Coparenting Quality and Family Quality of Life in Families of Children with Neurodevelopmental Disorders

by

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Abstract

Background: Neurodevelopmental disorders (NDs), such as autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD), present in childhood and are associated with needs in cognitive, social, academic, and adaptive domains. Parents of children with NDs face unique challenges, as they strive to meet the needs of their children. Having a parenting partner, or a coparent, with whom to share childrearing experiences and responsibilities can be beneficial. Individual family-member factors (e.g., child NDs) and family dynamics (e.g., coparenting) have the potential to impact family quality of life (FQOL), or the subjective sense of well-being within families.

Objectives: The current study compared FQOL and coparenting quality across families of neurotypical (NT) children, children with clinically significant symptoms of ASD, ADHD, and co-occurring ASD and ADHD (ASD+ADHD), and between mother-father dyads. In addition, the extent to which coparenting quality predicts FQOL in neurodevelopmentally diverse families and the potential moderating role of child ND symptomology were explored.

Method: 456 North American parents of children, ages 5 – 18 years, participated in an online survey including questions about coparenting quality and FQOL.

Results: Mothers of NT children reported higher levels of coparenting quality and FQOL than mothers of children in the ADHD and ASD+ADHD groups. Fathers of NT children reported greater coparenting quality than fathers in the ASD, ADHD, and ASD+ADHD groups, and fathers' coparenting quality was greater in the ADHD group than the ASD+ADHD group. Fathers of NT children reported greater FQOL than fathers in the ASD+ADHD group. No significant mother–father differences emerged within dyads. Coparenting quality significantly predicted FQOL, above and beyond effects of child age and child cognitive functioning for mothers and fathers in several neurodevelopmental groups. Child ND symptomology did not significantly moderate the association between coparenting quality and FQOL.

Implications: This research expands upon existing knowledge on the connection between coparenting quality and FQOL of life in neurodevelopmentally diverse families. This research may inform the practices of parent and family support services, by aiding in identifying families who would benefit from coparenting interventions and emphasizing the importance of tailoring coparenting targets with neurodevelopment and family strengths in mind.

Keywords: coparenting, family quality of life, neurodevelopmental disorders, ASD, ADHD, parent gender

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Introduction

Parents raising children with neurodevelopmental disorders (NDs), such as autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD), face unique challenges in meeting the needs of their child. NDs often present in childhood and are associated with challenges that impact functioning in personal, social, and academic domains (American Psychiatric Association [APA], 2013). Specifically, children with NDs may have difficulties with skills that are relevant to functioning effectively in daily life, such as communication, maintaining attention, or organization (APA, 2013). Additionally, children with NDs may engage in unusual or disruptive behaviours, such as repetitive movements or vocalizations, strong negative responses to changes in routine or sensory stimuli, excessive movement (e.g., running or climbing at inappropriate times), excessive talking, or interrupting (APA, 2013). Therefore, parents of children with NDs experience the additional pressures associated with supporting their children in developing skills where weaknesses are present and managing challenging behaviour.

In understanding families' perspectives on NDs, it is important to acknowledge neurodiversity perspectives in addition to diagnostic criteria, deficits, and challenging behaviours. The neurodiversity movement posits that differences in neurodevelopment can be viewed as forms of human diversity, like gender, ethnicity, or sexual orientation, and represent valuable forms of diversity as they bring both challenges and strengths (den Houting, 2019; Jaarsma & Welin, 2012; Nicolaidis, 2012). While the neurodiversity lens tends to acknowledge disabling aspects of NDs, connections to the social model of disability are drawn, wherein disability is conceptualized as resulting from a poor fit between the individual's characteristics and their socially constructed environment (den Houting, 2019). Some parents of children with

NDs have balanced views of their children's unique combination of strengths and challenges and make thoughtful adaptations to their environments to allow their children to move through life with greater ease; however, making accommodations can be effortful and having a child who struggles in many environments can be stressful (Myers et al., 2009). Therefore, even parents who fully acknowledge and appreciate their children's strengths may experience challenges and stressors. Research has shown that parents of children with NDs are at greater risk of elevated levels of parenting stress than parents of neurotypical (NT) children (Brobst et al., 2009; Estes et al., 2013; Hayes & Watson, 2013; Keen et al., 2010; May et al., 2014; Theule et al., 2013; Tomanik et al., 2004).

In addition to impacts on individual parenting experiences, NDs in children may also affect the way that parents work together to raise their children. When families are considered as systems composed of individual family members and the interactions between them (Minuchin, 1985), connections between NDs in children and various family processes are important to be explored. Coparenting is one important process that occurs within families and may be affected by the experiences of raising a child with a ND. Due to the experience of managing elevated levels of parenting stress and child behaviour problems (Brobst et al., 2009; Estes et al., 2012; Hayes & Watson, 2013; Keen et al., 2010; May et al., 2014; Theule et al., 2013; Tomanik et al., 2004), mothers and fathers of children with NDs may face greater challenges when it comes to working collaboratively to raise their children than parents of NT children.

NDs have also been found to have an impact on functioning of the family as a whole. Family quality of life (FQOL) refers to the level of satisfaction families experience in various domains of life (Zuna et al., 2010). FQOL is an important concept to consider, as it provides a comprehensive measure of the extent to which families' needs are being met from the perspective of family members. While many families of children with NDs report family strengths and positive experiences associated with raising children with disabilities (Bayat, 2007; Myers et al., 2009; Ooi et al., 2016), previous research has found that parents of children with NDs report lower levels of FQOL than parents of NT children (Brown et al., 2006; Poston et al., 2003).

Understanding family processes such as coparenting quality and FQOL is important as they have implications for the well-being of parents and children. Furthermore, examining how coparenting quality and FQOL may differ between families with NDs and families of NT children is valuable, as parents in these groups experience unique strengths and challenges. Understanding the connection between coparenting quality and FQOL in diverse families might lead to insight into ways to support these families.

Neurodevelopmental Disorders

Autism Spectrum Disorder

ASD is a ND characterized by weaknesses in social communication and interaction competence and the presence of restricted, repetitive patterns of behaviour, interests, or activities (APA, 2013). More specifically, social deficits associated with ASD may present as problems engaging in social-emotional reciprocity, understanding nonverbal communication, and forming, maintaining, and understanding relationships (APA, 2013). Examples of repetitive patterns of behaviour include stereotyped or repetitive motor movements (e.g., rocking or arm flapping), interactions with objects (e.g., lining up toys), or echolalia (i.e., repeated speech or sounds; APA, 2013). Restricted patterns of behaviour and interest may appear as inflexible adherence to routines, highly restricted or fixated interests, or levels of responsiveness to sensory input that are greater than or less than typical (e.g., lack of responsiveness to pain or temperature, distress in response to particular sounds or textures, or fascination with the appearance of lights or movement; APA, 2013).

Symptoms of ASD present in childhood and typically become apparent during the second year of life; however, symptoms may become noticeable at varying stages depending on individual and environmental factors (APA, 2013). Furthermore, an individual's level of impairment may vary depending on disorder severity, chronological age, developmental level, interventions, or other supports. Approximately 1% of children have ASD (APA, 2013). In terms of gender composition, the prevalence ratio for ASD in childhood is 4:1, wherein boys are diagnosed more frequently than girls (APA, 2013). Early symptoms of ASD often include delayed language development, lack of social interest or unusual social behaviour, patterns of atypical play behaviour, and patterns of unusual communication (APA, 2013). Over the course of development, symptoms such as odd and repetitive behaviours often become more noticeable. Through learning and compensation strategies, individuals with ASD often show developmental gains in some areas (APA, 2013). Estimates of heritability range from 37% to above 90% (APA, 2013). Some cases of ASD seem to be linked to specific gene mutations; however, many cases of ASD may be polygenetic, meaning that many genes are implicated (APA, 2013). Children with ASD are at risk for learning difficulties (due to social and communication challenges), restrictive eating patterns, sleep disturbances, lower adaptive (daily living) skills, difficulties with planning and organization, challenges coping with change, and social isolation (APA, 2013).

Attention Deficit Hyperactivity Disorder

ADHD is a ND that involves persistent patterns of inattention, hyperactivity, and impulsivity at levels that significantly impair development or one's ability to function in their daily life (APA, 2013). More specifically, inattention may appear as difficulty maintaining focus, lower levels of persistence, or disorganization (APA, 2013). Hyperactivity is characterized by excessive motor activity, fidgeting, or talkativeness (APA, 2013). Impulsivity involves actions that are carried out quickly, without sufficient thought for consequences or potential harm (APA, 2013).

Symptoms of ADHD present during childhood and affect functioning in various aspects of life, including life at home and at school (APA, 2013). ADHD occurs in approximately 5% of children (APA, 2013). In terms of gender composition, the prevalence ratio for ADHD in childhood is 2:1, wherein boys are more frequently diagnosed than girls (APA, 2013). Furthermore, girls present with predominantly inattentive symptoms at a greater rate than boys. ADHD tends to be relatively stable over the course of childhood and adolescence. While some hyperactive symptoms may lessen over time, other symptoms often persist into adulthood (APA, 2013). ADHD is a relatively heritable disorder with genetic correlates (APA, 2013). As a result, children of parents with ADHD are at an elevated risk of ADHD. In childhood, ADHD has been associated with several functional consequences. Children with ADHD are at risk for lower school performance and academic attainment, social difficulties (e.g., peer rejection or teasing), higher rates of injuries, and increased likelihood of developing subsequent conduct or substance use disorders (APA, 2013). Additionally, individuals with ADHD are at an increased risk of discord and negative interactions within family relationships (APA, 2013).

Co-occurring ASD and ADHD

According to the American Psychiatric Association (2013) approximately 70% of individuals with ASD have one or more co-occurring psychological disorders. Furthermore, some studies have found that between 30% and 50% of children with ASD also present with significant symptoms of ADHD (Amr et al., 2012; Gadow et al., 2004; Gjevik et al., 2011;

Holtmann et al., 2007; Leitner, 2014; Leyfer et al., 2006; Saito et al., 2020; Sikora et al., 2012; Simonoff et al., 2008; Sinzig et al., 2009). The results of meta-analysis indicated that the prevalence of ADHD in the ASD population is approximately 28% (Lai et al., 2019). Likewise, Mulligan et al. (2009) found that 69% of children with ADHD in their sample exhibited higher levels of ASD symptomology than NT children. Additionally, it is estimated that over 20% of children with ADHD may have clinically significant levels of ASD symptoms (Reiersen et al., 2007). ASD and ADHD share several similarities, such as problems with attention, communication with peers, impulsivity, and restlessness or excessive motor activity (Leitner, 2014). Furthermore, ASD and ADHD are both more frequently diagnosed in boys than girls and are associated with predisposing genetic factors (Leitner, 2014). Family and twin studies have suggested similar genetic factors contributing to ASD and ADHD (Ghirardi et al., 2018; Ghirardi et al., 2019). While results are mixed, some evidence has also been found in support of common neurobiological features of ASD and ADHD (Aoki et al., 2017; Bethlehem et al., 2017; Gargaro et al., 2011; Rommelse et al., 2011).

Some studies have found that the presence of co-occurring ASD and ADHD (ASD+ADHD) is associated with increased risk for impairment and psychosocial problems in comparison to either disorder alone (Leitner, 2014). Specifically, children with ASD+ADHD have been found to have more severe weaknesses in cognitive functioning, academic functioning, social functioning, emotional functioning, and adaptive behaviour than children with ASD alone (Jang et al., 2013; Rao & Landa, 2014; Sikora et al., 2012; Yerys et al., 2009). Given these difficulties, parents of children with ASD+ADHD may face challenging circumstances as they work to support and meet the needs of their children.

Coparenting

The concept of coparenting emerged through efforts to better understand the connection between marital and parenting experiences (Feinberg, 2003). In the most general terms, coparenting can be described as "the way that parents and/or parental figures relate to each other in the role of parent" (Feinberg, 2003, p. 96). The coparenting relationship is distinct from the marital relationship, as it pertains directly to shared childrearing responsibilities and does not include romantic, sexual, companionate, emotional, financial, or legal components that are extraneous to parenting (Feinberg, 2003). For these purposes, parenting is thought of as actions or behaviours with the goal of meeting the needs of children. As a result, less emphasis is placed on factors such as biology, gender, or legal status and the role of coparent can be held by people who are not the biological mother or father of the child in question. For instance, adoptive parents, stepparents, and grandparents may be involved in coparenting (Feinberg, 2003). For the sake of simplicity and clarity, the term *parents* will be used throughout this document to represent primary caregivers who are involved in coparenting.

Conceptualizing Coparenting

Family Systems Theory. Prior to the 1990s, the study of coparenting had largely been restricted to post-divorce coparenting, focusing on the cooperation and conflict between separated parents (Beaton et al., 2013). Over the last three decades, the study of coparenting in a variety of families, including intact families, has increased (e.g., Conway et al., 2025; Downes & Cappe, 2021; Feinberg, 2003; McDaniel et al., 2018; Teubert & Pinquart, 2010). One of the factors contributing to the increase in interest in coparenting more generally has been the influence from the field of family therapy, and specifically concepts from family systems theories (Beaton et al., 2013). Family systems theory (FST) suggests that families can be conceptualized as organized systems, composed of subsystems (Minuchin, 1985). A subsystem can consist of an individual family member; however, there are a number of larger possible subsystems within families, such as the spouse subsystem, the parent subsystem, parent-child subsystems, sibling subsystems, and subsystems including grandparents or other important family members (Minuchin, 1985). The same individuals can be included in multiple different subsystems.

While each subsystem is considered to be distinct, one of the core principles of FST is that subsystems within families are necessarily interdependent (Minuchin, 1985). That is, the actions of individual family members and the interactions between family members exert influence on other subsystems through a number of direct and indirect pathways (Belsky, 1981; Minuchin, 1985). More specifically, subsystems are separated by boundaries that provide structure to interactions within families (Minuchin, 1985). Additionally, implicit rules and behavioural patterns, created within the family, provide further structure to interactions across boundaries. Furthermore, interactional patterns within family systems tend to be circular in nature, as opposed to linear pathways in which one subsystem solely influences another (Belsky, 1981; Minuchin, 1985). These interactions are best represented as “a spiral of recursive feedback loops” (Minuchin, 1985, p. 290), wherein subsystems prompt and respond to changes in other subsystems progressively over time.

Patterns of behaviour within families are formed and sustained over time through corrective feedback loops that serve to maintain homeostasis (Minuchin, 1985). Despite these homeostatic features, family systems are open and susceptible to change (Minuchin, 1985). Morphogenesis, or change of form, occurs when a catalyst acts to disrupt existing patterns and creates the need for the system to evolve towards new patterns that better fit the altered circumstances (Minuchin, 1985). Change is a natural, normative process within families. For example, a new couple must negotiate boundaries and adapt as their relationship develops (Nichols, 2014). Furthermore, the system including the couple will be subjected to further reorganization upon the birth of a child (Nichols, 2014), which acts as a significant catalyst. New patterns will be established as parent-child subsystems and a coparenting subsystem are created.

Given the way subsystems interact, it is important to consider a variety of subsystems together, within the family context, in order to better understand family functioning. Early parenting research was typically restricted to the mother-child subsystem; however, as researchers became interested in learning about the father-child subsystem, they found that examining the mother-child and father-child relations in isolation was insufficient, as this view captures only a portion of the processes within the system (Belsky, 1981) This change in perspective is reflective of the interconnected nature of family systems and complex relational dynamics. Furthermore, this evolution in perspective contributed to an increased interest in the ways in which mothers and fathers interact within their roles as parents.

FST provides a useful conceptual framework from which to study relationships within families. Rather than focusing on individuals within a family, adopting a FST approach allows for broader consideration of patterns of relationships between system members (Minuchin, 1985). For these reasons, prominent models of coparenting utilize concepts from FST (e.g., Feinberg, 2003; Margolin et al., 2001).

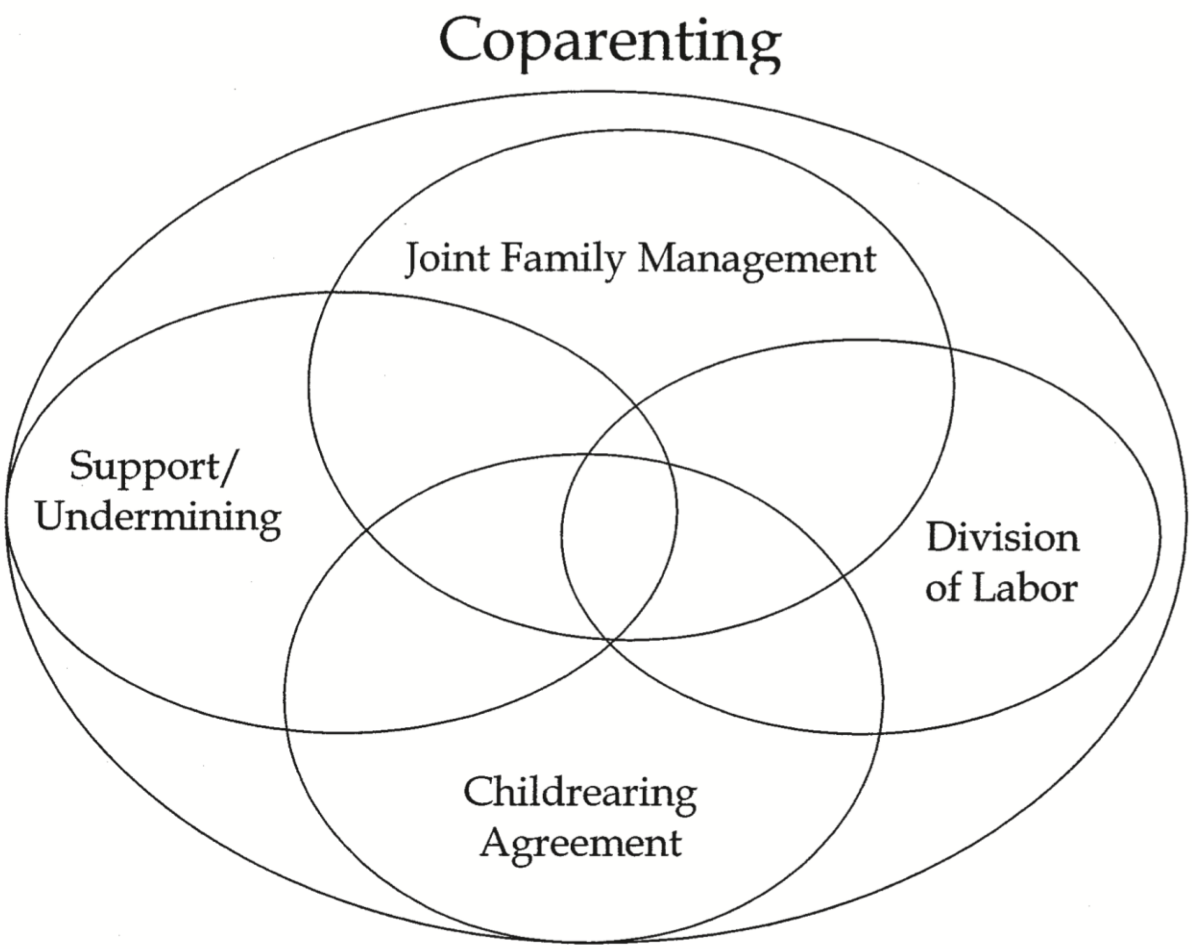
Feinberg's Models of Coparenting. Around the 1980s, evidence suggesting that marital dysfunction is a strong predicter of child behaviour problems had been growing (Emery, 1982; Feinberg, 2003; Reid & Crisafulli, 1990). Simultaneously, family sociologists were investigating the effects of a new baby on marital functioning, and the work of developmental psychologists was focused on the parent-infant relationship (Belsky, 1981; Feinberg, 2003). Belsky (1981) identified the separation of these fields of research as problematic and advocated for interdisciplinary research that could effectively examine all pathways within the family system (i.e., between the marital relationship, parenting, and infant behaviour and development). Similarly, the majority of applied family research was separated into research focusing on interventions targeting the couple relationship or parenting and child outcomes (Feinberg, 2003). Feinberg (2003) posited that a comprehensive conceptualization of coparenting could bridge the divide between research on marital and parenting interventions and serve as a framework on which to base applied coparenting research.

Feinberg (2003) proposed two conceptual models of coparenting that draw upon the principles of FST. The first model is a structural model in which the concept of coparenting is further refined into four components. In order to provide a broader view of the coparenting relationship within the context of other family systems, Feinberg (2003) also proposed a second model, which took a macroscopic perspective, and provided an ecological model of coparenting.

Feinberg's Structural Model of Coparenting. Feinberg (2003) suggested that the coparenting relationship involves underlying mechanisms through which the parent subsystem is connected to other subsystems within the family. Therefore, Feinberg's (2003) first model illustrates four components of the coparenting relationship that were selected based on previous coparenting research (Belsky et al., 1996; Brody, Flor, & Neubaum, 1998; Cowan & Cowan, 2000; Feinberg, 2003; Ihinger-Tallman et al., 1995; Margolin et al., 2001; McHale, 1995): agreement or disagreement on childrearing issues, division of (child-related) labor, support/undermining for the coparental role, and the joint management of family interactions (See Figure 1).

Figure 1

Model of Coparenting Components (Feinberg, 2003)



Childrearing Agreement. Childrearing agreement refers to the extent to which parents agree on a variety of childrearing matters, such as values, behavioural expectations and consequences, children's emotional needs, educational priorities, safety issues, and peer relations (Feinberg, 2003). Research on childrearing agreement has found positive associations with compliance in infants (Lindsey & Caldera, 2005), behavioural and emotional control in preschool and early school-aged children (Block et al., 1981; Lamb et al., 1989), and negative associations with behaviour problems in preschool children (Deal et al., 1989), and internalizing and externalizing problems in childhood (Lamela et al., 2016; Teubert & Pinquart, 2010). Furthermore, childrearing agreement has also been linked to subsequent intelligence and moral judgement in adolescent boys (Vaughn et al., 1988) and self-esteem in adolescent girls (Vaughn et al., 1988). In addition to child outcomes, childrearing agreement has been found to be associated with parent and family outcomes, such as more positive parenting practices (Deal et al., 1989), reports of a more positive family environment by parents (Deal et al., 1989), greater marital quality (Block et al., 1981; Don et al., 2013; Lamb et al., 1989), parental mental health (Don et al., 2013), and life satisfaction (Lamela et al., 2016). Despite childrearing agreement's association with a number of child and family outcomes, Feinberg (2003) suggests that disagreement in itself may not be problematic if parents are able to negotiate their differences in a productive way, such that it does not create conflict or impede their ability to coordinate family management and provide support.

Division of Labor. Division of labor refers to the way in which childcare-related responsibilities and tasks are divided up or shared between parents (Feinberg, 2003). Observations of the division of household and childcare tasks have tended not to predict marital functioning (Belsky & Hsieh, 1998). In contrast, parents' satisfaction with the division of labor has been found to predict overall coparenting quality (Feinberg et al., 2012), parents' positive coparenting experiences (Van Egeren, 2004), reports of happiness (Voydanoff & Donnelly, 1999), less negative affect (Lamela et al., 2016), fewer depressive symptoms (Tornello, 2020), and sexual satisfaction (Maas et al., 2018). For mothers in particular, violated expectations about the division of labor have been associated with lower marital satisfaction (Block, 2016; Farr & Patterson, 2013; Khazan et al., 2008). Often, mothers in heterosexual couples take on a larger proportion of household and childcare duties than fathers and tend to report lower levels of satisfaction with the division of labor (Farr & Patterson, 2013; Van Egeren, 2004). In addition to possible impacts on parent well-being, parents' satisfaction with division of labor has been associated with fewer parent-reported child internalizing and externalizing problems (Lamela et al., 2016).

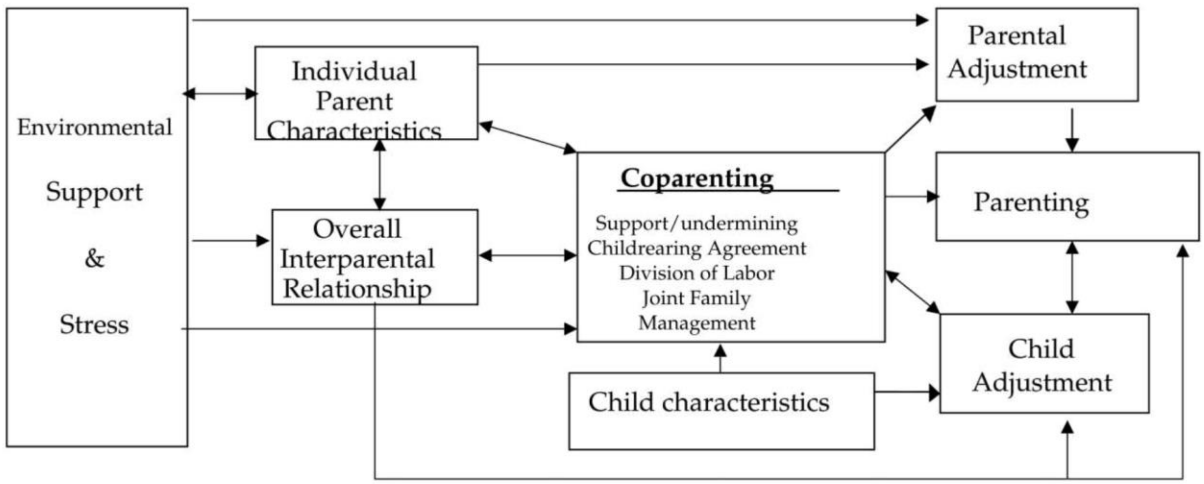
Support/Undermining. *Coparenting support* refers to the extent to which parents provide support for their coparent through means including "affirmation of the other's competency as a parent, acknowledging and respecting the other's contributions, and upholding the other's parenting decisions and authority" (Feinberg, 2003, p. 104). In contrast, *undermining coparenting* includes coparenting behaviours that compromise the other parent's parenting effectiveness or confidence. Examples of undermining coparenting include criticism, disparagement, and blame (Feinberg, 2003). Research has found associations between coparenting support and overall coparenting quality (Feinberg et al., 2012), relationship quality (Bonds & Gondoli, 2007; Le et al., 2016; Le et al., 2019; Van Egeren & Hawkins, 2004), positive relationship behaviors with their partner (Kuo & Nelson, 2025), maternal warmth (Bonds & Gondoli, 2007), parental life satisfaction (Lamela et al., 2016), lower parenting stress (Johnson et al., 2024), less perceived child difficulty (Johnson et al., 2024), and fewer child externalizing problems (Lamela et al., 2016). Undermining coparenting has been found to be associated with lower overall coparenting quality (Feinberg et al., 2012), poorer relationship quality (Le et al., 2016; Van Egeren & Hawkins, 2004), lower parenting self-efficacy or parenting confidence (Floyd & Zmich, 1991; Merrifield & Gamble, 2013), negative parenting behaviours (Wang & Schoppe-Sullivan, 2025), and infant behaviour problems (LeRoy et al., 2013).

Joint Family Management. The domain of joint family management is characterized by the nature of the interactions between parents (e.g., cooperative, hostile, etc.), the formation and maintenance of boundaries within the family, and the level of involvement parents have in various family activities (Feinberg, 2003). Parents' abilities to regulate their own behaviour and communication styles are important as exposure of children to interparental conflict has been found to be associated with poor marital adjustment (Kerig, 1996), negative parenting practices (Krishnakumar & Buehler, 2008), internalizing and externalizing problems in youth (Buehler et al., 1997; Grych et al., 2004; Grych et al., 1992; Kerig, 1996), and child emotional reactivity (Davies et al., 2006).

An Ecological Model of Coparenting. Feinberg's (2003) ecological model of coparenting depicts the coparenting relationship, which includes the components of the structural model, as being at the center of a network of individual, family, and extra-familial factors (see Figure 2). This model suggests that coparenting is influenced by environmental support and stress, individual parent characteristics (e.g., gender, education level), the overall interparental relationship, child characteristics (e.g., neurodevelopmental disorders), and child adjustment (Feinberg, 2003). Furthermore, the model illustrates the pathways through which coparenting may influence individual parent characteristics, the overall interparental relationship, parental adjustment, parenting, and child adjustment (Feinberg, 2003). Feinberg's (2003) ecological model of coparenting provides a useful conceptual framework from which to explore the ways in which individual parent characteristics, individual child characteristics, and family level factors impact coparenting quality.

