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RELATIONS BETWEEN PARENT COPING WITH THE STRESS OF PARENTING AND
SYMPTOMS OF ANXIETY AND DEPRESSION

A Thesis

presented in partial fulfillment of requirements

for the degree of Master of Arts

in Clinical Psychology

The University of Mississippi

Maxwell J. Luber

December 2023

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ABSTRACT

It is important to refine understanding of the impact of adolescent behaviors on parents. In particular there is a need to improve understanding of the potential increase in parental distress caused by challenging youth behaviors. Parenting stress may play a critical role in these processes. Various coping strategies have been associated with different psychosocial outcomes, including anxiety and depression. In contrast, less effective coping strategies are linked to a higher likelihood of meeting criteria for mood or anxiety disorders. Gender differences in stress coping between women and men may contribute to women reporting higher levels of psychological distress, depression, and anxiety. However, there is a lack of research on gender differences in stress responses and coping behaviors among parents in response to the stress of parenting adolescents. This study investigated parental coping strategies for parenting stress and their relationship to affective symptoms, including gender differences. The results indicated that mothers reported experiencing lower levels of anxiety and depressive symptoms compared to fathers. Primary and secondary control coping strategies were negatively correlated with symptoms, indicating that these strategies were associated with lower levels of anxiety and depression. Conversely, disengagement coping strategies were positively correlated with symptoms, suggesting that they were associated with higher levels of anxiety and depression. Secondary control coping was negatively associated with parental reactions to stressful interactions. Parental anxiety was linked to increased anger and anxiety responses, while depression showed no significant association. Fathers reported higher disengagement coping

than mothers, with no other significant gender differences in coping strategies. These findings highlight the importance of promoting primary and secondary control coping strategies to reduce parental anxiety and depression and improve parent-adolescent interactions.

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INTRODUCTION

Parent-adolescent interactions are bidirectional (O'Connor, 2002), and the literature shows that family structure and contextual factors may exacerbate overall family-related distress (Laursen & Collins, 2009). Adolescent behaviors impact parents, and difficult youth behaviors likely increase parental distress. For example, research has shown that higher levels of adolescent aggression and depressive symptoms predict higher levels of subsequent mother-adolescent conflict (Steeger & Gondoli, 2013), highlighting a pressing need to examine the impact of adolescent's behavior on parental well-being. Stress responses affect individuals in a host of ways (e.g., affectively, physically, cognitively; Connor-Smith et al., 2000; Jamieson et al., 2012; Schneiderman et al., 2005). Therefore, it is important to understand the impact of parenting stress among parents of adolescents (Maliken & Katz, 2013).

Stress responses have two components – involuntary, or automatic stress responses, and voluntary, or coping responses. Involuntary stress responses are automatic, unplanned reactions to environmental stress that reflect individual differences in temperament and conditioned patterns of stress reactivity. Voluntary stress responses, or coping responses, involve effortful emotional, cognitive, and behavioral responses selected to manage environmental stress (Connor-Smith et al., 2000). Coping responses have been repeatedly linked to mental health outcomes, and data suggests that the way individuals cope with stress plays a key role, either increasing risk for poor mental health functioning or alternatively, serving as buffers (Compas et al., 2015). The Responses to Stress Model (RSM; Connor-Smith et al., 2000) separates responses

to stress into five factors that encompass both effortful and deliberate stress responses (i.e., coping) and automatic cognitive, affective, behavioral, and physiological reactions to stress. The three coping (voluntary) dimensions include primary control coping (i.e., problem solving, emotional expression, emotional regulation), secondary control coping (i.e., acceptance, cognitive restructuring, distraction, positive thinking), and disengagement coping (i.e., avoidance, denial, wishful thinking). The two remaining factors constitute the Involuntary Stress Responses (ISRs), involuntary engagement (i.e., emotional arousal, impulsive action, intrusive thoughts, physiological arousal, rumination), and involuntary disengagement (i.e., emotional numbing, cognitive interference, escape, inaction).

The current study focuses primarily on voluntary coping efforts, which include primary control coping, secondary control coping, and disengagement coping. Primary control coping is comprised of direct efforts to manage a stressful situation or one's reactions to it. This form of coping includes strategies such as problem solving, emotional expression, and emotion regulation. Examples of primary control coping responses include trying to think of different ways to change a problem or letting someone or something know when you are feeling distress (Connor-Smith et al., 2000). Secondary control coping refers to strategies designed to change an individual's emotional reactions to a stressor. Individuals employing secondary control coping adapt themselves to a stressful situation through strategies including cognitive restructuring, distraction, and positive thinking (Band & Weisz, 1990). Examples of secondary control coping responses include telling oneself that everything will be all right or that they will just have to live with things the way they are (Connor-Smith et al., 2000). Disengagement coping reflects avoidance responses, where the individual orients themselves away from a stressor or reactions. An example of a disengagement coping response would be staying away from people and things

that make a person feel upset or remind them of the problem or keeping one's mind off their adolescent by exercising, seeing friends, doing a hobby, or watching TV (Connor-Smith et al., 2000).

Coping and Psychosocial Outcomes

Coping strategies, particularly primary and secondary control coping, have been found to be related to a variety of psychosocial outcomes, including anxiety and depression (Raviv & Wadsworth, 2010; Wadsworth & Compas, 2002). Indeed, evidence suggests that individuals with anxiety and depressive symptoms tend to prioritize short term goals that provide immediate relief over long-term goals that, although less emotionally salient, might lead to greater adjustment (e.g., Aldao & Mennin, 2014; Barlow, 2004; Hayes et al., 1999; Martell et al., 2001; Rodebaugh & Shumaker, 2012; Watkins, 2011). For example, individuals with elevated anxiety tend to respond to anxiety-provoking situations by avoiding them. Although this is useful for achieving the short-term goal of anxiety reduction, it interferes with the goal of actively engaging with the external world and, consequently, leads to greater isolation, more symptoms, and more pervasive dysfunction (Barlow, 2004; Mennin & Fresco, 2014).

Adults who engage in fewer effective coping strategies are also more likely to meet criteria for a mood or anxiety disorder (Campbell-Sills & Barlow, 2007). For example, previous studies have shown that secondary control coping strategies are related to better adjustment and fewer symptoms of anxiety and depression (Compas et al., 2006; Jaser et al., 2005). There is reason to believe that use of secondary control coping, in particular, may be a useful strategy for managing familial stress. A recent coping skills intervention, which focused on teaching secondary control coping skills to the offspring of depressed parents, was associated with reductions in offspring's internalizing and externalizing symptoms (Compas et al., 2009, 2010).

Furthermore, increases in offspring's use of secondary control coping mediated the changes that took place in their internalizing and externalizing symptoms between the intervention and control conditions (Compas et al., 2010). These findings suggest that secondary control coping may play an important role in reducing the impact of established risk factors (i.e., maternal depression) on offspring symptomatology.

Parenting Daily Hassles and Adolescents

A large body of work has demonstrated that among youth, secondary control coping and primary engagement coping are related to fewer internalizing symptoms, and disengagement coping is related to greater internalizing symptoms, particularly in cross-sectional studies (Compas et al., 2017). A growing body of work has begun to examine how parents cope with various stressors (e.g., Compas et al., 2015; Rodriguez et al., 2012; Wadsworth et al., 2011). For example, parent primary and secondary control coping with poverty-related distress was found to be negatively related to depression (Wadsworth et al., 2011). In addition, the use of parental secondary control coping when their offspring has a cancer diagnosis is related to higher anxiety levels for parents (Rodriguez et al., 2012). To date, however, no work has examined how parental coping strategies for managing stress related to parenting is associated with parental anxiety and depressive symptoms. This is a significant gap in the literature, as parenting stress is common, and is related to a number of affective symptoms among parents (Crnic & Ross, 2017).

Indeed, evidence suggests that daily parenting hassles appear to be an important source of stress for parents, and can also be seen as an important measure of stress within the parent-child context. According to the parenting daily hassles theory (PDH; Crnic & Greenberg, 1990), normative stressors faced by parents (e.g., sibling conflicts, child whining/complaining, repeatedly cleaning up messes) can accumulate over time, and may affect parental well-being.

Furthermore, individual differences in terms of how parents react to these stressors may be related to psychological and family outcomes. For example, maternal stress in response to challenging offspring behaviors (e.g., children whining) was related to maternal affective symptoms, over and above the effects of offspring behaviors problem, and general life stress (Crnic & Greenberg, 1990). These results suggest that maternal stress in response to difficult offspring behaviors may be related to maternal psychological functioning over and above the effects of objective assessments of offspring behavior, and more general life stressors.

Interestingly, parenting stress associated with daily hassles appears to be associated with less positive parental behavior, while stress related to daily hassles may be unrelated to levels of negative parenting behavior (Crnic et al., 2005; Jackson & Huang, 2000). For example, Crnic & Ross (2017) found that parenting daily hassles were strongly predictive of less maternal positivity and less dyadic pleasure in interactions with five-year-old children, but did not predict more maternal negativity or greater dyadic conflict. This suggests that normative daily hassles may impede parents' ability to enjoy interactions with their offspring, although to date, limited work has examined these processes among parents of adolescents.

Parent Gender, Parenting Stress, and Coping

Findings from epidemiological studies have repeatedly shown that anxiety and depression diagnoses are more common among women than men (Angst et al., 2009; Bebbington, 1996; Bruce et al., 2005; Nolen-Hoeksema, 1990; Regier et al., 1990; Sprock & Yoder, 1997; Wolk & Weissman, 1995). These studies indicate that the female-to-male ratio is approximately 2:1 or greater for several anxiety disorders (i.e., panic disorder, agoraphobia without panic disorder, specific phobias, generalized anxiety disorder) and for major depression (Gater et al., 1998; Kessler et al., 1994; Weissman et al., 1996). It has been hypothesized that gender differences in

the way women and men typically cope with stress could be one reason why women tend to report more psychological distress and symptoms of depression and anxiety than men (Craske, 2003; Hammen, 2005; Matud, 2004; Mazure & Maciejewski, 2003), which could in turn be reflected in higher prevalence rates of depression and anxiety in women (Barlow, 2004; Kuehner, 2003; Nolen-Hoeksema et al., 1999).

