Aunt
___ Uncle
___ Other (please specify): ______________

Parental Figure 2:
___ Mother
___ Father
___ Stepmother
___ Stepfather
___ Grandmother
___ Grandfather
___ Aunt
___ Uncle
___ Other (please specify): ______________
Do you live with your Parental Figures?

___ Yes, I live with BOTH of my Parental Figures
___ Yes, I live with Parental Figure 1
___ Yes, I live with Parental Figure 2
___ No, I do not live with either of my Parental Figures

Do your Parental Figures currently live together?

___ Yes
___ No

What is the relationship between your parental figures?

___ My Parental Figures are currently married to each other
___ My Parental Figures are not married, but they are living together
___ My Parental Figures are currently dating each other
___ My Parental Figures are currently separated
___ My Parental Figures are divorced
___ My Parental Figures have never been married to each other, but they are friendly to one another
___ Parental Figure 2 is Parental Figure 1’s Mom/Dad
___ Parental Figure 2 is Parental Figure 1’s Sister/Brother
___ Parental Figure 2 is Parental Figure 1’s Sister-in-law/Brother-in-law
___ Other (please specify)

Parental Figure 1’s highest level of education:

☐ Some high school
☐ Completed high school
☐ Completed GED
☐ Received a degree from a trade/technical school
☐ Some college
☐ Completed college
  ☐ Associate’s degree (typically a 2-year program)
  ☐ Bachelor’s degree (typically a 4-year program)
☐ Graduate school

Parental Figure 2’s highest level of education:

☐ Some high school
☐ Completed high school
☐ Completed GED
☐ Received a degree from a trade/technical school
☐ Some college
☐ Completed college
  ☐ Associate’s degree (typically a 2-year program)
  ☐ Bachelor’s degree (typically a 4-year program)
☐ Graduate school
Which of the following describes your grades:

- Mostly A’s
- Mostly A’s and B’s
- Mostly B’s
- Mostly B’s and C’s
- Mostly C’s
- Mostly C’s and D’s
- Mostly D’s
- Mostly D’s and F’s
- Mostly F’s

What best describes your family’s standard of living? Would you say your family:

- Has more than enough money
- Is comfortable
- Has enough money for the basics
- Is living under meager conditions (i.e., barely making ends meet)
- Has extreme financial hardships/is living in poverty (i.e., not making ends meet)

Where are you receiving therapy services? ____________________

How long have you been receiving therapy services?

- Less than 1 month
- 1 – 3 months
- 3 – 6 months
- 6 – 8 months
- More than 8 months

How would you describe your parents’ involvement in your therapy sessions?

- I only/mostly meet with my therapist individually (i.e., without my parents in the room)
- My parents are sometimes involved in the therapy room with me
  Please describe their amount of involvement in the room:
  - My parents are in the room for the entire session during every session
  - My parents are in the room for the entire session during every few sessions
  - My parents are in the room for a few minutes of every session
  - My parents are in the room for a few minutes during every few sessions
  Explain: ________________________________
- My parents are mostly/always involved in the therapy room with me
  Please describe their amount of involvement in the room:
  - My parents are in the room for the entire session during every session
  - My parents are in the room for the entire session during every few sessions
  - My parents are in the room for a few minutes of every session
  - My parents are in the room for a few minutes during every few sessions
  Explain: ________________________________
APPENDIX E

COPARENTING INVENTORY FOR PARENTS & ADOLESCENTS
Thinking of the two parental figures that you indicated earlier, please answer the following questions:

<table>
<thead>
<tr>
<th>My parents reach shared decisions with regard to my upbringing. <strong>CP</strong></th>
<th>Completely True (0)</th>
<th>Somewhat True (1)</th>
<th>Neither True nor False (2)</th>
<th>Somewhat False (3)</th>
<th>Not at all True (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I have a problem, my parents solve it together. <strong>CP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My parents are a bad team in my upbringing. <strong>CP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My parents decide together on important decisions that concern me. <strong>CP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My parents agree on whether I did something wrong or not. <strong>CN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My mother and my father set the same rules for me. <strong>CN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If there is a problem that concerns me, my parents find a solution together. <strong>CN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My parents agree on whether to fulfill my wishes and demands or not. <strong>CN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If my parents talk about childrearing, they start to argue. <strong>TR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My parents fight about how to raise me. <strong>TR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I notice it when my parents argue about child-rearing. <strong>TR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I get involved in my parents’ arguments about raising me. <strong>TR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CP:** Coparenting Cooperation; **CN:** Coparenting Conflict; **TR:** Triangulation
APPENDIX F

CHILDREN’S PERCEIVED INTERPARENTAL CONFLICT SCALE – CONFLICT PROPERTIES SUBSCALE
Family Disagreements

In every family there are times when the parents don't get along. Below are some things that kids sometimes think or feel when their parents have arguments or disagreements. We would like you to write what you think or feel when your parents argue by answering each of the sentences below.