Figure 2

Ecological Model of Coparenting (Feinberg, 2003)



Individual Parent Characteristics and Coparenting

Parent Gender. Parenting has long been a gendered experience, wherein mothers and fathers take on differing roles within the family (Cowan & Cowan, 2000; Hays, 1998; Shelton & Harold, 2008). Mothers are typically the primary caregivers, taking on a greater proportion of household and childcare duties (Farr & Patterson, 2013; Raley et al., 2012; Van Egeren, 2004). A study conducted using time-diary data from Australian Bureau of Statistics Time Use Survey 1997 found that mothers spent more time (M = 5.89 hours per day) caring for their children than fathers (M = 2.37 hours per day; Craig, 2006). Similarly, mothers spent more time (M = 11.85 hours per day) in the company of their children than fathers (M = 7.84 hours per day; Craig, 2006). A more recent study using a nationally representative sample of parents in the United States found that mothers spent an average of 49.8 hours per week with their children, while fathers spent 31.4 hours (Raley et al., 2012). Further, when it came to time spent as the sole caregiver, both studies found that mothers spent nearly three times the amount of time that fathers did. Craig (2006) found that mothers spent 33% of their childcare time as the sole caregiver, compared to only 13% of fathers' childcare time. Similarly, the Raley et al. (2012) study found that mothers spent 30.2 hours per week as the sole caregiver, whereas fathers spent 10.7 hours per week.

The types of childcare tasks that mothers and fathers typically engage in may differ as well. Craig (2006) found that mothers spent a greater proportion of their childcare time (51%) providing physical and emotional care (e.g., bathing, feeding, and dressing) than fathers (31%). In contrast, fathers spent a greater proportion of their childcare time (40%) providing interactive care (talking, playing, reading, teaching, or reprimanding) than mothers (22%). Likewise, the Raley et al. (2012) study found that while fathers engaged in recreational childcare activities almost as often as mothers, they reported participating in physical or routine childcare and managerial childcare far less often than mothers.

As mentioned previously, division of labor is a component of Feinberg's (2003) model of coparenting components. Violated expectations about the division of labor has been identified as a factor contributing to lower marital satisfaction in mothers (Block, 2016; Farr & Patterson, 2013; Khazan et al., 2008). Along with differing roles, mothers and fathers may also have different subjective parenting experiences. Specifically, some studies have found that mothers of children with disabilities experience slightly higher levels of parenting stress than fathers of children with disabilities (Baker, 1994; Esdaile & Greenwood, 2003; Si et al., 2020; Theule et al., 2013). Similarly, a meta-analysis of the association between coparenting quality and marital satisfaction found a stronger effect for mothers than fathers (Ronaghan et al., 2024). These findings suggest that the gender roles that parents occupy within the family system influence their coparenting experience as well as the marital relationship.

With regards to gender differences in coparenting satisfaction, there has been variation in results of previous studies. Findings from some studies indicate that mother and father reports of their coparenting quality tend to be moderately to highly correlated (Feinberg et al., 2012; Schoppe-Sullivan et al., 2004). In contrast, other studies have found that fathers tend to report greater levels of satisfaction with their coparenting relationships than mothers (Floyd & Zmich, 1991; Van Egeren, 2004). Additionally, mothers have been found to display higher levels of coparenting cooperation than fathers (Margolin et al., 2001).

Parent Education and SES. Education provides parents with information and resources that can influence the way they interact with their parenting partner and the extent to which they are able to work collaboratively to meet the needs of their children (Stright & Bales, 2003). Furthermore, parents with lower education and lower socioeconomic status (SES) may experience more daily stressors that impede their capacity to engage in supportive, sensitive parenting, as they may have access to fewer economic and emotional resources to support them in coping with parenting demands (Evans & English, 2002; McLoyd, 1990; Raphael et al., 2010).

Previous research has found an association between parents' education and parenting quality. Specifically, parents with higher levels of education have been found to display more verbal responsiveness (Richman et al., 1992), emotional support (Padilla et al., 2020), cognitive stimulation (Padilla et al., 2020), and less corporal punishment (Padilla et al., 2020). Furthermore, Stright and Bales (2003) found that mothers with higher levels of education engaged in more supportive coparenting during triadic interactions. The effects of parental education on parenting and coparenting may also lead to more positive parent-child relationships. Some studies have found that parents with higher levels of education report higher levels of satisfaction with their relationship with their adolescent children (Downing-Matibag, 2009) and have children who report stronger parent-child relationships (Li et al., 2020).

More generally, SES has been linked to child and adolescent mental health problems. In a systematic review, Reiss (2013) found that 52 studies have demonstrated a negative relation between SES and mental health problems in children and adolescents (Reiss, 2013). Specifically, children from lower SES families were between two and three times as likely to experience mental health problems (Reiss, 2013). Reiss (2013) found that parental education was among the strongest SES variables in predicting mental health problems in children and that it significantly predicted the persistence and severity of mental health problems (Reiss, 2013). Children of parents with lower levels of education were also found to have less access to mental health care resources, suggesting that limited access to resources may be a mechanism contributing to the association between low SES and mental health problems (Reiss, 2013).

Individual Child Characteristics and Coparenting

Autism Spectrum Disorder. In their efforts to meet the unique needs of their children, parents of children with ASD face different demands than parents of NT children (Downes & Cappe, 2021; Karst & Van Hecke, 2012). Parents of children with ASD are at greater risk for experiencing lower levels of parenting efficacy, suggesting that they feel less confident in their ability to successfully meet their child's needs (Karst & Van Hecke, 2012). Furthermore, parents of children with ASD report more intense child behaviour problems (Brobst et al., 2009) and are at risk for elevated levels of parenting stress compared to parents of NT children or children with other disabilities (Brobst et al., 2009; Estes et al., 2012; Hayes & Watson, 2013; Keen et al., 2010; May et al., 2015; Tomanik et al., 2004). Parents' efforts to meet the needs of their child with ASD seem to serve as a catalyst for reorganization of the family system, including changes in roles, responsibilities, and interactional patterns (Downes & Cappe, 2021; Hock et al., 2012; May et al., 2017; Sim et al., 2017).

The results of a systematic review of studies on coparenting in families of children with ASD found that lower coparenting quality was associated with higher levels of parenting stress (Downes & Cappe, 2021). Stronger associations between coparenting quality and parenting stress were found for fathers than mothers (Downes & Cappe, 2021; May et al., 2015; Thullen & Bonsall, 2017). Furthermore, elevated levels of parenting stress were found to be associated with reduced satisfaction with the division of labour (Downes & Cappe, 2021). In contrast, it has been suggested that the reorganization of roles and increased attention placed on working together to meet the child's needs is beneficial to the coparenting relationship in this population (Downes & Cappe, 2021; Hock et al., 2012).

Attention Deficit Hyperactivity Disorder. Similar to parents of children with ASD, parents of children with ADHD encounter child behaviours that represent unique challenges for the coparenting subsystem. ADHD symptom severity has been found to be associated with poorer social skills and higher levels of aggressive behaviour in children (Kaiser et al., 2011), as well as higher levels of home chaos (Mokrova et al., 2010). Additionally, parents of children with ADHD report greater deficits in their children's executive functioning, including behavioural control and metacognitive abilities (i.e., planning, organization, working memory, and problem solving) than do parents of NT children (Schroeder & Kelley, 2009). The results of a meta-analysis on ADHD and parenting stress indicated that parents of children with ADHD experience greater levels of parenting stress compared to parents of NT children (Theule et al., 2013). Furthermore, increased levels of symptom severity were found to be associated with elevated parenting stress (Theule et al., 2013). In terms of parental gender differences, mothers experienced more parenting stress directly linked to child characteristics (child domain parenting stress) than fathers (Theule et al., 2013).

With regards to parenting practices, negative parenting practices have been found to mediate the associations between ADHD symptom severity and child social skills and between ADHD symptom severity and child aggression (Kaiser et al., 2011). Furthermore, Williamson and Johnston (2016) found that child ADHD symptoms predicted a poorer quality parenting alliance in the reports of mothers. These relations suggest that ADHD symptomology is linked to parenting practices, the coparenting subsystem, and specific child outcomes.

Co-occurring ASD and ADHD. To date, there has been a lack of research on the coparenting experiences of parents of children with ASD+ADHD; however, research on parenting stress in families of children with ASD+ADHD can provide some insight into the parenting experiences of these families. Hong et al. (2021) measured ADHD symptomology in a sample of parents of toddlers and preschool-aged children with ASD, finding that higher levels of ADHD symptomology were associated with greater affective problems, anxiety problems, pervasive developmental problems, oppositional defiant problems, and parenting stress. Van Steijn et al. (2014) compared parenting stress across families of children with ASD, ADHD, ASD+ADHD, and NT children, with results indicating that parents in the ND groups all reported higher levels of parenting stress than parents in the NT group; however, no differences in parenting stress were found between the ND groups. Similarly, Miranda et al. (2015) found no additional impact of ADHD symptomology on parenting stress in parents of children with ASD. Based on these mixed results, it is uncertain whether there is a cumulative effect of ASD and

ADHD symptomology on parenting stress; however, similar to parents of children with ASD or ADHD, parents of children with ASD+ADHD certainly seem to experience greater levels of parenting stress than parents of NT children. Therefore, as parenting stress is negatively associated with coparenting quality, it is likely that parents of children with ASD+ADHD experience coparenting challenges similar to, or greater than, parents of children with ASD or ADHD.

Cognitive Functioning. Cognitive functioning represents another individual child factor that varies between families. Parents of children with lower levels of cognitive functioning may face specific parenting and coparenting challenges. More specifically, children with intellectual developmental disorders (IDDs; also referred to as intellectual disabilities [IDs]), have been found to display higher levels of behaviour problems (Baker et al., 2003; Neece & Baker, 2008) and lower social skills (Neece & Baker, 2008) than NT children, which may place greater demands on parents. Parents of children with IDDs are at risk for increased levels of parenting stress (Baker et al., 2003; Neece & Baker, 2008; Norlin & Broberg, 2013). In a study comparing coparenting quality in families of children with IDs and NT children, Norlin and Broberg (2013) observed a trend towards lower levels of coparenting quality reported by parents of children with IDs.

Child Age. Just as parents face differing challenges meeting the needs of children depending on their neurodevelopment or level of cognitive functioning, parents also encounter different parenting demands and stressors as they parent children at different ages. At various developmental stages, children require different levels and types of support from their parents. Younger children are highly dependent on their parents to meet their needs and require frequent support. Therefore, in order to meet the constant needs of young children, cooperation and teamwork between coparents is vital (Margolin et al., 2001). While adolescents rely less on their parents to meet their needs than young children, they deal with complex social and emotional issues as they develop towards greater independence. Therefore, parents of adolescents may face new, complex parenting challenges. Furthermore, as children gain more sophisticated communication abilities and social understanding, the risk for individual parents to attempt to form coalitions with their child against the other parent (triangulation) increases (Margolin et al., 2001).

Margolin et al. (2001) found that parents of preschool children reported higher levels of coparenting cooperation than parents of preadolescent children. Furthermore, coparenting agreement was found to have a stronger negative association with internalizing problems in samples of younger children (Teubert & Pinquart, 2010). With regards to maladaptive coparenting practices, previous research has suggested that parents of younger children tend to experience higher levels of conflict, while parents of older children tend to show greater levels of disengagement (Maccoby et al., 1990; Maccoby et al., 1993). Changes in difficult child behaviour and parenting stress as children grow and develop may also influence coparenting experiences. In samples of NT children and children with developmental delays, some research has provided evidence for a decline in child behaviour problems from the ages of 3 years to 9 years (Neece et al., 2012). Furthermore, in families of NT children, levels of parenting stress have been found to decrease as child age increases (Neece et al., 2012). Together, this research suggests that parents have different experiences raising children over the course of their development. These changing parenting responsibilities may be accompanied by qualitatively different coparenting experiences across child age.

Family Quality of Life (FQOL)

Consistent with FST, FQOL represents a family functioning outcome that addresses the needs of individual family members while also emphasizing the importance of viewing the family as a cohesive unit. Zuna et al. (2010) reviewed 24 articles on FQOL to create a comprehensive definition. Across the articles reviewed, three themes emerged (Zuna et al., 2010). First, the idea of satisfaction was common. More specifically, FQOL is characterized by a family's subjective sense of well-being in relation to their personal values, rather than being determined based on the perspectives or judgments of outsiders (Zuna et al., 2010). Second, definitions of FQOL tend to imply a responsibility for the family unit to meet the unique needs of individual family members (Zuna et al., 2010). Third, the family unit cannot simply be understood by examining the attributes of individual family members; instead, a thorough understanding of FQOL acknowledges the characteristics of the family unit itself in addition to those of individual family members (Zuna et al., 2010). As with FST, when it comes to FQOL, the complete understanding is more than the sum of the quality of life of individual family members. Therefore, drawing from these common themes, FQOL can be defined as "a dynamic sense of well-being of the family, collectively and subjectively defined and informed by its members, in which individual and family-level needs interact" (Zuna et al., 2010, p. 262).

Conceptualizing FQOL

Movement Towards Conceptualizing FQOL. The concept of FQOL arose from within the field of disability intervention, as a result of the perceived need for a wholistic outcome that acknowledges the importance of the family system in the lives of individuals with disabilities (Samuel et al., 2012). Previously, the concept of individual quality of life had been widely recognized within the disability field, including domains such as physical well-being, emotional well-being, interpersonal relations, social inclusion, personal development, material well-being, self-determination, and rights (Poston et al., 2003; Schalock et al., 2002); however, starting in the 1980s, there was a movement to emphasize the importance of family-centered service delivery (Poston et al., 2003). This approach adopted a family strengths perspective, emphasized family choice, and advocated for targeting the family as the unit of support (Allen & Petr, 1996; Dunst et al., 1991; Poston et al., 2003; Turnbull et al., 2000). This movement reflected the understanding that disability has an impact on the entire family (Turnbull et al., 2001). Families were then viewed both as partners in efforts to support individuals with disabilities, as well as targets for their own support services (Summers et al., 2005; Turnbull et al., 2001). This development in the field led to a push for services targeting the needs of the whole family and the desire to measure the effectiveness and accountability of such services (Summers et al., 2005).

Conceptual Frameworks for FQOL. In response to a call for FQOL to be adopted as an outcome to evaluate policies and services (Dunst & Bruder, 2002; Summers et al., 2005; Turnbull et al., 2004), several measures of FQOL were introduced. Brown et al. (2003) created a theoretical framework and survey intended to measure FQOL. This survey utilized a mixture of quantitative and qualitative questions to assess the extent to which families have opportunities, take initiative in accessing opportunities, are able to attain valued activities and experiences, and are satisfied with family life (Brown et al., 2003). Specifically, these outcomes were assessed in the following family life domains: Health, Financial Well-Being, Family Relationships, Support from Other People, Support from Services, Careers and Preparing for Careers, Spiritual and Cultural Life, Leisure, and Community and Civic Involvement (Brown et al., 2003).

Another notable framework for conceptualizing FQOL was created by Poston et al. (2003). This framework was developed based on a qualitative study that asked families of children and youth with disabilities what FQOL means to them (Poston et al. 2003). In defining a family, Poston et al. (2003) noted that it was left to families to determine who is part of the family, placing more emphasis on those people "who support and care for each other on a regular basis" (p. 319), rather than adhering strictly to biological or marital relations. Based on the data collected, Poston et al. (2003) proposed a domain structure for FQOL that included domains with an individual orientation and domains with a family orientation. Domains with an individual orientation were characterized by processes in which quality of life of individual family members influence the quality of life of other family members or the entire family. These domains are: Advocacy (advocacy role, advocacy activities, facilitators of advocacy), Emotional Well-Being (identity, respect, reducing stress, choice), Health (physical health, mental health, health care), Physical Environment (home, school, work, neighborhood & community environments), Productivity (education, work, leisure, personal development), and Social Well-Being (social acceptance, relationships, and support; Poston et al. 2003). The family-oriented domains involve collective processes occurring at the family unit level: Daily Family Life (family care, daily activities, getting help), Family Interaction (positive interactional environment, communication, supporting each other, flexibility), Financial Well-Being (paying for necessities, paying for health care, paying for other needs, sources of income, financial security), and Parenting (providing parental guidance, discipline, teaching; Poston et al. 2003).

The findings of Poston et al. (2003) were utilized in the development of the Beach Center Family Quality of Life Scale. Items were created based on the information gathered from families and factor analyses were then used to create a 25-item scale including five domains:

Family Interaction, Parenting, Emotional Well-Being, Physical/Material Well-Being, and Disability-Related Support (Poston et al. 2003).

A Unified Theory of FQOL. Following the development of multiple conceptual frameworks including domains of FQOL, Zuna et al. (2010) proposed a unified theory. Four categories of concepts were created: (a) family-unit concepts, (b) individual family-member concepts, (c) performance concepts, and (d) systemic concepts. Zuna et al. (2010) suggest that these concepts and the processes that link them constitute a comprehensive, conceptual theory of FQOL.

Family-Unit Concepts. The family-unit is conceptualized as a whole, composed of the individuals who perceive themselves to be part of the family, and who regularly interact with each other and participate in joint activities (Zuna et al., 2010). In terms of family-level concepts, Zuna et al. (2010) distinguish between family characteristics and family dynamics. Family characteristics are “traits or descriptors of the family as a whole” (Zuna et al., 2010, p. 263), such as size of family, family form, family income, and ethnic background. Family dynamics are concepts pertaining to interactions and relationships between family members, such as family sense of coherence, adaptability, and decision-making (Zuna et al., 2010).

Individual Family-Member Concepts. Individual family-member concepts refer to the qualities of each family member, including characteristics, demographics, and beliefs (Zuna et al., 2010). Individual demographics include basic traits such as age, disability, gender, and education level. Individual characteristics are more complex traits that may be multidimensional or change over time (e.g., child behaviour, parent mental health, sibling health status, etc.; Zuna et al., 2010). Finally, beliefs are defined as “an individual family member’s attributions of meaning, expectations, or understanding about a phenomenon” (Zuna et al., 2010, p. 264), which may include ideas relating to the child's disability, expectations for the family's future, or roles of parents.

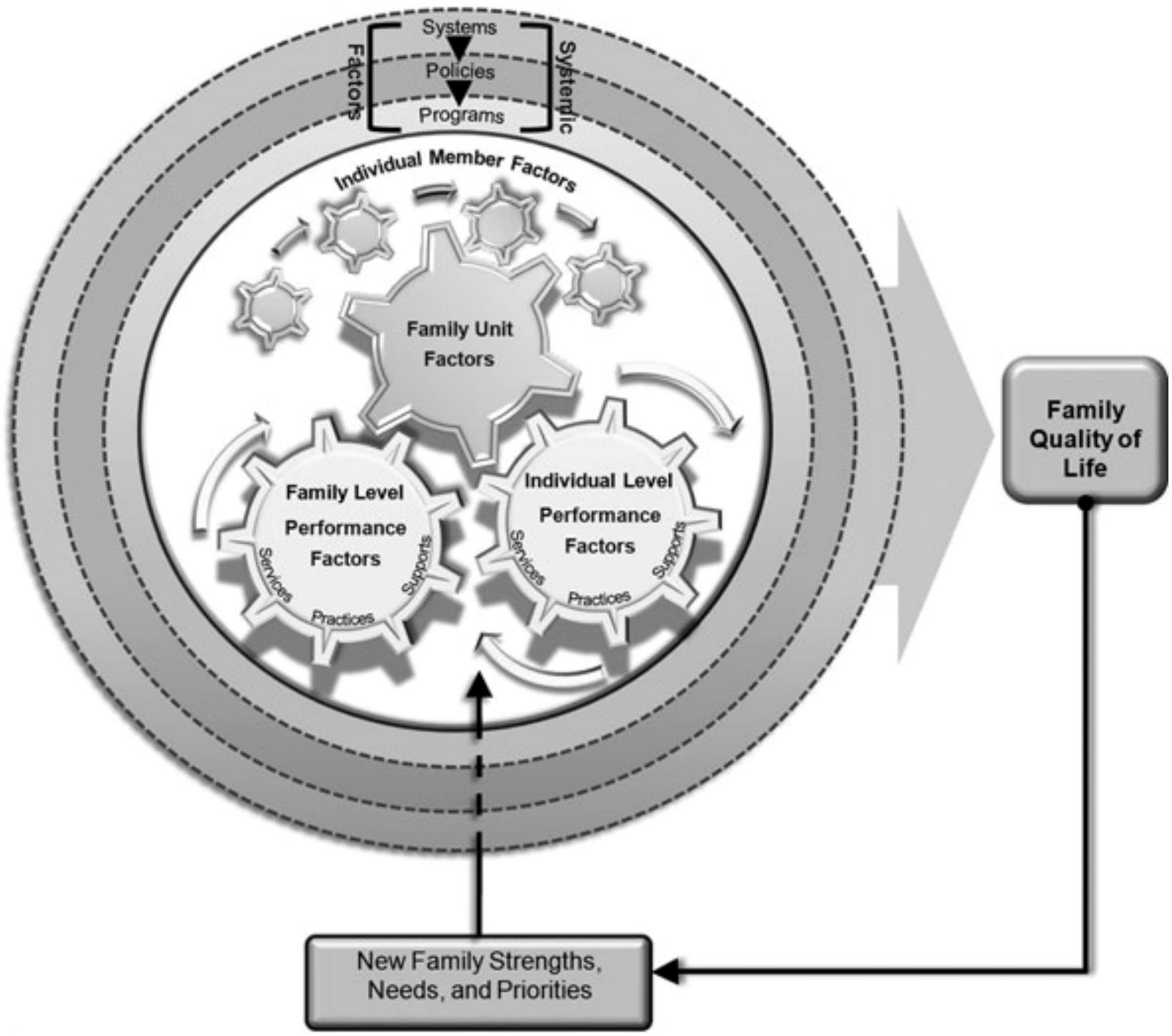
Performance Concepts. The set of performance concepts are characterized by actions that take place and consists of services, supports, and practices (Zuna et al., 2010). Services refer to a variety of educational, social, and health-based activities that are intended to have a positive impact within the family (e.g., respite care, counseling, medical care, etc.). Supports are described as less formal or structured resources for families (e.g., emotional support from service providers, information learned in classes, etc.). Practices are more specific actions, referring to the procedures or processes that are involved in the delivery of services and supports (Zuna et al., 2010).

Systemic Concepts. Systemic concepts include systems, policies, and programs (Zuna et al., 2010). More specifically, systems are described as interrelated networks that are put in place to meet a range of needs within communities (e.g., health care, education, legal systems, etc.; Zuna et al., 2010). Policies represent regulating guidelines that provide order and organization within the context of programs and systems (Zuna et al., 2010). Finally, programs are organized operations that aim to deliver services and support to specified populations (e.g., early intervention programs, family support programs, etc.; Zuna et al., 2010).

The Unified Theory. Zuna et al. (2010) created a graphic representation of their unified theory of FQOL (See Figure 3). The unified theory states that individual family-member factors (demographics, characteristics, and beliefs) and family-unit factors (characteristics and dynamics) function as direct predictors of FQOL (Zuna et al., 2010). Furthermore, individual family-member and family-unit factors interact with each other to predict FQOL. Additionally, individual and family-level performance factors (services, supports, and practices) interact with individual and family factors to influence FQOL (Zuna et al., 2010). More distally, the systemic factors (systems, policies, and programs) act to influence individual and family-level services, supports, and practices (Zuna et al., 2010). Together, these factors contribute to the FQOL outcome. Based on the unique circumstances of each family and the current state of their FQOL, new family strengths, needs, and priorities are created (Zuna et al., 2010). The novel strengths, needs, and priorities are then reintroduced to the model via an interactive feedback loop that may function to maintain patterns or initiate change over time (Zuna et al., 2010). While Zuna et al. (2010) recognize that their model is complex, they suggest that this necessary due to the inherent complexity of families.

Figure 3

Unified theory of family quality of life (Zuna et al., 2010)



FQOL in Populations with Disabilities

Overall FQOL. Brown et al. (2003) conducted a study of FQOL in families of individuals with disabilities. In general, families in this sample tended to rate their satisfaction levels across domains quite highly, suggesting that these families maintained relatively positive perspectives of family life, despite the challenges associated with caring for a child with a disability (Brown et al., 2003). Nevertheless, when compared to families of children without disabilities, families of children with disabilities tend to report lower levels of FQOL (Brown et al., 2006; Poston et al., 2003). Specifically, Poston et al. (2003) compared the FQOL of families of children with and without disabilities across individually-oriented (advocacy, emotional well-being, health, physical environment, productivity, and social well-being) and family-oriented (daily family life, family interaction, financial well-being, and parenting) domains. Overall, parents of children with disabilities reported concerns in these domains at a greater intensity and frequency than parents of children without disabilities (Poston et al., 2003).

Comparisons have also been made between families of children with different disabilities. Brown et al. (2006) compared levels of FQOL across families of children with Down syndrome (DS), families of children with ASD, and families of NT children. They found that less than 50% of families of children with DS indicated that they were satisfied with their FQOL in four out of nine domains. In six out of nine domains, less than 50% of families of children with ASD reported that they were satisfied with their FQOL (Brown et al., 2006). For families of NT children, there was only one domain in which less than 50% of families were satisfied with their FQOL (Brown et al., 2006). Some studies have also compared levels of FQOL between parents of children with ASD and ADHD. Green et al. (2016) compared FQOL across parents of children with ADHD, co-occurring ADHD and ASD (ASD+ADHD), and NT children, finding that parents of children with ASD+ADHD had the lowest FQOL, followed by families of children with ADHD, and families of NT children had the highest FQOL. Two more studies found no significant difference in FQOL between parents of children with ASD and parents of children with ADHD (Romaniuk, 2020; Şipoş et al., 2012). While the differences did not reach significance, Romaniuk (2020) observed a pattern of results in which mothers of children with

ASD+ADHD experienced the lowest levels of FQOL, followed by mothers of children with ASD, and mothers of children with ADHD had the highest levels of FQOL. Collectively, these results suggest that families of children with disabilities experience greater concerns relating to FQOL than families of NT children. Furthermore, different disabilities may present specific challenges to FQOL.

Various factors associated with disabilities have been explored in relation to FQOL. Multiple studies have investigated the effects of symptom severity, finding mixed results. For instance, Wang et al. (2004) found an inverse relation between the severity of various disabilities and FQOL, wherein more severe disability symptomology was associated with poorer FQOL. Similarly, Green et al. (2016) found that, in families of children with ADHD, greater levels of co-occurring ASD symptomology were associated with poorer FQOL. In contrast, in a study by Gardiner and Iarocci (2015), there was no significant association between disability severity and FQOL. On the other hand, Gardiner and Iarocci (2015) found a negative association between behaviour problems (but not ASD severity) and FQOL in families of adolescents with ASD. Similarly, child externalizing behaviour has been found to predict FQOL (McStay et al., 2014). Furthermore, Gardiner and Iarocci (2015) found a positive association between adaptive functioning and FQOL. More specifically, daily living skills (e.g., eating, dressing, hygiene, toileting, safety awareness, tidying, food preparation, rule following, telling time, and using money) emerged as the adaptive skill set that was the strongest predictor of FQOL (Gardiner & Iarocci, 2015). Further, families of children whose daily living skills were rated as “adequate”, as opposed to “low” or “moderate”, reported higher levels of satisfaction across every FQOL domain (family interaction, parenting, emotional well-being, physical/material well-being, & disability-related support; Gardiner & Iarocci, 2015). In addition to trends relating to overall

FQOL, there has been investigation into the way families of children with disabilities rate FQOL in specific domains.

Health/Physical Well-Being. Families of individuals with disabilities have been found to report that the health of the family is of high importance (Petrowski et al., 2008; Schertz et al., 2016); however, Brown et al. (2003) found that families of children with disabilities felt that the availability of opportunities relating to health were relatively low for them. This reflects families' sense that not all of their health needs were being met. In terms of families' satisfaction with their health, Brown et al. (2006) found that most families were satisfied with their family's health; however, families of NT children rated their family's health more highly than families of children with DS and families of children with ASD. The health domain was also significantly associated with overall FQOL.