A number of studies have examined gender differences in coping styles. Although no previous studies have examined gender difference using the RSM, studies using alternate theories (e.g. Billings & Moos, 1981, 1984; Folkman & Lazarus, 1980; Pearlin & Schooler, 1978; Sigmon et al., 1995), have examined similar coping strategies to those used in RSM. Numerous studies have demonstrated that men tend to use problem focused coping (analogous to primary control coping) more than women, whereas women tend to use emotion focused coping (analogous to secondary control coping) more than men (e.g., Baker & Berenbaum, 2007; Folkman & Lazarus, 1980; Li et al., 2006; Renk & Creasey, 2003).

However, to date findings on studies of gender differences in stress sensitivity and coping behaviors have been mixed. Several studies have found various differences in stress sensitivity and coping between women and men. For example, some researchers have reported that women were more likely to feel as though they experienced higher levels of stress under several different contexts, such as smoking cessation and living in an academic university environment (Ng & Jeffrey, 2003; Thawabieh & Quaisy, 2012). Other studies have demonstrated differences in coping styles between men and women. For example, men reported controlling their emotions, accepting the problem, not thinking about the situation, and engaging in problem-solving efforts more often than women, while women more often reported seeking social support, distracting themselves, letting out their feelings, and turning to prayer (Thoits, 1995). These inconsistencies

in overall findings across studies may be because researchers use very different coping classifications and means of assessment—i.e., coping in response to a particular stressor versus measures of cross-situational coping style.

Additionally, while several experiments have found evidence for gender differences in terms of coping, their findings often contradict one another. For example, one study indicated that women have reported using more problem-focused coping strategies in regard to social support (Matud, 2004), while another study noted that men used problem focused coping strategies more than women (Ptacek et al., 1992). Similarly, additional studies have found that men used more emotion-focused strategies than women (Eaton & Bradley, 2008; Sigmon et al., 1995). However, this too has been contradicted by other studies that concluded women used more emotion-focused coping strategies than men (Harju & Bolen, 1998).

Interestingly, gender differences in coping styles have not been observed in a number of other studies (Hamilton & Fagot, 1988; Rosario et al., 1988). For example, in a study focused on children and adolescents, no gender differences in coping with stress were found under several contexts, including school, siblings, family, and peers (Donaldson et al., 2000). Another study concluded more similarities than differences existed in perceived stress with women and men, but more investigation regarding those differences were warranted (Furman et al., 2018). Taken together, results suggest that there is a lack of clarity regarding gender-based differences in coping strategies. Further, no studies to date have examined if there are gender differences in terms of parent's ability to cope with stress related to parenting.

The Current Study

The current study was designed to address these gaps in the literature by investigating how parental strategies for coping with parenting stress may be related to parental affective

symptoms (i.e., anxiety and depression symptoms, as well as their “real time reactions” to adolescent distress). A second aim of the study was to examine if there were gender differences in terms of how parents cope with parenting stress. In the current study using archival data, parents completed a series of questionnaires designed to assess their self-reported anxiety and depressive symptoms, as well as their approaches for coping with stress related to parenting. In addition, as a part of a larger study, parents listened to a series of audio vignettes depicting stressful interactions between parents and adolescents. Parents then rated their emotional responses (i.e., anxiety, anger, and negative feelings) after each vignette.

A number of hypotheses guide the current study. First, it was hypothesized that mothers would report higher anxiety and depressive symptoms than fathers (Hypothesis 1). Second, it was hypothesized that self-reported primary engagement coping would be negatively correlated with anxiety and depressive symptoms (Hypothesis 2a), self-reported secondary coping would be negatively correlated with anxiety and depressive symptoms (Hypothesis 2b), and self-reported disengagement coping would be positively correlated with anxiety and depressive symptoms (Hypothesis 2c). In addition, it was hypothesized that parental self-reported secondary coping would evidence negative associations with parental reactions to the vignettes (Hypothesis 2d). Third, it was hypothesized that parental anxiety and depressive symptoms would be positively associated with parental affective reactions (i.e., anxiety [Hypothesis 3a], anger [Hypothesis 3b], negative feelings [Hypothesis 3c]) to audio vignettes depicting stressful interactions with adolescents. Lastly, given that no previous study had investigated parent gender differences in coping within the context of adolescent stress, an exploratory hypothesis was proposed to investigate gender differences in coping strategies (Hypothesis 4).

METHOD

Participants

Participants were adult, English speaking parents of adolescents aged 12 to 16 years old. Parents of adolescents were selected for this study because adolescence is a developmental period in which conflict typically increases between parents and their offspring (Laursen et al., 1998). The sample was drawn using the Qualtrics survey panel services, which is a web-based platform that manages research participation and surveys. The initial sample for this online study consisted of 400 parent participants (200 mothers and 200 fathers). Participant data were excluded if any items were left unanswered. After the data was cleaned, the sample was comprised of 366 parent participants (183 mothers and 183 fathers) aged 18 or over ($M_{\text{age}} = 42.08$, $SD = 14.50$). Please see Table 1 for more demographic information. All participants provided informed consent and received compensation for their participation based on the schedule agreed upon between them and Qualtrics.

Measures

Demographics. Participants were asked to self-report their age, gender, education, relationship status, ethnicity, racial background, socioeconomic status, child demographics (e.g., number of children, and ages), and family responsibilities (i.e., primary caretaker, shared responsibilities, etc.).

Depression and Anxiety Stress Scale-21 (DASS-21; Lovibond & Lovibond, 1995). The 21-item version of the Depression Anxiety Stress Scale-21 (DASS-21) was used to assess

parental depression, anxiety, and stress symptoms. The DASS-21 is a self-report inventory containing 21 items that assess anxiety, depression, and stress symptoms over the past week (Lovibond & Lovibond, 1995). Each subscale includes seven statements. Respondents are asked to read each statement (e.g., “I found it hard to wind down”) and rate how often they have experienced each statement on a 0 (*did not apply to me at all/never*) to 3 (*applied to me very much/always*) scale. Scores are summed and multiplied by two, with higher scores indicating more severe emotional distress. The DASS-21 has demonstrated good reliability and construct validity in both clinical and non-clinical samples (Henry & Crawford, 2005). The DASS-21 demonstrated excellent internal consistency for the anxiety ($\alpha = .91$), depression ($\alpha = .92$), and stress ($\alpha = .91$) subscales in the current study.

Responses to Stress Questionnaire (RSQ; Connor-Smith et al., 2000). Parent responses to stress were measured using the Responses to Stress Questionnaire (RSQ), a 57-item measure that assesses how a person responds to a provided stressful situation (Connor-Smith et al., 2000). The RSQ produces five factor scores: primary control coping, secondary control coping, disengagement coping, involuntary engagement, and involuntary disengagement. The current study focused on the primary control coping, the secondary control coping, and the disengagement coping subscales. Items on the measure include “I tried to think of different ways to change the problem or fix the situation” (Primary Control), “I realized that I just have to live with things the way they are” (Secondary Control), “I try to stay away from people and things that make me feel upset or remind me of the problem” (Disengagement Coping). Participants rated their responses on a Likert scale ranging from 1 (*not at all*) to 4 (*a lot*). Proportion scores are created for each factor to control for individual differences in rates of endorsing items. Previous studies have demonstrated that the RSQ has good reliability, validity and internal

consistency (Compas et al., 2006; Connor-Smith et al., 2000). In the current study, the RSQ primary control coping subscale ($\alpha = .85$), the RSQ secondary control coping subscale ($\alpha = .87$), and the disengagement subscale demonstrated good internal consistency ($\alpha = .88$).

Vignette Paradigm. Parents completed an experimental assessment of coping and emotion regulation that was designed to depict stress associated with common parental demands, including adolescent displays of sadness and irritability. Parents listened to nine vignettes and rated their emotional responses after each vignette. In each vignette, a child is confronted with a parental demand and exhibits a distress response. Prior to engaging in the task, parents were instructed to do one of three things: 1) react naturally, 2) try to make the situation more positive by telling themselves something to make it positive, or 3) to try and distract themselves while listening to the conversation.

Parents were asked to imagine that the adolescent in the vignette was their own child. Modeled after prior studies using similar tasks (Bettis et al., 2019), this task included three conditions: two experimental conditions (reappraisal and distraction) and one control condition (react natural). For the purpose and aims of this study, only the react natural condition was examined. In the react natural condition, parents were instructed to listen to the vignette and react as they normally would.

After each vignette, parents rated their emotions (e.g., angry, anxious, negative) on a scale from 0 (*none*) to 5 (*very much so*). This was repeated for each of the nine vignettes within each condition (three per condition). Finally, a question measuring vignette credibility was administered (i.e., “How believable is this scenario?”) to address any confounds introduced by asking parents to consider their response to a situation they viewed as highly improbable.

Appendix C shows vignettes and the questions asked following the vignette.

Procedure

Participants were recruited through the Qualtrics survey panel services. After informed consent was obtained, participants were asked to fill out the measures described above (randomly ordered to limit order effects). Participants then completed the vignette paradigm and were asked to rate their own emotional response following each clip. The current study included two levels of randomization. First, vignettes were randomly assigned to condition. Next, the order of presentation was randomized. After the participant had finished, they were debriefed and compensated for their participation.

Analytic Approach

The study data set was cleaned prior to conducting data analyses. Missing data was addressed through listwise deletion. Twenty-six participants were excluded from analyses as they did not fully complete the measures. In order to test Hypothesis 1, an independent samples t-test was used to examine gender differences in parent reports on anxiety and depressive symptoms. Next, in order to test Hypotheses 2a, 2b, 2c, and 2d a series of correlations were conducted to examine associations between self-reported primary engagement coping, secondary coping, and disengagement coping and anxiety and depressive symptoms. Third, in order to test Hypothesis 3a, 3b, and 3c, three separate regressions were conducted to examine associations between parental anxiety and depressive symptoms and parental affective reactions (i.e., anxiety, anger, negative feelings) to the audio vignettes depicting stressful interactions with adolescents. Anxiety and depressive symptoms were entered as independent variables while the reactions to the vignettes were entered as the dependent variable in each regression. Finally, in order to address the fourth hypothesis, an independent samples t-test was used to examine gender differences in coping strategies.

RESULTS

Preliminary Analyses

All analyses were conducted using SPSS version 26.0 (IBM Corp., 2019). The initial sample consisted of 400 participants and upon completion of data cleaning, 34 participants were excluded from the analysis as they did not fully complete the measures. Following data cleaning, a normal, linear distribution was demonstrated with no multicollinearity identified. The final sample consisted of 366 participants.

