

The Role of Non-Marital Coparents in the Psychosocial Adjustment of  
African American Youth from Single Mother-Headed Families

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A thesis submitted to the faculty of the University of North Carolina at Chapel Hill in  
partial fulfillment of the requirements for the degree of Master of Arts in the  
Department of Psychology.

Chapel Hill  
2007

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## **Abstract**

Emma M. Sterrett: The Role of Non-Marital Coparents in the Psychosocial Adjustment of African American Youth from Single Mother-Headed Families  
(Under the direction of Deborah J. Jones, Ph.D.)

Little empirical attention has considered the quality of the relationships that African American youths from single mother homes may have with extended family and other non-marital coparents. The current study examined associations between coparent support and three measures of youth adjustment, internalizing symptoms, externalizing symptoms, and cognitive competence, in a sample of low-income, urban African American single mother families (n = 141). Findings revealed that coparent support was not directly associated with youth outcomes. However, the two-way interaction of coparent support X positive parenting was significant at Assessment 1 for both externalizing and internalizing symptoms. The negative association between positive parenting and symptoms was strongest in the context of high levels of coparent support. Finally, exploratory analyses revealed some associations of coparent identity (i.e. father, grandmother, sister or other) with the outcome variables. Implications and future directions for research are discussed.

## **Acknowledgements**

I am very grateful to my primary advisor, Dr. Deborah Jones, for her endless guidance, support, and input in the preparation of this document. Thank you also to the Principal Investigators of the Family Health Project, Drs. Gene Brody and Rex Forehand, who allowed me to use their data, and to the members of my masters committee, Drs. Mitch Prinstein and Beth Kurtz-Costes, for their thought-provoking and inspiring feedback.

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## **Chapter I**

### **Background**

Children and adolescents from single mother homes, especially those living in impoverished and under-resourced communities, have been shown to be at an increased risk for adjustment problems, including psychological distress (Barrett & Turner, 2005; O'Connor, Dunn, Jenkins, Pickering, & Rasbash, 2001; Rubenstein, Halton & Kasten, 1998) and conduct problems (e.g. Lipman, Boyle, Dooley, & Offord, 2002; McLoyd, Jayaratne, Ceballo, & Borquez, 1994; Simons, Chen, Simons, Brody, & Cutrona, 2006). Moreover, the percent of African American youth being raised in single mother homes is double the rate for all children nationally, with 51% of African American youth, as compared to 23% of American youth, in general, currently being raised in single mother households (U.S. Census, 2006). Given that some African American adolescents from single mother homes have been found to overcome their risk for maladjustment (e.g. Brody & Flor, 1998; Jessor, 1993; Kim & Brody, 2005), identifying factors associated with lower levels of adjustment difficulties among these high-risk youth is critical for the development and implementation of successful prevention and intervention programming.

Social ecological theory contends that, in addition to intrapersonal characteristics, environmental factors, including interpersonal relationships, shape the psychosocial adjustment of youth (e.g. Baumrind, 1967; Brofenbrenner, 1979; Conger et. al., 1992). In early- to middle-childhood, the caregiver-youth relationship appears to be the singular, most



important interpersonal characteristic that affects psychosocial well-being of youth (e.g. Amato & Fowler, 2002; Ainsworth, 1978; Baumrind, 1989). Despite the growing influence of peers as children enter adolescence, research suggests that children's relationships with their caregivers, as well as caregiver parenting behaviors, continue to play a significant role in youth adjustment (e.g. Liddle, Rowe, Dakof, & Lyke, 1998; Smetana, Campione-Barr, & Metzger, 2006; Steinberg, 2001). Consistent with the growing number of African American youth raised in single mother homes, mother-child relationship quality and maternal parenting factors have been the primary research focus in this population (e.g. Brody & Flor, 1998; Brody, Flor, & Gibson, 1999; Bynum & Brody, 2005). Importantly, African American single mothers who maintain a balance of warmth/support and monitoring/control, often referred to as "positive parenting" or "authoritative parenting," have youth who exhibit lower levels of a broad range of adjustment difficulties, including internalizing symptoms, such as depression and anxiety symptoms, and externalizing symptoms, such as disruptive behavior and hyperactivity (e.g. Brody & Flor, 1998; Kim & Brody, 2005; Jones, Forehand, Brody, & Armistead, 2002a).

In addition to maternal parenting, some attention has been devoted to the role of the broader extended family and community networks in which many African American youth are embedded (e.g. Hill, 1999; Pallock & Lamborn, 2006; Wilson, 1986). Of greatest relevance to the current study, a growing body of empirical work suggests that extended family members often assist African American single mothers with parenting responsibilities (see Jones, Zalot, Foster, Chester, & Sterrett, in press, for a review). For example, in a study of low-income African American single mothers (Jones, Shaffer, Forehand, Brody, & Armistead, 2003), the majority (97%) of mothers identified a non-marital coparent or another

adult or family member who assisted with childrearing responsibilities, including the child's maternal grandmother (31%), biological father (26%), maternal aunt (11%), sister (11%), or other adults or family members, such as maternal friends or more distal relatives (11%). Moreover, the quality of the relationships between African American single mothers and their non-marital coparents has been shown to be associated with maternal and youth well-being. For example, mother-coparent relationship quality has been found to predict both maternal parenting and youth internalizing and externalizing symptoms (Jones et. al., 2003) and to buffer youth from well-established risk factors, such as neighborhood violence (Forehand & Jones, 2003).

Although increased attention has been given to mother-coparent relationship quality (see Jones et. al., in press), far less empirical attention has considered the quality of the relationship that non-marital coparents have with youth, or the impact of this relationship on youth adjustment. Of relevance, emotional security theory posits that a positive caregiver-child relationship, as well as other positive family factors, increases a child's sense of security and well-being, (Cummings, Schermerhorn, Davies, Goeke-Morey & Cummings, 2006). Similarly, social support theory contends that social support, which encompasses various types of support, including emotional, appraisal, informational, and instrumental assistance, can improve well-being and buffer the effects of stressors (Secco & Moffat, 1994). Although emotional security theory focuses on parent-child relationships and social support theory focuses on any individuals who offer social support, both theories provide a useful conceptual framework for examining the role of non-marital coparents in the lives of African American youth from single mother homes. Furthermore, support from a male role-model or family member has been linked to lower levels of externalizing behaviors among

African American youth (Florsheim, Tolan, & Gorman-Smith, 1998), as well as to psychosocial adjustment among adolescents in both two-parent and single mother families (Bryant & Zimmerman, 2003; Lamborn & Nguyen, 2004). In addition, recent empirical work suggests that it is normative for youth to form relationships with “very important” non-parental adults, or adults who have a significant influence on the adolescent, who serve as a support person during difficult times or who engage in good “role-model” behavior (Beam, Chen, & Greenberger, 2002). Building upon the aforementioned theory and research, the current study examined the role of the relationship that African American youth from single mother homes have with their non-marital coparents on youth psychosocial adjustment. Specifically, it was predicted that youth who have a more positive relationship with their non-marital coparents would have lower levels of psychosocial adjustment difficulties.

In addition to the predicted main effect of youth-coparent relationship quality, a positive relationship with a non-marital coparent may also interact with other familial predictors of youth adjustment, most notably maternal parenting. One way in which maternal positive parenting and youth-coparent relationship quality may interact is consistent with the “protective-protective model,” in which one factor is expected to enhance or increase the effect of another factor (Zimmerman, Bingenheimer, & Notaro, 2002). For example, in their study of Hispanic youth, Brook, Pahl, Balka and Fei (2004) reported that low father control and high father communication enhanced the positive role of other protective factors, such as greater family orientation and greater ethnic identity, respectively. Consistent with a protective-protective model, it was predicted that higher levels of relationship quality with non-marital coparents would enhance the protective role of maternal positive parenting on youth psychosocial adjustment among African American youth in the current study.

Finally, coparent identity (i.e. father, grandmother, sister, or “other”) was also examined as a moderator of the proposed associations. However, these analyses are considered exploratory due to limited prior research and theory to guide the hypotheses.

The indices of youth psychosocial adjustment chosen for this study were internalizing and externalizing symptoms. Importantly, both internalizing and externalizing symptoms have been found to be linked to various constructs of youth functioning, as well as to predict future well-being and behavior. Youth who have higher levels of internalizing symptoms have been shown to be at a heightened risk for substance abuse problems (Kumpulainen, 2000; Rowe, Liddle, & Dakof, 2001) and for anxiety and depression in adulthood (Rueter, Scaramella, Wallace, & Conger, 1999). In addition, externalizing symptoms have been linked to an array of academic problems (Hinshaw, 1992; Richards, Symons, Greene, & Szuszkiewicz, 1995), and have been found to predict future delinquency (Ferguson & Horwood, 1995).