Financial/Material Well-Being. Within Brown et al.'s (2006) Canadian sample, families' satisfaction with their financial well-being was significantly lower in the DS and ASD groups compared to the NT group. Fifty-three percent of families in the NT group reported being satisfied with their financial well-being, compared to only 42% of families in the DS group and 29% of families in the ASD group (Brown et al., 2006). In addition to lower levels of satisfaction, families in the ASD group reported lower family financial earnings compared to the DS group and the NT group. In families with two parents, both parents worked outside of the home in 53% of families in the DS group and 29% of families in the ASD group (Brown et al., 2006). This suggests that parents of children with challenging behaviours may prioritize childcare over paid employment. More generally, family income has been associated with FQOL (Gardiner & Iarocci, 2015; Hsiao, 2018). Providing appropriate support services for children can also be costly for families (Zablotsky et al., 2014); families with higher incomes may have better access to resources to support their children and to manage other disability-related issues (Davis & Gavidia-Payne, 2009; Park et al., 2002; Wang et al., 2004).

Family Relations/Interactions. Families of children with disabilities tend to rate family relationships positively (Brown et al., 2003; Brown et al., 2006; Summers et al., 2007). Specifically, these families perceive family relations as important (Brown et al., 2006; Schertz et al., 2016) and see positive relational outcomes within their families as attainable (Brown et al., 2003). Furthermore, some studies have found that families of children with disabilities report higher levels of initiative, attainment, and satisfaction with family relationships compared to other domains (Petrowski et al., 2008; Schertz et al., 2016; Werner et al., 2009). In contrast, families of children with disabilities often express concerns with the lack of opportunities to engage positively or participate in activities with family members (Brown et al., 2003; Brown et al., 2006; Poston et al., 2003). Approximately one quarter of families with children with ASD and those with children with DS indicated that they have very limited opportunities for family activities (Brown et al., 2006). Additionally, families of children with disabilities often report the need for additional support to allow them to engage in activities as a family, particularly for families of children with behaviour problems or complicated medical conditions (Poston et al., 2003). In families of children with ASD, satisfaction with parenting was highly correlated with overall FQOL (Hsiao, et al., 2017).

Support from Other People. Families of children with disabilities tend to perceive a lack of opportunities and success in attaining support from others (Brown et al., 2003; Petrowski et al., 2008; Werner et al., 2009). Similarly, families of children with disabilities are often dissatisfied with the level of support they receive from their communities, including other relatives, friends, and neighbors (Brown et al., 2006; Petrowski et al., 2008). Specifically, 78%

of families of children with DS and 82% of families of children with ASD indicated that they receive almost no practical support from friends and neighbors. Further, families of NT children reported experiencing significantly more support from others than families of children with ASD or DS (Brown et al., 2006). Specifically, 88% of families with NT children reported being satisfied with the support they received from others, compared to 42% of families of children with DS and 39% of families of children with ASD (Brown et al., 2006). Further, families of children with disabilities tend to report experiencing feelings of isolation (Brown et al., 2006).

Support from Disability-Related Services. Studies have found that families of individuals with disabilities rated support from disability-related services as relatively important to them and indicated that they took initiative to seek out services (Petrowski et al., 2008; Schertz et al., 2016); however, families' ratings for availability of opportunities and satisfaction with services were relatively low. Brown et al. (2006) found that 44% of families of children with ASD and 48% of families of children with DS were satisfied with the support they receive from disability-related services. While some families may receive services that are very helpful to them, some considerable concerns remain. Scores for disability-related services were not significantly associated with overall FQOL in this Western Canadian sample (Brown et al., 2006). In a Chinese sample, Zeng et al. (2020) found that a support composite, which included support from disability-related services along with other types of support, was a strong predictor of FQOL for parents of children with ASD. Similarly, in an Australian sample of families of children with developmental disabilities, levels of professional support were found to be highly predictive of FQOL (Davis & Gavidia-Payne, 2009).

Social and Emotional Well-Being. Regarding social well-being, families of children with disabilities reported greater concerns relating to acceptance for their children and themselves (Poston et al., 2003). In terms of emotional well-being, families of children with disabilities often described feelings of stress associated with working with professionals and disability service systems to support their child, as well as stress related to challenging child characteristics such as behavioural problems (Poston et al., 2003). Furthermore, in a study including parents of children with ASD, parents were found to be least satisfied with their family's emotional well-being compared to other domains of FQOL (Gardiner & Iarocci, 2015). Similarly, Summers et al. (2007) found that families of children with disabilities reported lower levels of satisfaction with their emotional well-being relative to other domains of FQOL.

FQOL in NT Populations

Olson and Barnes (1982) created a measure, the Quality of Life (QOL) Scale, that was designed to evaluate quality of life in families of NT adolescents. Olson and Barnes (1982) conceptualized FQOL as the sense of fit a family perceives between the family and their environment (Summers et al., 2005). This measure offered parent and adolescent forms that measure 12 and 11 domains of life satisfaction, including items measuring the following areas: marriage and family life, friends, extended family, health, home, education, free time, religion, employment, mass media, financial well-being, and neighborhood and community. In some cases, the QOL Scale was used to investigate relational factors associated with FQOL. In one study, the QOL Scale was used to measure the quality of life of families in which couples were in long-term marriages (MacKinnon et al., 1984), finding that these families scored high on overall life satisfaction and that health, sexual relations, financial matters, and personality issues were important factors. Additionally, the QOL Scale was used in a study investigating sibling interactions in married and divorced couples (MacKinnon, 1989), wherein the quality of sibling interactions was found to predict FQOL reported by mothers. The QOL Scale has also been used in NT populations where a family member has an illness. For instance, the QOL Scale was used in a study investigating factors contributing to quality of life in families of cancer survivors (Mellon & Northouse, 2001). Results indicated that strongest predictors of QOL were concurrent family stressors, social support, family members' fear of illness recurrence, family meaning of the illness, and patient employment status. Relative to measures of FQOL created for populations with disabilities, the QOL Scale has not been widely used in published research (Summers et al., 2005).

As stated previously, studies comparing families of NT children to families of children with disabilities tend to find that families of NT children report higher levels of FQOL, both overall and across domains (Brown et al., 2006; Poston et al., 2003). For instance, 80 to 89% of families with NT children reported satisfaction with five of the FQOL domains (i.e., Spiritual and Cultural Beliefs, Support from Other People, Health, Family Relations, and Careers and Preparation for Careers; Brown et al., 2006). In contrast, while over 80% of families of children with DS were satisfied with the Family Relations domain, the percent satisfied ranged from 38% (Community and Civic Involvement) to 67% (Health) in the other domains (Brown et al., 2006). Furthermore, for families of children with ASD, the domain with the greatest proportion of satisfied families was also Family Relations, with 65% of families being satisfied (Brown et al., 2006). Percentages of families with ASD who were satisfied with the other domains ranged from 22% (Community and Civic Involvement) and 61% (Health and Spiritual and Cultural Beliefs; Brown et al., 2006). As the field of FQOL research was created from within the field of disability intervention, NT populations tend to be included as a comparison group rather than being the focus of research.

Gender Differences in FQOL

Given that parenting is a gendered experience (Farr & Patterson, 2013; Raley et al., 2012; Van Egeren, 2004), it is reasonable to expect that mothers and fathers may experience differing levels of FQOL. Of note, many studies of FQOL rely on one parent or family member to report on FQOL for the family (e.g., Brown et al., 2006; Gardiner & Iarocci, 2015; Hsiao, et al., 2017; Schertz et al., 2016; Summers et al., 2007; Werner et al., 2009). In many cases, the majority of the study's sample is made up of mothers (Brown et al., 2006; Davis & Gavidia-Payne, 2009; Gardiner & Iarocci, 2015; Hsiao, et al., 2017; Summers et al., 2007). Therefore, often research reports on FQOL from the mother's perspective.

Some studies have found that mothers report lower levels of FQOL than fathers (Hsiao, 2018; McStay et al., 2014). McStay et al. (2014) found that 95% of mothers in their sample of parents of children with ASD reported that they were their child's primary caregiver. More time spent caring for a child with a disability may increase exposure to the stressors and demands associated with general and disability-specific childrearing (Jones et al., 2013; Konstantareas & Homatidis, 1989). This interpretation is consistent with results indicating that mothers report higher levels of parenting stress than fathers (McStay et al., 2014; Si et al., 2020); however, results are mixed. Some studies show that mothers report slightly higher levels of parenting stress, but others show similar levels of parenting stress (Deater-Deckard, 1998). For instance, in NT families, mothers scored slightly higher than fathers on the Parenting Distress subscale of the Parenting Stress Index (PSI; Abidin, 1990); however, mothers' Parent-Child Dysfunctional Interaction Subscale scores were lower than fathers' (Deater-Deckard & Scarr, 1996). In families of children with ADHD, mothers perceive their children to be slightly more stressful than fathers (Baker, 1994).

Coparenting Quality and FQOL

To date, the connection between coparenting quality and FQOL has not been investigated directly. FQOL involves an interplay between environmental factors, individual family-member factors, and family-unit factors (Zuna et al., 2010). Based on FST, the coparenting subsystem is connected to mother, father, and child subsystems and, therefore, may influence experiences that each of these individuals have within the family system (Feinberg, 2003; Minuchin, 1985). Specifically, Feinberg's (2003) ecological model of coparenting posits that coparenting quality may directly impact parental adjustment. For instance, Solmeyer and Feinberg (2011) found that higher levels of coparenting undermining predicted higher levels of parenting stress, symptoms of depression, and lower parenting efficacy, whereas coparenting support predicted lower levels of parenting stress.

Similarly, Feinberg's (2003) ecological model of coparenting includes a bidirectional pathway through which coparenting may influence child adjustment. Results from a meta-analysis conducted by Teubert and Pinquart (2010) indicated that greater coparenting cooperation was associated with lower levels of child internalizing and externalizing symptoms, and higher levels of social functioning and secure attachment with parents. Likewise, greater coparenting agreement was associated with lower levels of child internalizing and externalizing symptoms, and higher levels of social functioning in children. In contrast, higher levels of coparenting conflict were associated with greater levels of internalizing and externalizing symptoms, and lower levels of social functioning and secure attachment. Finally, triangulation was found to be associated with higher levels of internalizing and externalizing symptoms, and less secure attachment in children. The results of these studies demonstrate connections between coparenting quality and aspects of individual family members' well-being (Teubert & Pinquart, 2010). As each family member contributes to the overall FQOL through individual family-member factors (Zuna et al., 2010), coparenting may be linked to FQOL on an individual level.

According to the unified theory of FQOL created by Zuna et al. (2010), family dynamics are concepts relating to interactions and relationships between family members. Similarly, the coparenting relationship is characterized as the interactions and relationship between parents. For example, Zuna et al. (2010) indicated that satisfaction with division of family labor is a family dynamic. Likewise, division of childrearing labor is one of Feinberg's (2003) components of the coparenting relationship. Feinberg's (2003) other three coparenting components (i.e., joint family management, childrearing agreement, and support/undermining) were not explicitly mentioned by Zuna et al. (2010); however, each coparenting component involves interaction between parents and contribute to the overall coparenting relationship; therefore, it would be reasonable to classify them as family dynamics and assume that they may influence FQOL. Taken together, this suggests that coparenting quality may influence FQOL by acting as a family-unit factor.

In addition to theoretical connections between coparenting quality and FQOL, previous research on parenting stress offers some insight into a potential connection between coparenting quality and FQOL. Parenting stress has been found to be negatively associated with coparenting quality for mothers and fathers of NT children (Abidin & Brunner, 1995; Bronte-Tinkew et al., 2010; McDaniel et al., 2018) and children with ASD (Downes & Cappe, 2021; May et al., 2015; Thullen & Bonsall, 2017). A study of factors influencing parenting stress in families of children with ADHD in China found a significant negative correlation between coparenting quality and parenting stress; however, coparenting quality did not significantly predict parenting stress once included in a regression model with other family variables (Si et al., 2020). Similarly, negative associations have been found between parenting stress and FQOL in families of children with

ASD (Hsiao et al., 2017; Zeng et al., 2020) and children with other disabilities (Droogmans et al., 2021). The inverse association that coparenting quality and FQOL share with parenting stress provides some evidence that coparenting quality and FQOL may be positively correlated.

Current Study

Coparenting quality is an important family process, as it has been shown to have an impact on parent (Solmeyer & Feinberg, 2011) and child adjustment (Teubert & Pinquart, 2010). In terms of measuring well-being within families, FQOL is a useful outcome, as it represents a wholistic reflection of family members' subjective sense of family well-being (Zuna et al., 2010). Given the conceptual overlap between coparenting quality and FQOL, it would be reasonable to expect that coparenting quality may contribute to FQOL; however, to date, no research has examined the association between coparenting quality and FQOL. Therefore, the current study employed a cross-sectional design to investigate the association between coparenting quality and FQOL.

Furthermore, due to the unique parenting challenges and family experiences associated with raising a child with a disability, the current study investigated coparenting quality and FQOL in families of children with clinically significant symptoms of ASD, ADHD, and co-occurring ASD and ADHD (ASD+ADHD), as well as families of NT children. Additionally, due to the gendered nature of parenting (Cowan & Cowan, 2000; Hays, 1998) and differing roles that mothers and fathers experience within families (Farr & Patterson, 2013; Raley et al., 2012; Van Egeren, 2004), parent gender was explored in relation to coparenting quality and FQOL.

Given the systemic nature of families, wherein family members influence each other and contextual factors influence the system as a whole, parents within one family share important connections. Furthermore, when data from both parents from one family are included in research, there is a lack of independence between their scores. In terms of coparenting quality, some studies have found that mother and father reports of coparenting tend to be moderately to highly correlated (Broderick et al., 2019; Camisasca et al., 2019; Feinberg et al., 2012; May et al., 2015; McDaniel et al., 2018). Similarly, the FQOL scores of mothers and fathers from the same family have been found to be significantly correlated (Zeng et al., 2020). Further, both FST and the unified theory of FQOL (Zuna et al., 2010) posit that important information is lost when families are studied by focusing on individual family members in isolation. In other words, when it comes to families, the whole is greater than the sum of its parts (Minuchin, 1985).

The extent to which previous FQOL research has integrated multiple family members' perspectives varies. Some studies have depended on one family member to report on the level of FQOL in their families (e.g., Brown et al., 2006; Gardiner & Iarocci, 2015; Hoffman et al., 2006; Hsiao, et al., 2017; Petrowski et al., 2008; Schertz et al., 2016; Summers et al., 2007). While there are certainly complications associated with involving multiple family members in research, the value of incorporating multiple family perspectives to be conceptually consistent with FQOL, as a family-level construct, is acknowledged (Brown et al., 2006; Zuna et al., 2010). Some studies have included multiple family members (Brown et al., 2003; McStay et al., 2014; Wang et al., 2004; Zeng et al., 2020), typically mothers and fathers. This raises important questions about how to treat this data. Calculating FQOL scores for mothers and fathers separately provides information on how mothers and fathers each view FQOL (individual-level perspectives on a family variable); however, it does not comprehensively capture FQOL on the family-level, as a concept that is collectively defined. Therefore, rather than focus on mothers and fathers in isolation, the current study included mother-father pairs.

Dyadic scores offer a broader perspective on family processes by providing information at the couple-level. Studies of FQOL that have included both mothers and fathers from the same family have taken a variety of approaches, including combining qualitative data with descriptive statistics (Brown et al., 2003), testing models separately in mothers and fathers and using t-tests to compare between mothers and fathers (McStay et al., 2014), and using structural equation modeling (SEM) to test models separately and compare between mothers and fathers (Wang et al., 2004). In their notable work on FQOL, Zuna et al. (2010) recognized the rarity of research measuring "FQOL as a collective or summative construct using multiple family members' perspectives" (p. 262). In efforts to consolidate the perspectives of multiple family members, several researchers have calculated collective FQOL, or family mean scores, by taking the average of mothers' and fathers' FQOL scores (Anderson, 1998; Park et al., 2003; Rettig & Bubolz, 1983; Rettig & Leichtentritt, 1999). Similarly, summed dyadic scores have been used to create collective scores in previous coparenting research (May et al., 2015). Some newer research has used an actor-partner interdependence model to explore the effects of family support on their and their partners' perspective on FQOL (Zeng et al., 2020). Taken together with mothers' and fathers' individual scores, the current study used aggregated, dyadic scores with the intention of approximating collective coparenting quality and FQOL measurements and gaining a comprehensive understanding of coparenting quality and FQOL within families.

Objectives

The overall objective of the current study was to explore the connection between coparenting quality and FQOL in mothers and fathers of NT children, children with elevated symptoms of ASD, children with elevated symptoms of ADHD, and children with elevated symptoms of ASD+ADHD. More specifically, coparenting and FQOL were examined across neurodevelopmental populations to gain a better understanding of the experiences of these different groups. Furthermore, coparenting quality and FQOL were compared between coupled mothers and fathers to examine any potential gender differences. In addition to comparing mothers' and fathers' family-related experiences, scores were aggregated to explore the connections between couples' collective coparenting quality and FQOL. Importantly, the association between parents' coparenting quality and FQOL was evaluated. Finally, the moderating role of child neurodevelopmental disorder symptoms on the association between coparenting quality and FQOL was investigated in order to gain a better understanding of how these constructs are connected in different neurodevelopmental populations.

Research Questions

1. Do parents of children with symptoms of ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of coparenting quality?
    a. Do *mothers* of children with symptoms of ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of coparenting quality?
    b. Do *fathers* of children with symptoms of ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of coparenting quality?
2. Do parents of children with symptoms of ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of FQOL?
    a. Do *mothers* of children with symptoms of ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of FQOL?
    b. Do *fathers* of children with symptoms of ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of FQOL?
3. Do paired mothers and fathers differ in their levels of coparenting quality?

   a. Do paired mothers and fathers of *NT* children differ in their levels of coparenting quality?
   b. Do paired mothers and fathers of children with symptoms of *ASD and/or ADHD* differ in their levels of coparenting quality?
4. Do paired mothers and fathers differ in their levels of FQOL?
   a. Do paired mothers and fathers of *NT* children differ in their levels of FQOL?
   b. Do paired mothers and fathers of children with symptoms of *ASD and/or ADHD* differ in their levels of FQOL?
5. Does greater coparenting quality predict higher FQOL in parents after controlling for child cognitive functioning and child age?
   a. Does greater coparenting quality predict higher FQOL in *mothers of NT children* after controlling for child cognitive functioning and child age?
   b. Does greater coparenting quality predict higher FQOL in *fathers of NT children* after controlling for child cognitive functioning and child age?
   c. Does greater coparenting quality predict higher composite FQOL in *paired parents (mother-father dyads) of NT children* after controlling for child cognitive functioning and child age?
   d. Does greater coparenting quality predict higher FQOL in *mothers of children with symptoms of ASD* after controlling for child cognitive functioning and child age?
   e. Does greater coparenting quality predict higher FQOL in *fathers of children with symptoms of ASD* after controlling for child cognitive functioning and child age?

f. Does greater coparenting quality predict higher FQOL in *mothers of children with symptoms of ADHD* after controlling for child cognitive functioning and child age?

g. Does greater coparenting quality predict higher FQOL in *fathers of children with symptoms of ADHD* after controlling for child cognitive functioning and child age?

h. Does greater coparenting quality predict higher FQOL in *mothers of children with symptoms of ASD+ADHD* after controlling for child cognitive functioning and child age?

i. Does greater coparenting quality predict higher FQOL in *fathers of children with symptoms of ASD+ADHD* after controlling for child cognitive functioning and child age?

j. Does greater coparenting quality predict higher composite FQOL in *paired parents (mother-father dyads) of children with symptoms of ASD and/or ADHD* after controlling for child cognitive functioning and child age?

6. Do clinical levels of child ASD, ADHD, or ASD+ADHD moderate the relation between parents' coparenting quality and FQOL?

    a. Do clinical levels of child ASD, ADHD, or ASD+ADHD moderate the relation between *mothers'* coparenting quality and FQOL?

    b. Do clinical levels of child ASD, ADHD, or ASD+ADHD moderate the relation between *fathers'* coparenting quality and FQOL?

c. Do clinical levels of child ASD, ADHD, or ASD+ADHD moderate the relation between *paired parents' (mother-father dyads)* coparenting quality and composite FQOL?

In addition to the above research questions, differences in components of coparenting quality (Coparenting Agreement, Coparenting Closeness, Exposure to Conflict, Coparenting Undermining, Endorsement of Partner Parenting, and Division of Labor) and FQOL (Family Interaction, Parenting, Emotional Well-Being, Physical/Material Well-Being, and Disability-Related Support) between parents across neurodevelopmental groups were investigated in an exploratory manner. Additionally, differences in components of coparenting quality and FQOL between mothers and fathers of NT children and children with ND symptomology were investigated in an exploratory manner. A list of exploratory research questions can be found in Appendix A.

Hypotheses

Previous research has investigated coparenting quality and parenting stress in families of NT children (Abidin & Brunner, 1995; Bronte-Tinkew et al., 2010; McDaniel et al., 2018) and children with ASD (May et al., 2015; Thullen & Bonsall, 2017; Downes & Cappe, 2021), levels of behaviour problems (Brobst et al., 2009) and parenting stress reported by parents of children with disabilities (Brobst et al., 2009; Estes et al., 2013; Hayes & Watson, 2013; Keen et al., 2010; May et al., 2014; Tomanik et al., 2004), and parenting stress and child ADHD symptom severity (Theule et al., 2013). Based on this previous research, I hypothesized that parents of NT children would have higher levels of coparenting quality than parents of children with ADHD, ASD, ASD+ADHD (Hypothesis 1). Similarly, based on previous research on FQOL (Brown et al., 2006; Poston et al., 2003), I hypothesized that parents of NT children would have higher levels of FQOL than parents of children with ADHD, ASD, ASD+ADHD (Hypothesis 2).

Based on studies comparing coparenting quality between mothers and fathers (Floyd & Zmich, 1991; Van Egeren, 2004), I hypothesized that fathers would report higher levels of coparenting quality than mothers (Hypothesis 3). Likewise, based on previous research comparing levels of FQOL between mothers and fathers (Hsiao, 2018; McStay et al., 2014), I hypothesized that fathers would report higher levels of FQOL than mothers (Hypothesis 4).

Based on theoretical connections between the coparenting subsystem (Feinberg, 2003; Minuchin, 1985), individual family-member and family-unit concepts (Zuna et al., 2010), and previous parenting stress research (Abidin & Brunner, 1995; Bronte-Tinkew et al., 2010; Downes & Cappe, 2021; Droogmans et al., 2021; Hsiao et al., 2017; May et al., 2015; McDaniel et al., 2018; Si et al., 2020; Thullen & Bonsall, 2017; Zeng et al., 2020), I hypothesized that greater coparenting quality would predict higher FQOL in parents after controlling for child cognitive functioning, and child age[1] (Hypothesis 5).

Previous research has found associations between parenting stress and ASD and ADHD symptomology (Brobst et al., 2009; Estes et al., 2013; Hayes & Watson, 2013; Keen et al., 2010; May et al., 2014; Theule et al., 2013; Tomanik et al., 2004), and has found lower coparenting quality in families of children with ASD (May et al., 2015; Thullen & Bonsall, 2017; Downes & Cappe, 2021), and lower FQOL in families of children with ASD (Hsiao et al., 2017; Zeng et al., 2020). Further, disability diagnoses and severity have been associated with lower levels of FQOL (Brown et al., 2006; Green et al., 2016; Hsiao et al., 2017; Poston et al., 2003; Zuna et al.,

[1] Parental education level was proposed as an additional control variable. Due to the high level of education within the sample, participants who completed less than some post-secondary education were identified as outliers. Therefore, this variable was judged to be less useful and was removed from the analysis.

2010). Based on the research linking parenting stress, ASD and ADHD symptomology, coparenting quality, and FQOL, I hypothesized that child diagnosis would moderate the relation between parents' coparenting quality and FQOL, such that parents of NT children would report the highest levels of FQOL, followed by the ADHD group, ASD group, and ASD+ADHD group (Hypothesis 6).

Method

Participants

Eligibility

Participants were parents of at least one child between 5 and 18 years of age, living in Canada or the United States (US). Parents could be biological, adoptive, or stepparents. To be eligible, parents were required to be involved in an active coparenting relationship, meaning that they currently live and share childrearing responsibilities with a parenting partner. Mothers and fathers (dyads) from the same family were recruited. Families with same-sex parents were not excluded from the study; however, I was unable to include same-sex families in dyadic analyses due to an insufficient number of same-sex families in the sample. Single-parent families were not included in the current study, due to the absence of an active coparenting relationship. Families including stepparents were eligible. Parents with children who are NT and those with children who had been diagnosed with ASD and/or ADHD were included. The age range was selected as reliable diagnoses of ASD and/or ADHD can typically be made by the age of 5 years (Lord et al., 2006; Rosenberg et al., 2011; Visser et al., 2014; Wiggins et al., 2006) and symptoms tend to be present and distinguishable by age 5 (APA, 2013). Furthermore, this extended age range was sufficient to allow for the examination of child age as a covariate.

Participants were placed into four groups: families of children with ASD, families of children with ADHD, families of children with ASD and co-occurring ADHD (ASD+ADHD), and families of NT children. To be included in the ASD group, at least one child in the family in the applicable age range was required to have clinically significant symptoms of ASD based on the parent's report, using the Social Communication Questionnaire (SCQ; Rutter et al., 2003. Additionally, to be in the ASD group, families could not have any children diagnosed with ADHD. To be included in the ADHD group, at least one child in the family in the applicable age range was required to have clinically significant symptoms of ADHD (combined presentation, predominantly inattentive presentation, or predominantly hyperactive-impulsive presentation). To determine the presence of clinically significant ADHD symptomology, parents completed the ADHD Rating Scale—5 (ADHD-RS-5; DuPaul et al., 2016a). Further, to be in the ADHD group, families could not have any children with an ASD diagnosis. To be included in the ASD+ADHD group, at least one child in the family in the applicable age was required to have clinically significant levels of both ASD and ADHD symptomology, based on parent report. Scores from both the SCQ (Rutter et al., 2003) and the ADHD-RS-5 (DuPaul et al., 2016a) were used to determine significant levels of ASD and ADHD symptomology for this group. To be included in the NT group, the family must not have any children who have previously received a diagnosis of ASD or ADHD. Furthermore, scores on the SCQ (Rutter et al., 2003) and the ADHD-RS-5 (DuPaul et al., 2016a) for the target child in the family needed to reflect sub-clinical levels of symptomology for inclusion in this group.

For families with more than one child in the target age range, parents were asked to complete all questionnaires with a specific child in mind. Families with NT children and children with ASD and/or ADHD in the target age range were asked to complete all questionnaires with their child with ASD and/or ADHD in mind. When families had (a) more than one child with ASD and/or ADHD within the target age range or (b) multiple NT children and no children with ASD and/or ADHD within the target age range, parents at the outset of recruitment were asked to complete all questionnaires with their eldest child (within the target age range) in mind. Later in the recruitment process, parents with (a) more than one child with ASD and/or ADHD within the target age range or (b) multiple NT children and no children with ASD and/or ADHD within the target age range, were asked to complete all questionnaires with their youngest child (within the target age range) in mind. This logic system for selecting the target child was chosen to ensure that parents with a child with ASD and/or ADHD reported on that child and to increase the age range of the target children.

Both parents in each family were invited to participate in the current study. Recruitment materials requested that parents complete the survey separately. At the beginning of the survey, participants were informed that their coparenting partner could be invited to participate. At the end of the survey, participants were asked to share the survey with their coparenting partner by entering their partner's email address. The partner's email address was then used to share the survey and to connect the responses for coparenting dyads.

Recruitment

Before initiating study recruitment, ethical approval was obtained (Protocol Number: HE2021-0241) through the Research Ethics Board (REB) at the University of Manitoba. Participants were recruited from Canada and the United States via community and disability-related sources. More specifically, families of NT children were recruited by advertising through research networks (relating to family and parenting research), and social media and websites, such as groups or blogs related to parenting or families (e.g., Parent Life Network-Canada, Parents of Winnipeg & Surrounding Areas- POWSA Village, Winnipeg Moms, Wolseley Parent, etc.). In addition to advertisements within the general parenting community, recruitment of families of children with NDs targeted ASD (e.g., St. Amant Centre, Autism Winnipeg PACE, Autism Speaks [Canada & US], American Autism Association, Autism Society of British Columbia) and ADHD (e.g., Canadian ADHD Resource Alliance [CADDRA], Centre for ADHD Awareness Canada, Children and Adults with Attention-Deficit/Hyperactivity Disorder [CHADD], Learning Disabilities Association of Canada) organizations, clinical and medical networks, and social media and websites for families of children with disabilities (e.g., Autism Parents Support Group, ADDitude - ADHD Support Group for Parents, Support for Canadian parents- ASD-ODD-ADHD, Parents Of Winnipeg & MB ADHD/ADD/ODD/Anxiety Disorders Support Group, Parents of Special Needs Children - Support and Discussion Group, Autism Parents' Support Group of Indiana, Autism Parents Support Group South Mississippi, ADHD Resource Group of Northern Virginia, Chicago Autism Parents And Providers, etc.). Paid Facebook advertisements were utilised to increase the reach of study advertisement materials.