Differences between completers and non-completers were assessed using chi-square and t-tests. Compared to non-completers ($M = 35.19$, $SD = 8.92$), completers ($M = 38.17$, $SD = 9.10$) did differ regarding age $t(397) = -2.14$, $p = .03$. Compared to non-completers, completers did not differ in anxiety $t(391) = -1.23$, $p = .22$, depression $t(393) = -1.29$, $p = .20$, income $t(396) = -1.52$, $p = .13$, primary control coping $t(394) = .30$, $p = .77$, secondary control coping $t(394) = .45$, $p = .66$, and disengagement coping $t(394) = .61$, $p = .55$. Compared to non-completers, completers did differ regarding gender $\chi^2(2,399) = 45.53$, $p < 0.001$, where completers had more men than non-completers.

Descriptive Analyses

See Table 2 for descriptive analyses and zero order correlations among descriptive and outcome variables. As expected, parent anxiety symptoms were positively associated with depressive symptoms. Anxiety and depressive symptoms were positively associated with

primary control coping, secondary control coping, disengagement coping, and reactions to the vignette (i.e., anxiety, anger, and negative feelings). Primary control coping was positively associated with secondary control coping and disengagement coping. Additionally, the vignettes demonstrated an average level of believability of 3.46 ($SD = 1.30$) on a scale from 0 (*not believable*) to 5 (*very believable*) indicating that parents viewed the vignettes as moderately believable.

Primary Analyses

Hypothesis 1. An independent samples t-test was conducted to determine if there were significant gender differences in parent reports on anxiety and depressive symptoms. DASS-21 scores were calculated on a 21-point scale. In terms of anxiety, and inconsistent with Hypothesis 1, on average, mothers ($M = 6.37, SD = 5.06$) reported lower levels of anxiety than fathers ($M = 8.05, SD = 5.90$). This difference $t(364) = 2.92, p = .004$ was significant with a small effect size ($d = .31$). In terms of depression, and inconsistent with Hypothesis 1, on average, mothers ($M = 7.04, SD = 5.50$) reported lower levels of depression than fathers ($M = 8.37, SD = 5.87$). This difference $t(364) = 2.23, p = .026$ was significant with a small effect size ($d = .23$).

Hypothesis 2. Next, a series of correlations were conducted to examine associations between self-reported primary control coping, secondary control coping, and disengagement coping and anxiety and depressive symptoms. DASS-21 scores were calculated on a 21-point scale. Consistent with Hypotheses 2a and 2b, and as noted in Table 2, anxiety and depressive symptoms were significantly negatively correlated with primary and secondary control coping. Consistent with Hypothesis 2c, both anxiety and depressive symptoms were significantly positively correlated with disengagement coping. Consistent with Hypothesis 2d, secondary

control coping was significantly negatively associated with parental reactions to the vignettes (anxiety, anger, negative feelings).

Hypothesis 3. In order to test Hypothesis 3a, 3b, and 3c three separate regressions were conducted to examine associations between parental anxiety and depressive symptoms and parental affective reactions (i.e., anxiety, anger, and negative feelings) to the audio vignettes depicting stressful interactions with adolescents. DASS-21 scores were calculated on a 21-point scale. Anxiety and depressive symptoms were entered as independent variables while the reactions to the vignettes were entered as the dependent variable in each regression.

A simple linear regression analysis was conducted to investigate the association between anxious responses to the vignettes and anxiety and depressive symptoms. The overall model was significant, $F(2,363) = 26.80, p < .001$. The regression model accounted for 13% of the variance in parental anxious reactions to the vignettes ($R^2 = .13$). In terms of anxiety, consistent with Hypothesis 3a, the results show that anxiety ($B = .077, SE = 0.024, p = .002, sr^2 = 0.03$) was significantly related to anxious responses with a small effect size. However, in terms of depression, inconsistent with Hypothesis 3a, the results show that depression ($B = .014, SE = 0.023, p = .545, sr^2 = 0.00$), was not significantly related to anxious responses to the vignettes.

A second simple linear regression analysis was conducted to investigate the association between angry responses to the vignettes and anxiety and depressive symptoms. The overall model was significant, $F(2,363) = 11.83, p < .001$. The regression model accounted for 6% of the variance in parental anger responses to the vignettes ($R^2 = .06$). In terms of anxiety, consistent with Hypothesis 3b, the results show that anxiety ($B = .078, SE = 0.025, p = .002, sr^2 = 0.03$) was significantly related to anger responses with a small effect size. However, in terms of depression,

inconsistent with Hypothesis 3b, the results show that depression ($B = -.019$, $SE = 0.024$, $p = .425$, $sr^2 = 0.00$) was not significantly related to anger responses to the vignettes.

A third simple linear regression analysis was conducted to investigate the relationship between negative responses to the vignettes and anxiety and depressive symptoms. The overall model was significant, $F(2,363) = 12.73$, $p < .001$. The regression model accounted for 7% of the variance in negative responses to the vignettes ($R^2 = .07$). In terms of anxiety and depression, and inconsistent with Hypothesis 3c, the results show that anxiety ($B = .042$, $SE = 0.024$, $p = .084$, $sr^2 = 0.01$) and depression ($B = .022$, $SE = 0.024$, $p = .352$, $sr^2 = 0.00$) were not significantly related to negative responses to the vignettes.

Hypothesis 4. Finally, three independent samples t-tests were used to examine gender differences in self-reported coping strategies. The first test found that, on average, there were no significant differences between mothers ($M = .18$, $SD = .04$) and fathers ($M = .17$, $SD = .03$) in terms of primary control coping $t(364) = -.83$, $p = .41$. The second test found that, on average, there were no significant differences between mothers ($M = .23$, $SD = .04$) and fathers ($M = .22$, $SD = .03$) in terms of secondary control coping $t(364) = -1.45$, $p = .15$. The third test found that, on average, there was a significant difference between mothers ($M = .15$, $SD = .02$) and fathers ($M = .16$, $SD = .02$), with fathers reporting higher levels of disengagement coping $t(364) = 2.32$, $p = .02$ with a medium effect size ($d = .50$), than mothers.

DISCUSSION

The current study aimed to investigate the association between parental strategies for coping with parenting stress and parental affective symptoms, as well as their real-time reactions to adolescent distress. Additionally, the study explored potential gender differences in coping strategies. It was hypothesized that mothers would report higher levels of anxiety and depressive symptoms compared to fathers (Hypothesis 1). Additionally, specific coping strategies were expected to be associated with parental mental health. It was predicted that self-reported primary engagement coping would have a negative correlation with anxiety and depressive symptoms (Hypothesis 2a), self-reported secondary coping would also be negatively correlated with anxiety and depressive symptoms (Hypothesis 2b), and self-reported disengagement coping would show a positive correlation with anxiety and depressive symptoms (Hypothesis 2c). Furthermore, it was anticipated that parental self-reported secondary coping would be negatively associated with parental reactions to stressful audio vignettes involving adolescents (Hypothesis 2d). The study also examined the relationship between parental anxiety and depressive symptoms and their affective reactions to the audio vignettes. It was hypothesized that parental anxiety and depressive symptoms would be positively associated with parental anxiety reactions to the audio vignettes (Hypothesis 3a), parental anger reactions to the audio vignettes (Hypothesis 3b), and parental negative feelings reactions to the audio vignettes (Hypothesis 3c). Lastly, the study conducted an exploratory analysis to investigate gender differences in coping strategies within the context of adolescent stress, without predicting a specific direction (Hypothesis 4). The

overall goal of the study was to examine the relationships between coping strategies, parental mental health, and reactions to adolescent stressors, while also exploring potential gender variations in coping patterns. Overall, results were mixed and somewhat consistent with hypotheses, and suggest a number of important future research directions. These results will be discussed in more detail below.

First, and inconsistent with Hypothesis 1, the results indicated that mothers reported lower levels of anxiety and depressive symptoms compared to fathers. Several factors could contribute to these unexpected findings. It is possible that societal changes in gender roles and expectations have influenced the way mothers and fathers experience and report anxiety and depression (Nomaguchi & Milkie, 2003). Evolving cultural norms may have led to shifts in the allocation of caregiving responsibilities and emotional expression within households, with fathers potentially experiencing increased pressure to break traditional norms and actively engage in caregiving responsibilities, thereby contributing to their own mental health challenges. Additionally, individual differences within the sample, such as support systems and personal coping strategies, may have played a role in these outcomes (Kelly et al., 2008). For instance, the presence or absence of strong support systems and effective personal coping strategies within the sample might have contributed to the observed variations in outcomes, highlighting the multifaceted nature of the study's findings. However, these results challenge traditional gender stereotypes regarding parental emotional distress. Historically, societal norms place a heavier emotional burden on mothers due to their caregiving roles (Sharma et al., 2016). This underscores the importance of reevaluating such stereotypes, acknowledging that fathers also face significant emotional challenges in parenting (Chaplin et al., 2005). Lower reported anxiety and depression levels among mothers may reflect evolving gender roles. In many modern

families, both parents are increasingly sharing childcare responsibilities, highlighting the need to recognize and support shared parenting roles (Bang & Jang, 2022; Ehrenberg et al., 2004). These findings also have implications for mental health stigma (Arends-Tóth & van de Vijver, 2009). Mothers may seek help more readily due to perceived vulnerability, while fathers might hesitate because of societal expectations (Raviv et al., 2008). Addressing mental health stigma is crucial for open discussions about well-being for both genders. Moreover, parental mental health significantly affects family dynamics and child well-being (Kahn et al., 2004). Recognizing that both mothers and fathers may experience these challenges can foster open communication within families and promote mutual support, creating healthier family environments. Mental health interventions should cater to the unique needs of both parents, considering that both genders may face mental health issues. This approach can lead to more effective and inclusive programs for all parents.