## **Chapter II**

### **Methods**

#### *Participants*

The study hypotheses were examined by conducting secondary analyses of data from a sample of 141 African American single mother families residing in urban communities in the Southeastern United States. Only communities in which 25% or more of the population was African American were sampled to ensure that a viable African American neighborhood existed in the county. Of the 141 families who participated, 97 percent received public assistance. Almost all of the families had a per capita income of \$3,800 or less. According to the criteria established by the U.S. Census Bureau (2000), this figure indicates that the majority of families were living below poverty level. In the counties from which the sample was drawn, 75 percent of single African American mothers with school-age children live in poverty (U.S. Census Bureau, 2000), suggesting that families in the current study were at somewhat higher risk for economic stress than were families from the population from which they were recruited.

On average, mothers were 36.33 years of age, either failed to complete high school (45%) or earned a HS diploma (32%), and worked outside the home at least part time (62%). In addition to the mothers, one child from each family participated in the

study. On average, children were 11.60 years of age; 51% were girls. Additional demographic characteristics are described in Table 1.

*Recruitment.* Families in the current study were recruited through two separate, but interrelated projects. In the initial study, 149 families participated in the first assessment. Thirty-two of these were married and, therefore, were excluded from the study. Eleven of the remaining 117 dropped out between the first and third assessment of the initial study because of moving or refusing to participate. An additional source of funding was obtained at the third assessment which provided the opportunity to increase the sample size. Accordingly, an additional 35 families participated in the third assessment, yielding a sample of 141. Given that the measures of interest for the current study were added at Assessment 3, data from these 141 families at the third assessment, and from those who remained at Assessment 4 ( $n = 124$ ), will be the focus of the current study.

#### *Procedure*

Assessment 1 (Assessment 3 of larger study) was constituted by two data collection sessions, each lasting between 1 and 2 hours. During the first session, the mother completed an informed consent form and was interviewed regarding demographic information. In the second session, all of the study variables of interest (e.g., maternal support and control; coparent support; and externalizing and internalizing symptoms and cognitive competence) were assessed. At both data collection sessions, self-report questionnaires were administered in an interview format. Each interview was conducted privately. Self-report questions were asked verbally, with response options presented on a series of cue cards for participant reference, as project staff did not assume participants

could read or write. Participants' verbal responses were recorded by the interviewers. The mother was paid \$50 for participation in each data-collection session.

Approximately 15 months later, mothers were contacted and invited to participate in a second assessment (Assessment 4 of larger study). Procedures for the second assessment were identical to the first assessment, including two sessions for data collection and participant payment.

### *Measures*

Of particular concern in study design was the fact that most instruments used to evaluate family processes and children's outcomes were developed for use with and standardized on European American middle-class families. Several steps were taken to ensure the use of culturally sensitive and appropriate measures for this study, including the use of focus groups, consisting of 60 people representative of the population studied, and the piloting of measures with demographically similar individuals. As a result, some new measures were created or the wording and/or items on some existing measures were modified. If measures were modified or had not been used previously with samples similar to the current one, a factor analysis was conducted and items loading at .40 and above were retained. Alpha coefficients were obtained for all measures in the current sample<sup>1</sup>. Copies of the measures for the current study are in Appendix A.

*Demographic information.* During the first session of each assessment, mothers answered a series of demographic questions (e.g., age, income).

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<sup>1</sup> Internal consistency analyses were also run separately for the 7-10 age group and the 11-15 age group for each measure, to examine whether the measures were adequately valid for the entire age range of the sample. With the exception of coparent support, which had an alpha coefficient of .54 for younger children, all of the other internal consistencies were not significantly different depending on age.

*Mother-Child Relationship.* Two aspects of the mother-child relationship, maternal warmth and maternal control, were assessed by child-report.

Child report of maternal warmth and control was assessed using the Children's Report of Parenting Behavior Inventory (CRPBI). The CRPBI is a 30-item child-report instrument that assesses parenting practices from the child's point of view. Children and adolescents rate each of the 30 items as "a lot like," "somewhat like," or "not like" the target parent. Items on the original instrument form three subscales, corresponding to acceptance/rejection (e.g., *My mother always listens to my ideas and opinions*), psychological autonomy/control (e.g., *My mother says that if I love her, I would do what she wants me to do*), and firm/lax behavioral control (e.g., *My mother lets me go any place I want without asking*). Only the acceptance/rejection and firm/lax behavioral control subscales, as measures of maternal support and maternal control, respectively, were administered in the present investigation. Discriminant and convergent validity have been established for this measure (Schludermann & Schludermann, 1970). Slight modifications were made in the instructions and items (e.g., adjusting reading level, items presented in second person) to simplify verbal administration. Accordingly, a confirmatory factor analysis was conducted and items loading at .40 or above were retained for the support and control scales in the current sample. Higher scores on these subscales indicate more warmth and control, respectively. The internal consistency of each scale was calculated yielding  $\alpha = .75$  for the warmth scale and  $\alpha = .65$  for control. Scores on the two subscales were then averaged to construct an overall positive parenting score.



*Coparent Support to Child.* To measure coparent support to child, youth were first asked to identify the person most involved in care-giving other than their mothers. This data was used to determine coparent identity. Child-report of the quality of his or her relationship with the coparent was then assessed with a revised version of the Parenting Convergence Scale (PC; Ahrons, 1981). The PC was developed to assess the quality of a parents' relationship with a co-parent; therefore, the wording was revised to assess the child's relationship with the coparent (7 items), as well as the child's perception of the mother's relationship with the coparent (3 items). Children were asked "Who do you think is the second most important person who takes care of you?", then asked to indicate the extent to which 10 statements were true using a 4-point scale of 1 (never) to 4 (often). For the purposes of the current study, the items assessing the child's relationship with the coparent were examined. Sample items on this subscale include "How often do you go to [caregiver] when you have a problem?", "How often do you ask [caregiver] for permission to do something instead of asking your mom?", and "How often does your caregiver take your side if you and your mother have an argument or you get into trouble?" Higher scores indicate a more positive child-coparent relationship. Confirmatory factor analyses on this subscale were conducted. Items loading at .40 or above were retained; the internal consistency was also calculated, yielding  $\alpha = .72$ .

*Child psychosocial adjustment.* Child adjustment was examined using mother-report of three domains: internalizing problems, externalizing problems, and cognitive competence .

Mothers completed the parent-report form of the Child Behavior Checklist (CBCL, Achenbach, 1991). This measure describes a child's problem behaviors and

requires parents to make ratings for the target child on a three-point scale: 0 (not true), 1 (sometimes or somewhat true), and 2 (very or often true). Achenbach (1991) has reported mean test-retest reliability of .87 as well as evidence for content and criterion-related validity with samples similar to the current one. Mothers completed two CBCL subscales, the aggression/conduct problems and internalizing problems subscales, with higher scores indicating more aggression/conduct problems and internalizing problems, respectively. Given the scales' use with nationally reported samples, the T-scores of the intact scales were used. Internal consistency analyses yielded  $\alpha = .92$  for the externalizing scale and  $\alpha = .85$  for the internalizing scale.

Child cognitive competence was assessed using the cognitive competence subscale of the Harter Perceived Competence Scale for Children (PCSC, 1982). The cognitive subscale consisted of seven items presented in a two-step, forced choice format. Mothers first indicated which of two contrasting statements best described the child, for example whether "This child has trouble figuring out the answers at school" or "This child almost always can figure out the answers at school." In the second step, mothers indicated whether the chosen statement was really or *sort of true* for the child. Higher scores on the subscales indicate higher levels of competence. Internal consistency analyses indicated  $\alpha = .82$ .

## Chapter III

### Results

#### *Preliminary analyses.*

The distribution of each study variable was checked for normality. Internalizing and externalizing symptoms were normally distributed; however, cognitive competence, positive parenting, and coparent support were not. Given that normality in the variables is not an assumption of regression, the primary analytic strategy in this study, and the sample size was large enough and the number of variables small enough to obviate assessing the normality of the residuals (Allison, 1999; Cohen, Cohen, West & Aiken, 2003), the variables were not transformed for the regression analyses.

Descriptive statistics, including means and standard deviations, on all sociodemographic and major study variables are presented in Table 1. There were no significant differences in any of the major study variables between Assessment 1 and Assessment 2. Finally, coparent identity was examined and the following four categories emerged: father (25.5%), grandmother (21.3%), sister (14.9%), and other (32.6%), e.g. brother, step-father, and grandfather.

Bivariate correlations of demographic and major study variables were also conducted. In accordance with the first hypothesis, positive parenting was significantly correlated with internalizing problems ( $r = -.17, p < .05$ ), externalizing problems ( $r = -.23, p < .05$ ), and cognitive competence ( $r = .18, p < .05$ ). Mothers reported fewer

internalizing and externalizing problems and greater cognitive competence for those children who reported greater levels of positive parenting. Contrary to the second hypothesis, coparent support was not correlated at the bivariate level with any of the outcome variables, internalizing symptoms ( $r = -.05, n.s.$ ), externalizing symptoms ( $r = -.06, n.s.$ ), and cognitive competence ( $r = .06, n.s.$ ).