Digital and physical advertisement materials for the study were created and provided to clinical, community, and ASD and ADHD networks with requests for those organizations to post or distribute the advertisement materials (i.e., physical posters in buildings or digital advertisements to be posted on a webpage or sent out via email). Study advertisement materials included key information, such as a brief description of the study, contact information, and a link that participants could use to access the online survey.

Sample Size

This study involved numerous statistical analyses, using multiple types of analysis. Amongst the planned analyses, regression analysis was the most complex to be conducted in the smallest subsamples. Twelve regression analyses were planned to test the ability of coparenting quality to predict FQOL in samples of mothers, fathers, and dyads in each of the four neurodevelopmental groups. Therefore, in order to determine the sample size required to have sufficient power to detect significant effects, a power analysis was run using G*Power 3.1 software (Faul et al., 2007). A medium effect size (Cohen's $f^2 = 0.15$) was selected based on the results from related research (May et al. 2015), power was set at 0.80, and an α of .05 was used. Based on the power analysis, a minimum of 55 families from each population (NT, ASD, ADHD, and ASD+ADHD), for a total of 220 families was recommended. To account for partial completion of surveys by some participants, oversampling from each of the groups was attempted.

Measures

Demographic Questionnaire

The online study survey included demographic questions that provided relevant information necessary for calculating descriptive statistics. Furthermore, some demographic information contributed to the data for moderator variables and covariates. Demographic variables included the following: parent age, child age, race/ethnicity, family composition, and child diagnoses (see Appendix B).

Child ASD Symptoms

The Lifetime form of the Social Communication Questionnaire (SCQ; Rutter et al., 2003), formerly known as the Autism Screening Questionnaire (Berument et al., 1999; Snow, 2013), was used to measure child ASD symptomology. The content of the SCQ is based on the Autism Diagnostic Interview - Revised (ADI-R; Lord et al., 1994) and modified for parents to be able to complete the measure independently (Berument et al., 1999). Parents were asked to respond *yes* or *no* to 40 items intended to assess communication skills and social functioning (Rutter et al., 2003). The SCQ includes items assessing reciprocal interaction (e.g., social smiling and interest in peers), language and communication (e.g., reciprocal conversation), and repetitive and stereotyped patterns of behaviour (e.g., restricted interests and atypical preoccupations; Berument et al., 1999). The SCQ (Rutter et al., 2003) can be used to assess ASD symptomology in children aged 4 years or older.

A total score can be calculated by summing scores (1 or 0) for 39 of the items (one item asking about language is not included in the total score); therefore, total scores may range from 0 to 39 (Berument et al., 1999). A score of 15 or higher suggests clinical levels of ASD symptomology (Berument et al., 1999; Chandler et al., 2007; Eaves et al., 2006). Internal reliability for the total scale was found to be high (Cronbach's $\alpha = .90$; Berument et al., 1999). The SCQ has been found to have sensitivity and specificity over .70 for identifying children with ASD diagnoses (Berument et al., 1999; Chandler et al., 2007; Eaves et al., 2006). The current study used the total score on the SCQ categorically to determine the presence of clinically significant ASD symptomology. Specifically, total scores were compared to the cut-off score (15) to inform which group (NT, ASD, ADHD, and ASD+ADHD) families were included in (see Appendix C for summary table).

Child ADHD Symptoms

The ADHD Rating Scale-5 (ADHD-RS-5; DuPaul et al., 2016a) was utilized to measure child ADHD symptomology. The ADHD-RS-5 (DuPaul et al., 2016a) is composed of items derived from ADHD symptoms included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; APA, 2013). Parents were asked to report on the extent to which their child displays 18 behaviours associated with ADHD (DuPaul et al., 2016b). More specifically, they were asked to rate the frequency of behaviours over the last 6 months on a 4-point Likert scale, using the following response options: 0 (*never or rarely*), 1 (*sometimes*), 2 (*often*), and 3 (*very often*; DuPaul et al., 2016b). The ADHD-RS-5 can be used to assess ADHD symptomology in children aged 5-18 years, with child (5-10) and adolescent (11-18) versions. In the adolescent version, the wording of some items has been adjusted to be more developmentally appropriate for this age group (DuPaul et al., 2016b).

Scores for all 18 items can be summed to create a total score (DuPaul et al., 2016b). Normative data was collected for a sample of 2079 parents and was utilized to create gender- and age-based norms that allow for the conversion of raw scores to percentiles (DuPaul et al., 2016a). A score falling at the 80th percentile suggests significant risk of ADHD symptomology (DuPaul et al., 2016b). DuPaul et al. (2016a) reported high levels of internal consistency for the Total scale as well as the Inattention and Hyperactivity–Impulsivity subscales, with alpha coefficients ranging from .89 to .96. The current study used the total score on the ADHD-RS-5 categorically to determine clinically significant ADHD symptomology. Participants' scores were compared to a cut-off score (falling at the 80th percentile) in order to inform which group (NT, ASD, ADHD, and ASD+ADHD) families were included in (see Appendix C for summary table).

Cognitive Functioning

The Cognitive scale of the Developmental Profile 4 (DP-4; Alpern, 2020) was used to measure child cognitive functioning. The DP-4 measures development in five domains: Physical, Adaptive Behavior, Social-Emotional, Cognitive, and Communication. For the current study, the Parent/Caregiver Checklist forms was utilized. The total measure includes 190 items and takes 20-40 minutes to complete (Alpern, 2020). For the purpose of the current study, parents were asked to respond to 42 *yes* or *no* questions (from the Cognitive scale) asking whether their child has mastered various skills (Alpern, 2020). In particular, the cognitive scale is intended to assess intellectual abilities and skills required for academic achievement. The DP-4 can be used to assess children from birth to age 21 years, 11 months.

Subscale scores can be converted into norm-based standard scores (Alpern, 2020). The norms were generated using a sample that included over 2000 individuals and was representative of the United States population (Alpern, 2020). The current study used standard scores for the Cognitive scale of the DP-4. Standard scores were used continuously to represent cognitive functioning. Cognitive functioning was utilized as a covariate in some analyses.

Externalizing Behaviours

The Conduct Difficulties scale of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) was used to assess conduct or externalizing problems in children. The SDQ is a questionnaire that is intended to measure aspects of the behaviours, emotions, and relationships of children and adolescents. The SDQ is made up of 25 items that can be broken down into five 5-item scales: Hyperactivity Scale, Emotional Symptom Scale, Conduct Problem Scale, Peer Problems Scale, and Prosocial Scale (Goodman, 1997). For the purposes of the current study, parents were asked to respond to the 5 items that compose the Conduct Problems scale. Participants responded to statements about their child (e.g., often has temper tantrums or hot tempers) on a 3-point scale, including 0 (*Not* True), 1 (*Somewhat True*), and 2 (*Certainly True*). The SDQ was originally developed for use with children ages 4-16 years (Goodman, 1997); however, variations have been provided for use with children aged 2-4 years and with youths 18 years of age and older. Furthermore, the parent form has been used within the context of research focusing on children and youth up to the age of 18 who live at home with their parents (Maurice-Stam et al., 2018). The reliability of the SDQ, including measures of internal consistency, cross-informant correlation, and retest stability, were found to be generally satisfactory, making it an appropriate brief measure suitable for screening purposes (Goodman, 2001). Within the current study, Conduct Difficulties scale scores were utilized for demographic purposes, to provide additional context to inform the interpretation of study results.

Coparenting Quality

The Coparenting Relationship Scale (CRS; Feinberg et al., 2012) was used to assess the coparenting relationship. The CRS is comprised of 35 items based on seven components of coparenting that have been suggested within previous theory and research (Feinberg, 2003). The CRS includes the following subscales: Coparenting Agreement (four items), Coparenting Closeness (five items), Exposure to Conflict (two items), Coparenting Support (six items), Coparenting Undermining (six items), Endorse Partner Parenting (seven items), and Division of Labor (two items; Feinberg et al., 2012). The seven subscales of the CRS are conceptually related to Feinberg's (2003) four proposed coparenting domains: Childrearing Agreement, Support/Undermining, Satisfaction with the Division of Labor, and Family Management

(Feinberg et al., 2012). Parents were asked to respond to statements about the way they work together with their partner as parents using a 7-point response scale. Response options for six of the seven subscales include 0 (*not true of us*), 2 (*a little bit true of us*), 4 (*somewhat true of us*), and 6 (*very true of us*). The Exposure to Conflict subscale assesses the frequency of conflictual interactions and the response options include 0 (*never*), 2 (*sometimes [once or twice a week]*), 4 (*often [once a day]*), and 6 (*very often [several times a day]*).

Feinberg et al. (2012) reported excellent internal consistency for the Total score, with alpha coefficients ranging from .91 to .94. Greater variability was found in the internal consistency of the subscales. More specifically, internal consistency for the subscales ranged from questionable to excellent across gender and time points: Coparenting Agreement (Cronbach's α = .66 - .74), Coparenting Closeness (Cronbach's α = .75 - .83), Exposure to Conflict (Cronbach's α = .81 - .90), Coparenting Support (Cronbach's α = .86 - .89), Coparenting Undermining (Cronbach's α = .80 - .85), Endorse Partner's Parenting (Cronbach's α = .61 - .88), and Division of Labor (*r* = .33 - .59; Feinberg et al., 2012). In terms of convergent validity, the CRS Total scale was positively correlated with couple love, couple efficacy, and quality of marriage (Feinberg et al., 2012). Furthermore, negative correlations between the CRS Total scale and couple conflict, ineffective arguing, and divorce proneness indicate adequate discriminant validity (Feinberg et al., 2012).

In the current study, CRS Total scores and subscale scores were utilized. While CRS scores of mothers and fathers were used individually for some analyses, dyadic scores were also created by aggregating the scores of mothers and fathers. Previous research (May et al., 2015) has used summed coparenting scores to represent dyadic scores when mothers and fathers coparenting scores were strongly correlated. This was done to simplify models while still numerically summarizing couples' coparenting experiences. Given that paired mothers' and fathers' coparenting scores were also strongly correlated in the current study a similar approach to aggregating dyadic data was used. For ease of interpretation, an average score in which each mother's and father's scores are weighted equally was calculated (Ferketich & Mercer, 1992).

Family Quality of Life

The Family Quality of Life Scale (FQOL; Hoffman et al., 2006) was used to measure mothers' and fathers' subjective assessments of their satisfaction with various aspects of their life as a family. The FQOL includes 25 items that contribute to five subscales: Family Interaction, Parenting, Emotional Well-Being, Physical/Material Well-Being, and Disability-Related Support (Hoffman et al., 2006). Parents were asked to respond to items referring to aspects of life with their family using a 5-point scale including the following anchors: 1 (*very dissatisfied*), 3 (*neither satisfied nor dissatisfied*), and 5 (*very satisfied*). Item scores can be summed for each family member to create total and subscale scores representing the level of satisfaction of individual family members (Hoffman et al., 2006). Additionally, the scores of multiple family members can be aggregated to create an overall FQOL score for the family (Hoffman et al., 2006). This can be done by calculating an average score in which each family member's score is weighted equally (Ferketich & Mercer, 1992; Park et al., 2003; Wang et al., 2006). In a study focusing on validating an earlier version of the FQOL, Park et al. (2003) used this method of aggregating scores of family members, finding Cronbach's α of 0.90 for Family Interaction, 0.87 for Health and Safety, 0.86 for Parenting, and 0.82 for a subscale that was previously referred to as General Resources. The FQOL was originally developed and validated for use by families of children with disabilities aged 0 – 21 years; however, it is suggested that the FQOL can also be used to assess family quality of life in families of children without disabilities (Hoffman et al., 2006). In the current study, the wording of these items was adapted for families of NT children. Specifically, the phrasing of items such as, "my child with a disability has support to accomplish goals at home" was changed to "my child has support to accomplish goals at home".

Factor analyses of the satisfaction ratings for the items within each of the five subscales found excellent fit (Hoffman et al., 2006). Further factor analyses of the overall FQOL found excellent fit for a model including subscale mean scores as indicators for one overall Family Quality of Life factor and good fit for a more complex model including individual item scores (Hoffman et al., 2006). In terms of convergent validity, subscales of the FQOL have been found to be associated with other similar measures. For instance, the Family Interaction subscale correlated positively with the Family APGAR (Smilkstein et al., 1982) and the Physical/Material Well-Being subscale correlated positively with the Family Resource Scale (Dunst & Leet, 1985; Hoffman et al., 2006). Furthermore, the subscales of the FQOL have good internal reliability (Cronbach's $\alpha = .88$).

In the current study, FQOL total scores and subscale scores were utilized. FQOL scores of mothers and fathers were used individually for some analyses; however, dyadic scores were created by calculating an equally weighted average of the scores of mothers and fathers as noted above.

Procedures

Data Collection

Study Questionnaire. Data was collected using an online questionnaire that was constructed using the measures described above and hosted by Prairie Research Associates (PRA), a data collection platform. Study advertisements instructed parents to access the questionnaire using a link. Upon following the link to the online questionnaire, parents were presented with an electronic consent form with a brief description of the study and information about the conditions and confidentiality associated with participation. Interested parents could indicate that they had chosen to provide consent by selecting the “I consent to participate” option on the consent page. Participants were then be directed to the first page of the questionnaire.

This study is part of a larger study; therefore, other measures were included in the online questionnaire in addition to the ones described above. Based on the measures included, it was estimated that the survey would take approximately 30-45 minutes to complete. In order to improve efficiency and reduce completion time, survey branching was used to direct participants to questions that apply to them, skipping inapplicable questions.

As part of the consent form at the beginning of the questionnaire, participants were informed that both parents in a family were welcome to complete the questionnaire and requesting that participants share the survey with their partner. If participants agreed to share the survey with their partner, they were provided with space to enter their partner’s email address to send the survey link to them. Parents were asked to complete the study questionnaire independently; however, the email address used to send the link was used to connect the responses of parents within the same family.

At the end of the questionnaire, participants were thanked for their participation and debriefing information was presented. Furthermore, in appreciation for participants' time and effort towards contributing to this research, draws were conducted for ten $50 Amazon gift cards. Due to difficulty recruiting couples, part way into recruitment an additional incentive was offered, in which the first 100 couples to complete the survey (both parents must have complete the survey to be eligible) received a $20 eGift Card. Participants were asked to indicate whether they wanted to receive a summary of the study results following its completion (see Appendix D). Participants who wished to be eligible for a gift card or receive a summary of the study results were prompted to enter their email address. The email addresses provided in this section of the survey were not linked to participants' questionnaire responses and were deleted following the completion of the study.

Data Preparation

Data Cleaning

Prior to analysis, study data was exported from PRA's secure servers to SPSS Version 25.0. Then, data cleaning was undertaken to prepare the data for analysis. The initial round of data cleaning was completed by the programmers at PRA. Participants must have gotten through 90% of the survey to be included in the sample. Previous research demonstrates that completing a survey extremely quickly is associated with greater rates of invalid/insufficient effort responding (Huang et al., 2012; Zhang & Conrad, 2014), and that completion times two to three times faster than average are considered far more likely to indicate insufficient effort responding (Leiner, 2019). Therefore, participants were required to have spent at least 10 minutes completing the survey. This was done to conservatively minimize invalid/insufficient effort responding, as the median survey response time was 33 minutes. Total scores and subscale scores were calculated for all measures, using scoring instructions specific to each scale.

After the data file was received from PRA, further data cleaning was carried out. Data was checked to ensure that responses fell within the valid range for each independent and dependent variable. Exact duplicates and cases that shared a degree of similarity with other cases that suggested they were not independent were deleted from the dataset. This data was collected as part of a multi-researcher/multi-study project. Therefore, further inclusion criteria were applied to ensure participants were appropriate for the current study. For instance, to be eligible for inclusion in this study, parents needed to be involved in an active coparenting relationship. Therefore, participants who did not have a coparenting partner were removed from the dataset of the current study. Furthermore, the inclusion criteria of this study stated that participants must have been currently living and sharing childrearing responsibilities with a parenting partner. Therefore, any participants who reported having a coparent living with them less than 50% of the time were removed from the dataset.

For separate analyses within the NT, ASD, and ADHD groups, further restrictions applied. For any group-specific analyses, participants with children who did not meet the symptom cutoffs but had previous diagnoses were removed, resulting in the removal of 22 participants. Additional participants were excluded if the target child had a sibling with a diagnosis that did not match the neurodevelopmental group the family had been assigned to. Therefore, in the ASD group, four participants were excluded from group-based analyses due to the presence of a sibling with ADHD. Similarly, in the ADHD group, five participants were excluded from group-based analyses due to the presence of a sibling with ASD or having responded “prefer not to answer” to the question about ASD diagnoses of siblings.

For families in which both parents participated, aggregated CRS and FQOL scores were created by calculating the average of the two parents' CRS and FQOL total scores, respectively. Although same-sex couples were not excluded from participating, they were not included in pair-wise analyses exploring differences between mothers and fathers. One couple from the ASD group was excluded from the pair-wise analyses because both parents identified as fathers. One couple from the ADHD group was excluded because both parents identified as mothers. One couple from the ASD+ADHD group was excluded because both parents identified as fathers.

Missing Data

The dataset was examined for missing values. As different measures used different methods for creating total scores and subscale scores, depending on the scale for which data values were missing, specific methods were used to resolve the situation. This was done to minimize the effect of small amounts of missing data on the accuracy of total and subtotal scores for each measure. The specific procedures for replacing missing data for each measure is described below.

For the ADHD-RS-5, DuPaul et al. (2016b) did not provide instructions for calculating total or subscale scores in the presence of missing data; therefore, the research team running the larger project that the current study was completed under came to consensus on a reasonable approach for dealing with missing data. When the response for one item in a subscale was missing, it was replaced with the average of the remaining items. If more than two items of a subscale were missing, the subscale score was not calculated. If one or two item responses were missing, the total score was calculated using the replaced values. If three or more item responses were missing, the total score was not calculated. This allowed for 10% of the data for this measure to be missing, with the assumption that the remaining 90% of the items represented sufficient data to create reasonably accurate subtotal and total scores.

For the DP-4, the manual (Alpern, 2020) did not include procedures for replacing missing data. Because the response options for the DP-4 are limited to 1 (“Yes”) or 0 (“No”), options for replacing missing values were limited. Given that the DP-4 was used to control for the presence of low cognitive functioning or potential intellectual developmental disorders, which may be a confounding factor, an approach that would err on the side of underestimating, rather than overestimating, cognitive functioning was chosen. Therefore, missing item responses were replaced with zeros and then the total was calculated. If five or more item responses were missing, the total was not calculated. Similar to the approach for the ADHD-RS-5, this allowed for a maximum of approximately 10% of data to be missing.

For the SCQ, the manual (Rutter et al., 2003) did not include procedures for replacing missing data. As with the DP-4, the SCQ has a 2-point scale, so options for replacing missing values were limited. As ASD symptomology was a main study variable, a strategy that would avoid overestimating ASD symptomology was chosen. Therefore, missing item responses were replaced with zeros. The response to the first item of this measure (Item 1) determines how many items are included in the calculation of the total; therefore, it was also used to determine how many missing item responses would be allowed before the total would not be calculated. If the response to Item 1 was “Yes”, the total score would be calculated with up to 6 missing values. If the response to Item 1 was “No”, the total score would be calculated with up to 5 missing values. This allowed for a maximum of 15% of data to be missing.

For the CRS, suggestions for managing missing data were not provided in the primary publication associated with the measure (Feinberg et al., 2012). Therefore, an approach was chosen that would make use of the available information (responses to similar items) to limit the impact of missing data. Missing item responses were manually replaced with the average score for the subscale the item contributes to. If two or more item responses within the same subscale were missing, the subscale score was not calculated, as that would result in over 25% of the data being missing for some subscales. Division of Labor subscale scores were not calculated if any contributing items were missing, as it only includes two items. If less than 30 items had been completed across the CRS, the total score was not calculated. This allowed for up to approximately 15% of data to be missing.

For the FQOL, suggestions for managing missing data were not provided in the primary publication associated with the measure (Hoffman et al., 2006). Given that the FQOL uses similar scoring methods to the CRS, a similar approach to handling missing data was used. When the response to one item on a subscale was missing, the missing value was replaced with the mean value of the remaining items on that subscale. If responses to two or more items on a subscale were missing, the subscale score was not calculated. This cut-off was chosen to avoid having more than 25% of any given subscale replaced due to missing data. Once missing item responses were replaced, the total score was calculated as long as the participant had responded to at least 22 items. If fewer than 22 items were completed, the total score was not calculated. This allowed for a maximum of approximately 10% of the data to be missing.

The Conduct Problems subscale of the SDQ only included five items; therefore, subscale scores were only calculated if participants responded to all five items. This approach was chosen because the replacement of any one missing response would constitute an estimation of 20% of the data for the subscale.

Demographics and Group Membership

Data was analyzed using SPSS Version 25.0. First, descriptive statistics were calculated to provide information about the demographic characteristics of the sample. Participants were placed into one of the four groups (ASD, ADHD, ASD+ADHD, or NT) based on scores on the ADHD-RS-5 (DuPaul et al., 2016a) and the SCQ (Rutter et al., 2003). In order to be placed in the ASD group, a score of 15 or higher was required on the SCQ, with a score below the 80th percentile on the ADHD-RS-5 and no reported diagnoses of ADHD for any children in the family (see Appendix C for summary table). Likewise, to be placed in the ADHD group, a score at or above the 80th percentile on the ADHD-RS-5 was required, with a score below 15 on the SCQ and no reported ASD diagnoses for any children in the family. Families of children with scores meeting the cut-off points for the ADHD-RS-5 and the SCQ were placed in the ASD+ADHD group. Parents of children with scores falling below the cut-off points for the ADHD-RS-5 and the SCQ, with no reported diagnoses of ASD or ADHD for children in the family, were placed in the NT group. To avoid discrepancies, questions from the SCQ and ADHD-RS-5 were only provided to one parent (Parent A). Parent A was the first parent to complete the survey. For analyses involving paired parents, the ASD, ADHD, and ASD+ADHD groups were combined to create an ASD and/or ADHD group. This was done to allow for a sufficient sample size within the clinical sample. Analyses were carried out in samples of mothers, samples of fathers, and samples of dyads. Importantly, both parents from the same family (dyads) were only ever included in dyadic analyses, where scores were compared via paired samples *t*-tests or mothers and fathers scores were aggregated into one dyadic score.

Univariate Outliers

Data was examined to identify univariate outliers for each of the independent and dependent variables. Total scores for each variable were converted into *z* scores. Any *z* scores > 3.29 were considered potential outliers (Tabachnick & Fidell, 2019). When considering groups of mothers and fathers within the total sample, there was one outlier on the CRS from the group of mothers of children with ASD+ADHD (RQ1). Regarding FQOL, there were two outliers from the group of fathers of children with ASD+ADHD (RQ2).

For research question 5 (RQ 5), univariate outliers were evaluated within subsamples of mothers, fathers, and dyads in each neurodevelopmental group. Within the subsample of mothers of NT children, there was one outlier on the CRS and one outlier on the DP-4. Within the subsample of fathers of NT children, there was one outlier on the FQOL. Within the subsample of mothers of children with ADHD, there was one outlier on the FQOL and one outlier on the DP-4. Within the subsample of mothers of children with ASD+ADHD, there was one outlier on the CRS. Within the subsample of fathers of children with ASD+ADHD, there was one outlier on the FQOL.

The data of all potential outliers was evaluated concerning the extent to which they could reasonably be assumed to be part of the population of the group they were assigned to. It was determined that all outliers were appropriate to be included in their assigned groups. Therefore, all these participants were retained for the purpose of analysis.

Exploratory Analyses. In preparation for exploratory analyses, univariate outliers on the subscale scores of the CRS were investigated. Within the sample of mothers, there were four outliers on the Exposure to Conflict subscale, and two outliers on the Coparenting Undermining subscale. Similarly, univariate outliers on the subscale scores of the FQOL were investigated. Within the sample of mothers, there were three outliers on the Family Interaction subscale, one outlier on the Parenting subscale, two outliers on the Physical/Material Well-Being subscale, and one outlier on the Disability-Related Support subscale. Within the sample of fathers, there were three outliers on the Family Interaction subscale, four outliers on the Parenting subscale, one outlier on the Emotional Well-Being subscale, and two outliers on the Physical/Material Well-Being subscale.

For exploratory analyses involving paired parents within neurodevelopmental groups, outliers were evaluated within the neurodevelopmental subgroups of paired parents. Within the NT group, there was one mother with an outlying score on the Emotional Well-Being subscale of the FQOL. Regarding the CRS subscale scores within the ASD+ADHD group, there was one outlying difference score (representing the difference between mothers' and fathers' scores) on the Coparenting Agreement subscale, one outlying difference score on the Exposure to Conflict subscale, and one outlying difference score on the Endorsement of Partner Parenting subscale. In terms of the FQOL subscale scores within the ASD+ADHD group, there was one father with an outlying score on the Parenting subscale score, one outlying father score and one outlying difference score on the Physical/Material Well-Being subscale, and one mother with an outlying score on the Disability-Related Support subscale.

As with the primary research questions, data of potential outliers was evaluated concerning the extent to which they could reasonably be assumed to be part of the population of the group they were assigned to. It was determined that the outliers identified prior to exploratory analyses were appropriate to be included in their assigned groups and were retained for the purpose of analysis.

Multivariate Outliers

Presence of multivariate outliers within the samples used for RQs 5 and 6 were evaluated using Mahalanobis distance. One participant was identified as a potential multivariate outlier within the analysis for RQ 5f, which involved a regression evaluating the ability of coparenting quality to predict FQOL within a sample of mothers of children with ADHD, after controlling for child cognitive functioning and child age. Upon examination of the data from this participant, several inconsistencies emerged, which suggested probable issues with the validity of the data. Therefore, the data from this participant was removed from all analyses.

Assumption Testing

Research Question 1. Next, data was evaluated with regards to the assumptions associated with the planned analyses. In preparation for RQs 1 and 2, one-way ANOVAs comparing levels of coparenting quality and FQOL across neurodevelopmental groups, assumptions of normality, homogeneity of variance, and independence of errors were assessed within samples of mothers and fathers. The assumption of normality was tested through multiple methods. First, histograms were examined visually. Next, skewness and kurtosis values for each group were checked. Finally, the Shapiro-Wilk test was utilized to evaluate significant deviations from a normal distribution, with p-values less than .01 indicating significant deviations (Tabachnick & Fidell, 2019). The assumption of homogeneity of variance was assessed using Levene's Test for Equality of Variances. Greater detail regarding assumption testing can be found in Appendix E.

RQ 1a (see Table 1) involved samples of mothers' coparenting quality scores across the four neurodevelopmental groups. Deviations from normality were found for the NT and ASD+ADHD groups. While the distribution of the ASD group passed statistical tests of normality, visual inspection of the distribution revealed deviations. The ADHD group met the assumption of normality based on the above measures. The results of Levene's Test indicated that the variances in mothers' coparenting scores across neurodevelopmental groups were not equal. RQ 1b (see Table 1) involved samples of fathers' coparenting quality scores across the four neurodevelopmental groups. Deviations from normality were found for the ASD+ADHD group. The NT, ASD, and ADHD groups met the assumption of normality based on these measures. The results of Levene's Test indicated that the variances in fathers' coparenting scores across neurodevelopmental groups were equal.