These unexpected outcomes raise important questions and prompt a reevaluation of our original hypotheses. While the effect sizes for both anxiety and depression were small, they indicate that there may be some meaningful distinctions between mothers and fathers in terms of their reported mental health symptoms. However, it is crucial to exercise caution when interpreting these results. The small effect sizes ($d = .23-.31$) suggest that the differences, while *statistically* significant, might not be *clinically* significant. Additionally, it is crucial to consider the context of the COVID-19 pandemic, when these data were collected. This highlights the need to account for the broader impact of the pandemic on mental health outcomes and the potential for confounding variables related to the COVID-19 pandemic

Second, results of the study supported Hypotheses 2a, 2b, and 2c. The findings indicated that both anxiety and depressive symptoms were negatively correlated with primary and

secondary control coping, suggesting that parents who engage in more active and problem-focused coping strategies report lower levels of anxiety and depression symptoms. Next, and consistent with hypotheses, disengagement coping was positively correlated with anxiety and depressive symptoms, indicating that avoidance and withdrawal coping strategies were associated with higher levels of parental affective symptoms. Previous research in various contexts has consistently shown that coping strategies play a crucial role in parents' ability to manage distress and psychological well-being. For example, studies have demonstrated that parents who utilize primary and secondary control coping strategies tend to experience lower levels of anxiety and depressive symptoms (Crnic et al., 2005). The impact of primary and secondary control coping has been evident in parents caring for a child with cancer where active coping enhances their well-being and support provision (Compas et al., 2015). Similarly, primary and secondary control coping aids parents facing poverty, reducing distress, and enhancing self-efficacy (Wadsworth et al., 2011). On the other hand, parents who rely on maladaptive coping strategies, such as avoidance, denial, or disengagement from stressors, tend to experience higher levels of psychological distress (Crnic et al., 2005).

Building on these findings, interventions aimed at supporting parents' mental health should focus on promoting adaptive coping strategies while discouraging maladaptive strategies. Cognitive-Behavioral Therapy (CBT) has shown effectiveness in helping individuals develop these adaptive coping skills (Compas et al., 2001). While equipping parents with tools to identify unhelpful thoughts, problem-solve, and manage stress, CBT aids in reducing anxiety and depression symptoms linked to parenting challenges. Education and psychoeducation also play a pivotal role in empowering parents to navigate stress effectively and help them build resilience (Bradley et al., 2003). Furthermore, social support is a critical resource that can aid in parents in

coping with distress. Research has consistently shown that parents with a strong social support network experience lower levels of stress and better mental health outcomes (Crnic et al., 2005). Encouraging parents to seek support from family, friends, and community resources can be beneficial in alleviating feelings of isolation and enhancing their coping abilities.

Third, consistent with Hypothesis 2d, results suggested that secondary control coping was negatively associated with parental reactions to the vignettes depicting stressful interactions with adolescents. Specifically, parents who reported higher levels of secondary control coping reported lower levels of anxiety, anger, and negative feelings in response to the vignettes. These findings suggest that parents who adopt strategies such as acceptance, positive reframing, and finding meaning in difficult situations may also be able to more effectively regulate their emotions in the face of adolescent distress. These findings underscore the importance of understanding and promoting positive coping strategies among parents. Research has consistently highlighted the role of cognitive reappraisal and positive coping in reducing negative affect and promoting emotional well-being (Gross & John, 2003). By adopting secondary control coping strategies, parents may be better equipped to reframe challenging situations with their adolescents in a more positive light, which can lead to a reduction in anxiety, anger, and negative emotions. This aligns with research emphasizing the role of cognitive reappraisal and positive coping strategies in reducing negative affect and promoting emotional well-being (Gross & John, 2003). An important next step in this line of work will be to examine these associations experimentally. Specifically, researchers could consider manipulating how parents cope with parenting stress to investigate whether it has a direct impact on parental reactions to adolescent distress. This experimental approach would provide a more controlled and causal understanding of the relationship between coping strategies and parental

reactions. By experimentally confirming the link between coping strategies and parental reactions, this research could inform interventions aimed at enhancing parental well-being during their children's adolescent years.

Fourth, Hypotheses 3a and 3b were partially supported, indicating that parental anxiety symptoms were positively associated with anxiety and anger responses to the vignettes. However, contrary to Hypotheses 3a and 3b, depression symptoms were not significantly related to anxiety and anger responses. Additionally, Hypothesis 3c was not supported, indicating that both parental anxiety and depressive symptoms were not significantly related to negative feelings in response to the vignettes. These results suggest that while anxiety symptoms were related to the specific feelings of anxiety and anger in response to vignettes, neither anxiety or depression symptoms appears to be associated with the experience of a more general negative feeling during stressful interactions with adolescents. These results underscore the nuanced relationship between different aspects of parental mental health and their emotional responses. The positive association between parental anxiety symptoms along with anxious or angry reactions align with previous research that has emphasized the intricate interplay between anxiety and anger (Potegal et al., 2009). Anxiety can heighten emotional reactivity and decrease emotional regulation, potentially leading to heightened anxiety or anger responses in challenging situations. This highlights the importance of considering multiple dimensions of parental psychological well-being when examining emotional reactions in parenting contexts.

Lastly, the exploratory analysis addressing Hypothesis 4 revealed that fathers reported higher disengagement coping than mothers, while there were no other significant gender differences in coping primary and secondary control coping strategies among parents. These results align with previous research in which fathers reported more disengagement coping

(Clarke et al., 2009; Compas et al., 2015). An important next step here will be to explore the potential sociocultural factors, gender roles, and societal expectations that may contribute to this distinction. Traditional gender roles and societal expectations may contribute, with fathers possibly using disengagement as a way to temporarily detach from parenting responsibilities and conform to stereotypical notions of masculinity (Harris et al., 1998). Meanwhile, mothers, who historically have taken on more caregiving duties, may employ different coping strategies (Sharma et al., 2016). The evolving nature of parenting and a shift towards shared responsibilities may also explain these differences, as fathers adapt to changing family dynamics and potentially face new stressors (Craig & Mullan, 2011). Further research is needed to better understand the interplay of these factors and the implications of higher disengagement coping among fathers in modern parenting contexts. Additionally, further research should delve into the potential consequences of higher disengagement coping among fathers, particularly in the context of parenting and family dynamics.

Despite the notable gender difference in disengagement coping, it is worth noting that there were no other significant differences in primary and secondary control coping strategies between fathers and mothers. This challenges previous assumptions that mothers and fathers may rely on distinct coping mechanisms (e.g., Matud, 2004). Furthermore, these findings highlight the importance of examining the specific mechanisms underlying gender differences in parental affective symptoms. Future research could explore the role coping strategies in mediating the relationship between gender and parental mental health (Nomaguchi & Milkie, 2003). For example, an interesting next step in this study would be to examine if gender differences in disengagement coping may account for the observed differences in anxiety and depression symptoms between mothers and fathers.

Identifying these underlying mechanisms can inform the development of more effective and targeted interventions to support parents' mental health. Moreover, future research could investigate the bidirectional relationships between parental mental health and child development, considering the unique contributions of both mothers and fathers. Maternal mental health has been shown to influence child well-being and development (Goodman et al., 2011; Nomaguchi & Milkie, 2003), while fewer studies have focused on the impact of paternal mental health on children's outcomes. Understanding the potential influence of fathers' mental health on family dynamics and child development can have significant implications for promoting positive parent-child interactions and child well-being (Goodman et al., 2011; Sarkadi et al., 2008).

Limitations and Future Directions

It is important to acknowledge some limitations of the current study. First, the data for affective symptoms and coping were based on self-report measures, which are subject to response biases and may not fully capture participants' actual behaviors or emotions (Barr & Raju, 2003; Murphy et al., 2004; Ng et al., 2011). Future research could employ a multi-method approach, incorporating observational measures and physiological indicators to provide a more comprehensive assessment of parental coping and affective responses (Cheng, 2001; Semmer et al., 2003). Additionally, the study utilized a cross-sectional design, which limits the ability to establish causal relationships between parental coping strategies, affective symptoms, and reactions to adolescent distress. Longitudinal or experimental designs could provide more robust evidence of the directionality of these relationships, provide valuable insights into the dynamic nature of parental mental health, and help identify critical periods for intervention and support. Moreover, the study sample consisted of a mostly White demographic, which may limit the generalizability of the findings to other populations. Future research should aim to include more

diverse samples to examine potential cultural or socioeconomic influences on parental coping and affective responses (e.g., Kuo, 2013; Wadsworth et al., 2011). Another limitation is the reliance on vignettes to elicit parental reactions to adolescent distress. While vignettes provide a controlled and standardized way to assess responses, they may not fully capture the complexity and variability of real-life parent-adolescent interactions. Incorporating ecologically valid measures, such as daily diary assessments or ecological momentary assessments, could offer a more accurate representation of parents' real-time reactions to their adolescents' distress and enhance the ecological validity of the findings (e.g., Ebner-Priemer & Trull, 2009). Furthermore, the study focused solely on parental coping strategies and affective symptoms, without considering other important factors that may influence parenting stress, such as social support, parenting self-efficacy, or child characteristics (Fu et al., 2023). Future research could explore the interplay between these factors and coping strategies to gain a more comprehensive understanding of the determinants of parental well-being and parent-adolescent interactions.

Conclusion

Despite these limitations, the current study contributes valuable insights into the association between parental coping strategies, affective symptoms, and reactions to adolescent distress. The findings provide preliminary evidence that it may be important to promote primary and secondary control coping to alleviate parental anxiety and depression symptoms and improve parent-adolescent interactions. These findings have practical implications as initial steps towards the development of interventions and support programs aimed at enhancing parental well-being and fostering positive parent-adolescent relationships. In addition, these findings indicate that important next steps include engaging in experimental and longitudinal approaches to further refine understanding of these associations.