*Primary analyses.*

Data was analyzed using hierarchical regression. For cross-sectional analyses at Assessment 1 and Assessment 2 and longitudinal analyses, three regressions were run, one for each of the outcome variables: youth externalizing problems, youth internalizing problems, and youth cognitive competence.

*Cross-Sectional Analyses at Assessment 1 and Assessment 2.* Sociodemographic variables (e.g., child age, gender) associated with the outcome variables were entered in the first block<sup>2</sup>. In the second block, child-report of maternal positive parenting was entered in order to investigate main effects of maternal variables<sup>3</sup>. Child-report of coparent support was entered in the third block. This order allowed for the investigation of associations between youth outcomes and coparent support, after controlling for associations with positive parenting. Since a long-standing body of literature highlights the association of positive parenting with youth adjustment, this investigation sought to

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<sup>2</sup> The regression analyses were also run including all possible interactions of age and gender with positive parenting and coparent support. As none of the interactions were found significant, they were excluded from the final analyses to maintain power.

<sup>3</sup> Regression analyses were also run using unweighted effects coding for positive parenting, in which parenting was divided into four categories, authoritative, authoritarian, permissive, and neglectful. The pattern of findings remained the same for authoritative parenting. Associations with child report of outcomes were also examined and revealed a similar pattern of findings.

examine any associations present after accounting for the well-established link with parenting. The two-way interaction term, positive parenting X coparent support, was entered in the fourth block. Positive parenting and coparent support were centered prior to creating the interaction term in order to reduce multicollinearity among variables (Baron & Kenny, 1986).

The results of the regression analyses at Assessment 1 are presented in Table 3. For internalizing symptoms, there was a significant association with maternal education,  $\beta = -.18, p < .05$ . Greater maternal education was associated with lower levels of internalizing symptoms as reported by mothers. Contrary to the first and second hypotheses, the associations with positive parenting and with coparent support were non-significant in the multivariate model examining internalizing symptoms,  $\beta = -.10, n.s.$ , and  $\beta = -.09, n.s.$ , respectively. However, there was a significant association with the interaction of positive parenting X coparent support  $\beta = -.19, p < .05$ . Explication of the interaction, utilizing procedures developed by Aiken & West (1991) and Preacher, Curran, & Bauer (2003), revealed that the protective role of positive parenting was most pronounced amidst the context of high coparent support, as defined by scores that were one standard deviation above the mean (Figure 1.).

For externalizing symptoms, there were no associations with demographic variables in the multivariate model. In support of the first hypothesis, there was a significant association of positive parenting with externalizing symptoms,  $\beta = -.19, p < .05$ . Higher levels of positive parenting as reported by the child were associated with lower levels of mother-reported externalizing symptoms. Although there was not a significant association of coparent support with externalizing symptoms,  $\beta = -.01, n.s.$ ,

the interaction of positive parenting X coparent support was significant,  $\beta = -.26, p = <.01$ . Consistent with the pattern of findings for internalizing symptoms, explication of the interaction revealed that the strongest negative relationship between positive parenting and symptoms occurred at higher levels of coparent support (see Figure 2.).

Finally, for cognitive competence, there was a significant association for maternal education,  $\beta = .31, p <.01$ . Mothers with higher levels of education had children with higher levels of cognitive competence. In agreement with the first hypothesis, there was also a significant association between positive parenting and cognitive competence,  $\beta = .18, p < .05$ . Higher levels of positive parenting were associated with higher levels of cognitive competence. However, neither coparent support nor the interaction of positive parenting X coparent support was significantly associated.

The results of the regression analyses at Assessment 2 are presented in Table 4. For internalizing symptoms, consistent with the Assessment 1 analyses, there was a significant relationship with maternal education,  $\beta = -.22, p < .01$ , but non-significant associations with positive parenting and coparent support. Differing from Assessment 1, the interaction of positive parenting X coparent support was also not significant. For externalizing symptoms, there were no significant associations. Finally, consistent with Assessment 1, there was a significant link between maternal education and cognitive competence,  $\beta = .31, p < .01$ ; however, none of the primary variables, positive parenting, coparent support, or the interaction of positive parenting X coparent support, were significant in the multivariate model.

*Longitudinal Analyses.* For the longitudinal analyses, Assessment 1 scores on the dependent variables were entered along with sociodemographic covariates in the first

block. The rest of the Assessment 1 variables were then entered following the same sequence as in the cross-sectional analyses. This allowed for examination of any variance due to Assessment 1 variables, after accounting for Assessment 1 outcomes. Again, positive parenting and coparent support were centered prior to creating the interaction term.

Results of the longitudinal analyses can be found in Table 5. None of the sociodemographic or independent variables, or the interaction of positive parenting X coparent support, were significant predictors of change in the outcome variables, after controlling for the outcome variable at Assessment 1.

#### *Exploratory Analyses.*

To examine the role of coparent identity (i.e. father, grandmother, sister or “other”) on the outcome variables, unweighted effects coding, a system of coding categorical variables so that main and interactive associations with them may be entered in a regression, was used (Cohen, Cohen, West & Aiken, 2003). “Other” was designated as the base group, since, in accordance with unweighted effects coding, it was the group about which information was least important for the purposes of the study. The coparent identity codes were entered in the first step of the regressions, along with the demographic variables. The variables entered in Step 2 and Step 3 were the same as described in the primary analyses. In Step 4, the two-way interactions of coparent identity (i.e. father, grandmother, or sister) X positive parenting were entered along with the coparent identity X positive parenting interaction. In Step 5, the two-way interactions of coparent identity (i.e. father, grandmother, or sister) X coparent support were entered, in order to examine whether the entire set of coparent identity moderated the relationship

between coparent support and youth outcomes. Again, for each of the cross-sectional and longitudinal analyses, three regressions were run for the outcome variables: youth externalizing problems, youth internalizing problems, and youth cognitive competence.

*Cross-Sectional Analyses at Assessment 1 and Assessment 2.* The results of the exploratory regression analyses at Assessment 1 are presented in Table 6. Coparent identity, interactions with coparent identity, or primary study variables were not significantly linked to internalizing symptoms. Nonsignificant findings with coparent identity also emerged for externalizing symptoms. Finally, for cognitive competence, there was a significant association with coparent being grandmother,  $\beta = -.33, p < .01$ . Youths whose coparents were their grandmothers, relative to youths who identified other individuals as their coparents, had lower cognitive competence. The interaction of coparent support X coparent identity was also significantly related,  $R^2 \Delta = .09, p < .01^4$ . Explication of the coparent support X coparent identity interaction was accomplished using the pick-a-point method, as recommended for regression interactions involving categorical and quantitative variables (Cohen, Cohen, West, & Aiken, 2003). Findings revealed that for sisters and, to a lesser degree, for “others,” there was a positive association between coparent support and cognitive competence (i.e. the greater the support, the greater the competence). However, for fathers and grandmothers there was a negative association between coparent support and cognitive competence, (i.e. the greater the support, the lower the competence, see Figure 3.). None of the other predictors were significant.

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<sup>4</sup> In unweighted effects coding, interpretations of the entire class of coded variables, in this case coparent identity, can only be accomplished by examining the  $R^2 \Delta$  after the set of coded variables is entered in the regression (Cohen, Cohen, West, & Aiken, 2003).



The results of the exploratory regression analyses at Assessment 2 are presented in Table 7. Similar to Assessment 1, coparent identity or interactions with major study variables not associated with internalizing and externalizing symptoms or cognitive competence.

*Longitudinal Analyses.* As in the primary analyses, for the exploratory longitudinal analyses, Assessment 1 scores on the dependent variables were entered along with sociodemographic covariates in the first block. The rest of the variables were entered following the same sequence as in the cross-sectional analyses. The results of the exploratory longitudinal analyses are presented in Table 8. For predicting change in internalizing symptoms, there was a significant effect of the interaction of coparent support X coparent identity,  $R^2 \Delta = .04$ ,  $p < .04$ . Explication of the interaction revealed that for grandmothers, there was an association between coparent support and a decrease in mother-report of internalizing symptoms (i.e. as coparent support increased, symptoms decreased). For sisters and fathers, coparent support and change in symptoms was unrelated. For “others,” there was an association between coparent support and an increase in symptoms (i.e. as coparent support from “others” increased, so did symptoms, see Figure 4.). There were no other significant predictors of change in internalizing symptoms. For externalizing symptoms, none of the variables significantly predicted change. Finally, for change in cognitive competence, there was a significant effect of coparent is sister,  $\beta = -.20$ ,  $p < .05$ . Having a sister for a coparent at Assessment 1 was associated with a decrease in cognitive competence from Assessment 1 to Assessment 2. None of the other variables were significant predictors of change in cognitive competence.