Table 1

Assumption Testing – RQ 1: Coparenting Quality Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 1a: Mothers				$F(3,247) = 3.03$, $p = .030$
NT Group	-1.35 (0.28)	2.15 (0.55)	$W(76) = .88$, $p < .001$	
ASD Group	0.16 (0.66)	-2.10 (1.28)	$W(11) = .83$, $p = .024$	
ADHD Group	-0.44 (0.25)	-0.26 (0.49)	$W(96) = .97$, $p = .020$	
ASD+ADHD Group	-0.64 (0.29)	-0.75 (0.57)	$W(68) = .95$, $p = .006$	
RQ 1b: Fathers				$F(3,150) = 1.56$, $p = .202$
NT Group	-0.39 (0.40)	-1.02 (0.78)	$W(35) = .94$, $p = .054$	
ASD Group	0.68 (0.45)	-0.70 (0.87)	$W(27) = .91$, $p = .026$	
ADHD Group	0.30 (0.45)	-1.07 (0.87)	$W(27) = .92$, $p = .031$	
ASD+ADHD Group	1.55 (0.30)	1.04 (0.59)	$W(65) = .73$, $p < .001$	

Research Question 2. RQ 2a (see Table 2) involved samples of mothers' FQOL scores across the four neurodevelopmental groups. Deviations from normality were found for the NT group. The ASD, ADHD, and ASD+ADHD groups met the assumption of normality based on these measures. The results of Levene's Test indicated that the variances in mothers' FQOL scores across neurodevelopmental groups were equal. RQ 2b (see Table 2) involved samples of fathers' FQOL scores across the four neurodevelopmental groups. Deviations from normality were found for the NT and ASD+ADHD groups. The ASD and ADHD groups met the assumption of normality based on these measures. The Levene's Test indicated that the variances in fathers' FQOL scores across neurodevelopmental groups were equal.

Table 2

Assumption Testing – RQ 2: FQOL Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 2a: Mothers				$F(3,283) = .95$, $p = .416$
NT Group	-0.90 (0.25)	0.69 (0.50)	$W(91) = .93$, $p < .001$	
ASD Group	1.23 (0.58)	2.26 (1.12)	$W(15) = .90$, $p = .092$	
ADHD Group	-0.40 (0.23)	0.62 (0.46)	$W(107) = .98$, $p = .074$	
ASD+ADHD Group	0.06 (0.28)	-0.46 (0.55)	$W(75) = .99$, $p = .802$	
RQ 2b: Fathers				$F(3,162) = .62$, $p = .606$
NT Group	-1.34 (0.40)	3.98 (0.78)	$W(35) = .88$, $p = .001$	
ASD Group	0.32 (0.44)	0.48 (0.86)	$W(28) = .96$, $p = .326$	
ADHD Group	0.12 (0.43)	0.46 (0.83)	$W(30) = .96$, $p = .276$	
ASD+ADHD Group	-1.07 (0.28)	2.30 (0.56)	$W(73) = .91$, $p < .001$	

The assumption of independence is assessed based on the research design. In this study, all data was independently sampled. When both parents from the same family completed the survey, Parent 1 was instructed to send the survey to their coparent by entering the coparent's email address. Then, a specific survey link was sent to Parent 2. This method allowed coparents' data to be linked and treated as one participant family. The data of two parents from the same family were never treated as independent. Data from Parent 2 was only used within the context of the dyad analyses, in paired samples *t*-tests or in aggregated coparenting quality or FQOL scores in regression analyses.

Research Questions 3 and 4. In preparation for RQs 3 and 4, paired samples *t*-tests comparing the levels of coparenting quality and FQOL between mothers and fathers, the assumption of normality was assessed within each neurodevelopmental group. Similar methods were used for testing the assumption of normality as for RQs 1 and 2; however, for RQs 3 and 4 the distributions of differences in scores between paired mothers and fathers were examined. RQ 3 (see Table 3) involved coparenting quality scores from samples of paired mothers and fathers in each of the neurodevelopmental groups. Deviations from normality were found for paired parents of children with ASD and/or ADHD. The distribution of difference scores for the NT group met the assumption of normality based on these measures. RQ 4 (see Table 3) involved FQOL scores from samples of paired mothers and fathers in each of the neurodevelopmental groups. The distribution of difference scores for both the NT and ASD and/or ADHD groups met the assumption of normality based on these measures.

Table 3

Assumption Testing – RQ 3 & 4: Coparenting Quality and FQOL Between Mothers and Fathers

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
RQ 3a: Coparenting Quality – NT Group	0.74 (0.58)	1.01 (1.12)	$W(15) = .92, p = .225$
RQ 3b: Coparenting Quality – ASD and/or ADHD Group	0.60 (0.32)	2.04 (0.62)	$W(57) = .93, p = .002$

RQ 4a: FQOL –NT Group	0.35 (0.52)	-0.67 (1.01)	$W(19) = .97, p = .774$
RQ 4b: FQOL – ASD and/or ADHD Group	0.01 (0.29)	0.30 (0.58)	$W(67) = .98, p = .240$

Research Question 5. In preparation for RQs 5 and 6, hierarchical multiple regression analyses of the ability of coparenting quality to predict FQOL and the moderating role of child neurodevelopmental symptomology, assumptions of normality, multicollinearity, and homoscedasticity were assessed. To assess for normality, expected normal probability plots were examined. Homoscedasticity was assessed through examination of scatterplots of residuals. To assess for multicollinearity, the variance inflation factor (VIF) was checked.

RQ 5 involved FQOL scores from samples of mothers and fathers in each of the neurodevelopmental groups. No significant deviations from normality were observed in the distributions of FQOL scores of mothers (RQ5a) and fathers (RQ5b) of NT children, paired parents of NT children (RQ5c), mothers (RQ5f) and fathers (RQ5g) of children with ADHD, and mothers of children with ASD+ADHD (RQ5h). Slight deviations from normality were observed in the distribution of FQOL scores of fathers of children with ASD (RQ5e), fathers of children with ASD+ADHD (RQ5i), and paired mothers and fathers of children with ASD and/or ADHD (RQ5j). A considerable deviation from normality was observed in the distribution of FQOL scores of mothers of children with ASD (RQ5d)

The distributions of FQOL scores for fathers of children with ASD (RQ5e), mothers (RQ5f) and fathers (RQ5g) of children with ADHD, fathers of children with ASD+ADHD (RQ5k), and paired mothers and fathers of children with ASD and/or ADHD (RQ5j) were relatively homoscedastic. A mild degree of heteroscedasticity was found in FQOL scores of mothers (RQ5a) and fathers (RQ5b) of NT children, and mothers of children with ASD+ADHD

(RQ5h). Scatterplots for the FQOL scores of paired parents of NT children (RQ5c) and mothers of children with ASD (RQ5d) appeared to show somewhat greater heteroscedasticity. This would generally suggest unequal variance in FQOL at different levels of coparenting quality in these samples; however, this was likely impacted by the small samples in each of these groups. While this could reduce the precision of the results, no particularly concerning patterns (e.g., fan-shape) were identified. Heteroscedasticity, variation, and small samples were considered in the interpretation of results. No problems with multicollinearity were indicated for any of the distributions involved in RQ 5.

Research Question 6. RQ 6 involved FQOL scores from samples mothers, fathers, and paired parents. For both mothers (RQ6a) and fathers (RQ6b), no significant deviations from normality were observed. Both distributions displayed a mild degree of heteroscedasticity, with scores clustered more tightly to the right of the plot. For paired parents (RQ6c), no significant deviations from normality were observed and the distribution was relatively homoscedastic. No problems with multicollinearity were indicated for any of the distributions involved in RQ 6.

Exploratory Analyses. Data was evaluated with regards to the assumptions associated with the exploratory analyses. See Appendix A for a list of the exploratory research questions. In preparation for the exploratory RQs 7 to 18, one-way ANOVAs comparing levels of aspects of coparenting quality and aspects of FQOL (subscale factors) across neurodevelopmental groups, assumptions of normality, homogeneity of variance, and independence of errors were assessed within samples of mothers and fathers. The assumption of normality was tested using the previously stated methods. See Appendix F for greater detail regarding the assumption testing for exploratory analyses.

RQ 7a involved samples of mothers' coparenting agreement scores across the four neurodevelopmental groups. Deviations from normality were found for the NT group. The ASD group was quite small, creating an abnormal shape in the distribution of coparenting agreement scores; however, deviations from normal were not significant based on the Shapiro-Wilk test. The ADHD and ASD+ADHD groups met the assumption of normality based on these measures. The results of Levene's Test indicated that the variances in mothers' coparenting agreement scores across neurodevelopmental groups were not significantly different.

RQ 7b involved samples of fathers' coparenting agreement scores. Deviations from normality were found for the ASD+ADHD group. The distribution for the ASD group had an abnormal shape; however, deviations from normal were not significant based on the Shapiro-Wilk test. The NT and ADHD groups met the assumption of normality. The results of Levene's Test indicated that the variances in fathers' coparenting agreement scores across neurodevelopmental groups were not significantly different.

RQ 8a involved samples of mothers' coparenting closeness scores. Deviations from normality were found for the NT, ADHD, and ASD+ADHD groups. For the ASD group, the distribution had an abnormal shape; however, deviations from normal were not significant based on the Shapiro-Wilk test. The results of Levene's Test indicated that the variances in mothers' coparenting closeness scores across neurodevelopmental groups were not significantly different.

RQ 8b involved samples of fathers' coparenting closeness scores. Deviations from normality were found for the NT group. The distribution for the ASD group had an abnormal shape but the deviations were not significant based on the Shapiro-Wilk test. The ADHD and ASD+ADHD groups met the assumption of normality. The results of Levene's Test indicated that the variances in fathers' coparenting closeness scores across neurodevelopmental groups differed significantly.

RQ 9a involved samples of mothers' exposure to coparenting conflict scores. Deviations from normality were found for all four groups, such that they tended to be positively skewed and leptokurtic. For RQ 9a, the results of Levene's Test indicated that the variances in mothers' exposure to coparenting conflict scores differed significantly across neurodevelopmental groups.

RQ 9b involved samples of fathers' exposure to coparenting conflict scores. Deviations from normality were found for all four groups, with some variation in the shapes of the distributions. For RQ 9b, the results of Levene's Test indicated that the variances in fathers' exposure to coparenting conflict scores differed significantly across neurodevelopmental groups.

RQ 10a involved samples of mothers' coparenting support scores. Deviations from normality were found for all four groups, such that the distributions tended to be negatively skewed. For RQ 10a, the results of Levene's Test indicated that the variances in mothers' coparenting support scores across neurodevelopmental groups were not significantly different.

RQ 10b involved samples of fathers' coparenting support scores. Deviations from normality were found for the NT, ASD, and ASD+ADHD groups, with some variation in the shape of the distributions. The ADHD group met the assumption of normality. For RQ 10b, the results of Levene's Test indicated that the variances in fathers' coparenting support scores across neurodevelopmental groups were not significantly different.

RQ 11a involved samples of mothers' coparenting undermining scores. Deviations from normality were found for the NT, ADHD, and ASD+ADHD groups, with a tendency for the distributions to be positively skewed and leptokurtic. The distribution for the ASD group had an abnormal shape; however, deviations from normal were not significant based on the Shapiro-

Wilk test. For RQ 11a, the results of Levene's Test indicated that the variances in mothers' coparenting undermining scores differed significantly across neurodevelopmental groups.

RQ 11b involved samples of fathers' coparenting undermining scores. Deviations from normality were found for the NT and ASD+ADHD groups, with variations in the shapes of the distributions. The ASD and ADHD groups met the assumption of normality. For RQ 11b, the results of Levene's Test indicated that the variances in fathers' coparenting undermining scores across neurodevelopmental groups were not significantly different.

RQ 12a involved samples of mothers' endorsement of parenting partner scores. Deviations from normality were found for the NT and ADHD groups, with a tendency for the distributions to be negatively skewed. For the ASD group, the distribution had an abnormal shape; however, deviations from normal were not significant based on the Shapiro-Wilk test. The ASD+ADHD group met the assumption of normality. For RQ 12a, the results of Levene's Test indicated that the variances in mothers' endorsement of parenting partner scores did not differ significantly across neurodevelopmental groups.

RQ 12b involved samples of fathers' endorsement of parenting partner scores. For the NT group, the distribution appeared to deviate from normal to some extent, but these deviations were not significant based on the Shapiro-Wilk test. The ASD, ADHD, and ASD+ADHD groups met the assumption of normality. For RQ 12b, the results of Levene's Test indicated that the variances in fathers' endorsement of parenting partner scores did not differ significantly across neurodevelopmental groups.

RQ 13a involved samples of mothers' division of labor scores. Deviations from normality were found for the NT, ADHD, and ASD+ADHD groups, with variations in the shapes of the distributions. The distribution of the ASD group had an abnormal shape; however, deviations from normal were not significant based on the Shapiro-Wilk test. For RQ 13a, the results of Levene's Test indicated that the variances in mothers' division of labor scores did not differ significantly across neurodevelopmental groups.

RQ 13b involved samples of fathers' division of labor scores. The distribution for the ASD+ADHD group was positively skewed and deviated significantly from normal based on the Shapiro-Wilk test. The NT, ASD, and ADHD groups met the assumption of normality. For RQ 13b, the results of Levene's Test indicated that the variances in fathers' division of labor scores did not differ significantly across neurodevelopmental groups.

RQ 14a involved samples of mothers' family interaction scores. Deviations from normality were found for the NT and ADHD groups, with a tendency for the distributions to be negatively skewed and leptokurtic. The distributions of the ASD and ASD+ADHD groups were negatively skewed; however, deviations from normal were not significant based on the Shapiro-Wilk test. For RQ 14a, the results of Levene's Test indicated that the variances in mothers' family interaction scores did not differ significantly across neurodevelopmental groups.

RQ 14b involved samples of fathers' family interaction scores. The distributions for the NT and ASD+ADHD groups were negatively skewed and leptokurtic; however, only the deviations for the ASD+ADHD group were significant based on the Shapiro-Wilk test. The ASD and ADHD groups met the assumption of normality. For RQ 14b, the results of Levene's Test indicated that the variances in fathers' family interaction scores did not differ significantly across neurodevelopmental groups.

RQ 15a involved samples of mothers' parenting scores. For the NT group, the distribution was negatively skewed, leptokurtic, and deviated significantly from normal based on the Shapiro-Wilk test. The distributions of the ASD and ADHD groups had somewhat abnormal shapes; however, the deviations from normal were not significant based on the Shapiro-Wilk test. The ASD+ADHD group met the assumption of normality. For RQ 15a, the results of Levene's Test indicated that the variances in mothers' parenting scores did not differ significantly across neurodevelopmental groups.

RQ 15b involved samples of fathers' parenting scores. Deviations from normality were found for the NT and ASD+ADHD groups, with a tendency for the distributions to be negatively skewed and leptokurtic. The distribution for the ADHD group was somewhat leptokurtic but did not deviate significantly from normal based on the Shapiro-Wilk test. The ASD group met the assumption of normality. For RQ 15b, the results of Levene's Test indicated that the variances in fathers' parenting scores did not differ significantly across neurodevelopmental groups.

RQ 16a involved samples of mothers' emotional well-being scores. For the NT group, the distribution had an unusual shape, was negatively skewed, and deviated significantly from normal based on the Shapiro-Wilk test. The distribution of the ASD group was negatively skewed and leptokurtic, but did not deviate significantly based on the Shapiro-Wilk test. The ADHD and ASD+ADHD groups met the assumption of normality. For RQ 16a, the results of Levene's Test indicated that the variances in mothers' emotional well-being scores did not differ significantly across neurodevelopmental groups.

RQ 16b involved samples of fathers' emotional well-being. The distribution for the ASD+ADHD group was negatively skewed and deviated significantly from normal based on the Shapiro-Wilk test. The distribution for the NT group was somewhat negatively skewed and leptokurtic but did not deviate significantly from normal based on the Shapiro-Wilk test. The ASD and ADHD groups met the assumption of normality. For RQ 16b, the results of Levene's

Test indicated that the variances in fathers' emotional well-being scores did not differ significantly across neurodevelopmental groups.

RQ 17a involved samples of mothers' physical/material well-being scores. Deviations from normality were found for the NT, ADHD, and ASD+ADHD groups, with a tendency for the distributions to be negatively skewed. The distribution of the ASD group was negatively skewed and leptokurtic, but did not deviate significantly based on the Shapiro-Wilk test. For RQ 17a, the results of Levene's Test indicated that the variances in mothers' physical/material well-being scores differed significantly across neurodevelopmental groups.

RQ 17b involved samples of fathers' physical/material well-being scores. Deviations from normality were found for the NT and ASD+ADHD groups, with variations in the shapes of the distributions. The ASD and ADHD groups met the assumption of normality. For RQ 17b, the results of Levene's Test indicated that the variances in fathers' physical/material well-being scores did not differ significantly across neurodevelopmental groups.

RQ 18a involved samples of mothers' disability-related support scores. Deviations from normality were found for the NT and ADHD groups, with variations in the shapes of the distributions. The distributions for the ASD and ASD+ADHD groups were somewhat negatively skewed; however, deviations from normal were not significant based on the Shapiro-Wilk test. For RQ 18a, the results of Levene's Test indicated that the variances in mothers' disability-related support scores differed significantly across neurodevelopmental groups.

RQ 18b involved samples of fathers' disability-related support scores. For the NT group, the distribution was negatively skewed, leptokurtic, and deviated significantly from normal based on the Shapiro-Wilk test. The distributions for the ASD, ADHD, and ASD+ADHD groups tended to be somewhat negatively skewed and leptokurtic (ASD group only); however, the deviations from normality were not significant based on the Shapiro-Wilk test. For RQ 18b, the results of Levene's Test indicated that the variances in fathers' disability-related support scores did not differ significantly across neurodevelopmental groups.

In preparation for exploratory RQs 19 to 30, paired samples *t*-tests comparing the levels of aspects of coparenting quality and FQOL between mothers and fathers, the assumption of normality was assessed within each neurodevelopmental group. The same methods that were used for 3 and 4 were used.

Exploratory RQ 19 involved coparenting agreement scores from samples of paired mothers and fathers in two neurodevelopmental groups. The distributions of difference scores for paired parents of NT children and paired parents of children with ASD and/or ADHD were positively skewed and leptokurtic, but only the deviations for the ASD and/or ADHD group were significant based on the Shapiro-Wilk test.

Exploratory RQ 20 involved coparenting closeness scores from samples of paired mothers and fathers. The distribution of for the NT group was positively skewed and deviated significantly from normal based on the Shapiro-Wilk test. The distribution for the ASD and/or ADHD group was negatively skewed and leptokurtic but did not deviate significantly based on the Shapiro-Wilk test.

Exploratory RQ 21 involved exposure to conflict scores from samples of paired mothers and fathers. The distribution of difference scores for the NT group met the assumption of normality based on these measures. The distribution for the ASD and/or ADHD group was negatively skewed, leptokurtic, and deviated significantly from normal based on the Shapiro-Wilk test.

Exploratory RQ 22 involved coparenting support scores from samples of paired mothers and fathers. The distribution of difference scores for the NT group met the assumption of normality. The distribution for the ASD and/or ADHD group was slightly leptokurtic but did not deviate significantly from normal based on the Shapiro-Wilk test.

Exploratory RQ 23 involved coparenting undermining scores from samples of paired mothers and fathers. The distribution of difference scores for the NT group met the assumption of normality. The distribution for the ASD and/or ADHD group was negatively skewed, leptokurtic, and deviated significantly from normal based on the Shapiro-Wilk test.

Exploratory RQ 24 involved endorsement of partner parenting scores from samples of paired mothers and fathers. The distribution of difference scores for the NT group met the assumption of normality. The distribution for the ASD and/or ADHD group was somewhat negatively skewed and leptokurtic but did not deviate significantly from normal based on the Shapiro-Wilk test.

Exploratory RQ 25 involved division of labor scores from samples of paired mothers and fathers. The distributions of difference scores for both the NT and ASD and/or ADHD groups met the assumption of normality based on these measures.

Exploratory RQ 26 involved family interaction scores from samples of paired mothers and fathers. The distribution of difference scores for the NT group was positively skewed and deviated significantly from normal based on the Shapiro-Wilk test. The distribution for the ASD and/or ADHD group met the assumption of normality.

Exploratory RQs 27 and 28 involved parenting and emotional well-being scores from samples of paired mothers and fathers, respectively. The distributions of difference scores for both the NT and ASD and/or ADHD groups met the assumption of normality.

Exploratory RQ 29 involved physical/material well-being scores from samples of paired mothers and fathers. The distribution of difference scores for the NT group met the assumption of normality. The distribution for the ASD and/or ADHD group was positively skewed, leptokurtic, and deviated significantly from normal based on the Shapiro-Wilk test.

Exploratory RQ 30 involved disability-related support scores from samples of paired mothers and fathers. The distribution of difference scores for the NT group met the assumption of normality. The distribution for the ASD and/or ADHD group was leptokurtic and deviated significantly from normal based on the Shapiro-Wilk test.

Plan for Analysis

Coparenting Quality Across Neurodevelopmental Groups. In order to answer Research Question (RQ) 1a, a one-way analysis of variance (ANOVA) was conducted to compare the mean levels of coparenting quality between mothers in the four neurodevelopmental groups (families of children with ADHD, ASD, ASD+ADHD, and NT children). Likewise, to answer RQ 1b, a one-way ANOVA was conducted to compare the mean levels of coparenting quality between fathers in the four neurodevelopmental groups. Prior to these analyses, the assumptions of homogeneity of variance, normality, and independence of errors were assessed.

FQOL Across Neurodevelopmental Groups. Similarly, to answer RQ 2a, a one-way ANOVA was conducted to compare the mean levels of family quality of life between mothers in the four neurodevelopmental groups. For RQ 2b, a one-way ANOVA was conducted to compare the mean levels of family quality of life between fathers in the four neurodevelopmental groups.

Gender Differences in Coparenting Quality. Next, to answer RQ 3a, a paired samples *t*-test was used to compare the mean total coparenting quality scores of mothers and fathers in the

NT group. For RQ 3b, a paired samples *t*-test was used to compare the mean total coparenting quality scores of mothers and fathers in the ASD and/or ADHD group.

Gender Differences in FQOL. To answer RQ 4a, a paired samples *t*-test was used to compare the mean total FQOL scores of mothers and fathers in the NT group. For RQ 4b, a paired samples *t*-test will be used to compare the mean total FQOL scores of mothers and fathers in the ASD and/or ADHD group.

Coparenting Quality and FQOL. To answer RQ 5a to 5j, hierarchical multiple regression analyses was used to assess the ability of coparenting quality to predict FQOL. Variables were entered in two steps. First, level of child cognitive functioning and child age were entered into the regression model in Step 1 in order to control for the effects of these variables. In Step 2, coparenting quality was added into the model as a predictor of FQOL. This model was tested using three separate sets of scores: mothers' scores, fathers' scores, and dyads' composite scores (aggregated scores based on mothers' and fathers' individual scores). Furthermore, separate sets of multiple regressions (mothers and fathers) were conducted in each of the neurodevelopmental groups (families of NT children and families of children with ASD, ADHD, and ASD+ADHD). Additionally, sets of multiple regressions were conducted with dyadic scores in the NT group and in the combined ASD and/or ADHD group. Prior to running these analyses, assumptions of multicollinearity, homogeneity of variance, normality, independence of errors, and absence of outliers were assessed.

Moderating Role of Child Diagnosis. Finally, to address RQ 6a to 6c, the moderating effect of child diagnosis on the relation between coparenting quality and FQOL was investigated. More specifically, the PROCESS macro (Hayes et al., 2017) for PROCESS Model 1 was used to analyse the moderation model through multiple regression. To improve the reliability of the results, a bootstrapping procedure with 5000 samples was employed to generate robust confidence intervals. In this model, coparenting quality served as the predictor variable, FQOL served as the dependent variable, and child ND group (ASD, ADHD, or ASD+ADHD) served as the moderator variable. Additionally, child cognitive functioning and child age were controlled for. This model was tested using the combined samples of families of NT children and families of children with ASD, ADHD, and ASD+ADHD. This analysis was conducted first using mothers' scores (RQ 6a), then fathers' scores (RQ 6b), and finally using dyads' composite scores (aggregated scores based on mothers' and fathers' individual scores; RQ 6c).

Coparenting and FQOL Components. Exploratory analyses were carried out to investigate gender and group differences across the CRS subscales: Coparenting Agreement, Coparenting Closeness, Exposure to Conflict, Coparenting Support, Coparenting Undermining, Endorse Partner Parenting, and Division of Labor. Similarly, exploratory analyses were carried out to investigate gender and group differences across FQOL subscales: Family Interaction, Parenting, Emotional Well-Being, Physical/Material Well-Being, and Disability-Related Support. Furthermore, associations between CRS subscales and FQOL subscales were carried out in an exploratory manner.

Results

Sample Characteristics

After determining the eligibility of participating parents, a total sample of 456 parents met criteria for inclusion in the current study. The total sample included 289 mothers and 167 fathers. Participation in this study was limited to parents living in Canada and the US. Mothers ranged in age from 20 years to 56 years (M = 39.7, SD = 6.2). Mothers in the sample had between 1 and 6 children (M = 2.2, SD = 1.0). The target children that mothers were asked to think of when responding to survey questions ranged in age from 5 to 18 years, with an average age of 9.7 years (*SD* = 3.6). Of the mothers in the total sample, 31.8% were in the NT group (had only NT children between the ages of 2-18 years), 5.2% were in the ASD group (had a child with clinically significant levels of ASD symptomology only), 36.7% were in the ADHD group (had a child with clinically significant levels of ADHD symptomology only), and 26.0% were in the ASD+ADHD group (had a child with clinically significant levels of both ASD and ADHD symptomology). Greater detail about the demographic information for mothers in each group (NT, ASD, ADHD, and ASD+ADHD) can be found in Table 4.

Table 4

Sample Characteristics – Mothers

	NT Group $n = 92$	ASD Group $n = 15$	ADHD Group $n = 106$	ASD+ADHD Group $n = 75$	All Mothers $n = 289$	Group Differences
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*F (p)*
Mother's Age (years)	39.5 (5.7)	35.5 (9.5)	40.6 (5.7)	39.6 (6.3)	39.7 (6.2)	3.3 (.022)
Number of Children	2.2 (0.9)	1.7 (0.6)	2.1 (0.9)	2.6 (1.2)	2.2 (1.0)	5.9 (< .001)
Target Child's Age (years)	9.2 (3.8)	9.4 (4.0)	10.2 (3.7)	9.7 (3.3)	9.7 (3.6)	1.5 (.217)
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	$X^2(p)$
Location of Residence						20.6 (< .001)
Canada	85 (92.4)	7 (46.7)	86 (81.1)	58 (77.3)	237 (82.0)	
United States	7 (7.6)	8 (53.3)	20 (18.9)	17 (22.7)	52 (18.0)	
Maternal Diagnosis						(.002)
ASD or ADHD	5 (5.4)	3 (20.0)	27 (25.5)	18 (24.0)	53 (18.3)	

Ethnicity						
White	81 (88.1)	12 (80.0)	95 (89.6)	58 (77.3)	247 (85.4)	
BIPOC	10 (10.9)	5 (34.5)	12 (11.2)	16 (20.3)	43 (14.8)	
Other	4 (4.4)	1 (6.7)	2 (1.9)	1 (1.3)	8 (2.5)	
Education Level						(.128)
High School or Less	3 (3.3)	0 (0.0)	3 (2.8)	3 (4.0)	9 (3.1)	
Post-Secondary	89 (96.7)	15 (100.0)	102 (96.2)	72 (96.0)	279 (96.5)	
Marital Status						(.511)
Single, Separated, Divorced, or Widowed	2 (2.2)	0 (0.0)	5 (4.6)	0 (0.0)	7 (2.3)	
Common-law	17 (18.5)	2 (13.3)	16 (15.1)	6 (8.0)	41 (14.2)	
Married	73 (79.3)	13 (86.7)	84 (79.2)	69 (92.0)	240 (83.0)	
Household Income						(.091)
< $60, 000	10 (10.9)	3 (20.0)	10 (9.4)	22 (29.4)	45 (15.6)	
$60,000 - $90,000	16 (17.4)	4 (26.7)	19 (17.9)	16 (21.3)	55 (19.0)	
$90,000 – $125,000	29 (31.5)	3 (20.0)	35 (33.0)	14 (18.7)	81 (28.0)	
> $125,000	33 (35.9)	5 (33.3)	40 (37.7)	20 (26.7)	99 (34.3)	
Target Child's Gender						(.015)
Male	43 (46.7)	13 (86.7)	58 (54.7)	54 (72.0)	169 (58.5)	
Female, non-binary, or does not identify with the genders listed	48 (52.2)	2 (13.3)	48 (45.3)	21 (28.0)	119 (41.2)	

Target Child Conduct Problems (SDQ)						(< .001)
Normal (score of 0-2)	81 (88.0)	12 (80.0)	51 (48.1)	28 (37.3)	172 (59.4)	
Borderline (score of 3)	5 (5.4)	1 (6.7)	22 (20.8)	14 (18.7)	43 (14.9)	
Clinically Elevated (score of 4-10)	6 (6.6)	2 (13.4)	26 (24.5)	28 (37.3)	62 (21.3)	

Note. Responses of parents who selected "I prefer not to answer" for questions are not represented in this table. Participants whose children identified as female, non-binary, and those whose children did not identify with the genders listed were grouped to avoid single-participant cells and preserve anonymity.