Thinking of the parental figures that you indicated earlier, please answer the following questions:

T = TRUE
ST = SORT OF OR SOMETIMES TRUE
F = FALSE

1. T ST F I never see my parents arguing or disagreeing
2. T ST F When my parents have an argument they usually work it out
3. T ST F My parents get really mad when they argue
4. T ST F They may not think I know it, but my parents argue or disagree a lot
5. T ST F Even after my parents stop arguing they stay mad at each other
6. T ST F When my parents have a disagreement they discuss it quietly
7. T ST F My parents are often mean to each other even when I'm around
8. T ST F I often see or hear my parents arguing
9. T ST F When my parents disagree about something, they usually come up with a solution
10. T ST F When my parents have an argument they say mean things to each other
11. T ST F My parents hardly ever argue
12. T ST F When my parents argue they usually make up right away
13. T ST F When my parents have an argument they yell at each other
14. T ST F My parents often nag and complain about each other around the house
15. T ST F My parents hardly ever yell when they have a disagreement
16. T ST F My parents have broken or thrown things during an argument
17. T ST F After my parents stop arguing, they are friendly towards each other
18. T ST F My parents have pushed or shoved each other during an argument
19. T ST F My parents still act mean after they have had an argument
APPENDIX G

RESPONSE TO STRESS QUESTIONNAIRE: PARENTAL CONFLICT
This is a list of things that children and teenagers sometimes find stressful when their parents argue. Please mark the response indicating how stressful the following things have been for you in the past 6 months.

<table>
<thead>
<tr>
<th>A = Not at all</th>
<th>B = A Little</th>
<th>C = Somewhat</th>
<th>D = Very</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My parents say mean things to each other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. My parents argue with each other.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. My parents do not talk to each other.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I see my parents get angry with each other.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. My parents avoid each other.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. My parents shout at each other.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. My parents do not look at each other.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Other: ______________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mark the response that shows how much control you generally think you have over these problems.

<table>
<thead>
<tr>
<th>A = None</th>
<th>B = A little</th>
<th>C = Some</th>
<th>D = A lot</th>
</tr>
</thead>
</table>

Below is a list of things that children and teenagers sometimes do, think, or feel when they are dealing with their parents’ arguing. Everyone deals with problems in their own way—some people do a lot of things on this list or have a bunch of feelings, other people just do or think a few of these things.

**Think of all the stressful parts of your parents’ arguing that you indicated above.** For each item below, mark **one** response from (not at all) to (a lot) that show **how much** you do or feel these things when you have the problems with your parents’ arguing like the ones you indicated above. Please let us know about everything you do, think, and feel, even if you don’t think it helps make things better.

**PEC** = Primary Engagement Coping
**SEC** = Secondary Engagement Coping
**VDC** = Voluntary Disengagement Coping
WHEN DEALING WITH THE STRESS OF MY PARENTS’ ARGUING:

How much do you do this?
A = Not at all   B = A little   C = Some   D = A lot

1. I try not to feel anything. VDC
2. I try to think of different ways to change or fix the situation. PEC
3. I wish that I were stronger and less sensitive so that things would be different. VDC
4. I let someone or something know how I feel. (Examples: parent, teacher, friend, God, brother/sister, stuffed animal, pet, other family member, clergy member) PEC
5. I decide I’m okay the way I am, even though I’m not perfect. SEC
6. When I’m around other people, I act like my parents’ arguing never happened. VDC
7. I deal with my parents’ arguing by wishing it would just go away, that everything would work itself out. VDC
8. I realize that I just have to live with things the way they are. SEC
9. I try not to think about it, to forget all about it. VDC
10. I ask other people or things for help or for ideas about how to make things better. (Examples: parent, teacher, friend, God, brother/sister, stuffed animal, pet, other family member, clergy member) PEC
11. I tell myself that I can get through this, or that I will be okay. SEC
12. I let my feelings out (Examples: I write in my journal/diary, complain to let off steam, listen to music, exercise, cry, draw/paint, make fun/sarcasm, punch a pillow, yell) PEC
13. I get help from other people or things when I’m trying to figure out how to deal with my feelings. (Examples: parent, teacher, friend, God, brother/sister, stuffed animal, pet, other family member, clergy member) PEC
14. I wish that someone would just come and take away my parents’ arguments. VDC
15. I do something to try to fix the problem or take action to change things. PEC
16. I try to stay away from people and things that make me feel upset or remind me of my parents’ arguments. VDC
17. I just take things as they are; I go with the flow. SEC
18. I think about happy things to take my mind off my parents’ arguments or how I’m feeling. SEC
19. I get sympathy, understanding, or support from someone. (Examples: parent, teacher, friend, God, brother/sister, stuffed animal, pet, other family member, clergy member) PEC
20. I tell myself that things could be worse. SEC
21. I tell myself that it doesn’t matter, that it isn’t a big deal. SEC
22. I think about the things I’m learning from the situation, or something good that will come from it. SEC
23. When my parents argue, I say to myself, “This isn’t real.” VDC
24. I keep my mind off my parents’ arguments by doing something else. (Examples: exercising, playing video games, seeing friends, doing a hobby, watching TV, listening to music) SEC
25. I do something to calm myself down when my parents argue. (Examples: Take deep breaths, listen to music, pray, take a break, walk, meditate) PEC
26. I keep my feelings under control when I have to, then let them out when they won’t make things worse. PEC
27. I tell myself that everything will be all right. SEC
28. I think of ways to laugh about it so that it won’t seem so bad. SEC
29. I imagine something really fun or exciting happening in my life. SEC
30. I try to believe that it never happened. VDC
Below is a list of items that describe kids. Please rate each item that described you now or within the past 7 days. Please circle the 2 if the item is very true of you. Circle the 1 if the item is somewhat true of you. If the item is not true of you, circle the 0. Please answer all items as well as you can.

<table>
<thead>
<tr>
<th></th>
<th>0 = Not True</th>
<th>1 = Somewhat True</th>
<th>2 = Very True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>0 1 2</td>
<td>I act too young for my age.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>0 1 2</td>
<td>I argue a lot.</td>
<td></td>
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<tr>
<td>3.</td>
<td>0 1 2</td>
<td>I fail to finish things I start.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>0 1 2</td>
<td>I have trouble concentrating or paying attention.</td>
<td></td>
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<tr>
<td>5.</td>
<td>0 1 2</td>
<td>I have trouble sitting still.</td>
<td></td>
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<tr>
<td>6.</td>
<td>0 1 2</td>
<td>I destroy things belonging to others.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>0 1 2</td>
<td>I disobey my parents.</td>
<td></td>
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<tr>
<td>8.</td>
<td>0 1 2</td>
<td>I disobey at school.</td>
<td></td>
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<tr>
<td>9.</td>
<td>0 1 2</td>
<td>I feel worthless or inferior.</td>
<td></td>
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<tr>
<td>10.</td>
<td>0 1 2</td>
<td>I act without stopping to think.</td>
<td></td>
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<tr>
<td>11.</td>
<td>0 1 2</td>
<td>I am too fearful or anxious.</td>
<td></td>
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<tr>
<td>12.</td>
<td>0 1 2</td>
<td>I feel too guilty.</td>
<td></td>
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<tr>
<td>13.</td>
<td>0 1 2</td>
<td>I am self-conscious or easily embarrassed.</td>
<td></td>
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<tr>
<td>14.</td>
<td>0 1 2</td>
<td>I am inattentive or easily distracted.</td>
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<tr>
<td>15.</td>
<td>0 1 2</td>
<td>I am stubborn.</td>
<td></td>
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<tr>
<td>16.</td>
<td>0 1 2</td>
<td>I have a hot temper.</td>
<td></td>
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<tr>
<td>17.</td>
<td>0 1 2</td>
<td>I threaten to hurt people.</td>
<td></td>
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<tr>
<td>18.</td>
<td>0 1 2</td>
<td>I am unhappy, sad, or depressed.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>0 1 2</td>
<td>I worry a lot.</td>
<td></td>
</tr>
</tbody>
</table>