## **Chapter IV**

### **Discussion**

The purpose of this investigation was to determine whether child-report of support from non-marital coparents would be associated, either directly or indirectly through an interaction with positive parenting, with three domains of youth adjustment: internalizing symptoms, externalizing symptoms, and cognitive competence. An exploratory aim was to assess the role of coparent identity (i.e. father, grandmother, sister or other) on the proposed associations. Positive parenting was found to be linked to externalizing symptoms and cognitive competence at Assessment 1, but not internalizing symptoms. Contrary to the proposed hypothesis, coparent support was not found to be associated with the outcomes in cross-sectional or longitudinal analyses. However, the aforementioned findings are qualified by the obtained interaction of positive parenting and coparent support for internalizing and externalizing symptoms at Assessment 1. The inclusion of coparent identity in the analyses revealed main and interactive associations of coparent identity with cognitive competence at Assessment 1 and with change in internalizing symptoms and change in cognitive competence from Assessment 1 and Assessment 2.

Before addressing the primary findings of the study, it is notable that neither youth age nor gender was correlated with internalizing or externalizing symptoms. In terms of age, it is important to note that although children ranged in age from 7- to 15-years-old in the

sample, approximately 70 percent of the children fell within the 10- to 13-year-old age range. This constrained variability in age may account for the non-significance of the age variable. Furthermore, findings have been inconsistent regarding the association of age with socioemotional difficulties, with some studies showing no significant age differences in the prevalence of conduct disorder (Costello et al., 1996; Offord et al., 1996) or depression (Bean, Barber, & Crane, 2006). Youth gender also was not associated with the outcome variables. While several studies have documented gender differences in behavior problems, with boys tending to display more conduct-disordered behaviors than girls (see Lahey et al., 2000 for a review), the findings have been much less consistent for less severe oppositional behaviors, and several studies have reported no gender differences (Lewinsohn, Hops, Robert, Seeley, & Andrews, 1993; Verhulst, Van der Ende, Ferdinand, & Kasius, 1997; Williams, McGee, Anderson, & Silva, 1989). In addition, some studies have demonstrated no gender difference in terms of youth depression symptoms during early adolescence, particularly in studies of low-income and African American youth (e.g. Klein & Forehand, 2000; Shaffer, Forehand, & Kotchick, 2002). Therefore, the concentration of youth in this study in the 10-to 13-year-old age range may have diluted gender effects.

It is also notable that positive parenting was associated with youth externalizing, but not internalizing, symptoms in the multivariate analyses. Although positive parenting has been associated with a wide range of child outcomes (e.g. Dornbusch, Ritter, Leiderman, Roberts, & Fraleigh, 1987; Jones et. al., 2002a; Murry, Bynum, Brody, Willert, & Stephens, 2001), possible explanations exist for the inconsistent findings in the current study. First, consistent with the current pattern of findings, some evidence suggests that parenting is a more robust correlate of externalizing than internalizing symptoms (e.g. Galambos, Barker,

& Almeida, 2003; Mesman & Koot, 2000; McCarty, Zimmerman, Digiuseppe, & Christakis, 2005). In contrast, positive parenting may be associated with both psychosocial outcomes for youth in our sample, but the CRPBI may not have adequately captured the critical aspects of positive parenting associated with internalizing symptoms among African American youth from single mother homes.

With regard to the primary focus of the study, the first hypothesis, that youth-coparent relationship quality would be directly associated with youth adjustment was not supported; however, the second hypothesis, that youth-coparent relationship quality would enhance the protective effect of maternal positive parenting, was supported. Consistent with the “protective-protective” moderation model (Zimmerman, Bingenheimer, & Notaro, 2006), higher levels of coparent support strengthened the negative association between maternal positive parenting and internalizing and externalizing symptoms. One possible explanation for this finding is that a positive relationship between coparents and youth may decrease the overall stress a family experiences by, for example, increasing emotional and/or financial resources in the family or by facilitating an overall more positive family environment. This lowered family stress may, in turn, allow a mother’s parenting to be more effective. Consistent with this idea, parent training that includes a problem-solving component to address stressors affecting families, such as finances and relationships with extended family, has been found to be more effective than parent training that did not take those factors into account (Kazdin & Whitley, 2003). In addition, another possible explanation is that a positive youth-coparent relationship may improve factors intrinsic to youth, such as self-esteem, which may make parenting more effective. Related to this idea, studies have shown that a child’s personality and behavioral tendencies can moderate the association between

parenting practices and youth internalizing and externalizing problems (O'Connor & Dvorak, 2001; Prinzie et. al. 2003). Finally, it has also been suggested that an involved secondary caregiver can improve and strengthen the legitimacy of mothers as authority figures in families (Murry et. al., 2001).

It should also be noted that, at low levels of positive parenting, there was an association between higher levels of coparent support and higher levels of externalizing symptoms. While this finding was not expected, one explanation is that as a result of observing high levels of youth disruptive behavior in the context of low maternal positive parenting, coparents exhibited more involvement and engagement with youth, in an effort to offset perceived effects of compromised parenting. Consistent with this idea, externalizing behaviors have been shown to predict an increase in parental involvement among two-parent families (Reitz, Dekovic, & Meijer, 2006). Replication of these findings in longitudinal studies, however, will be necessary before a thorough understanding of this association can be established.

Finally, exploratory analyses examined associations between coparent identity and youth psychosocial adjustment. At Assessment 1, but not Assessment 2, having a coparent who was a child's grandmother was negatively associated with cognitive competence. In addition, the interaction of coparent support X coparent identity was significantly associated with cognitive competence, such that receiving coparent support was associated with higher cognitive competence for youths whose coparent was a sister, but not for youths whose coparents were fathers or grandmothers. These two findings could be related to the fact that sisters are younger than grandmothers or fathers and may have more recent memories of academic concepts younger siblings are learning, resulting

in their ability to be more helpful with school work. Accordingly, future research should take into account age of the coparent as well as specificity of the association between specific coparent behaviors (e.g., tutoring) and specific child outcomes (e.g., cognitive competence). In addition, sisters may be more likely to reside in the same home as the youth, particularly more likely than fathers. Accordingly, sisters may be more accessible and involved with the youths than fathers, in particular; higher support from fathers may translate into the youths being out of the home more, as well as fathers being less able to be consistently involved in daily childrearing activities, including schoolwork. Finally, it should also be noted that since mother-report was used for the outcome variables, the fact that more positive outcomes were associated with sisters and grandmothers as coparents than with fathers as coparents could be partially a result of bias, on the part of some mothers, against fathers. Of course, since these findings were not replicated at Assessment 2, they should be interpreted cautiously.

Longitudinally, coparent identity (sister) was a predictor of decreased cognitive competence. That having a sister as coparent at Assessment 1 was associated with greater decreases in cognitive competence between Assessment 1 and Assessment 2, merits attention in future research. One possibility is that sisters may be less involved in childrearing at older ages due to focusing more on their own personal lives. Another possibility is that sisters may be less involved in discipline than fathers and grandmothers, and greater discipline may be more important to cognitive competence for older youth. In addition, longitudinal analyses also revealed that, for youths whose coparents were grandmothers, but not for youths with other categories of coparents, higher coparent support was associated with a decrease in internalizing symptoms.

Grandmothers may be more able to help youth with socioemotional difficulties due to the fact that they are older than sisters and perhaps fathers, and presumably may have more experience coping with difficulties. Again, grandmothers are also more likely to live in the youth's home than fathers and, therefore, have more contact with youths and more opportunities to assist them.

As already alluded to, the findings of this study must be considered within the context of its limitations. First, youth-coparent relationship quality was measured by youth-report of one dimension of relationship quality, the level of support received from the non-marital coparent. Although perceived support has been identified as the most important variable in caregiver-child relationships (Johnston, Steele, Herrera, & Phipps, 2003), future studies should also examine objective indicators of children's relationships with coparents (i.e. observations), as well as multiple dimensions of relationship functioning (e.g. conflict, involvement). In addition, this study only included one assessment, precluding the opportunity to examine the link between changes in coparent support and youth adjustment over time. Consistent with developmental psychopathology theory (Cummings, Davies, & Campbell, 2000), future research should consider likely bidirectional associations, as well as longitudinal associations, among coparent-youth relationships and youth adjustment. Third, although the measures were modified based on focus group feedback to increase the cultural relevance for the sample, this is not a substitute for the development and standardization of measures with African American samples. Fourth, although most youth were between the ages of 11 and 15, the study should be replicated with measures validated for the entire age range included in the sample. Finally, we do not view our focus on African American single mother families as a limitation of the study given the importance of examining within group

variability in diverse samples; however, caution is warranted in generalizing findings to other groups.