Neurodevelopmental groups of mothers were compared on demographic variables using ANOVA, Chi-Square, or Fisher's Exact tests, as appropriate. The groups were found to differ in terms of mothers' age ($F[3, 285] = 3.26$, $p = .022$), number of children ($F[3, 285] = 5.95$, $p < .001$), location of residence ($X^2[3] = 20.57$, $p < .001$), maternal ND diagnoses ($X^2[3] = 14.78$, $p = .002$), child gender ($X^2[12] = 21.88$, $p = .015$), and child conduct problems ($X^2[6] = 52.51$, $p < .001$). The results of the Bonferroni test indicated that mothers in the ADHD group had more advanced age than mothers in the ASD group ($p = .014$, 95% C.I. = [0.68, 9.60]). Mothers in the ASD+ADHD group had more children than mothers in the NT ($p = .045$, 95% C.I. = [0.01, .82]), ASD, ($p = .006$, 95% C.I. = [0.19, 1.68]), and ADHD ($p = .004$, 95% C.I. = [0.12, .91]) groups. For categorical variables, standardized residuals were used to identify groups with frequencies that differed considerably from expected frequencies. The proportion of mothers living in the United States was greater than expected in the ASD group and less than expected in the NT group. The proportion of mothers with diagnoses of ASD and/or ADHD was less than expected in the NT group. The proportion of female target children was higher than expected in the NT group and lower in the ASD and ASD+ADHD groups. The proportion of target children with conduct problems was lower than expected in the NT group and higher than expected in the ASD+ADHD group.

Fathers ranged in age from 20 years to 50 years (*M* = 35.7, *SD* = 5.5). Fathers in the sample had between 1 and 4 children (*M* = 1.7, *SD* = 0.8). The target children that fathers were asked to think of when responding to survey questions ranged in age from 5 to 17 years, with an average age of 9.0 years (*SD* = 3.1). Of the fathers in the total sample, 20.4% were in the NT group (had only NT children between the ages of 2-18 years), 16.8% were in the ASD group (had a child with clinically significant levels of ASD symptomology only), 18.0% were in the ADHD group (had a child with clinically significant levels of ADHD symptomology only), and 44.3% were in the ASD+ADHD group (had a child with clinically significant levels of both ASD and ADHD symptomology). Greater detail about the demographic information for fathers in each group (NT, ASD, ADHD, and ASD+ADHD) can be found in Table 5.

Table 5

Sample Characteristics – Fathers

	NT Group *n* = 34	ASD Group *n* = 28	ADHD Group *n* = 30	ASD+ADHD Group *n* = 74	All Fathers *n* = 167	Group Differences
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*F (p)*
Father's Age (years)	38.4 (5.2)	35.5 (5.4)	35.0 (5.9)	35.2 (5.2)	35.7 (5.5)	3.6 (.015)
Number of Children	1.9 (0.9)	1.6 (0.7)	1.7 (0.8)	1.6 (0.7)	1.7 (0.8)	2.1 (.310)
Target Child's Age (years)	8.0 (3.0)	8.8 (3.0)	9.1 (4.0)	9.4 (2.9)	9.0 (3.1)	1.57 (.199)
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	$X^2(p)$
Location of Residence						33.5 (< .001)
Canada	21 (61.8)	2 (7.1)	13 (43.3)	11 (14.9)	47 (28.1)	

United States	13 (38.2)	26 (92.9)	17 (56.7)	63 (85.1)	120 (71.9)	
Paternal Diagnosis						41.4 (< .001)
ASD or ADHD	1 (2.9)	3 (10.7)	14 (46.7)	43 (58.1)	62 (37.1)	
Ethnicity						
White	24 (70.5)	24 (85.7)	24 (80.0)	57 (77.0)	130 (77.8)	
BIPOC	9 (26.4)	5 (17.9)	11 (36.7)	15 (20.3)	40 (24)	
Other	2 (5.9)	0 (0.0)	1 (3.3)	2 (2.8)	5 (3.0)	
Education Level						(.350)
High School or Less	0 (0.0)	2 (7.1)	1 (3.3)	1 (1.4)	4 (2.4)	
Post-Secondary	34 (100.0)	26 (92.8)	29 (96.7)	73 (98.7)	163 (97.6)	
Marital Status						(.668)
Single, Separated, or Divorced	1 (2.9)	0 (0.0)	1 (3.3)	1 (1.4)	3 (1.8)	
Common-law	2 (5.9)	0 (0.0)	2 (6.7)	2 (2.7)	6 (3.6)	
Married	31 (91.2)	28 (100.0)	27 (90.0)	70 (94.6)	157 (94.0)	
Household Income						(.546)
< $60, 000	7 (20.6)	4 (14.3)	5 (16.6)	8 (10.9)	24 (14.4)	
$60,000 - $90,000	5 (14.7)	9 (32.1)	8 (26.7)	13 (17.6)	36 (21.6)	
$90,000 – $125,000	10 (29.4)	4 (14.3)	5 (16.7)	17 (23.0)	36 (21.6)	
> $125,000	12 (35.3)	10 (35.7)	12 (40.0)	36 (48.6)	70 (41.9)	
Target Child's Gender						13.2 (.039)
Male	19 (55.9)	22 (78.6)	20 (66.7)	61 (82.4)	123 (73.7)	
Female or Non-Binary	15 (44.1)	6 (21.4)	10 (33.3)	13 (17.6)	44 (26.3)	

Target Child Conduct Problems (SDQ)						(<.001)
Normal (score of 0-2)	30 (88.2)	14 (49.9)	8 (26.7)	13 (17.6)	65 (39.0)	
Borderline (score of 3)	4 (11.8)	2 (7.1)	5 (16.7)	6 (8.1)	18 (10.8)	
Abnormal (score of 4-10)	0 (0.0)	9 (32.1)	16 (53.3)	50 (67.6)	75 (45.0)	

Note. Responses of parents who selected "I prefer not to answer" for questions are not represented in this table. Participants whose children identified as female and non-binary were grouped to avoid single-participant cells and preserve anonymity.

Neurodevelopmental groups of fathers were compared on demographic variables using ANOVA, Chi-Square, or Fisher's Exact tests, as appropriate. The groups were found to differ in terms of fathers' age ($F[3, 163] = 3.60$, $p = .015$), location of residence ($X^2[3] = 33.55$, $p < .001$), paternal ND diagnoses ($X^2[3] = 41.40$, $p < .001$), child gender ($X^2[6] = 13.24$, $p = .039$), and child conduct problems ($p < .001$). The results of the Bonferroni test indicated that fathers in the NT group had more advanced age than fathers in the ASD ($p = .035$, 95% C.I. = [0.17, 7.44]) and ASD+ADHD groups ($p = .033$, 95% C.I. = [0.16, 6.04]). For categorical variables, standardized residuals were used to identify groups with frequencies that differed considerably from expected frequencies. The proportion of fathers living in Canada was greater than expected in the NT group and less than expected in the ASD and ASD+ADHD groups. The proportion of fathers with diagnoses of ASD and/or ADHD was less than expected in the NT and ASD groups and greater than expected in the ASD+ADHD group. The proportion of female target children was higher than expected in the NT group. The proportion of target children with conduct problems was lower than expected in the NT group and higher than expected in the ASD+ADHD group.

Within the dyadic sample, mothers ranged in age from 22 years to 55 years (*M* = 35.9, *SD* = 6.5). Fathers ranged in age from 25 years to 54 years (*M* = 38.3, *SD* = 6.1). Parents in this sample had between 1 and 5 children (*M* = 2.0, *SD* = 1.0). The target children that parents were asked to think of when responding to survey questions ranged in age from 5 to 17 years, with an average age of 9.8 years (*SD* = 3.6). Of the parents in the total sample, 21.1% were in the NT group (had only NT children between the ages of 2-18 years) and 78.9% were in the ASD and/or ADHD group (had a child with clinically significant levels of ASD and/or ADHD symptomology). Greater detail about the demographic information for parents in the dyadic sample can be found in Table 6.

Table 6

Sample Characteristics – Dyads

	NT Dyads n = 19	Clinical Dyads n = 71	All Dyads n = 90	Group Differences
	M (SD)	*M (SD)*	*M (SD)*	*t(p)*
Mother's Age (years)	39.3 (5.9)	35.0 (6.4)	35.9 (6.5)	2.6 (.010)
Father's Age (years)	42.2 (6.2)	37.3 (5.7)	38.3 (6.1)	3.25 (.002)
Number of Children	2.4 (1.0)	2.0 (1.0)	2.0 (1.0)	1.65 (.051)
Target Child's Age (years)	10.0 (4.5)	9.7 (3.4)	9.8 (3.6)	.207 (.838)
	n (%)	*n* (%)	*n* (%)	$X^2(p)$
Location of Residence				14.2
Canada	17 (89.5)	29 (40.8)	46 (51.1)	(< .001)
United States	2 (10.5)	42 (59.2)	44 (48.9)	
Maternal Diagnosis of ASD or ADHD	0 (0.0)	13 (18.3)	13 (14.4)	(.062)
Paternal Diagnosis of ASD or ADHD	0 (0.0)	15 (21.1)	15 (16.7)	(.034)
Maternal Ethnicity				
White	17 (89.5)	52 (73.2)	69 (76.6)	
BIPOC	3 (15.8)	21 (29.6)	24 (26.6)	
Other	0 (0.0)	1 (1.4)	1 (1.1)	

Paternal Ethnicity				
White	17 (89.5)	53 (74.6)	70 (77.8)	
BIPOC	2 (10.5)	18 (25.4)	20 (22.2)	
Other	0 (0.0)	2 (2.8)	2 (2.2)	
Maternal Education Level				(.708)
High School or Less	1 (5.3)	5 (7.0)	6 (6.7)	
Post-Secondary	18 (94.7)	65 (91.5)	83 (92.2)	
Paternal Education Level				(.109)
High School or Less	1 (5.3)	4 (5.6)	5 (5.6)	
Post-Secondary	18 (94.7)	66 (93.0)	84 (93.3)	
Marital Status				(1.00)
Common-law	0 (0.0)	2 (2.8)	2 (2.2)	
Married	19 (100.0)	69 (97.2)	88 (97.8)	
Household Income				(.903)
< $60, 000	2 (10.5)	10 (14.1)	12 (13.3)	
$60,000 - $90,000	5 (26.3)	16 (22.5)	21 (23.3)	
$90,000 – $125,000	3 (15.8)	16 (22.5)	19 (21.1)	
> $125,000	8 (42.1)	27 (38.0)	35 (38.9)	
Target Child's Gender				(.203)
Male	9 (47.4)	47 (66.2)	56 (62.2)	
Female, non-binary, or does not identify with the genders listed	10 (52.6)	24 (33.8)	34 (37.7)	
Target Child Conduct Problems (SDQ)				14.4 (< .001)
Normal (score of 0-2)	15 (78.9)	26 (36.6)	41 (45.6)	
Borderline (score of 3)	4 (21.1)	8 (11.3)	12 (13.3)	
Clinically Elevated (score of 4-10)	0 (0.0)	31 (43.7)	31 (34.4)	

Note. Responses of parents who selected "I prefer not to answer" for questions are not represented in this table.

The samples of NT dyads (paired parents of NT children) and clinical dyads (paired parents of children with ASD and/or ADHD) were compared on demographic variables using *t*-

tests, Chi-Square, or Fisher's Exact tests, as appropriate. The groups were found to differ in terms of mothers' age (t[88] = 2.64, p = .010), fathers' age (t[88] = 3.25, p = .002), location of residence (X^2[1] = 14.19, p < .001), paternal ND diagnoses (p = .034), and child conduct problems (X^2[2] = 14.42, p < .001). Mothers in the NT group had more advanced age than mothers in the clinical group. Fathers in the NT group had more advanced age than fathers in the clinical group. For categorical variables, standardized residuals were used to identify groups with frequencies that differed considerably from expected frequencies. In the NT group, a greater than expected proportion of dyads were living in Canada. The proportion of dyads in which fathers had diagnoses of ASD and/or ADHD was less than expected in the NT group. The proportion of target children with conduct problems was lower than expected in the NT group.

In addition, associations between paired mothers' and fathers' scores for coparenting quality, FQOL, and the components of these variables were calculated. The coparenting and FQOL correlations for paired mothers and fathers of NT children can be found in Table 7. The coparenting and FQOL correlations for paired mothers and fathers of children with ASD and/or ADHD can be found in Table 8.

Table 7

Correlations Between Mothers' and Fathers' Coparenting and FQOL Scores – Paired Parents of NT Children

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Coparenting – Total	.202	.865**	.713**	-.088	.755**	-.771**	.860**	.817**	.434	.379	.687**	.084	.448	.072
2. Coparenting Agreement	.509*	-.214	.525*	-.131	.769**	-.651**	.574*	.814**	.410	.346	.671**	.189	.379	.001
3. Coparenting Closeness	.838**	.155	.154	.190	.558*	-.273	.527*	.670**	.060	-.080	.362	-.137	.102	-.120
4. Exposure to Conflict	-.833**	-.322	-.643**	.630*	-.052	-.063	-.052	-.035	.091	-.069	.191	-.099	.166	.174
5. Coparenting Support	.916**	.436	.841**	-.754**	.305	-.385	.410	.740**	.272	.190	.583*	.002	.255	-.037
6. Coparenting Undermining	-.811**	-.481*	-.501**	.659**	-.699**	.525*	-.822**	-.475	-.590*	-.529*	-.687**	-.222	-.654**	-.292
7. Endorsement of Partner Parenting	.496*	.037	.320	-.404	.244	-.243	-.116	.495	.573*	.567*	.674**	.207	.572*	.285
8. Division of Labor	.211	-.226	.291	-.279	-.023	.018	.379	.108	.002	-.007	.311	-.286	.064	-.252
9. FQOL – Total	.796**	.243	.827**	-.579**	.706**	-.536*	.494*	.293	.569*	.906**	.934**	.863**	.764**	.570*
10. Family Interaction	.799**	.180	.855**	-.672**	.721**	-.522*	.409	.407	.939**	.417	.796**	.759**	.699**	.379
11. Parenting	.719**	.118	.760**	-.490*	.617**	-.490*	.566*	.311	.966**	.864**	.637**	.828**	.616**	.379
12. Emotional Well-Being	.768**	.146	.818**	-.564*	.714**	-.448	.506*	.420	.911**	.863**	.892**	.566*	.387	.308
13. Physical/ Material Well-Being	.616**	.311	.630**	-.377	.559*	-.529*	.260	-.065	.828**	.661**	.797**	.630**	.361	.670**
14. Disability-Related Support	.663**	.484*	.598**	-.453	.542*	-.422	.459*	.116	.842**	.786**	.757**	.642**	.699**	.138

Note. Correlations between mothers' scores are above the diagonal. Correlations between fathers' scores are below the diagonal. Correlations between mothers' and fathers' scores are on the diagonal. * Correlation is significant at the .05 level. ** Correlation is significant at the .01 level.

Table 8

Correlations Between Mothers' and Fathers' Coparenting and FQOL Scores – Paired Parents of Children with ASD and/or ADHD

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Coparenting – Total	.731**	.489**	.693**	-.770**	.443**	-.832**	.784**	.668**	.112	.304	.139	.039	-.085	-.029
2. Coparenting Agreement	.648**	.642**	.092	-.309*	-.088	-.548**	.188	.311*	-.167	-.014	-.078	-.163	-.207	-.225
3. Coparenting Closeness	.497**	.048	.594**	-.438**	.749**	-.290*	.661**	.160	.413**	.535**	.324*	.400**	.137	.117
4. Exposure to Conflict	-.782**	-.555**	-.197	.796**	-.115	.632**	-.458**	-.487**	.031	-.131	.070	.066	.069	.053
5. Coparenting Support	.363**	-.133	.793**	-.011	.471**	-.006	.538**	.013	.496**	.497**	.453**	.451**	.135	.282*
6. Coparenting Undermining	-.835**	-.623**	-.088	.674**	.078	.698**	-.490**	-.791**	.204	-.024	.140	.271*	.191	.222
7. Endorsement of Partner Parenting	.817**	.420**	.501**	-.434**	.511**	-.569**	.287*	.409**	.320*	.370**	.390**	.228	.015	.142
8. Division of Labor	.705**	.468**	.031	-.508**	-.035	-.772**	.526**	.696**	-.190	-.025	-.111	-.241	-.249	-.131
9. FQOL – Total	.017	-.182	.308*	.090	.450**	.212	.152	-.155	.620**	.774**	.872**	.761**	.623**	.741**
10. Family Interaction	.222	-.060	.422**	-.113	.472**	.031	.291	-.010	.760**	.522**	.596**	.412**	.453**	.472**
11. Parenting	.082	-.129	.305*	.059	.449**	.147	.219	-.052	.865**	.667**	.276*	.600**	.429**	.608**
12. Emotional Well-Being	-.186	-.315*	.219*	.230	.374**	.385**	-.094	-.300*	.756**	.430**	.569**	.576**	.295*	.466**
13. Physical/ Material Well-Being	.021	-.039	.040	.045	.147	.038	.141	-.082	.739**	.400**	.531**	.371**	.574**	.311**
14. Disability-Related Support	-.059	-.145	.113	.117	.295*	.204	.052	-.147	.827**	.506**	.627**	.541**	.657**	.507**

Note. Correlations between mothers' scores are above the diagonal. Correlations between fathers' scores are below the diagonal. Correlations between mothers' and fathers' scores are on the diagonal. * Correlation is significant at the .05 level. ** Correlation is significant at the .01 level.

Scale Reliability

Cronbach's alphas were calculated to measure the reliability of the scales included for both sample descriptive purposes and analyses in the current study. Cronbach's alphas calculated based on mothers' responses can be found in Table G-1 in Appendix G. Cronbach's alphas calculated based on fathers' responses can be found in Table G-1 in Appendix G.

Descriptive Statistics

Descriptive statistics for key variables relating to the research questions were calculated. Descriptive statistics corresponding to mothers in the total sample and in the neurodevelopmental subsamples are displayed in Table 9. Descriptive statistics for fathers in the total sample and the neurodevelopmental subsamples are displayed in Table 10. Finally, descriptive statistics pertaining to the dyads in the total sample, the NT subsample, and the clinical subsamples are displayed in Table 11.

Table 9

Descriptive Statistics – Mothers

	NT Group $n = 92^a$	ASD Group $n = 15^b$	ADHD Group $n = 106^c$	ASD+ADHD Group $n = 75^d$	All Mothers $n = 289^e$
Variable	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*
Child Age	9.2 (3.8)	9.4 (4.0)	10.2 (3.7)	9.7 (3.3)	9.7 (3.6)
Child Cognitive Functioning	112.1(18.7)	96.4 (33.1)	104.0 (14.4)	83.0 (23.1)	100.6 (22.7)
Child ASD Symptoms	4.0 (3.5)	18.8 (4.7)	6.9 (4.1)	22.3 (6.1)	10.6 (8.9)
Child ADHD Symptoms	43.3 (26.5)	51.8 (27.2)	92.2 (5.9)	93.9 (5.5)	75.1 (28.8)
Coparenting Quality	4.7 (0.9)	4.3 (1.4)	4.2 (1.0)	4.1 (1.2)	4.3 (1.1)
Coparenting Agreement	4.3 (1.4)	4.1 (1.6)	3.8 (1.4)	3.7 (1.5)	3.9 (1.5)
Coparenting Closeness	4.5 (1.3)	4.7 (1.4)	3.8 (1.5)	4.0 (1.4)	4.1 (1.4)
Exposure to Conflict	0.8 (0.8)	1.2 (1.9)	1.1 (1.0)	1.3 (1.4)	1.1 (1.1)

Coparenting Support	4.6 (1.5)	4.5 (1.8)	4.0 (1.5)	4.0 (1.6)	4.2 (1.5)
Coparenting Undermining	0.8 (1.0)	1.9 (2.3)	1.3 (1.3)	1.5 (1.5)	1.2 (1.4)
Endorsement of Partner's Parenting	4.6 (1.1)	4.2 (1.5)	4.2 (1.2)	4.0 (1.3)	4.3 (1.2)
Division of Labor	4.0 (1.7)	3.5 (2.1)	3.7 (1.9)	3.5 (1.7)	3.7 (1.8)
Family Quality of Life (FQOL)	4.2 (0.6)	4.2 (0.7)	3.8 (0.5)	3.6 (0.6)	3.9 (0.6)
Family Interaction	4.2 (0.7)	4.2 (0.9)	3.9 (0.6)	3.8 (0.7)	4.0 (0.7)
Parenting	4.2 (0.7)	4.1 (0.7)	3.8 (0.6)	3.6 (0.7)	3.9 (0.7)
Emotional Well-Being	3.8 (1.1)	4.1 (0.8)	3.1 (1.0)	2.9 (1.0)	3.3 (1.1)
Physical/Material Well-Being	4.4 (0.6)	4.2 (0.8)	4.2 (0.6)	3.9 (0.8)	4.2 (0.7)
Disability-Related Support	4.3 (0.6)	4.2 (0.7)	3.8 (0.7)	3.7 (0.9)	3.9 (0.8)

[a] The number of mothers in the NT group who completed the measures associated with these scores varied: Coparenting Quality (Coparenting Relationship Scale [CRS]), Coparenting Agreement, Coparenting Closeness, Exposure to Conflict, Coparenting Support, Coparenting Undermining, and Endorsement of Partner's Parenting n = 76, Division of Labor n = 75, FQOL, Physical/Material Well-Being, and Disability-Related Support n = 91.

[b] The number of mothers in the ASD group who completed the measures associated with these scores varied: Child Cognitive Functioning (Developmental Profile 4 [DP-4]– Cognitive Scale) n = 14, Coparenting Quality (CRS), Coparenting Agreement, Coparenting Closeness, Coparenting Support, Coparenting Undermining, and Endorsement of Partner's Parenting n = 11, Exposure to Conflict and Division of Labor n = 10.

[c] The number of mothers in the ADHD group who completed the measures associated with these scores varied: Coparenting Quality (CRS), Coparenting Agreement, Coparenting Closeness, Coparenting Support, and Coparenting Undermining n = 95, Exposure to Conflict, Endorsement of Partner's Parenting, and Division of Labor n = 96, FQOL, Parenting and Physical/Material Well-Being n = 105.

[d] The number of mothers in the ASD+ADHD group who completed the measures associated with these scores varied: Child Cognitive Functioning (Developmental Profile 4 [DP-4]– Cognitive Scale) n = 74, Coparenting Quality (CRS), Coparenting Agreement, Coparenting Closeness, Exposure to Conflict, Coparenting Support, Coparenting Undermining, Endorsement of Partner's Parenting, and Division of Labor n = 68.

[e] The number of mothers in the total sample who completed the measures associated with these scores varied: Child Cognitive Functioning (DP-4 – Cognitive Scale) n = 287, Coparenting Quality (CRS), Coparenting Agreement, Coparenting Closeness, Exposure to Conflict, Coparenting Support, and Coparenting Undermining n = 251, Endorsement of Partner's Parenting n = 252, Division of Labor n = 250, FQOL and Physical/Material Well-Being n = 287, Parenting and Disability-Related Support n = 288.

Table 10

Descriptive Statistics – Fathers

	NT Group $n = 34$[a]	ASD Group $n = 28$[b]	ADHD Group $n = 30$[c]	ASD+ADHD Group $n = 74$[d]	All Fathers $n = 167$[e]
Variable	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*
Child Age	8.0 (3.0)	8.8 (3.0)	9.1 (4.0)	9.4 (2.9)	8.96 (3.1)
Child Cognitive Functioning	115.7 (22.4)	85.5 (31.6)	107.9 (32.9)	89.3 (29.2)	97.5 (31.2)
Child ASD Symptoms	6.2 (3.9)	17.7 (2.6)	10.3 (3.7)	17.6 (3.3)	13.9 (5.9)
Child ADHD Symptoms	41.6 (25.0)	51.6 (23.6)	90.7 (5.8)	93.3 (4.9)	75.0 (27.4)
Coparenting Quality	4.6 (1.0)	3.8 (0.8)	3.9 (0.8)	3.3 (0.8)	3.8 (1.0)
Coparenting Agreement	4.3 (1.3)	2.8 (1.1)	3.5 (1.1)	2.5 (1.1)	3.1 (1.3)
Coparenting Closeness	4.5 (1.3)	4.3 (0.9)	4.3 (0.8)	4.2 (0.9)	4.3 (1.0)
Exposure to Conflict	0.9 (1.1)	2.0 (1.9)	1.7 (1.6)	3.9 (1.9)	2.5 (2.1)
Coparenting Support	4.5 (1.4)	4.9 (1.1)	4.1 (1.2)	4.7 (1.0)	4.6 (1.2)
Coparenting Undermining	1.6 (1.5)	3.3 (1.5)	2.5 (1.5)	4.0 (1.6)	3.1 (1.8)
Endorsement of Partner's Parenting	4.9 (0.9)	4.0 (0.8)	4.1 (0.9)	4.1 (0.8)	4.3 (0.9)
Division of Labor	4.0 (1.6)	3.1 (1.9)	2.9 (1.8)	1.8 (1.7)	2.7 (1.9)
FQOL	4.3 (0.5)	3.9 (0.4)	4.1 (0.5)	3.9 (0.6)	4.0 (0.5)
Family Interaction	4.3 (0.6)	3.9 (0.5)	4.2 (0.5)	3.9 (0.7)	4.0 (0.7)
Parenting	4.3 (0.6)	4.0 (0.4)	4.2 (0.5)	3.9 (0.7)	4.1 (0.6)
Emotional Well-Being	4.0 (0.6)	3.9 (0.6)	3.9 (0.6)	3.8 (0.7)	3.9 (0.6)
Physical/Material Well-Being	4.4 (0.6)	3.9 (0.4)	4.1 (0.6)	4.0 (0.6)	4.1 (0.6)
Disability-Related Support	4.3 (0.6)	3.9 (0.5)	4.1 (0.8)	3.9 (0.6)	4.0 (0.6)

[a] The number of fathers in the NT group who completed the measures associated with these scores varied: Child Cognitive Functioning (Developmental Profile 4 [DP-4]– Cognitive Scale) $n = 33$.

[b] The number of fathers in the ASD group who completed the measures associated with these scores varied: Coparenting Quality (Coparenting Relationship Scale [CRS]), Coparenting Agreement, Coparenting Closeness, Exposure to Conflict, Coparenting Undermining, Endorsement of Partner's Parenting, and Division of Labor $n = 27$, Coparenting Support $n = 26$.

[c] The number of fathers in the ADHD group who completed the measures associated with these scores varied: Coparenting Quality (CRS), Coparenting Agreement, Coparenting Closeness, Exposure to Conflict, Coparenting Support, Coparenting Undermining, Endorsement of Partner's Parenting, and Division of Labor $n = 27$.

[d] The number of fathers in the ASD+ADHD group who completed the measures associated with these scores varied: Child Cognitive Functioning (DP-4 – Cognitive Scale) *n* = 74, Coparenting Quality (CRS) *n* = 68, Coparenting Agreement and Coparenting Closeness *n* = 66, Exposure to Conflict, Coparenting Support, and Endorsement of Partner's Parenting *n* = 65, Coparenting Undermining and Division of Labor *n* = 64, Family Interaction, Parenting, Emotional Well-Being, Physical/Material Well-Being, and Disability-Related Support *n* = 73.

[e] The number of fathers in the total sample who completed the measures associated with these scores varied: Child Cognitive Functioning (DP-4 – Cognitive Scale) *n* = 165, Coparenting Quality (CRS), Exposure to Conflict, and Endorsement of Partner's Parenting *n* = 154, Coparenting Agreement and Coparenting Closeness *n* = 155, Coparenting Support, Coparenting Undermining, and Division of Labor *n* = 153, FQOL Family Interaction, Parenting, Emotional Well-Being, Physical/Material Well-Being, and Disability-Related Support *n* = 166.