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APPENDICES

APPENDIX A. TABLES

Table 1
Descriptive Data for Demographic Variables

<i>n</i> = 366	<i>n</i> (%)
Age (SD)	42.08 (14.50)
Gender (Male, <i>n</i>)	183 (50.0%)
Education	
11 th grade or below	13 (3.6%)
High School Diploma	73 (19.9%)
Some College	73 (19.9%)
College Degree	111 (30.3%)
Some Graduate School	11 (3.0%)
Graduate Degree (Masters)	42 (11.5%)
Graduate Degree (M.D., Ph.D., J.D.)	43 (11.7%)
Relationship Status	
Single	114 (31.1%)
Married	212 (57.9%)
Divorced	37 (7.4%)
Separated	13 (3.6%)
Race/Ethnicity*	
White	265 (72.4%)
Asian	4 (1.1%)
African American	69 (18.9%)
Hispanic/Latino	37 (10.1%)
American	9 (2.2%)
Indian/Alaskan Native	4 (1.1%)
Other	4 (1.1%)
Socioeconomic Status	
Less than \$20,000/year	59 (16.1%)
\$21,000-\$40,000	70 (19.1%)
\$41,000-\$60,000	58 (15.8%)
\$61,000-\$70,000	23 (6.3%)

\$71,000-\$90,000	25 (6.8%)
\$91,000-\$100,000	26 (7.1%)
More than \$100,000	105 (28.7%)
Number of Children	
1	139 (37.98%)
2	133 (36.34%)
3	62 (16.94%)
4	23 (6.28%)
5	5 (1.37%)
6	4 (1.09%)
Age of children in household	
7 years old	1
8 years old	3
9 years old	3
12 years old	64
13 years old	107
14 years old	91
15 years old	65
16 years old	29
17 years old	6
Child Gender (Male, n)	217 (59.3%)
Family responsibilities	
Married co-parents	127 (34.4%)
Married primary caretaker	76 (20.8%)
Separated or divorced primary caretaker	17 (4.6%)
Separated or divorced co-parent	14 (3.8%)
Single parent	90 (24.6%)
Caretaker on weekends or fewer than three days a week	11 (3.0%)
Co-parenting with a partner	11 (3.0%)
Primary caretaker with a partner	20 (5.5%)

*Note that race/ethnicity percentages do not sum to 100 because race/ethnicity categories were not mutually exclusive.

Table 2
Descriptive Data and Zero-Order Correlations Between Relevant Variables

	M (SD)	1	2	3	4	5	6	7	8
1. DASS21_anx	7.21 (5.55)	-							
2.DASS21_dep	7.70 (5.72)	.86***	-						
3. Primary Control Coping	.17 (.03)	-.34***	-.43***	-					
4. Secondary Control Coping	.22 (.04)	-.43***	-.47***	.48***	-				
5. Disengagement Coping	.15 (.02)	.14**	.21***	-.55***	-.43***	-			
6. Reaction to Vignettes – Anger	2.54 (1.38)	.24***	.19***	-.18**	-.26***	.08	-		
7. Reaction to Vignettes – Anxious	2.30 (1.38)	.36***	.32***	-.25***	-.34***	.11*	.67***	-	
8. Reaction to Vignettes – Negative	2.56 (1.37)	.25***	.24***	-.20***	-.24***	.09	.77***	.64***	-

Note. DASS-21 scores were calculated on a 21-point scale. DASS_21anx = Depression Anxiety Stress Scale-21, Anxiety Subscale; DASS21_dep = Depression Anxiety Stress Scale-21, Depression Subscale. * $p < .05$ (two-tailed); ** $p < .01$ (two-tailed); *** $p < .001$ (two-tailed).

Table 3
Means and Standard Deviations by Gender

Measure	Fathers		Mothers		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
DASS21_anx ^b	8.05	5.90	6.37	5.06 2.92**	
DASS21_dep ^b	8.37	5.87	7.04	5.50 2.23*	
Coping Strategies					
Primary Control Coping	.17	0.03	.18	0.04	- .83
Secondary Control Coping	.22	0.03	.23	0.04 1.45	-
Disengagement Coping ^a	.16	0.02	.15	0.02 2.32*	

Note. DASS-21 scores were calculated on a 21-point scale. DASS_21anx = Depression Anxiety Stress Scale-21, Anxiety Subscale; DASS21_dep = Depression Anxiety Stress Scale-21, Depression Subscale.

* $p < .05$ (two-tailed); ** $p < .01$ (two-tailed); *** $p < .001$ (two-tailed).

^a greater in fathers

^b greater in mothers

Table 4a
Simple Regression Analysis: Anxious Reactions to Vignettes

Effect	<i>B</i>	<i>SE</i>	95% CI		<i>p</i>	<i>sr</i> ²
			<i>LL</i>	<i>UL</i>		
Constant	2.127	.120	1.891	2.362	.000	
DASS21_anx	.078	.025	.029	.127	.002	.02
					.425	
DASS21_dep	-.019	.024	-.067	.028	.0009	

Note. DASS-21 scores were calculated on a 21-point scale. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; DASS_21anx = Depression Anxiety Stress Scale-21, Anxiety Subscale; DASS21_dep = Depression Anxiety Stress Scale-21, Depression Subscale.

Table 4b
Simple Regression Analysis: Anger Reactions to Vignettes

Effect	<i>B</i>	<i>SE</i>	95% CI		<i>p</i>	<i>sr</i> ²
			<i>LL</i>	<i>UL</i>		
Constant	2.127	.120	1.891	2.362	.000	
DASS21_anx	.078	.025	.029	.127	.002	.03
DASS21_dep	-.019	.024	-.067	.028	.425	.002

Note. DASS-21 scores were calculated on a 21-point scale. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; DASS_21anx = Depression Anxiety Stress Scale-21, Anxiety Subscale; DASS21_dep = Depression Anxiety Stress Scale-21, Depression Subscale.

Table 4c
Simple Regression Analysis: Negative Reactions to Vignettes

Effect	<i>B</i>	<i>SE</i>	95% CI		<i>p</i>	<i>sr</i> ²
			<i>LL</i>	<i>UL</i>		
Constant	2.086	.118	1.854	2.317	.000	
DASS21_anx	.042	.024	-.06	.090	.084	.01
DASS21_dep	.022	.024	-.025	.069	.352	.002

Note. DASS-21 scores were calculated on a 21-point scale. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; DASS_21anx = Depression Anxiety Stress Scale-21, Anxiety Subscale; DASS21_dep = Depression Anxiety Stress Scale-21, Depression Subscale.

APPENDIX B. RESPONSES TO STRESS – FAMILY STRESS (SR-M)

Even when things are going well almost everyone still has some tough times getting along with people in their family, like children, step-children, spouses and significant others. So that we can find out how things have been going for you lately, please circle the number indicating how stressful the following things have been for *you* in the last 6 months.

	Not at All	A Little	Somewhat	Very
a. Arguing with your child(ren)	1	2	3	4
b. Arguing with your spouse or significant other	1	2	3	4
c. Your children competing with each other	1	2	3	4
d. Your children arguing or fighting with each other	1	2	3	4
e. Your children not being as close to each other as you would like	1	2	3	4
f. Your spouse or significant other not understanding you	1	2	3	4
g. Having a hard time talking with your child(ren)	1	2	3	4
h. Your children not respecting each other's property	1	2	3	4
i. Your child(ren) having problems with your spouse or significant other	1	2	3	4
j. Not spending as much time as you would like to with your child(ren)	1	2	3	4
k. Not spending as much time as you would like to with your spouse or significant other	1	2	3	4
l. Having other kinds of problems with your family	1	2	3	4
Explain _____				

***** Circle the number that shows how much control you think you have over these problems.**

1	2	3	4
None	A little	Some	A lot

Below is a list of things that people sometimes do, think, or feel when something stressful happens. Everybody deals with problems in their own way - some people do a lot of the things on this list or have a bunch of feelings, other people just do or think a few things.

Think of all the problems that you indicated above. For each item below, circle one number from 1 (not at all) to 4 (a lot) that shows how much you do or feel these things when you have problems with your family 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.

How much do you do this?

WHEN DEALING WITH PROBLEMS IN MY FAMILY:

Not at all A little Some A lot

1. I try not to feel anything.	1	2	3	4
2. When I have problems with my family, I feel sick to my stomach or get headaches.	1	2	3	4
3. I try to think of different ways to change or fix the situation. Write one plan you thought of: _____ _____	1	2	3	4
4. When problems with my family happen, I don't feel any emotions at all, it's like I have no feelings.	1	2	3	4
5. I wish that I were stronger, smarter, or more popular so that things would be different.	1	2	3	4

How much do you do this?

WHEN DEALING WITH PROBLEMS IN MY FAMILY:

Not at all A little Some A lot

6. I keep remembering what happened with my family or can't stop thinking about what might happen.	1	2	3	4
7. I let someone or something know how I feel. (<i>remember to circle a number.</i>) Check all you talked to: <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Therapist/Counselor <input type="checkbox"/> Clergy Member <input type="checkbox"/> Child(ren) <input type="checkbox"/> God <input type="checkbox"/> Spouse/Significant Other <input type="checkbox"/> Other Family Member <input type="checkbox"/> None of these	1	2	3	4
8. I decide I'm okay the way I am, even though I'm not perfect.	1	2	3	4
9. When I'm around other people I act like the problems in my family never happened.	1	2	3	4
10. I just have to get away when I have problems with my family, I can't stop myself.	1	2	3	4
11. I deal with the problem by wishing it would just go away, that everything would work itself out.	1	2	3	4
12. I get really jumpy when I'm having problems with my family.	1	2	3	4
13. I realize that I just have to live with things the way they are.	1	2	3	4
14. When I have problems with my family, I just can't be near anything that reminds me of the situation.	1	2	3	4
15. I try not to think about it, to forget all about it.	1	2	3	4
16. When problems with my family come up I really don't know what I feel.	1	2	3	4
17. I ask other people or things for help or for ideas about how to make the problem better. (<i>remember to circle a number.</i>) Check all you talked to: <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Therapist/Counselor <input type="checkbox"/> Clergy Member <input type="checkbox"/> Child(ren) <input type="checkbox"/> God <input type="checkbox"/> Spouse/Significant Other <input type="checkbox"/> Other Family Member <input type="checkbox"/> None of these	1	2	3	4
18. When I'm having problems with my family, I can't stop thinking about them when I try to sleep, or I have bad dreams about them.	1	2	3	4

- | | | | | |
|--|---|---|---|---|
| 19. I tell myself that I can get through this, or that I'll do better next time. | 1 | 2 | 3 | 4 |
| 20. I let my feelings out. (<i>remember to circle a number.</i>) | 1 | 2 | 3 | 4 |

I do this by: (Check all that you did.)