This study also had several strengths which merit attention. First, the sample consisted of African American single mothers and youth living in a high-risk urban community, which has traditionally been an understudied group. Accordingly, our findings contribute to a growing literature which highlights the relevance of culturally-informed models of child and family functioning (e.g. Ball, Pelton, Forehand, Long & Wallace, 2004; Coard, Wallace, Stevenson, & Brotman, 2004; Murry et. al., 2005). This study also used multiple reporters (i.e., youth-report of maternal positive parenting and coparent support and mother-report of child internalizing and externalizing symptoms). Importantly, the use of separate reporters for the predictor (and moderator) and outcome variables minimized the likelihood that significant findings were due to common-reporter variance. Third, the obtained 2-way interaction was replicated across two outcomes, internalizing and externalizing symptoms. Although these findings will need to be replicated in future research, the consistency across outcomes increases our confidence in the obtained pattern of findings. Finally, but perhaps most importantly, this study represents an initial attempt to understand the implications of the youth-coparent relationship for youth raised in single mother homes.

In summary, the findings of this study demonstrate the need to consider complex models of association between family processes and youth adjustment, which may be particularly important when studying low-income families or other families experiencing chronic stress. Many studies have already tested mediational and moderational models involving African-American single mothers and their children (e.g. Bynum & Brody, 2005;



Kim & Brody, 2005; Jones et. al., 2002). Given the substantial number of African American youth being raised in single mother homes (U.S. Census 2006) and the documented role of coparents in the lives of these children, future studies which examine the quality of youth-coparent relationships are critical in understanding youth adjustment. Future research is necessary before definitive decisions can be made regarding the inclusion of coparents, or attention to youth-coparent relationships, in prevention and intervention programs. However, current findings begin to suggest that programs that address maternal parenting alone, without attention to the broader extended family context in which maternal parenting occurs, may miss valuable opportunities to enhance the protective effects of maternal parenting.

**Table 1.** Demographic Characteristics

Variable	<i>M (SD)</i>	N (%)	Range
Child			
Age (yrs.)	11.60(1.75)		8.08-14.92
% Female		72(51)	
Mother			
Age	35.85(6.0)		25-52
Education			
Less than high school		63(44.7)	
High school or GED		46(32.6)	
High school +		13(9.2)	
Vocational college			
High school + Some		19(13.5)	
Employment			
Not employed		60(42.6)	
Part-Time		49(34.8)	
Full-Time		32(22.7)	
Family			
Monthly Income	759.78(481.05)		65-2,500
Coparent Identity			
Father		36(25.5)	
Grandmother		30(21.3)	
Sister		21(14.9)	
Other		46(32.6)	
Primary Study Variables:			
Assessment 1			
Positive Parenting	27.34(3.27)		14.5-33
Coparent Support	15.35(3.01)		6-20
Internalizing Problems	55.86 (10.17)		31-86
Externalizing Problems	58.28 (11.68)		30-90
Cognitive Competence	22.35(4.27)		9-28
Primary Study Variables:			
Assessment 2			
Positive Parenting	29.72(4.24)		19-39
Coparent Support	15.52(2.87)		8-20
Internalizing Problems	55.15(11.07)		31-89
Externalizing Problems	58.97(12.05)		30-96
Cognitive Competence	22.13(4.79)		9-28

**Table 2.** Bivariate Correlations of Major Study Variables

	Mat. Age	Monthly Income	Maternal Educ.	Maternal Employ. Status	Child Age	Child Gender	Pos. Par.	Youth- Cop. Rel.	Internal. Sx	Extern. al. Sx
Mat. Age	-----	.05	.03	-.08	.24**	-.04	.06	-.03	-.12	-.12
Income		-----	.18*	.47**	.06	.04	-.10	-.11	-.22*	-.04
Mat. Educ.			-----	.41**	-.07	.03	.10	-.13	-.19*	-.16
Mat. Emp. Stat.				-----	.02	.03	.03	-.16	-.20*	-.24**
Child Age					-----	.08	.14	0	.04	.07
Child Gen.						-----	-.02	-.04	-.04	.11
Pos. Par.							-----	.33**	-.17*	-.24**
Youth- Cop. Rel.								-----	-.05	-.06
Internal. Sx.									-----	.66**
External. Sx										-----

\* $p \leq .05$     \*\* $p \leq .01$

**Table 3.** Regression Analyses Examining Internalizing Symptoms, Externalizing Symptoms, and Cognitive Competence at Assessment 1.

	F	R <sup>2</sup> Δ	β	t
<b>Internalizing Symptoms</b>				
Block 1: Demographics	2.52	.07		
Monthly Income			-.17	-1.94 <sup>a</sup>
Maternal Education			-.18	-2.05*
Child Gender			-.04	-.45
Child Age			-.03	-.37
Block 2: Positive Parenting	2.26	.01	-.10	-1.11
Block 3: Coparent Support	2.05	.01	-.09	-1.00
Block 4: Positive Parenting * Coparent Support	2.43	.03	-.19	-2.09*
<b>Externalizing Symptoms</b>				
Block 1: Demographics	.83	.01		
Child Gender			.11	1.26
Child Age			.02	.176
Block 2: Positive Parenting	2.10	.03	-.19	-2.15*
Block 3: Coparent Support	1.57	.00	-.01	-.141
Block 4: Positive Parenting * Coparent Support	3.02	.06	-.26	-2.91**
<b>Cognitive Competence</b>				
Block 1: Demographics	5.03	.11		
Maternal Education			.31	3.66**
Child Gender			.11	1.34
Child Age			-.03	-.38
Block 2: Positive Parenting	4.96	.03	.18	2.06*
Block 3: Coparent Support	3.94	.00	.01	.07
Block 4: Positive Parenting * Coparent Support	3.28	.11	.03	.33

<sup>a</sup> $p \leq .10$     \* $p \leq .05$     \*\* $p \leq .01$

**Table 4.** Regression Analyses Examining Internalizing Symptoms, Externalizing Symptoms, and Cognitive Competence at Assessment 2.

	F	R2 Δ	β	t
<b>Internalizing Symptoms</b>				
Block 1: Demographics	2.81	.01		
Monthly Income			-.15	-1.67 <sup>a</sup>
Maternal Education			-.22	-2.42*
Child Gender			-.07	-.70
Child Age			-.02	-.24
Block 2: Positive Parenting	2.23	.00	-.01	-.14
Block 3: Coparent Support	2.02	.01	.09	.99
Block 4: Positive Parenting * Coparent Support	1.90	.01	-.01	-1.06
<b>Externalizing Symptoms</b>				
Block 1: Demographics	1.44	.03		
Child Gender			.07	.72
Child Age			.14	1.49
Block 2: Positive Parenting	.99	.00	.03	.34
Block 3: Coparent Support	.73	.00	.00	.04
Block 4: Positive Parenting * Coparent Support	1.29	.03	-.18	-1.86 <sup>a</sup>
<b>Cognitive Competence</b>				
Block 1: Demographics	3.90	.09		
Maternal Education			.29	3.18*
Child Gender			.10	1.03
Child Age			.03	.30
Block 2: Positive Parenting	3.99	.03	.17	1.90 <sup>a</sup>
Block 3: Coparent Support	3.46	.01	-.11	-1.27
Block 4: Positive Parenting * Coparent Support	3.06	.01	.09	1.04

<sup>a</sup> $p \leq .10$     \* $p \leq .05$     \*\* $p \leq .01$

**Table 5.** Regression Analyses Examining Change in Internalizing Symptoms, Externalizing Symptoms, and Cognitive Competence Assessment 1 to Assessment 2.

	F	R2 Δ	β	t
<b>Internalizing Symptoms</b>				
Block 1: Demographics & Assessment 1 Score	17.06	.43		
Assessment 1 Internalizing Score			.61	8.24**
Monthly Income			-.04	-.55
Maternal Education			-.10	-1.30
Child Gender			-.07	-.95
Child Age			.01	.11
Block 2: Positive Parenting	14.12	.00	.02	.29
Block 3: Coparent Support	12.28	.01	.08	1.06
Block 4: Positive Parenting * Coparent Support	10.85	.01	-.08	-.97
<b>Externalizing Symptoms</b>				
Block 1: Demographics & Assessment 1 Score	55.35	.59		
Assessment 1 Externalizing Score			.77	12.76**
Child Gender			.00	.05
Child Age			.06	.91
Block 2: Positive Parenting	42.22	.01	.08	1.32
Block 3: Coparent Support	33.64	.00	.04	.57
Block 4: Positive Parenting * Coparent Support	28.03	.00	-.05	-.77
<b>Cognitive Competence</b>				
Block 1: Demographics & Assessment 1 Score	38.13	.58		
Assessment 1 Cognitive Competence			.73	11.19**
Maternal Education			.07	1.01
Child Gender			.04	.71
Child Age			.05	.74
Block 2: Positive Parenting	30.39	.00	.04	.57
Block 3: Coparent Support	25.10	.00	.01	.11
Block 4: Positive Parenting * Coparent Support	21.32	.00	.01	.10

\*\* $p \leq .01$

**Table 6.** Regression Analyses Examining Internalizing Symptoms, Externalizing Symptoms, and Cognitive Competence Including Coparent Identity as a Predictor at Assessment 1.