Table 11

Descriptive Statistics – Dyads

	NT Dyads *n* = 19[a]	Clinical Dyads *n* = 71[b]	All Dyads *n* = 90[c]
Variable	*M (SD)*	*M (SD)*	*M (SD)*
Child Age	10.2 (4.6)	9.7 (3.4)	9.8 (3.6)
Child Cognitive Functioning	112.9 (19.1)	82.1 (25.6)	88.3 (27.5)
Child ASD Symptoms	3.4 (3.1)	16.9 (6.5)	14.1 (8.1)
Child ADHD Symptoms	36.7 (23.9)	79.5 (25.7)	70.5 (30.7)
Coparenting Quality	5.0 (0.4)	3.9 (0.9)	4.1 (1.0)
FQOL	4.2 (0.5)	4.0 (0.5)	4.1 (0.5)

[a] The number of parents in the sample of NT dyads who completed the measures associated with these scores varied: Coparenting Quality (Coparenting Relationship Scale [CRS]) *n* = 15.

[b] The number of parents in the sample of Clinical dyads who completed the measures associated with these scores varied: Child Cognitive Functioning (Developmental Profile 4 [DP-4]– Cognitive Scale) *n* = 69, Coparenting Quality (CRS) *n* = 60.

[c] The number of parents in the total sample of dyads who completed the measures associated with these scores varied: Child Cognitive Functioning (DP-4 – Cognitive Scale) *n* = 88, Coparenting Quality (CRS) *n* = 75.

Research Question 1: Coparenting Quality Across Neurodevelopmental Groups

1a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Coparenting Quality?

A one-way ANOVA was conducted to compare levels of coparenting quality between mothers in the four neurodevelopmental groups (families of children with ASD, ADHD, ASD+ADHD, and NT children). Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 247) = (4.41)$, $p = .005$. These results are displayed in Table 12. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to coparenting quality. Results of the Bonferroni test indicated that the mean coparenting quality scores differed significantly between the NT group and the ADHD group ($p = .016$, 95% C.I. = [0.60, 0.92]), as well as the NT group and the ASD+ADHD group ($p = .006$, 95% C.I. = [0.12, 1.06]), such that the mean for the NT group was higher than both the ADHD and ASD+ADHD groups. For a visual depiction of the levels of coparenting quality reported by mothers across neurodevelopmental groups, see Figure 4.

Table 12

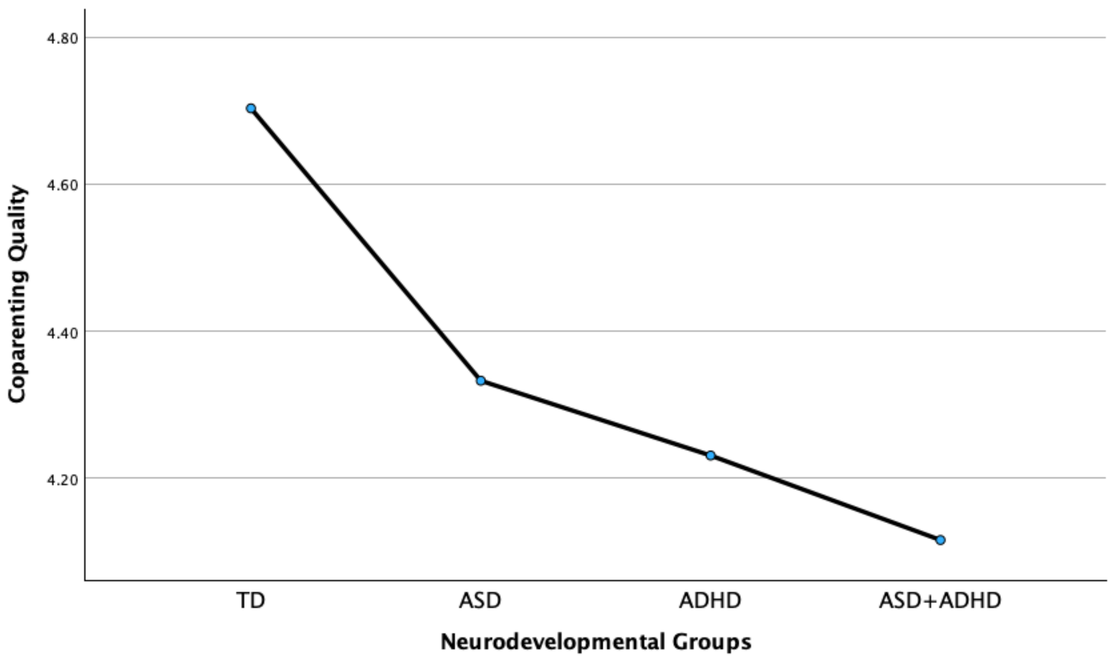
RQ 1a – Mothers' Coparenting Quality Across Groups

Measure	NT Group (n = 76)		ASD Group (n = 11)		ADHD Group (n = 96)		ASD+ADHD Group (n = 68)		$F(3, 247)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Coparenting Quality	4.70	0.95	4.33	1.35	4.23	1.00	4.12	1.17	4.41^{**}	.05

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Figure 4

RQ 1a – Graph Representing Mothers' Coparenting Quality Across Groups



1b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Coparenting Quality?

A one-way ANOVA was conducted to compare levels of coparenting quality between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups ($F(3, 150) = [17.47]$, $p < .001$). These results are displayed in Table 13. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to coparenting quality. Results of the Bonferroni test indicated that the mean coparenting quality scores differed significantly between the NT group and the ASD group (p = .003, 95% C.I. = [0.20, 1.37]), the NT group and the ADHD group (p = .020, 95% C.I. = [0.07, 1.23]), the NT group and the ASD+ADHD group (p < .001, 95% C.I. = [0.80, 1.76]), as well as the ADHD group and the ASD+ADHD group (p = .009, 95% C.I. = [0.11, 1.15]). These groups differ such that the mean for the NT group was significantly higher than the means of all three clinical groups (ASD, ADHD, and ASD+ADHD) and the mean of the ADHD group was significantly higher than the mean of the ASD+ADHD group. For a visual depiction of the levels of coparenting quality reported by fathers across neurodevelopmental groups, see Figure 5.

Table 13

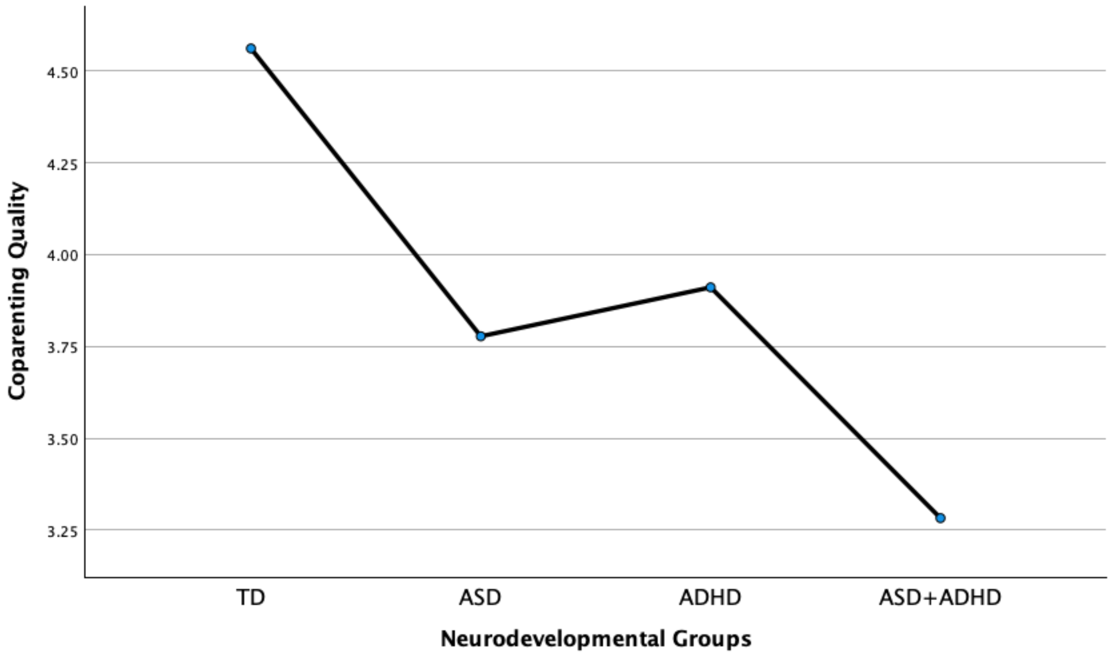
RQ 1b – Fathers' Coparenting Quality Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 27)		ADHD Group (n = 27)		ASD+ADHD Group (n = 65)		$F(3, 150)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Coparenting Quality	4.56	0.97	3.78	0.82	3.91	0.79	3.28	0.98	17.47***	.26

*p < .05. **p < .01. ***p < .001

Figure 5

RQ 1b – Graph Representing Fathers' Coparenting Quality Across Groups



Research Question 2: FQOL Across Neurodevelopmental Groups

2a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of FQOL?

A one-way ANOVA was conducted to compare levels of FQOL between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 283) = (14.34)$, $p < .001$. These results are displayed in Table 14. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to FQOL. Results of the Bonferroni test indicated that the mean FQOL scores differed significantly between the NT group and the ADHD group ($p < .001$, 95% C.I. = [0.14, 0.60]), the NT group and the

ASD+ADHD group ($p < .001$, 95% C.I. = [0.33, 0.82]), as well as the ASD group and the ASD+ADHD group ($p = .009$, 95% C.I. = [0.09, 0.99]). These groups differ such that the mean of the NT group was significantly higher than the means of the ADHD and ASD+ADHD groups, and the mean of the ASD group was significantly higher than the mean of the ASD+ADHD group. For a visual depiction of the levels of FQOL reported by mothers across neurodevelopmental groups, see Figure 6.

Table 14

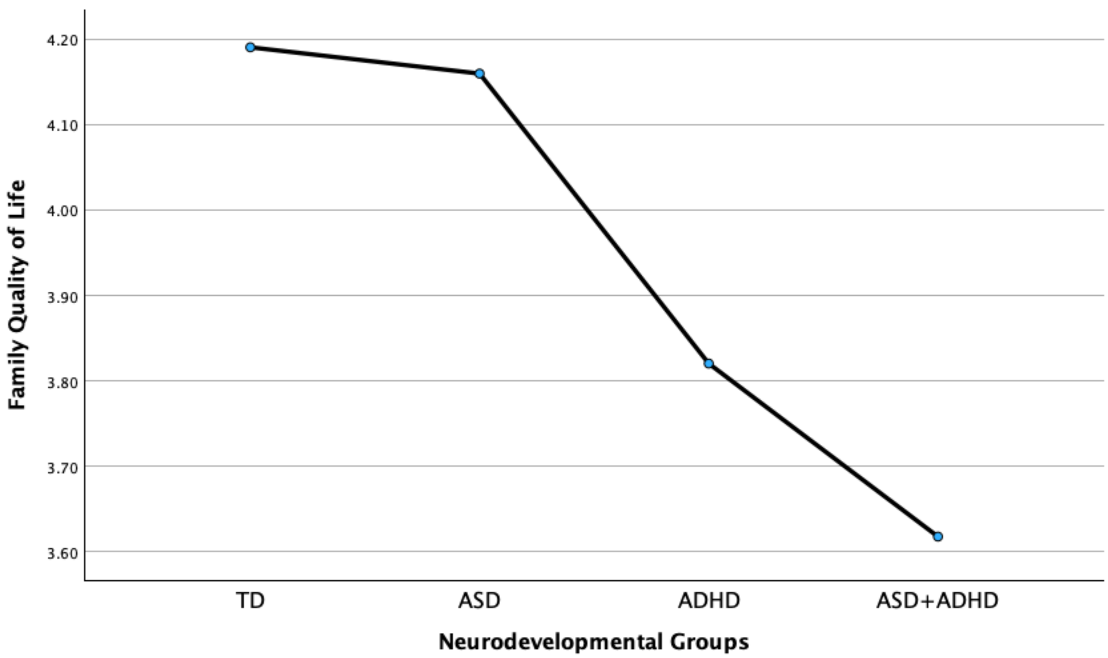
RQ 2a – Mothers' FQOL Across Groups

Measure	NT Group ($n = 91$)		ASD Group ($n = 15$)		ADHD Group ($n = 106$)		ASD+ADHD Group ($n = 75$)		$F(3, 283)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
FQOL	4.19	0.61	4.16	0.74	3.82	0.55	3.62	0.62	14.34^{***}	.13

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Figure 6

RQ 2a – Graph Representing Mothers' FQOL Across Groups



2b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of FQOL?

A one-way ANOVA was conducted to compare levels of FQOL between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 162) = 3.95$, $p = .009$. These results are displayed in Table 15. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to FQOL. Results of the Bonferroni test indicated that the mean FQOL scores differed significantly between the NT group and the ASD+ADHD group ($p < .010$, 95% C.I. = [0.06, 0.63]), such that the mean of the NT group was significantly higher than the mean of the ASD+ADHD groups. For a visual depiction of the levels of FQOL reported by fathers across neurodevelopmental groups, see Figure 7.

Table 15

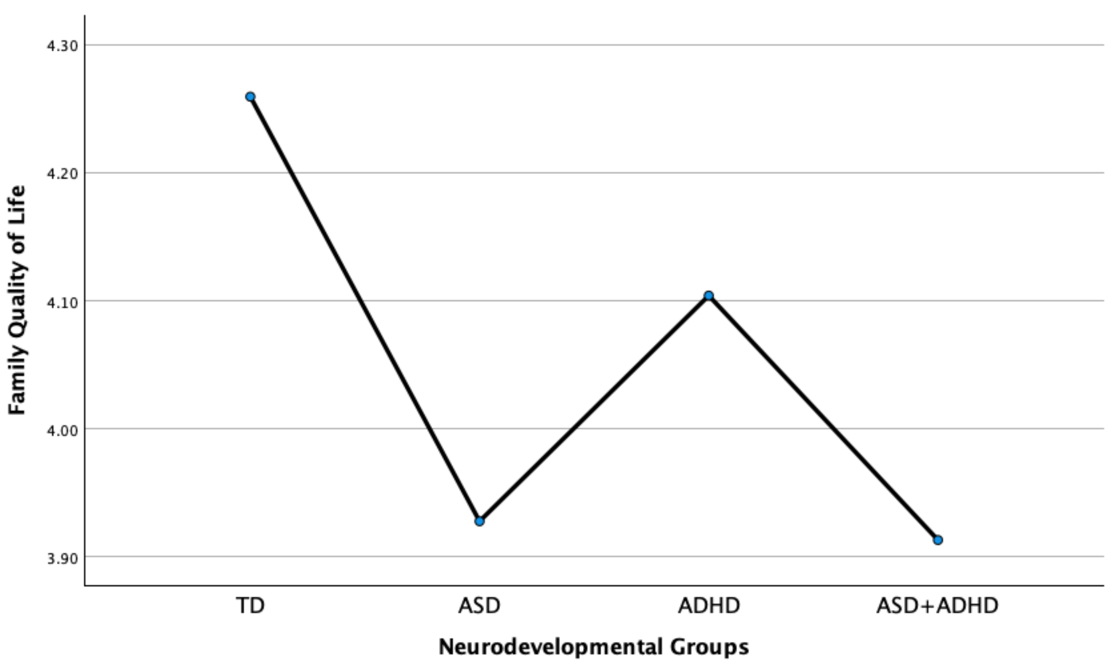
RQ 2b – Fathers' FQOL Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 28)		ADHD Group (n = 30)		ASD+ADHD Group (n = 73)		F(3, 162)	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
FQOL	4.26	0.52	3.93	0.40	4.10	0.46	3.91	0.59	3.95^{**}	.07

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Figure 7

RQ 2b – Graph Representing Fathers' FQOL Across Groups



Research Question 3: Coparenting Quality Between Paired Mothers and Fathers

3a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Coparenting Quality?

A paired samples *t*-test was performed to determine whether there was a difference between the reported coparenting quality scores of paired mothers and fathers of NT children. While, on average, mothers ($M = 4.99$, $SD = 0.80$) reported higher levels of coparenting quality than fathers ($M = 4.70$, $SD = 0.72$) in the NT group, the results indicated that this difference did not reach statistical significance, $t(14) = 2.03$, $p = .062$. These results are displayed in Table 16.

Table 16

RQ 3a – Coparenting Quality of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(14)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Coparenting Quality	4.99	0.80	4.70	0.72	2.03	.062	0.523

3b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Coparenting Quality?

A paired samples *t*-test was performed to determine whether there was a difference between the reported coparenting quality scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in coparenting quality scores between mothers ($M = 3.88$, $SD = 0.99$) and fathers ($M = 3.82$, $SD = 0.95$) in the clinical (ASD and/or ADHD) sample, $t(56) = 0.70$, $p = .486$. These results are displayed in Table 17.

Table 17

RQ 3b – Coparenting Quality of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		*t*(56)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Coparenting Quality	3.88	0.99	3.82	0.95	0.70	.486	0.093

Research Question 4: FQOL Between Paired Mothers and Fathers

4a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of FQOL?

A paired samples *t*-test was performed to determine whether there was a difference between the reported FQOL scores of paired mothers and fathers of NT children. The results indicated that there was no significant difference in FQOL scores between mothers ($M = 4.32$, $SD = 0.49$) and fathers ($M = 4.15$, $SD = 0.53$) in the NT sample, $t(18) = 1.55$, $p = .139$. These results are displayed in Table 18.

Table 18

RQ 4a – FQOL of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(18)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
FQOL	4.32	0.49	4.15	0.53	1.55	.139	0.355

4b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of FQOL?

A paired samples *t*-test was performed to determine whether there was a difference between the reported FQOL scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in FQOL scores between mothers (*M* = 3.98, *SD* = 0.54) and fathers (*M* = 3.98, *SD* = 0.51) in the clinical sample, $t(66) = -0.06$, $p = .957$. These results are displayed in Table 19.

Table 19

RQ 4b – FQOL of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		*t*(66)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
FQOL	3.98	0.54	3.98	0.51	-0.06	.957	-0.007

Research Question 5: Coparenting Quality as a Predictor of FQOL

5a. Does Greater Coparenting Quality Predict Higher FQOL in Mothers of NT Children After Controlling for Child Cognitive Functioning and Child Age?

To answer RQ 5a, a hierarchical multiple regression was conducted to assess the ability of coparenting quality to predict FQOL in mothers of NT children. Variables were entered in two steps. First, level of child cognitive functioning and child age were entered into the regression model in Step 1 in order to control for the effects of these variables. In Step 2, coparenting quality was added into the model as a predictor of FQOL, the dependent variable. Correlations between the variables involved in this analysis can be found in Table 20. Overall, the results indicated that the first model was not significant $F(2, 72) = .75$, $p = .477$, $R^2 = .02$. Neither child age ($b = 0.003$, $t = 0.14$, $p = .892$) nor cognitive functioning ($b = 0.005$, $t = 1.03$, $p = .308$) were significantly associated with FQOL. The second model ($F(3, 71) = 13.02$, $p < .001$, $R^2 = .36$), which included coparenting quality ($b = 0.35$, $t = 6.07$, $p < .001$) showed significant improvement from the first model $\Delta F(1, 71) = 36.82$, $p < .001$, $\Delta R^2 = .34$. Overall, when child age and cognitive functioning were included in the model, the variables explained 2.0% of the variance in FQOL, with the final model, including coparenting quality accounting for 35.5% of the variance in FQOL. Therefore, the change from model one to model two represented a shift from a small effect size to a large effect size. A summary of the results of this analysis can be found in Table 21.

Table 20

Correlation Matrix – Mothers of NT Children

Measure	*N*	*M*	*SD*	1	2	3
1. Child Age	75	10.11	3.54	-		
2. Child Cognitive Functioning	75	109.59	17.56	$-.633^{***}$	-	
3. Coparenting Quality	75	4.69	0.95	-.033	$.236^{*}$	-
4. FQOL	75	4.21	0.56	-.077	.142	$.591^{***}$

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Table 21

Summary of Hierarchical Regression Analysis of Variables Predicting FQOL of Mothers of NT Children

Predictor	*B*	*SE B*	β	R^2
Step 1				.020
Child Age	0.003	0.024	0.021	
Child Cognitive Functioning	0.005	0.005	0.155	
Step 2				$.355^{***}$
Child Age	-0.015	0.020	-0.096	
Child Cognitive Functioning	-0.002	0.004	-0.062	
Coparenting Quality	0.352	0.058	0.603	

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

5b. Does Greater Coparenting Quality Predict Higher FQOL in Fathers of NT Children After Controlling for Child Cognitive Functioning and Child Age?

To answer RQ 5b, a hierarchical multiple regression was conducted to assess the ability of coparenting quality to predict FQOL in fathers of NT children. Variables were entered into the model in the same manner as was described for RQ5a. Correlations between the variables involved in this analysis can be found in Table 22. Overall, the results indicated that the first model was not significant $F(2, 30) = .19$, $p = .827$, $R^2 = .01$. Neither child age ($b = -0.023$, $t = -0.58$, $p = .570$) nor cognitive functioning ($b = -0.001$, $t = -0.11$, $p = .915$) were significantly associated with FQOL. The second model ($F[3, 29] = 5.49$, $p = .004$, $R^2 = .36$), which included coparenting quality ($b = 0.341$, $t = 3.99$, $p < .001$) showed significant improvement from the first model $\Delta F(1, 29) = 15.90$, $p < .001$, $\Delta R^2 = .35$. Overall, when child age and cognitive functioning were included in the model, the variables explained 1.3% of the variance in FQOL, with the final model, including coparenting quality, accounting for 36.2% of the variance in FQOL. Therefore, the change from model one to model two represented a shift from a nonsignificant effect size to a large effect size. A summary of the results of this analysis can be found in Table 23.

Table 22

Correlation Matrix – Fathers of NT Children

Measure	*N*	*M*	*SD*	1	2	3
1. Child Age	33	7.88	0.53	-		
2. Child Cognitive Functioning	33	115.73	22.44	$-.526^{**}$	-	
3. Coparenting Quality	33	4.56	0.97	-.056	.284	-
4. FQOL	33	4.23	0.53	-.111	.041	$.564^{***}$

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Table 23

Summary of Hierarchical Regression Analysis of Variables Predicting FQOL of Fathers of NT Children

Predictor	*B*	*SE B*	β	R^2
Step 1				.013
Child Age	-0.023	0.039	-0.123	
Child Cognitive Functioning	-0.001	0.005	-0.023	
Step 2				$.362^{***}$
Child Age	-0.037	0.032	-0.203	
Child Cognitive Functioning	-0.006	0.004	-0.241	
Coparenting Quality	0.341	0.086	0.621	

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

5c. Does Greater Coparenting Quality Predict Higher Composite FQOL in Paired Parents (Mother-Father Dyads) of NT Children After Controlling for Child Cognitive Functioning and Child Age?

To answer RQ 5c, a hierarchical multiple regression was conducted to assess the ability of coparenting quality to predict composite FQOL in paired parents of NT children. Variables were entered into the model in the same manner as was described for RQ5a. Correlations between the variables involved in this analysis can be found in Table 24. Overall, the results indicated that the first model was just slightly short of significance $F(2, 12) = 3.84$, $p = .051$, $R^2 = .39$. Both child age ($b = -0.043$, $t = -2.49$, $p = .028$) and cognitive functioning ($b = -0.011$, $t = -2.43$, $p = .032$) were significantly associated with FQOL. The second model ($F[3, 11] = 6.70$, $p = .008$, $R^2 = .65$), which included coparenting quality ($b = 0.397$, $t = 2.82$, $p = .017$) showed significant improvement from the first model $\Delta F(1, 11) = 7.98$, $p = .017$, $\Delta R^2 = .26$. Overall, when child age and cognitive functioning were included in the model, the variables explained 39.0% of the variance in FQOL, with the final model, including coparenting quality accounting for 64.6% of the variance in FQOL. While, both models had a large effect size, the second model also reached statistical significance. A summary of the results of this analysis can be found in Table 25.

Table 24

Correlation Matrix – Paired Parents of NT Children

Measure	*N*	*M*	*SD*	1	2	3
1. Child Age	15	11.6	4.22	-		
2. Child Cognitive Functioning	15	108.40	16.18	-.578*	-	
3. Coparenting Quality	15	4.97	0.36	-.314	.249	-
4. FQOL	15	4.29	0.27	.302	-.272	.528*

$^*p < .05$. $^{**}p < .01$. $^{***}p < .001$

Table 25

Summary of Hierarchical Regression Analysis of Variables Predicting Composite FQOL of Paired Parents of NT Children

Predictor	*B*	*SE B*	β	R^2
Step 1				.390
Child Age	-0.043	0.017	-0.689	
Child Cognitive Functioning	-0.011	0.005	-0.670	
Step 2				.646*
Child Age	-0.035	0.014	-0.552	
Child Cognitive Functioning	-0.012	0.004	-0.724	
Coparenting Quality	0.397	0.141	0.535	

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

5d. Does Greater Coparenting Quality Predict Higher FQOL in Mothers of Children with ASD After Controlling for Child Cognitive Functioning and Child Age?

To answer RQ 5d, a hierarchical multiple regression was conducted to assess the ability of coparenting quality to predict FQOL in mothers of children with ASD. Variables were entered into the model in the same manner as was described for RQ5a. Correlations between the variables involved in this analysis can be found in Table 26. Overall, the results indicated that the first model was not significant $F(2, 7) = 2.33$, $p = .167$, $R^2 = .40$. Neither child age ($b = 0.122$, $t = 1.91$, $p = .098$) nor cognitive functioning ($b = 0.011$, $t = 1.383$, $p = .209$) were significantly associated with FQOL. The second model ($F(3, 6) = 1.374$, $p = .338$, $R^2 = .007$), which included coparenting quality ($b = 0.060$, $t = 0.27$, $p = .797$) was also not significant and did not show significant improvement from the first model $\Delta F(1, 6) = 0.07$, $p = .797$, $\Delta R^2 = .01$. A summary of the results of this analysis can be found in Table 27.

Table 26

Correlation Matrix – Mothers of Children with ASD

Measure	*N*	*M*	*SD*	1	2	3
1. Child Age	10	10.90	3.96	-		
2. Child Cognitive Functioning	10	89.40	31.05	-.202	-	
3. Coparenting Quality	10	4.41	1.40	.517	.018	-
4. FQOL	10	4.20	0.85	.486	.298	.374

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Table 27

Summary of Hierarchical Regression Analysis of Variables Predicting FQOL of Mothers Children with ASD

Predictor	*B*	*SE B*	β	R^2
Step 1				.400
Child Age	0.122	0.064	0.569	
Child Cognitive Functioning	-0.011	0.005	-0.670	
Step 2				.407
Child Age	0.110	0.081	0.515	
Child Cognitive Functioning	0.011	0.009	0.401	
Coparenting Quality	0.060	0.225	0.100	

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

5e. Does Greater Coparenting Quality Predict Higher FQOL in Fathers of Children with ASD After Controlling for Child Cognitive Functioning and Child Age?

To answer RQ 5e, a hierarchical multiple regression was conducted to assess the ability of coparenting quality to predict FQOL in fathers of children with ASD. Variables were entered into the model in the same manner as was described for RQ5a. Correlations between the variables involved in this analysis can be found in Table 28. Overall, the results indicated that the first model was not significant $F(2, 24) = 2.89$, $p = .075$, $R^2 = .19$. Child age ($b = 0.061$, $t = 2.36$, $p = .027$), but not cognitive functioning ($b = 0.001$, $t = 0.31$, $p = .314$), was significantly associated with FQOL. The second model (*F*[3, 23] = 5.70, $p = .005$, $R^2 = .43$), which included coparenting quality ($b = 0.299$, $t = 3.05$, $p = .006$) showed significant improvement from the first model $\Delta F(1, 23) = 9.30$, $p = .006$, $\Delta R^2 = .23$. Overall, when child age and cognitive functioning were included in the model, the variables explained 19.4% of the variance in FQOL, with the final model, including coparenting quality accounting for 42.6% of the variance in FQOL. Therefore, the change from model one to model two represented a shift from a nonsignificant effect size to a large effect size. A summary of the results of this analysis can be found in Table 29.