- | | |
|---|---|
| <input type="checkbox"/> Writing in my journal/diary | <input type="checkbox"/> Drawing/painting |
| <input type="checkbox"/> Complaining to let off steam | <input type="checkbox"/> Being sarcastic/making fun |
| <input type="checkbox"/> Listening to music | <input type="checkbox"/> Punching a pillow |
| <input type="checkbox"/> Exercising | <input type="checkbox"/> Yelling |
| <input type="checkbox"/> Crying | <input type="checkbox"/> None of these |

- | | | | | |
|--|---|---|---|---|
| 21. I get help from other people or things when I'm trying to figure out how to deal with my feelings. (<i>remember to circle a number.</i>) | 1 | 2 | 3 | 4 |
|--|---|---|---|---|

Check all that you went to:

- | | | | | |
|-------------------------------------|---------------------------------|---|--|--|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Friend | <input type="checkbox"/> Brother/Sister | <input type="checkbox"/> Therapist/Counselor | <input type="checkbox"/> Clergy Member |
| <input type="checkbox"/> Child(ren) | <input type="checkbox"/> God | <input type="checkbox"/> Spouse/Significant Other | <input type="checkbox"/> Other Family Member | <input type="checkbox"/> None of these |

- | | | | | |
|---|---|---|---|---|
| 22. I just can't get myself to face the person I'm having problems with or the situation. | 1 | 2 | 3 | 4 |
| 23. I wish that someone would just come and get me out of the mess. | 1 | 2 | 3 | 4 |

You're half done. Before you keep working, look back at the first page so you remember what kinds of problems with your family you told us about. Remember to answer the questions below thinking about these things.

How much do you do this?

WHEN DEALING WITH PROBLEMS IN MY FAMILY:

Not at all A little Some A lot

- | | | | | |
|---|---|---|---|---|
| 24. I do something to try to fix the problem or take action to change things. | 1 | 2 | 3 | 4 |
|---|---|---|---|---|

Write one thing you did: _____

- | | | | | |
|---|---|---|---|---|
| 25. Thoughts about the problems with my family just pop into my head. | 1 | 2 | 3 | 4 |
|---|---|---|---|---|

- | | | | | |
|--|---|---|---|---|
| 26. When I have problems with my family, I feel it in my body. (<i>remember to circle a number.</i>) | 1 | 2 | 3 | 4 |
|--|---|---|---|---|

Check all that happen:

- | | | |
|---|---|--|
| <input type="checkbox"/> My heart races | <input type="checkbox"/> My breathing speeds up | <input type="checkbox"/> None of these |
| <input type="checkbox"/> I feel hot or sweaty | <input type="checkbox"/> My muscles get tight | |

- | | | | | |
|---|---|---|---|---|
| 27. I try to stay away from people and things that make me feel upset or remind me of the problem. | 1 | 2 | 3 | 4 |
|---|---|---|---|---|

- | | | | | |
|---|---|---|---|---|
| 28. I don't feel like myself when I am dealing with problems in my family, it's like I am far away from everything. | 1 | 2 | 3 | 4 |
|---|---|---|---|---|

29. I just take things as they are; I go with the flow. 1 2 3 4

30. I think about happy things to take my mind off the problem or how I'm feeling. 1 2 3 4

31. When problems with my family come up, I **can't stop** thinking about how I am feeling 1 2 3 4

32. I get sympathy, understanding, or support from someone. (*remember to circle a number.*) 1 2 3 4

Check all you went to:

- Parent Friend Brother/Sister Therapist/Counselor Clergy Member
 Teacher God Spouse/Significant Other Other Family Member None of these

33. When problems with my family happen, I can't always control what I do. 1 2 3 4

(*remember to circle a number.*)

Check all that happen:

- I can't stop eating I can't stop talking
 I do dangerous things I have to keep fixing/checking things
 None of these

34. I tell myself that things could be worse. 1 2 3 4

35. My mind just goes blank when I have problems with my family, I can't think at all 1 2 3 4

36. I tell myself that it doesn't matter, that it isn't a big deal. 1 2 3 4

37. When I have problems with my family, right away I feel really: 1 2 3 4

(*remember to circle a number.*)

Check all that you feel:

- Angry Sad None of these
 Worried/anxious Scared

38. It's really hard for me to concentrate or pay attention when I have problems with my family. 1 2 3 4

39. I think about the things I'm learning from the situation, or something good that will come from it. 1 2 3 4

40. When I have problems with my family, I **can't stop** thinking about what I did or said. 1 2 3 4

41. When I'm having problems with my family, I say to myself, "This isn't real." 1 2 3 4

How much do you do this?

WHEN DEALING WITH PROBLEMS IN MY FAMILY:

Not at all A little Some A lot

42. When I'm having problems with my family, I end up just lying around or sleeping a lot. 1 2 3 4

43. I keep my mind off problems with my family by: (*remember to circle a number.*)

Check all that you do: 1 2 3 4

- Exercising Seeing friends Watching TV
 Playing video games Doing a hobby Listening to music None of these

44. When problems with my family come up, I get upset by things that don't usually bother me.	1	2	3	4
45. I do something to calm myself down when having problems with my family. (remember to circle a number.) Check all that you do: <input type="checkbox"/> Take deep breaths <input type="checkbox"/> Pray <input type="checkbox"/> Walk <input type="checkbox"/> Listen to music <input type="checkbox"/> Take a break <input type="checkbox"/> Meditate <input type="checkbox"/> None of these	1	2	3	4
46. I just freeze when I have problems with my family, I can't do anything.	1	2	3	4
47. When I'm having problems with my family, sometimes I act without thinking.	1	2	3	4
48. I keep my feelings under control when I have to, then let them out when they won't make things worse.	1	2	3	4
49. When problems with my family happen, I can't seem to get around to doing things I'm supposed to do.	1	2	3	4
50. I tell myself that everything will be all right.	1	2	3	4
51. When I have problems with my family, I can't stop thinking about why this is happening.	1	2	3	4
52. I think of ways to laugh about it so that it won't seem so bad.	1	2	3	4
53. My thoughts start racing when I am having problems with my family.	1	2	3	4
54. I imagine something really fun or exciting happening in my life.	1	2	3	4
55. When I'm having problems with my family, I can get so upset that I can't remember what happened or what I did.	1	2	3	4
56. I try to believe that it never happened.	1	2	3	4
57. When I am having problems with my family, sometimes I can't control what I do or say.	1	2	3	4

APPENDIX C. VIGNETTE PARADIGM

Vignette 1 Hygiene/Bedroom

Parent: Clean your room.

Adolescent: I'll clean my room later. It's not even that dirty. I just cleaned my room last week anyway. I'm too busy. Why are you always telling me that I have to do things? Can't I just relax for a bit. Leave me alone.

Vignette 2 Cell Phone

Parent: Put your phone away at dinner, you've been texting too much lately.

Adolescent: It's my phone, I should be able to use it whenever I want to use it. I'm just texting my friends anyway. I don't see what the big deal is. I need to use it to stay in touch with my friends. I have important stuff to talk to them about. All of my other friends are allowed to use their phones as much as they want, so I should be able to also.

Vignette 3 Food disagreements

Parent: You need to sit down and eat with the family.

Adolescent: I'm not ready yet. I'm not even hungry. I'll just eat by myself later. You don't need me there to eat dinner. I'm not going to talk to you anyways. My friends don't have to eat dinner with their parents every night. This is way too early to eat.

Vignette 4 Getting up in the morning

Parent: You need to wake up, it's time for school.

Adolescent: Ugh- you are being so annoying right now. Just give me 10 more minutes. I'm still really tired, I didn't sleep at all last night. I have plenty of time. I will get up on my own. You are just rushing me for no reason.

Vignette 5 Doing homework

Parent: Please start on your homework.

Adolescent: Stop bothering me about my homework. I already told you it's mostly done. I'll get the rest done eventually. It doesn't take very long, and it's not that big of a deal. It doesn't really affect my grades that much, and I can get it done on my own.

Vignette 6 Video games

Parent: You've been spending too much time playing video games, this is the third time I've asked you to stop. You should go outside. Please turn it off.

Adolescent: I just started an hour ago, I haven't even been playing for a long time. I have more levels to get to before it makes sense to stop. If I stop now I will lose all of my progress. All my friends are playing with me. You just don't understand.

Vignette 7 Taking care of possessions

Parent: You need to take better care of your belongings.

Adolescent: Why does it matter to you? They are my things. I should be able to treat them however I want. I take perfectly fine care of my stuff anyways. You're just always trying to both me and tell me what to do.

Vignette 8 TV

Parent: You've been home watching TV all day. Go spend some time outside.

Adolescent: I should be able to do what I want. I'm not five years old anymore. How come everything I do has to be your way? It's not fair.

Vignette 9 Calling

Parent: You need to call me when you are going out somewhere.

Adolescent: You need to give me some breathing room. If I want to go out with my friends, let me go. I'm always home when you want me to be but you can't obsess over me and call me fifty times a day. And if I don't answer my phone, you flip out on me. When you call me fifty times a day in of a single afternoon, it gets really annoying.

CURRICULUM VITAE

Maxwell J. Luber

EDUCATION

- 08/2020 - present** Ph.D. Program in Clinical Psychology
University of Mississippi, Oxford, MS (APA-Accredited)
Advisor: Sarah A. Bilsky, Ph.D.
- 08/2011 - 05/2015** Bachelor of Arts, Psychology
Temple University, Philadelphia, PA
Senior Thesis: Firstborn Attachment in Relation to Parent-Child
Interactions in the Context of the Birth of a Newborn Sibling.
Thesis Advisor: Deborah Drabick, Ph.D.