	F	R2 $\Delta$	$\beta$	t
<b>Internalizing Symptoms</b>				
Block 1: Demographics	2.91	.11*		
Monthly Income			-.20	-2.36*
Maternal Education			-.19	-2.11*
Coparent = Father			.09	.705
Coparent = Grandmother			.16	1.33
Coparent = Sister			-.11	-.92
Block 2: Positive Parenting	2.56	.01	-.08	-.91
Block 3: Coparent Support	2.45	.01	-.12	-1.32
Block 4: Interactions with Positive Parenting	2.52	.07*		
Positive Parenting * Coparent Support			-.12	-1.22
Positive Parenting * Coparent = Father			.06	.46
Positive Parenting * Coparent = Grand.			.01	..08
Positive Parenting * Coparent = Sister			.18	1.49
Block 5: Coparent Support X Coparent ID	2.12	.02		
Coparent Support * Coparent = Father			.02	.15
Coparent Support * Coparent = Grand.			-.02	-.18
Coparent Support * Coparent = Sister			-.14	-1.14
<b>Externalizing Symptoms</b>				
Block 1: Demographics	1.39	.03		
Coparent = Father			-.02	-.16
Coparent = Grandmother			.20	1.67 <sup>a</sup>
Coparent = Sister			-.02	-.13
Block 2: Positive Parenting	1.88	.03	-.16	-1.81 <sup>a</sup>
Block 3: Coparent Support	1.52	.00	-.04	-.39
Block 4: Interactions With Positive Parenting	1.77	.06		
Positive Parenting * Coparent Support			-.23	-2.47*
Positive Parenting * Coparent = Father			.09	.70
Positive Parenting * Coparent = Grand.			-.00	-.02
Positive Parenting * Coparent = Sister			.05	.39
Block 5: Coparent Support X Coparent ID	1.54	.02		
Coparent Support * Coparent = Father			.16	1.31
Coparent Support * Coparent = Grand.			-.17	-1.28
Coparent Support * Coparent = Sister			.04	.34

<sup>a</sup> $p \leq .10$     \* $p \leq .05$     \*\* $p \leq .01$

Regression Analyses Examining Internalizing Symptoms, Externalizing Symptoms, and Cognitive Competence Including Coparent Identity as a Predictor at Assessment 1 (continued).

	F	R <sup>2</sup> Δ	β	t
<b>Cognitive Competence</b>				
Block 1: Demographics	6.88	.18**		
Maternal Education			.38	4.56**
Coparent = Father			-.04	-.33
Coparent = Grandmother			-.33	-2.99**
Coparent = Sister			.20	1.75 <sup>a</sup>
Block 2: Positive Parenting	6.40	.03	.16	1.96 <sup>a</sup>
Block 3: Coparent Support	5.29	.00	.00	.00
Block 4: Interactions With Positive Parenting	3.41	.02		
Positive Parenting * Coparent Support			.02	.16
Positive Parenting * Coparent = Father			-.04	-.34
Positive Parenting * Coparent =			-.14	-1.17
Grand.			.06	.49
Positive Parenting * Coparent = Sister				
Block 5: Coparent Support X Coparent ID	3.98	.09**		
Coparent Support * Coparent = Father			-.25	-2.21*
Coparent Support * Coparent = Grand.			.12	1.02
Coparent Support * Coparent = Sister			.36	3.04**

<sup>a</sup> $p \leq .10$     \* $p \leq .05$     \*\* $p \leq .01$



**Table 7.** Regression Analyses Examining Internalizing Symptoms, Externalizing Symptoms, and Cognitive Competence Including Coparent Identity as a Predictor at Assessment 2.

	F	R2 Δ	β	t
<b>Internalizing Symptoms</b>				
Block 1: Demographics	2.29	.09		
Monthly Income			-.17	-1.80 <sup>a</sup>
Maternal Education			-.23	-2.45*
Coparent = Father			-.01	-.11
Coparent = Grandmother			.10	.81
Coparent = Sister			-.10	-.72
Block 2: Positive Parenting	1.90	.00	-.02	-.21
Block 3: Coparent Support	1.75	.01	.09	.94
Block 4: Interactions With Positive Parenting	1.28	.02		
Positive Parenting * Coparent Support			-.08	-.74
Positive Parenting * Coparent = Father			.11	.86
Positive Parenting * Coparent = Grand.			-.04	-.31
Positive Parenting * Coparent = Sister			.02	.14
<hr/>				
Block 5: Coparent Support X Coparent ID	1.26	.03		
Coparent Support * Coparent = Father			-.23	-1.22
Coparent Support * Coparent = Grand.			-.21	-1.17
Coparent Support * Coparent = Sister			.35	.97
<hr/>				
<b>Externalizing Symptoms</b>				
Block 1: Demographics	.91	.02		
Coparent = Father			.12	.90
Coparent = Grandmother			.11	.86
Coparent = Sister			-.23	-1.62
Block 2: Positive Parenting	.70	.00	.03	.33
Block 3: Coparent Support	.56	.00	.01	.09
Block 4: Interactions with Positive Parenting	.91	.05		
Positive Parenting * Coparent Support			-.14	-1.22
Positive Parenting * Coparent = Father			.07	.58
Positive Parenting * Coparent = Grand.			.01	.71
Positive Parenting * Coparent = Sister			.03	.21
Block 5: Coparent Support X Coparent ID	.89	.02		
Coparent Support * Coparent = Father			-.16	-.87
Coparent Support * Coparent = Grand.			-.11	-.60
Coparent Support * Coparent = Sister			.14	.37

<sup>a</sup>p ≤ .10    \*p ≤ .05    \*\*p ≤ .01

Regression Analyses Examining Internalizing Symptoms, Externalizing Symptoms, and Cognitive Competence Including Coparent Identity at Assessment 2(continued).

	F	R2 Δ	β	t
<b>Cognitive Competence</b>				
Block 1: Demographics	3.05	.10*		
Maternal Education			.29	3.24**
Coparent = Father			-.09	-.70
Coparent = Grandmother			-.12	-.91
Coparent = Sister			.12	.85
Block 2: Positive Parenting	3.17	.03	.16	1.84 <sup>a</sup>
Block 3: Coparent Support.	2.83	.01	-.10	-1.06
Block 4: Interactions With Positive Parenting	2.14	.03		
Positive Parenting * Coparent Support			.07	.62
Positive Parenting * Coparent = Father			-.16	-1.26
Positive Parenting * Coparent =			-.04	-.28
Grand.			.01	.07
Positive Parenting * Coparent = Sister				
Block 5: Coparent Support X Coparent ID	1.70	.01		
Coparent Support * Coparent = Father			-.11	-.60
Coparent Support * Coparent = Grand.			.12	.65
Coparent Support * Coparent = Sister			.00	.01

<sup>a</sup>p ≤ .10    \*p ≤ .05    \*\*p ≤ .01

**Table 8.** Regression Analyses Examining Change in Internalizing Symptoms, Externalizing Symptoms, and Cognitive Competence Including Coparent Identity.

	F	R2 Δ	β	t
<b>Internalizing Symptoms</b>				
Block 1: Demographics & Assessment 1 Score	14.26	.45**		
Assessment 1 Internalizing Score			.61	7.97**
Monthly Income			-.03	-.33
Maternal Education			-.11	-1.49
Coparent = Father			-.13	-1.31
Coparent = Grandmother			.10	1.01
Coparent = Sister			.10	.95
Block 2: Positive Parenting	12.12	.00	.02	.25
Block 3: Coparent Support	10.96	.01	.12	1.42
Block 4: Interactions With Positive Parenting	7.97	.03		
Positive Parenting * Coparent Supp.			-.12	-1.29
Positive Parenting * Coparent = Fath.			-.02	-.23
Positive Parenting * Coparent = Gran.			.00	.01
Positive Parenting * Coparent = Sister			.17	1.57
Block 5: Coparent Support X Coparent ID	7.33	.04*		
Coparent Support * Coparent = Fath.			.05	.53
Coparent Support * Coparent = Gran.			-.25	-2.30*
Coparent Support * Coparent = Sister			-.05	-.47
<b>Externalizing Symptoms</b>				
Block 1: Demographics & Assessment 1 Score	41.20	.60**		
Assessment 1 Externalizing Score			.77	12.47*
Coparent = Father			-.05	*
Coparent = Grandmother			-.01	-.56
Coparent = Sister			.07	-.17
				.80
Block 2: Positive Parenting	33.42	.01	.08	1.29
Block 3: Coparent Support	27.75	.00	.04	.62
Block 4: Interactions With Positive Parenting	17.65	.02		
Positive Parenting * Coparent Supp.			-.06	-.93
Positive Parenting * Coparent = Fath.			.03	.28
Positive Parenting * Coparent = Gran.			-.05	-.55
Positive Parenting * Coparent = Sister			.16	1.80 <sup>a</sup>
Block 5: Coparent Support X Coparent ID	14.11	.02		
Coparent Support * Coparent = Fath.			-.04	-.47
Coparent Support * Coparent = Gran.			-.14	-1.54
Coparent Support * Coparent = Sister			.05	.53

<sup>a</sup>p ≤ .10    \*p ≤ .05    \*\*p ≤ .01

Regression Analyses Examining Change in Internalizing Symptoms, Externalizing Symptoms, and Cognitive Competence Including Coparent Identity Assessment 1 to Assessment 2 (continued).

	F	R2 Δ	β	t
<b>Cognitive Competence</b>				
Block 1: Demographics & Assessment 1 Score	34.51	.62**		
Assessment 1 Cog. Competence Score			.76	11.38**
Maternal Education			.04	.53
Coparent = Father			-.02	-.28
Coparent = Grandmother			.10	1.19
Coparent = Sister			-.20	-2.43*
Block 2: Positive Parenting	28.70	.00	.04	.70
Block 3: Coparent Support	24.36	.00	.00	.04
Block 4: Interactions With Positive Parenting	15.92	.02		
Positive Parenting * Coparent Support			.08	1.09
Positive Parenting * Coparent = Father			-.10	-1.09
Positive Parenting * Coparent = Grand.			.01	.10
Positive Parenting * Coparent = Sister			-.04	-.44
Block 5: Coparent Support X Coparent ID	12.99	.02		
Coparent Support * Coparent = Father			.14	1.56
Coparent Support * Coparent = Grand.			-.17	-1.83 <sup>a</sup>
Coparent Support * Coparent = Sister			-.03	-.29

<sup>a</sup>p ≤ .10    \*p ≤ .05    \*\*p ≤ .01

Figure 1. The interaction of positive parenting X coparent support and internalizing symptoms at Assessment 1.

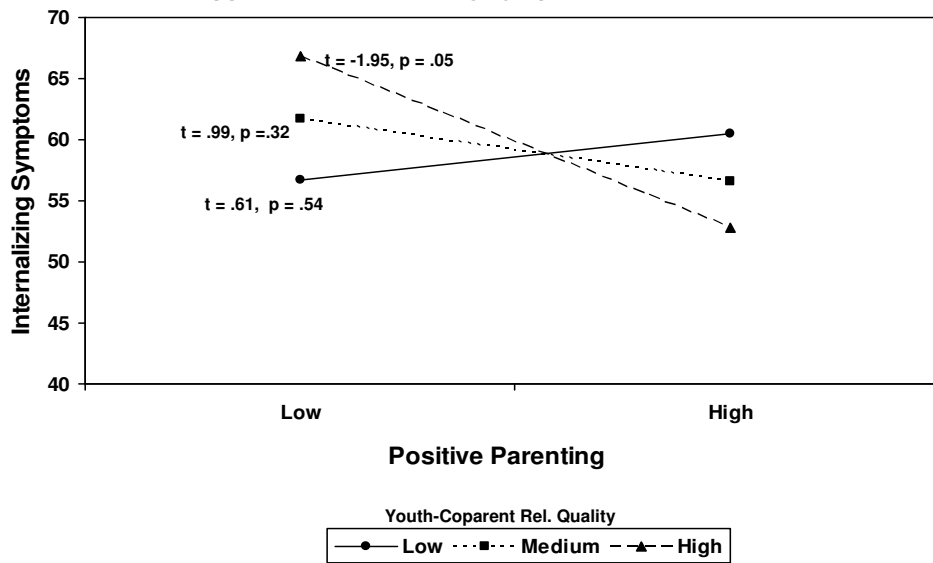


Figure 2. The interaction of positive parenting X coparent support and externalizing symptoms at Assessment 1.

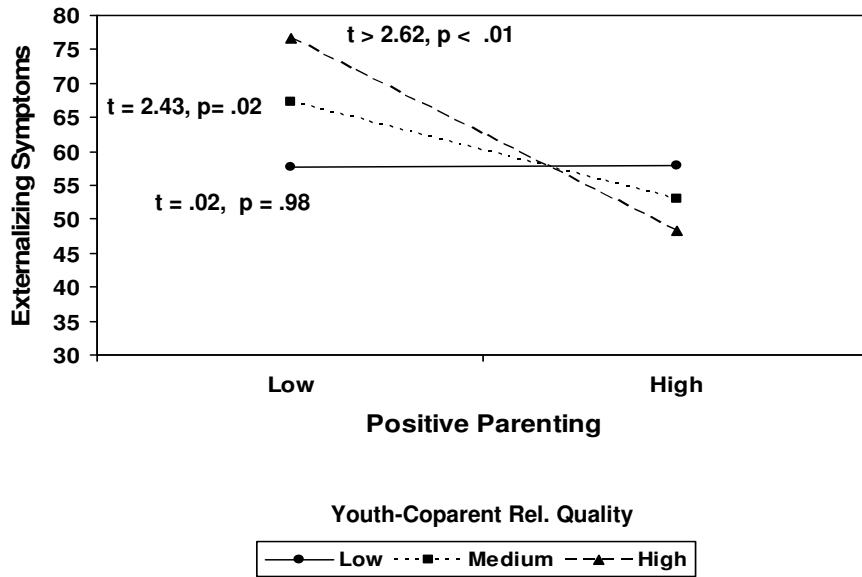


Figure 3. The interaction of coparent support X coparent identity and cognitive competence at Assessment 1.

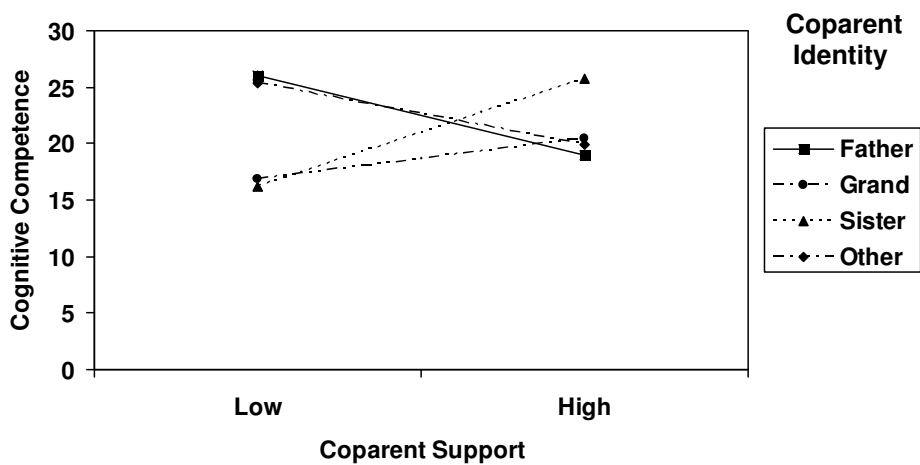
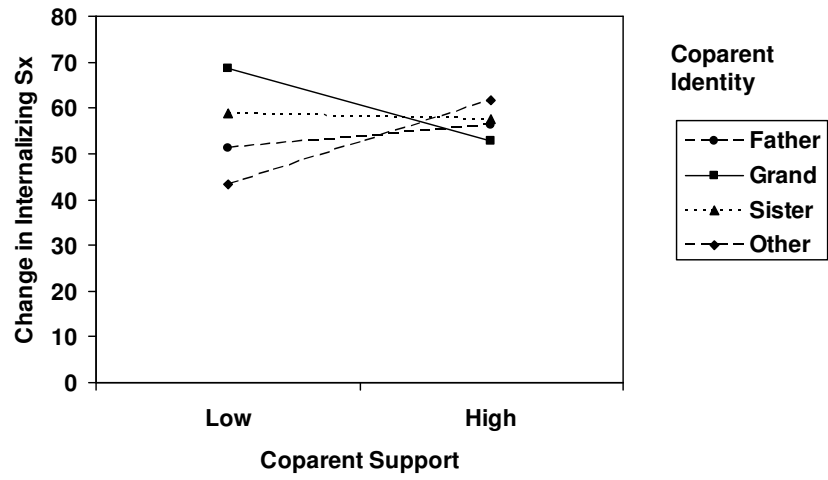


Figure 4. The interaction of coparent support X coparent identity and change in internalizing symptoms.





## Appendix A

### Children's Report of Parenting Behavior Inventory (CRPBI)

These next questions are about what your Mom is like. Please listen to the sentence and look at this card. If you think that the statement describes a person NOT LIKE your mother say Not Like. If you think the statement describes a person SORT OF LIKE your mother, say Sort of Like. If you think that the statement describes a person A LOT LIKE your mother, say Like.