HONORS AND AWARDS

- Spring 2015 Temple University Dean's List

PUBLICATIONS

Manuscripts Published in Peer-Reviewed Journals:

17. Friedman, H. P., Bilsky, S. A., & **Luber, M. J.** (2023). Parent anxiety, child anxiety, parental beliefs about anxiety, and parenting behaviors: Examining direct and indirect associations. *Journal of Child and Family Studies*, 1-11.
<https://doi.org/10.1007/s10826-023-02665-2>
16. Bilsky, S. A., **Luber, M. J.**, & Hopper, K. M. (2022). Parenting stress, disengagement strategies for managing parenting stress, and hazardous alcohol use among mothers of adolescents. *Substance use & misuse*, 57(10), 1608–1617.
<https://doi.org/10.1080/10826084.2022.2102190>
15. Bilsky, S. A., Olson, E. K., **Luber, M. J.**, Petell, J. A., & Friedman, H. P. (2022). An initial

- examination of the associations between appearance-related safety behaviors, socioemotional, and body dysmorphia symptoms during adolescence. *Journal of adolescence*, 94(7), 939–954. <https://doi.org/10.1002/jad.12074>
14. Bilsky, S. A., **Luber, M. J.**, Cloutier, R. M., Dietch, J. R., Taylor, D. J., & Friedman, H. P. (2021). Cigarette use, anxiety, and insomnia from adolescence to early adulthood: A longitudinal indirect effects test. *Addictive Behaviors*, 120, 106981. <https://doi.org/10.1016/j.addbeh.2021.106981>
 13. Cox, R. C., Jessup, S. C., **Luber, M. J.**, & Olatunji, B. O. (2020). Pre-pandemic disgust proneness predicts increased coronavirus anxiety and safety behaviors: Evidence for a diathesis-stress model. *Journal of anxiety disorders*, 76, 102315. <https://doi.org/10.1016/j.janxdis.2020.102315>
 12. Doucet, G. E., Moser, D. A., **Luber, M. J.**, Leibur, E., & Frangou, S. (2020). Baseline brain structural and functional predictors of clinical outcome in the early course of schizophrenia. *Molecular psychiatry*, 25(4), 863–872. <https://doi.org/10.1038/s41380-018-0269-0>
 11. Janiri, D., Moser, D. A., Doucet, G. E., **Luber, M. J.**, Rasgon, A., Lee, W. H., Murrough, J. W., Sani, G., Eickhoff, S. B., & Frangou, S. (2019). Shared neural phenotypes for mood and anxiety disorders: A Meta-analysis of 226 task-related functional imaging studies. *JAMA psychiatry*, 77(2), 1–8. <https://doi.org/10.1001/jamapsychiatry.2019.3351>
 10. Doucet, G. E., **Luber, M. J.**, Balchandani, P., Sommer, I. E., & Frangou, S. (2019). Abnormal auditory tonotopy in patients with schizophrenia. *NPJ Schizophrenia*, 5, 1-6. <http://dx.doi.org.umiss.idm.oclc.org/10.1038/s41537-019-0084-x>
 9. Kim, Y., Kim, J., Cohen, A., Backus, M., Arnovitz, M., Rice, T., **Luber, M. J.**, & Coffey, B. J. (2017). Medication nonadherence secondary to choking phobia (phagophobia) in an adolescent with significant trauma history: Addressing the issue of mental contamination. *Journal of child and adolescent psychopharmacology*, 27(7), 667–672. <https://doi.org/10.1089/cap.2017.29138.bjc>
 8. Yang, T. C., **Luber, M. J.**, & Coffey, B. J. (2017). Impulsive aggressive behavior triggered by headaches in a child with severe attention-deficit/hyperactivity disorder. *Journal of child and adolescent psychopharmacology*, 27(6), 555–558. <https://doi.org/10.1089/cap.2017.29137.bjc>
 7. **Luber, M. J.**, Coffey, B. J., & Gamms, S. H. (2017). Paradoxical hypertensive urgency in a child after initiation of guanfacine. *Journal of child and adolescent psychopharmacology*, 27(5), 466–468. <https://doi.org/10.1089/cap.2017.29134.bjc>

6. Thom, R. P., Hall, W., Maneta, E., **Luber, M. J.**, & Coffey, B. J. (2017). Treatment of hallucinations in the context of anxiety: When less is more. *Journal of child and adolescent psychopharmacology*, 27(4), 389–392. <https://doi.org/10.1089/cap.2017.29133.bjc>
5. Rice, P. T., Kufert, Y., **Luber, M. J.**, & Coffey, B. J. (2017). Lithium and heart block in an adolescent boy. *Journal of child and adolescent psychopharmacology*, 27(3), 285–288. <https://doi.org/10.1089/cap.2017.29130.bjc>
4. Kolli, V., Bourke, D., Ngo, J., **Luber, M. J.**, & Coffey, B. J. (2017). Clozapine-related tachycardia in an adolescent with treatment-resistant early onset schizophrenia. *Journal of child and adolescent psychopharmacology*, 27(2), 206–208. <https://doi.org/10.1089/cap.2017.29123.bjc>
3. Mehdi, A., Schweinsburg, B. C., Zehgeer, A., Connor, D. F., **Luber, M. J.**, & Coffey, B. J. (2016). Challenges in the psychopharmacological management of very early-onset schizophrenia and anxiety. *Journal of child and adolescent psychopharmacology*, 26(10), 944–947. <https://doi.org/10.1089/cap.2016.29120.bjc>
2. Garcia-Delgar, B., Morer, A., **Luber, M. J.**, & Coffey, B. J. (2016). Obsessive-compulsive disorder, tics, and autoinflammatory diseases: Beyond PANDAS. *Journal of child and adolescent psychopharmacology*, 26(9), 847–850. <https://doi.org/10.1089/cap.2016.29118.bjc>
1. Kostek, N. T., Garcia-Delgar, B., Rojas, A., **Luber, M.** & Coffey B. J. (2016). Approaches to the diagnosis and treatment of OCD with comorbid tic disorders. *Current Treatment Options in Psychiatry*, 3(3), 253–265. <https://doi.org/10.1007/s40501-016-0091-8>

Authorship in Popular Press:

1. Coffey B. J. & **Luber M. J.** (2016). Definition and DSM-5: Classification: Tic Disorders. *News Medical Life Sciences – Health*. Web.

Paper Presentations:

1. Bilsky, S. A., Friedman, H. P., & **Luber, M. J.** (2021). A preliminary examination of the interaction between maternal generalized anxiety disorder and offspring negative affect in relation to maladaptive parenting behaviors. In S. Francis (chair) and K. Allen (discussant). Parenting styles and behaviors as considered in the context of child and adolescent internalizing presentations. Symposium presented at the 55th annual meeting of the Association of Behavioral and Cognitive Therapies, New Orleans, LA.

Poster Presentations:

17. Luber, M. J., Friedman H. P., Hopper, K. M., Sherrod, A., Sachner, L., & Bilsky, S. A. (2023). *The Indirect Effect of Emotion Regulation on the Association Between Distress Tolerance and Anxiety Symptoms*. Poster session to be presented at the Association for Behavioral and Cognitive Therapies Annual Convention, Seattle, WA.
16. Sachner, L., Sherrod, A., Hopper, K. M., **Luber, M. J.**, & Bilsky, S. A. (2023). *Exploring the Relationship between Maternal Anxiety Sensitivity and Emotion Regulation Strategies During Conflict with Adolescents*. Poster session to be presented at the Association for Behavioral and Cognitive Therapies Annual Convention, Seattle, WA.
15. Hopper, K. M., Armstrong, G., Friedman, H. P., Sachner, L., **Luber, M. J.**, & Bilsky, S. A. (2023). *The Relationship between Sleep Quality, Anxiety, and Alcohol Use among Adolescents*. Poster session to be presented at the Association for Behavioral and Cognitive Therapies Annual Convention, Seattle, WA.
14. Friedman, H., Sachner, L., Sherrod, A., **Luber, M.**, Hopper, K., & Bilsky, S. A. (2023). *The Impact of Maternal Social Anxiety on Maternal Responses to Adolescent Positive Affect*. Poster presented at the 2023 Anxiety and Depression Association of America Conference.
13. Hopper, K. M., Armstrong, G., **Luber, M. J.**, & Bilsky, S. A. (2022) *The Impact of Dual Use of Cigarettes and Alcohol on Perceived Parental Stress in Mothers*. Poster presented at the Association for Behavioral and Cognitive Therapies Annual Convention, New York, NY.
12. **Luber, M. J.**, Friedman, H. P., K. M. Hopper, & Bilsky, S. A. (2022) *The Indirect Effect of Parenting Stress on the Association Between Distress Tolerance and Anxiety/Depressive Symptoms*. Poster presented at the Association for Behavioral and Cognitive Therapies Annual Convention during the Parenting and Families Special Interest Group Exposition, New York, NY.
11. Humphrey, C. E., **Luber, M. J.**, & Bilsky, & S. A. (2022). *The Indirect Effect of Negative Affect Relief on the Association Between Anxiety Sensitivity and Nicotine Dependence*. Poster presented at the 73rd annual convention of the Mississippi Psychological Association, Hattiesburg, MS.
10. **Luber, M. J.**, Friedman, H. P., & Bilsky, S. A. (2021). *Disgust Sensitivity and the Encouragement of COVID-19 Safety Behaviors in a Parent Sample*. Poster presented at the Association for Behavioral and Cognitive Therapies Meeting, New Orleans, LA.
9. Friedman, H. P., **Luber, M. J.**, & Bilsky, S. A. (2021). *Examining the Indirect Effect of Parental Beliefs about Offspring Anxiety in the Association Between Parental Anxiety and Parenting Behaviors*. Poster presented at the Association for Behavioral and Cognitive Therapies Meeting, New Orleans, LA.

8. Olson, E., **Luber, M. J.**, Friedman, H. P., & Bilsky, S. A. (2021) *The interaction between anxiety sensitivity and sleep disturbances in relation to adolescent symptoms of panic disorder*. Poster presented at the Association for Behavioral and Cognitive Therapies Meeting, New Orleans, LA.
7. Friedman, H. P., **Luber, M. J.**, Olson, E., & Bilsky, S. A. (2020). *Adolescent sleep difficulties and maternal and adolescent conflict reactivity among families with elevated anxiety*. Poster presented at the Society for Research on Child Development Biennial Meeting, Minneapolis, MN.
6. Saleem S., **Luber M. J.**, & Coffey B. J. (2018). *Internalizing and Externalizing Problems in Children and Adolescents with Tourette's Disorder: An Exploratory Analysis of Gender Differences*. Poster presented at the American Academy of Child & Adolescent Psychiatry's 65th annual convention, Seattle, WA.
5. Doucet G., Moser D. A., Lee W. H., **Luber M.**, Rasgon A., & Frangou S. (2018). *Inter-Subject Variability in Bipolar Disorder Using Multi-Modal Imaging Datasets*. Poster presented at the 73rd Society of Biological Psychiatry annual convention, New York, NY.
4. Doucet G., Moser D. A., Lee W. H., **Luber M.**, Rasgon A., & Frangou S. (2018). *Parsing Heterogeneity in Schizophrenia Using Inter-Subject Variability in Multimodal Neuroimaging Phenotypes*. Poster presented at the 73rd Society of Biological Psychiatry annual convention, New York, NY.
3. Moser D. A., Doucet G., Lee W. H., Rasgon A., Ing A., **Luber M.**, Leibu E., Schumann G., & Frangou S. (2018). *Multivariate associations between multimodal imaging and behavioral and clinical data psychosis*. Poster presented at the 73rd Society of Biological Psychiatry annual convention, New York, NY.
2. Saleem S., **Luber M. J.**, de Larrechea A., Fazio T., Zappa L. M., Garcia-delgar B., Moyano B. B., & Coffey B. J. (2017). *Psychopathology and Tourette's Disorder in Two Countries: What Does the Child Behavior Checklist (CBCL) Tell Us?* Poster presented at the American Academy of Child & Adolescent Psychiatry's 64th annual convention, Washington, D.C.
1. Garcia-Delgar B., **Luber M.**, de Larrechea A., Moyano B.B., Redondo M., Morer A., Nonaka M., Kano Y., & Coffey B. J. (2016). *Depression and Anxiety in Tourette's Disorder: An International Perspective*. Poster presented at the American Academy of Child & Adolescent Psychiatry's 63rd annual convention, New York, NY.