**NL=1**

**SL=2**

**L=3**

1. Your mother gets upset with you easily. Is that not like your mother, somewhat like her, or a lot like her? \_\_\_\_\_
  2. Your mother wants you to tell her if you don't like the way she treats you \_\_\_\_\_
  3. Your mother doesn't spend much time with you \_\_\_\_\_
  4. Your mother forgets to help you when you need it. \_\_\_\_\_
  5. Your mother becomes very involved in your life (She knows a lot about what you are doing). \_\_\_\_\_
  6. Your mother almost always complains about what you do (She says you don't do things very well). \_\_\_\_\_
  7. Your mother always listens to your ideas and opinions (how you feel and what you think about things). \_\_\_\_\_
- CUE: Remember to say 'not like' if the sentence isn't like your mother, 'sort of like' if it's sort of like your mother, and 'like' if it's a lot like your mother.
8. Your mother does not do many things with you. \_\_\_\_\_
  9. Your mother enjoys (likes) doing things with you. \_\_\_\_\_
  10. Your mother makes her whole life center around you and your brothers and sisters (she does a lot for all of you). \_\_\_\_\_
  11. Your mother believes in having a lot of rules and making you obey them. \_\_\_\_\_
  12. Your mother makes you obey her rules. \_\_\_\_\_
  13. Your mother doesn't pay attention when you act bad. \_\_\_\_\_

14. Your mother does not tell you what time to be back home when you go out. \_\_\_\_\_
15. Your mother does not check up to see whether you have done what she tells you. \_\_\_\_\_
16. Your mother lets you go any place you want without asking. \_\_\_\_\_
17. Your mother makes sure that you do exactly what you are told. \_\_\_\_\_
18. If you fuss enough, your mother does not make you obey. \_\_\_\_\_
19. Your mother can be talked into things easily. \_\_\_\_\_
20. Your mother has more rules than you can remember. \_\_\_\_\_
21. Your mother punishes you by not allowing you to be with your friends. \_\_\_\_\_
22. Your mother punishes you by not letting you do your favorite things for awhile. \_\_\_\_\_
23. Your mother spans you. \_\_\_\_\_

## Appendix B

### Co-Parent Support

Is your mom the main person that takes care of you? \_\_\_\_\_

If no: Who is the main person who takes care of you? \_\_\_\_\_

If yes: Who do you think is the second most important person who takes care of you?  
\_\_\_\_\_

I would like for you to tell me a little bit about you and care giver. Tell me how often each of these things happen. Your choices are:

1= Never

2= Not very much

3= Sometimes

4 = Often

How often do you...

1. Go to care giver when you have a problem? \_\_\_\_\_

2. Ask care giver for permission to do something instead of asking your mom? \_\_\_\_\_

3. Tell care giver about what is happening in school or something fun that you did? \_\_\_\_\_

4. Tell care giver how you are feeling? \_\_\_\_\_

How often do your mom and your care giver...

5. Disagree about how you should act? \_\_\_\_\_

6. Disagree about how you are punished? \_\_\_\_\_

7. Get angry at each other when you are around? \_\_\_\_\_

8. How often does your care giver take your side if you and your Mom have an argument or you get in trouble? \_\_\_\_\_

9. How often is care giver a help to you? \_\_\_\_\_

10. If you need help, how often do you go to care giver for help? \_\_\_\_\_

## Appendix C

### Child Behavior Problems Checklist - Internalizing Problems

**DIRECTIONS:** The sentences I'm going to read describe children. For each item that describes your child now or within the past 6 months, please say whether the item is "very or often true," "somewhat or sometimes true," or "not true" of your child. In the last 6 months.

0 = Not True      1 = Somewhat or Sometimes True      2 = Very True or Often True

In the last 6 months:

[TARGET CHILD] complains of loneliness. \_\_\_\_\_

1. S/he cries a lot. \_\_\_\_\_

2. S/he fears he or she might think or do something bad. \_\_\_\_\_

3. S/he feels he or she has to be perfect. \_\_\_\_\_

4. S/he feels or complains that no one loves him or her. \_\_\_\_\_

5. S/he feels that others are out to get him or her. \_\_\_\_\_

6. S/he feels worthless or inferior. \_\_\_\_\_

7. S/he would rather be alone than with others. \_\_\_\_\_

8. S/he is nervous, high-strung, or tense. \_\_\_\_\_

9. S/he is too fearful or anxious. \_\_\_\_\_

10. [TARGET CHILD] feels too guilty. \_\_\_\_\_

11. S/he is often tired. \_\_\_\_\_

12. S/he has physical problems without a known medical cause:

a. Aches or pains (not headaches) \_\_\_\_\_

b. Headaches \_\_\_\_\_

c. Nausea, feels sick \_\_\_\_\_

d. Problems with eyes \_\_\_\_\_

- e. Rashes or other skin problems \_\_\_\_\_
  - f. Stomachaches or cramps \_\_\_\_\_
  - g. Vomiting, throwing up \_\_\_\_\_
13. S/he refuses to talk. \_\_\_\_\_
  14. [TARGET CHILD] is secretive, keeps things to him- or herself. \_\_\_\_\_
  15. S/he is self-conscious or easily embarrassed. \_\_\_\_\_
  16. S/he is shy or timid. \_\_\_\_\_
  17. S/he is suspicious. \_\_\_\_\_
  18. S/he is underactive, slow moving, or lacks energy. \_\_\_\_\_
  19. S/he is unhappy, sad, or depressed. \_\_\_\_\_
  20. S/he is withdrawn, doesn't get involved with others. \_\_\_\_\_
  21. S/he worries. \_\_\_\_\_

## Appendix D

### Child Behavior Checklist- Externalizing Symptoms

The sentences I'm going to read describe children. For each item that describes your child now or within the past 6 months, please say "very true" if the item is very true or often true of target child. Say "somewhat true" if the item is somewhat or sometimes true of her or him and say "not true" if the item is not true of target child.

0 = Not True      1 = Somewhat or Sometimes True      2 = Very True or Often True

In the last 6 months:

1. S/he argues a lot. \_\_\_\_\_
2. S/he brags or boasts. \_\_\_\_\_
3. S/he is cruel to others, bullying or being mean to them. \_\_\_\_\_
4. [TARGET CHILD] demands a lot of attention. \_\_\_\_\_
5. S/he destroys his/her own things. \_\_\_\_\_
6. S/he destroys things belonging to his/her family or others. \_\_\_\_\_
7. S/he is disobedient at home. \_\_\_\_\_
8. S/he is disobedient at school. \_\_\_\_\_
9. S/he doesn't seem to feel guilty after misbehaving. \_\_\_\_\_
10. [TARGET CHILD] is easily jealous. \_\_\_\_\_
11. [TARGET CHILD] gets in many fights. \_\_\_\_\_
12. S/he hangs around with others who get in trouble. \_\_\_\_\_
13. [TARGET CHILD] lies or cheats. \_\_\_\_\_
14. S/he physically attacks people. \_\_\_\_\_
15. S/he prefers being with older kids. \_\_\_\_\_
16. S/he runs away from home. \_\_\_\_\_

17. [TARGET CHILD] screams a lot. \_\_\_\_\_
18. S/he sets fires. \_\_\_\_\_
19. S/he shows off or clowns too much. \_\_\_\_\_
20. S/he steals at home. \_\_\_\_\_
21. S/he steals outside the home. \_\_\_\_\_
22. S/he is stubborn, sullen, or irritable. \_\_\_\_\_
23. S/he has sudden changes in mood or feelings. \_\_\_\_\_
24. S/he swears or uses obscene language. \_\_\_\_\_
25. S/he talks too much. \_\_\_\_\_
26. [TARGET CHILD] teases others a lot. \_\_\_\_\_
27. S/he has temper tantrums or a hot temper. \_\_\_\_\_
28. S/he threatens people. \_\_\_\_\_
29. S/he skips school. \_\_\_\_\_
30. S/he is unusually loud. \_\_\_\_\_
31. S/he uses alcohol or drugs for non-medical purposes. \_\_\_\_\_
32. S/he vandalizes property. \_\_\_\_\_

## Appendix E

### Rating Scale of Child's Cognitive Competence

I am going to read you several sentences that often describe people. After I read each one to you, I want you to decide how well the sentence describes your child. 1 means "not at all like target child," 2 means "a little bit like target child," 3 means "quite a bit like target child," 4 means "always (or extremely) like target child." Of course, there are no right or wrong answers, so please answer as honestly as possible.

1= Not at all   2= A little bit   3= Quite a bit   4=Always like

1. Target child is very good at his/her school work. \_\_\_\_\_
2. S/he is just as smart as other kids his/her age. \_\_\_\_\_
3. S/he is pretty slow at finishing his/her school work. \_\_\_\_\_
4. S/he can remember things easily. \_\_\_\_\_
5. S/he does well in class. \_\_\_\_\_
6. S/he has difficulty understanding what s/he reads. \_\_\_\_\_
7. S/he has trouble figuring out the answers in school. \_\_\_\_\_



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