RESEARCH EXPERIENCE

- **Graduate Student Researcher** in the Parent and Adolescent Anxiety (PANDAA) Lab, under the supervision of Dr. Sarah Bilsky at the University of Mississippi in the Department of Psychology. (August 2020 - present)
 - Assist with data collection, study recruitment, and conducting clinical interviews for study examining how parent and adolescent emotional vulnerability factors bi-directionally influence development of anxiety disorders throughout adolescence.
 - Supervise undergraduate research assistants in conducting research in the PANDAA lab.
 - Develop and maintain recruitment database listing locations and businesses where study flyers may be posted.
 - Create and update PANDAA lab website to display current research projects and lab information.

- **Graduate Student Researcher** in Dr. Katianne Sharp's lab at St. Jude Children's Research Hospital in the Department of Psychology. (July 2021 – June 2022)
 - Assist in manuscript preparation for submission to academic journals.
 - Conduct statistical data analyses for manuscript preparation.
 - Assist with data collection and conduct clinical interviews with children and parents for study examining the impact of genetic testing result disclosure for pathogenic/likely pathogenic germline variant in a known cancer predisposing gene versus negative results on parenting and parent adjustment.
 - Complete chart reviews and enter data for study examining how children, adolescents, and young adults are included in genetic counseling consults, germline results disclosure conversations, and follow-up appointments.
 - Transcribe and provide quality assurance for qualitative interview data.

- **Research Analyst** in the Emotion and Anxiety Research Laboratory under the supervision of Dr. Bunmi Olatunji at Vanderbilt University in the Department of Psychology. (July 2019 - July 2020)
 - Recruited and consented eligible research participants with Obsessive-Compulsive Disorder for a NIMH-funded neuroimaging research study on OCD and its relation to disgust.
 - Administered the MINI, BAT, YBOCS, and OCI-R with research participants.
 - Analyzed and organized experimental data on Microsoft Excel and SPSS.
 - Prepared manuscripts for submission to various academic journals.
 - Managed four ongoing research studies.
 - Facilitated weekly lab discussions.
 - Oversaw and mentored ten undergraduate and post-baccalaureate research assistants.
 - Assisted with literature reviews and manuscript preparation.

- **Clinical Research Coordinator** in Dr. Sophia Frangou's lab at the Icahn School of Medicine at Mount Sinai in the Department of Psychiatry. (September 2017 - July 2019)
 - Review patient medical records and decide who to approach based on the study's eligibility requirements.
 - Recruit and consent inpatients and outpatients for psychosis research studies.
 - Administer the SCID, PANSS, HAM-D, MINI, WASI, MATRICS, YBOCS, YMRS, BPRS clinical assessments with participants.
 - Supervise neuroimaging procedures and blood draws, coordinate patient transport and training on functional paradigms.
 - Attend daily patient rounds on psychiatry wards.
 - Communicate with attendings, residents, social workers, and nurses regarding the eligibility and availability of inpatients.
 - Record and organize patient data.
 - Conduct MRI-based brain segmentation for noninvasive brain modulation in psychosis.
 - CPI (crisis prevention) trained and EPIC trained.

- **Clinical Research Coordinator** in the Tics and Tourette's Clinical and Research Program under the supervision of Dr. Barbara J. Coffey at the Icahn School of Medicine at Mount Sinai in the Department of Psychiatry. (November 2015 - September 2017)
 - Recruit child and adult participants for clinical trials and Tourette's Disorder research studies.
 - Manage and maintain study schedules for each participant.
 - Collect data from parent, teacher, and clinician forms, including the CBCL, SNAP, SCARED, MASC, TSSR, and C-FOCI.
 - Escort patients for lab testing and ECG scans.
 - Create and manage databases and prepare data for analysis.
 - Submit annual protocol summary forms and consent forms to the Institutional Review Board (IRB).
 - Assist PI with grant writing and management.
 - Assist with editing research articles and preparing poster presentations.
 - Conduct literature searches for academic conferences and presentations.

- **Clinical Research Coordinator** in Drs. Barbara J. Coffey and Russell Tobe's lab at the Nathan Kline Institute for Psychiatric Research. (January 2016 - September 2017)
 - Submit annual protocol summary forms and consent forms to the Institutional Review Board (IRB).
 - Recruit, manage, and collect genomics research data.

- **Research Assistant** in the Child & Adolescent Anxiety Disorder Clinic under the supervision of Dr. Philip C. Kendall at Temple University in the Department of Psychology. (August 2014 - September 2015)
 - Perform daily data entry for numerous clinical and research projects.
 - Transcribe audio recordings of conversational dialogue between clinical workers and study participants.
 - Administer assessments for youths with anxiety and Autism Spectrum Disorder.

- Prospect with pediatricians and other agencies to recruit new participants for research studies.
- Supervise patients while parents meet with therapists.
- Assist in Cognitive-Behavioral Therapy (CBT) techniques and exercises, such as exposure therapy, with the intent to treat anxiety disorders.
- Train newly recruited Research Assistants.

CLINICAL EXPERIENCE

- **Graduate Clinician** at the Baddour Center under the supervision of Dr. Joshua Fulwiler (July 2023 – present).
 - Administered evidence-based interventions to geriatric and adult-aged persons with intellectual/developmental disabilities and various comorbid psychiatric disorders.
 - Created behavior plans for geriatric and adult-aged persons with intellectual/developmental disabilities.
 - Attended weekly supervision meetings.
 - Participated in didactics related to evidence-based clinical interventions.
 - Facilitated group therapy sessions for social skills.

- **Behavioral Therapist and Consultant** at the Behavior, Attention, and Developmental Disabilities clinic under the supervision of Dr. Emily Johnson (July 2022 – June 2023).
 - Plan and implement a wide variety of interventions pertaining to behavior management, social-emotional learning and social skill development in Tate County Schools, Mississippi.
 - Conduct individual and group therapy sessions on a weekly basis for students in kindergarten through high-school to meet goals as developed on their Individualized Education Plan (IEP).
 - Consult with teachers and provide evidence-based resources and strategies for general classroom management and for individual students.
 - Assist on the IEP team to develop appropriate behavioral/social-emotional goals for students who are eligible under the Individuals with Disabilities Education Act.
 - Conduct comprehensive psychological assessments including intelligence, achievement, adaptive, structured observations, behavioral, and social-emotional evaluations.

- **Graduate Clinician** at the Psychological Services Center under the supervision of Dr. Kristin Austin (Summer, 2021, Summer, 2022, Summer 2023), Dr. Laura Dixon (Fall 2021 – Spring 2022), Dr. Sarah Bilsky (Fall 2022 – Spring 2023), and Dr. John Young (Fall 2023 – present) at the University of Mississippi.
 - Implement evidence-based practices within individual therapy while receiving group supervision. Emphasis on working with the childhood and adolescent populations.

- Provide interventions to clients struggling with a range of psychological difficulties such as emotion dysregulation, social anxiety, problematic anger, and generalized anxiety.
 - Administer measures to evaluate treatment effectiveness, including RCADS, RCADS-P, and OQ-45.
 - Implement the following structured clinical interviews during intake appointments: MINI 5.0, CHIPS, and PCHIPS.
- **Founder and Leader** at the Children’s Social Skills Group under the supervision of Dr. Kristin Austin (Fall 2021 – Spring 2022) at the University of Mississippi.
- Lead weekly socials skills group for children with autism spectrum disorder and their parents using the PEERS manual.
 - Recruit and screen eligible clients for enrollment in the group.
 - Administer measures to collect weekly outcome data.

TEACHING EXPERIENCE

Spring 2021	Graduate Teaching Assistant Developmental Psychology, Undergraduate Course Instructor: Donald Skinner, M.A. Department of Psychology, University of Mississippi
Fall 2020	Graduate Teaching Assistant Introduction to Psychology, Undergraduate Course Instructor: Donald Skinner, M.A. Department of Psychology, University of Mississippi

MENTORING EXPERIENCE

Fall 2021 - present	Mentor for Undergraduate Psychology Majors Department of Psychology, University of Mississippi
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SERVICE AND ADMINISTRATIVE EXPERIENCE

Fall 2021 - present	Assistant to Director of Undergraduate Studies Department of Psychology, University of Mississippi
Fall 2023 – present	President and Co-Leader of Lambda LGBTQ+ Group University of Mississippi

COMMUNITY INVOLVEMENT

- **Camp Counselor** in Dr. Ariz Roja’s OCD Day Camp at the Icahn School of Medicine at Mount Sinai. (Summer 2017)

- Assist psychologist team with Cognitive-Behavioral Therapy (CBT) and Exposure and Response Prevention (ERP) in a group format for children with Obsessive-Compulsive Disorder (OCD).
- Supervise and give guidance to children during field trips for exposure practice.

RELEVANT TRAINING AND WORKSHOPS ATTENDED

1. Young, J. (August 2021 - December 2021). *Evidence-based services seminar*. Seminar conducted at the University of Mississippi at Oxford, MS.
2. McCracken, H.T. (October, 2022). *Administration and scoring of the Delis-Kaplan Executive Functioning Systems (DKEFS)*. Workshop conducted at the University of Mississippi at Oxford, MS.
3. McCracken, H.T. (2023, March). *Administration and scoring of the Wide Range Assessment of Memory and Learning—Third Edition (WRAML-3)*. Workshop conducted at the University of Mississippi at Oxford, MS.
4. Fulwiler, J. (2023, April). *Autism Diagnostic Observation Schedule—2 (ADOS-2) Workshop*. Workshop conducted at the University of Mississippi at Oxford, MS.

AD HOC REVIEWING EXPERIENCES/ACTIVITIES

- Journal of Child and Adolescent Psychopharmacology
- Journal of Psychopathology and Behavioral Assessment