Table 28

Correlation Matrix – Fathers of Children with ASD

Measure	*N*	*M*	*SD*	1	2	3
1. Child Age	27	8.96	2.93	-		
2. Child Cognitive Functioning	27	84.81	32.02	-.327*	-	
3. Coparenting Quality	27	3.78	0.82	-.105	.639***	-
4. FQOL	27	3.95	0.39	.437*	-.088	.358*

*$p < .05$. **$p < .01$. ***$p < .001$

Table 29

Summary of Hierarchical Regression Analysis of Variables Predicting FQOL of Fathers of Children with ASD

Predictor	*B*	*SE B*	β	R^2
Step 1				.194
Child Age	0.061	0.026	0.457	
Child Cognitive Functioning	0.001	0.002	0.061	
Step 2				.426**
Child Age	0.051	0.022	0.383	
Child Cognitive Functioning	-0.004	0.003	-0.368	
Coparenting Quality	0.299	0.098	0.633	

*$p < .05$. **$p < .01$. ***$p < .001$

5f. Does Greater Coparenting Quality Predict Higher FQOL in Mothers of Children with ADHD After Controlling for Child Cognitive Functioning and Child Age?

To answer RQ 5f, a hierarchical multiple regression was conducted to assess the ability of coparenting quality to predict FQOL in mothers of children with ADHD. Variables were entered into the model in the same manner as was described for RQ5a. Correlations between the variables involved in this analysis can be found in Table 30. Overall, the results indicated that the first model was significant $F(2, 91) = 3.81$, $p = .026$, $R^2 = .08$. Child age ($b = 0.050$, $t = 2.71$, $p = .008$), but not cognitive functioning ($b = 0.003$, $t = 0.63$, $p = .630$), was significantly associated with FQOL. The second model ($F[3, 90] = 20.11$, $p < .001$, $R^2 = .40$), which included coparenting quality ($b = 0.325$, $t = 6.98$, $p < .001$) showed significant improvement from the first model, $\Delta F(1, 90) = 48.72$, $p < .001$, $\Delta R^2 = .32$. Overall, when child age and cognitive functioning were included in the model, the variables explained 7.7% of the variance in FQOL, with the final model, including coparenting quality accounting for 40.1% of the variance in FQOL. Therefore, the change from model one to model two represented a shift from a small effect size to a large effect size. A summary of the results of this analysis can be found in Table 31.

Table 30

Correlation Matrix – Mothers of Children with ADHD

Measure	*N*	*M*	*SD*	1	2	3
1. Child Age	94	10.49	3.41	-		
2. Child Cognitive Functioning	94	104.66	13.75	-.415***	-	
3. Coparenting Quality	94	4.22	1.00	.134	.021	-
4. FQOL	94	3.81	0.57	.271**	-.053	.600***

*$p < .05$. **$p < .01$. ***$p < .001$

Table 31

Summary of Hierarchical Regression Analysis of Variables Predicting FQOL of Mothers of Children with ADHD

Predictor	*B*	*SE B*	β	R^2
Step 1				$.077^{*}$
Child Age	0.050	0.018	0.299	
Child Cognitive Functioning	0.003	0.005	0.070	
Step 2				$.401^{***}$
Child Age	0.037	0.015	0.222	
Child Cognitive Functioning	0.003	0.004	0.068	
Coparenting Quality	0.325	0.047	0.574	

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

5g. Does Greater Coparenting Quality Predict Higher FQOL in Fathers of Children with ADHD After Controlling for Child Cognitive Functioning and Child Age?

To answer RQ 5g, a hierarchical multiple regression was conducted to assess the ability of coparenting quality to predict FQOL in fathers of children with ADHD. Variables were entered into the model in the same manner as was described for RQ5a. Correlations between the variables involved in this analysis can be found in Table 32. Overall, the results indicated that the first model was significant $F(2, 24) = 4.89$, $p = .017$, $R^2 = .29$. Child cognitive functioning ($b = 0.010$, $t = 3.01$, $p = .005$), but not age ($b = 0.038$, $t = 1.49$, $p = .150$), was significantly associated with FQOL. The second model ($F[3, 23] = 3.45$, $p = .033$, $R^2 = .31$), which included coparenting quality ($b = 0.100$, $t =.83$, $p = .417$) did not show significant improvement from the first model $\Delta F(1, 23) = 0.68$, $p = .417$, $\Delta R^2 = .02$. Overall, when child age and cognitive functioning were included in the model, the variables explained 29.0% of the variance in FQOL, with the final model, including coparenting quality accounting for 31.0% of the variance in FQOL. Therefore, the change from model one to model two represented a nonsignificant shift to an already large effect size. A summary of the results of this analysis can be found in Table 33.

Table 32

Correlation Matrix – Fathers of Children with ADHD

Measure	*N*	*M*	*SD*	1	2	3
1. Child Age	27	9.56	3.99	-		
2. Child Cognitive Functioning	27	107.44	26.97	-.589**	-	
3. Coparenting Quality	27	3.91	0.79	.335*	.102	-
4. FQOL	27	4.01	0.47	-.072	.473**	.298

*$p < .05$. **$p < .01$. ***$p < .001$

Table 33

Summary of Hierarchical Regression Analysis of Variables Predicting FQOL of Fathers of Children with ADHD

Predictor	*B*	*SE B*	β	R^2
Step 1				.290*
Child Age	0.038	0.025	0.317	
Child Cognitive Functioning	0.010	0.003	0.660	
Step 2				.310*
Child Age	0.026	0.029	0.217	
Child Cognitive Functioning	0.009	0.004	0.584	
Coparenting Quality	0.100	0.120	0.165	

*$p < .05$. **$p < .01$. ***$p < .001$

5h. Does Greater Coparenting Quality Predict Higher FQOL in Mothers of Children with ASD+ADHD After Controlling for Child Cognitive Functioning and Child Age?

To answer RQ 5h, a hierarchical multiple regression was conducted to assess the ability of coparenting quality to predict FQOL in mothers of children with ASD+ADHD. Variables were entered into the model in the same manner as was described for RQ5a. Correlations between the variables involved in this analysis can be found in Table 34. Overall, the results indicated that the first model was significant $F(2, 64) = 4.53$, $p = .014$, $R^2 = .12$. Child age ($b = -0.070$, $t = -2.81$, $p = .006$), but not cognitive functioning ($b = 0.004$, $t = 1.36$, $p = .178$), was significantly associated with FQOL. The second model ($F[3, 63] = 9.70$, $p < .001$, $R^2 = .32$), which included coparenting quality ($b = 0.240$, $t = 4.21$, $p < .001$) showed significant improvement from the first model $\Delta F(1, 63) = 17.68$, $p < .001$, $\Delta R^2 = .19$. Overall, when child age and cognitive functioning were included in the model, the variables explained 12.4% of the variance in FQOL, with the final model, including coparenting quality accounting for 31.6% of the variance in FQOL. Therefore, the change from model one to model two represented a shift from a small effect size to a large effect size. A summary of the results of this analysis can be found in Table 35.

Table 34

Correlation Matrix – Mothers of Children with ASD+ADHD

Measure	*N*	*M*	*SD*	1	2	3
1. Child Age	67	10.27	3.00	-		
2. Child Cognitive Functioning	67	83.12	23.29	.105	-	
3. Coparenting Quality	67	4.11	1.18	-.135	.020	-
4. FQOL	67	3.61	0.64	-.314**	.125	.482***

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Table 35

Summary of Hierarchical Regression Analysis of Variables Predicting FQOL of Mothers of Children with ASD+ADHD

Predictor	*B*	*SE B*	β	R^2
Step 1				.124*
Child Age	-0.070	0.025	-0.331	
Child Cognitive Functioning	0.004	0.003	0.160	
Step 2				.316***
Child Age	-0.057	0.022	-0.270	
Child Cognitive Functioning	0.004	0.003	0.145	
Coparenting Quality	0.240	0.057	0.442	

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

5i. Does Greater Coparenting Quality Predict Higher FQOL in Fathers of Children with ASD+ADHD After Controlling for Child Cognitive Functioning and Child Age?

To answer RQ 5i, a hierarchical multiple regression was conducted to assess the ability of coparenting quality to predict FQOL in fathers of children with ASD+ADHD. Variables were entered into the model in the same manner as was described for RQ5a. Correlations between the variables involved in this analysis can be found in Table 36. Overall, the results indicated that the first model was significant $F(2, 60) = 9.65$, $p < .001$, $R^2 = .24$. Both child age ($b = 0.083$, $t = 3.77$, $p < .001$) and cognitive functioning ($b = 0.006$, $t = 2.98$, $p = .004$) were significantly associated with FQOL. The second model ($F[3, 59] = 8.56$, $p < .001$, $R^2 = .30$), which included coparenting quality ($b = 0.153$, $t = 2.25$, $p = .028$) showed significant improvement from the first model $\Delta F(1, 59) = 5.08$, $p = .028$, $\Delta R^2 = .06$. Overall, when child age and cognitive functioning were included in the model, the variables explained 24.3% of the variance in FQOL, with the final model, including coparenting quality accounting for 30.3% of the variance in FQOL. Therefore, the change from model one to model two represented a shift from a medium effect size to a large effect size. A summary of the results of this analysis can be found in Table 37.

Table 36

Correlation Matrix – Fathers of Children with ASD+ADHD

Measure	*N*	*M*	*SD*	1	2	3
1. Child Age	63	9.86	2.69	-		
2. Child Cognitive Functioning	63	88.83	27.70	-.207	-	
3. Coparenting Quality	63	3.29	0.83	-.034	-.137	-
4. FQOL	63	3.93	0.51	.362**	.253*	.181

*$p < .05$. **$p < .01$. ***$p < .001$

Table 37

Summary of Hierarchical Regression Analysis of Variables Predicting FQOL of Fathers of Children with ASD+ADHD

Predictor	*B*	*SE B*	β	R^2
Step 1				$.243^{***}$
Child Age	0.083	0.022	0.433	
Child Cognitive Functioning	0.006	0.002	0.342	
Step 2				$.303^{***}$
Child Age	0.086	0.021	0.449	
Child Cognitive Functioning	0.007	0.002	0.380	
Coparenting Quality	0.153	0.068	0.248	

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

5j. Does Greater Coparenting Quality Predict Higher Composite FQOL in Paired Parents (mother-father dyads) of Children with ASD and/or ADHD After Controlling for Child Cognitive Functioning and Child Age?

To answer RQ 5j, a hierarchical multiple regression was conducted to assess the ability of coparenting quality to predict composite FQOL in paired parents (mother-father dyads) of children with ASD+ADHD. Variables were entered into the model in the same manner as was described for RQ5a. Correlations between the variables involved in this analysis can be found in Table 38. Overall, the results indicated that the first model was not significant $F(2, 55) = 2.48$, $p = .093$, $R^2 = .08$. Neither child age ($b = 0.038$, $t = 1.90$, $p = .063$) nor cognitive functioning ($b = 0.003$, $t = 1.39$, $p = .169$) were significantly associated with FQOL. The second model ($F[3, 54] = 1.68$, $p = .183$, $R^2 = .09$), which included coparenting quality ($b = -0.026$, $t = -0.38$ $p = .706$), was also not significant and did not show significant improvement from the first model $\Delta F(1, 54) = 0.14$, $p = .706$, $\Delta R^2 = .00$. When child age and cognitive functioning were included in the model, the variables explained 8.3% of the variance in composite FQOL. The final model, including coparenting quality, accounted for 8.5% of the variance in composite FQOL.

Therefore, both models represent a small effect size. A summary of the results of this analysis can be found in Table 39.

Table 38

Correlation Matrix – Paired Parents of Children with ASD and/or ADHD

Measure	*N*	*M*	*SD*	1	2	3
1. Child Age	58	10.64	3.01	-		
2. Child Cognitive Functioning	58	81.78	26.03	-.125	-	
3. Coparenting Quality	58	3.86	0.94	-.021	.343**	-
4. FQOL	58	4.02	0.46	.224*	.150	.011

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Table 39

Summary of Hierarchical Regression Analysis of Variables Predicting FQOL of Fathers of Children with ASD+ADHD

Predictor	*B*	*SE B*	Β	R^2
Step 1				.083
Child Age	0.038	0.020	0.247	
Child Cognitive Functioning	0.003	0.002	0.181	
Step 2				.085
Child Age	0.038	0.020	0.248	
Child Cognitive Functioning	0.004	0.002	0.200	
Coparenting Quality	-0.026	0.068	-0.052	

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .00$

Research Question 6: Moderating Effects of Child Neurodevelopmental Symptomology

6a. Does Child Neurodevelopmental Symptomology (ASD, ADHD, or ASD+ADHD) Moderate the Relation Between Mothers' Coparenting Quality and FQOL?

To answer RQ 6a, a hierarchical multiple regression with moderation was conducted to assess the moderating effect of child neurodevelopmental symptomology (ASD, ADHD, and ASD+ADHD) on the relation between coparenting quality and FQOL in mothers. The

PROCESS macro (Hayes et al., 2017) for PROCESS Model 1 was used. Child age and level of child cognitive functioning were entered into the regression model in Step 1 to control for the effects of these variables. In Step 2, coparenting quality was added into the model as a predictor of FQOL, the dependent variable. Child neurodevelopmental symptomology was included as a categorical moderator variable with four levels (NT, ASD, ADHD, and ASD+ADHD).

Results of this moderation analysis are presented in Table 40. Collectively, coparenting quality, child neurodevelopmental symptomology, and covariate predictors (i.e., child age and child cognitive functioning) accounted for significant variability in mother's FQOL, $F(9, 237) = 18.15$, $p < .001$, $R^2 = .41$. Significant main effects were found for coparenting quality ($b = 0.336$, $t = 5.44$, $p < .001$), ADHD ($b = -0.240$, $t = -2.97$, $p = .003$), and ASD+ADHD ($b = -0.375$, $t = -3.80$, $p < .001$). These results indicate a positive association between mothers' coparenting quality and FQOL and higher levels of FQOL being reported by mothers of NT children than mothers of children with ADHD and mothers of children with ASD+ADHD. None of the interactions between coparenting quality and the child neurodevelopmental symptomology groups (ASD, ADHD, and ASD+ADHD) were significant. Therefore, the addition of the child neurodevelopmental symptomology moderator did not provide a significant change to the model, $F(3, 237) = 0.61$, $p = .609$, $\Delta R^2 = .00$. For visual illustrations of the relationships among these variables, see the statistical diagram provided in Figure 8.

Table 40

Summary of Moderation Analysis of Child Neurodevelopmental Symptomology in the Relation Between Mothers' Coparenting Quality and FQOL

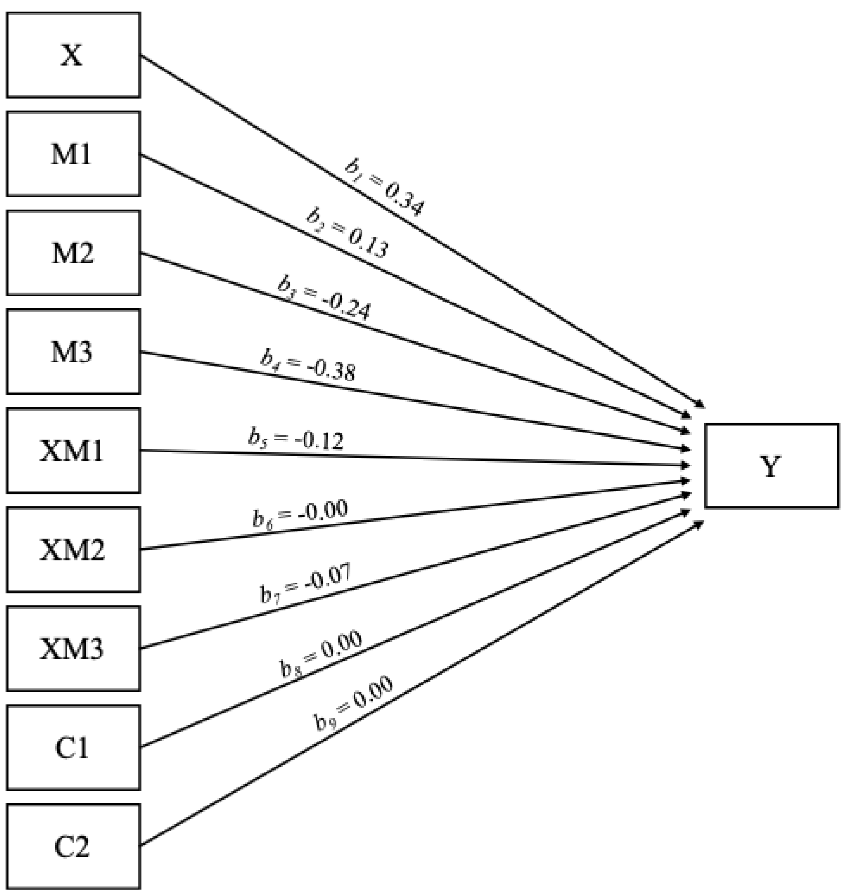
Variable	*b*	*SE*	*T*	*p*	*95% CI*
Constant	3.810	0.255	14.956	< .001	3.301, 4.311
Coparenting Quality (X)	0.336	0.062	5.437	< .001	0.214, 0.458
ASD (M1)	0.127	0.174	0.731	.466	-0.215, 0.469
ADHD (M2)	-0.240	0.081	-2.966	.003	-0.399, -0.081
ASD+ADHD (M3)	-0.375	0.099	-3.800	< .001	-0.570, -0.180

Coparenting*ASD (XM1)	-0.118	0.135	-0.870	.385	-0.384, 0.149
Coparenting*ADHD (XM2)	-0.000	0.081	0.005	.996	-0.159, 0.160
Coparenting*ASD+ADHD (XM3)	-0.074	0.081	-0.917	.360	-0.234, 0.085
Child Age (C1)	0.005	0.010	0.460	.646	-0.015, 0.025
Child Cognitive Functioning (C2)	0.002	0.002	1.240	.216	-0.001, 0.006

Note. $N = 247$

Figure 8

Research Question 6a – Statistical Diagram



Note. A pathway diagram of the unstandardized regression coefficients for the moderation of mothers' coparenting quality on family quality by child neurodevelopmental symptomology. X = mothers' coparenting quality, M1 = child ASD symptomology, M2 = child ADHD symptomology, M3 = child ASD+ADHD symptomology, Y = FQOL, C1 = child age, and C2 = child cognitive functioning.

6b. Does Child Neurodevelopmental Symptomology (ASD, ADHD, or ASD+ADHD) Moderate the Relation Between Fathers' Coparenting Quality and FQOL?

To answer RQ 6b, a hierarchical multiple regression with moderation was conducted to assess the moderating effect of child neurodevelopmental symptomology (ASD, ADHD, and ASD+ADHD) on the relation between coparenting quality and FQOL in fathers. The same procedures as were used for RQ 6a, with the data from mothers, were used for this analysis, with the data from fathers.

Results of this moderation analysis are presented in Table 41. Collectively, coparenting quality, child neurodevelopmental symptomology, and covariate predictors (i.e., child age and child cognitive functioning) accounted for significant variability in father's FQOL, $F(9, 141) = 5.14$, $p < .001$, $R^2 = .25$. A significant main effect was found for coparenting quality ($b = 0.275$, $t = 3.39$, $p = .001$). Child age ($b = 0.042$, $t = 3.06$, $p = .003$) and cognitive functioning ($b = 0.005$, $t = 2.94$, $p = .004$) also contributed significantly to the model. These results indicate a positive association between fathers' coparenting quality and FQOL. No significant differences in FQOL between fathers of NT children and fathers of children with ASD and/or ADHD were demonstrated. Additionally, none of the interactions between coparenting quality and the child neurodevelopmental symptomology groups (ASD, ADHD, and ASD+ADHD) were significant. Therefore, the addition of the child neurodevelopmental symptomology moderator did not provide a significant change to the model, $F(3, 141) = 1.06$, $p = .369$, $\Delta R^2 = .02$. For visual illustrations of the relationships among these variables, see the statistical diagram provided in Figure 9.

Table 41

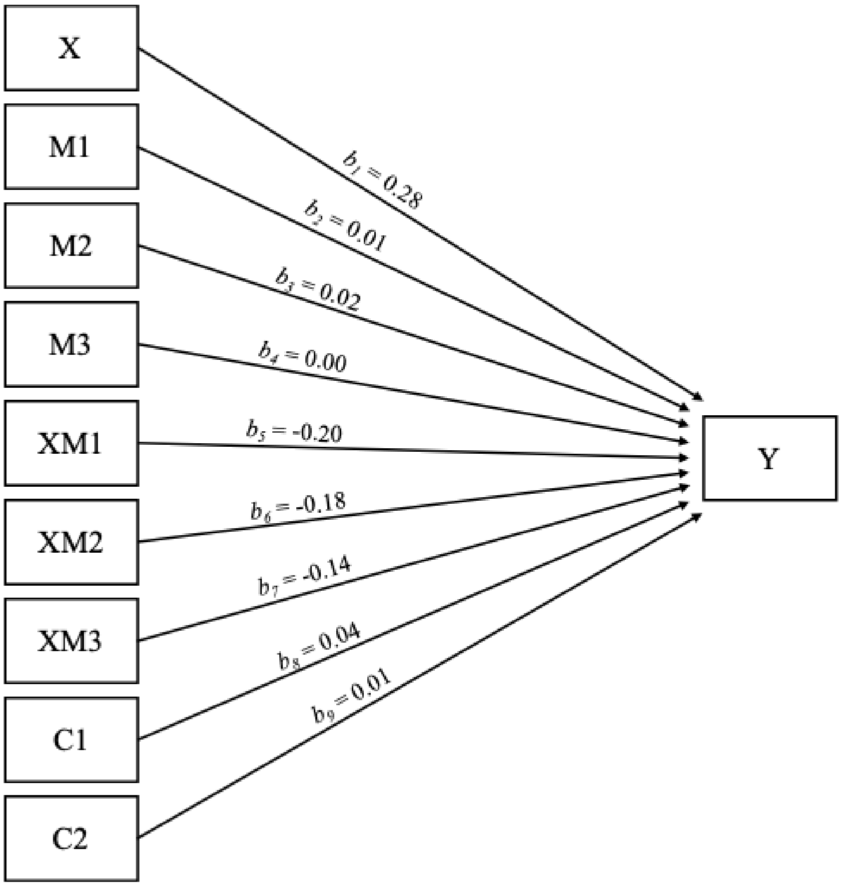
Summary of Moderation Analysis of Child Neurodevelopmental Symptomology in the Relation Between Fathers' Coparenting Quality and FQOL

Variable	*b*	*SE*	*T*	*p*	*95% CI*
Constant	3.181	0.257	12.399	< .001	2.674, 3.688
Coparenting Quality (X)	0.275	0.081	3.387	.001	0.115, 0.436
ASD (M1)	0.014	0.136	0.099	.921	-0.256, 0.282
ADHD (M2)	0.020	0.133	0.151	.880	-0.242, 0.282
ASD+ADHD (M3)	0.004	0.123	0.032	.975	-0.240, 0.248
Coparenting*ASD (XM1)	-0.204	0.137	-1.489	.139	-0.474, 0.067
Coparenting*ADHD (XM2)	-0.184	0.140	-1.318	.190	-0.461, 0.092
Coparenting*ASD+ADHD (XM3)	-0.138	0.107	-1.289	.200	-0.351, 0.074
Child Age (C1)	0.042	0.014	3.062	.003	0.015, 0.068
Child Cognitive Functioning (C2)	0.005	0.002	2.936	.004	0.002, 0.008

Note. $N = 151$

Figure 9

Research Question 6b – Statistical Diagram



Note. A pathway diagram of the unstandardized regression coefficients for the moderation of fathers' coparenting quality on family quality by child neurodevelopmental symptomology. X = fathers' coparenting quality, M1 = child ASD symptomology, M2 = child ADHD symptomology, M3 = child ASD+ADHD symptomology, Y = FQOL, C1 = child age, and C2 = child cognitive functioning.

6c. Does Child Neurodevelopmental Symptomology (ASD, ADHD, or ASD+ADHD) Moderate the Relation Between Paired Parents' (mother-father dyads) Coparenting Quality and Composite FQOL?

To answer RQ 6c, a hierarchical multiple regression with moderation was conducted to assess the moderating effect of child neurodevelopmental symptomology (ASD, ADHD, and ASD+ADHD) on the relation between coparenting quality and FQOL in paired parents (mother-father dyads). The same procedures as were used for RQ 6a, with the data from mothers, were used for this analysis, with the data from mother-father dyads (using composite scores for coparenting quality and FQOL).

Results of this moderation analysis are presented in Table 42. Collectively, coparenting quality, child neurodevelopmental symptomology, and covariate predictors (i.e., child age and child cognitive functioning) did not accounted for significant variability in paired parents' composite FQOL, $F(9, 63) = 1.72$, $p = .103$, $R^2 = .20$. No significant main effects were found. The results indicate a significant difference ($t = -2.02$, $p = .048$) in the composite FQOL between paired parents of NT children and paired parents of children with ASD+ADHD. None of the interactions between coparenting quality and the child neurodevelopmental symptomology groups (ASD, ADHD, and ASD+ADHD) were significant. Therefore, the addition of the child neurodevelopmental symptomology moderator did not provide a significant change to the model, $F(3, 63) = 0.12$, $p = .950$, $\Delta R^2 = .00$. For visual illustrations of the relationships among these variables, see the statistical diagram provided in Figure 10.

Table 42

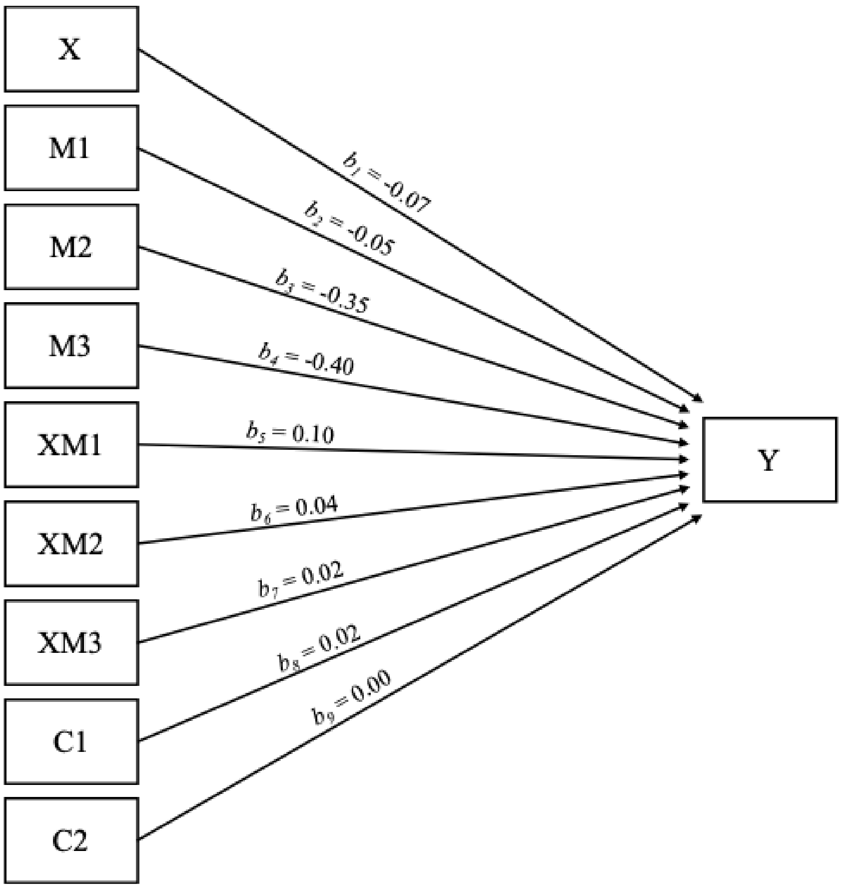
Summary of Moderation Analysis of Child Neurodevelopmental Symptomology in the Relation Between Paired Parents' Coparenting Quality and Composite FQOL

Variable	*b*	*SE*	*T*	*p*	*95% CI*
Constant	3.847	0.380	10.118	< .001	3.087, 4.607
Coparenting Quality (X)	-0.069	0.168	-0.408	.685	-0.405, 0.268
ASD (M1)	-0.047	0.205	-0.228	.820	-0.456, 0.363
ADHD (M2)	-0.352	0.202	-1.743	.086	-0.755, 0.052
ASD+ADHD (M3)	-0.397	0.197	-2.021	.048	-0.790, -0.005
Coparenting*ASD (XM1)	0.103	0.210	0.490	.626	-0.317, 0.522
Coparenting*ADHD (XM2)	0.037	0.202	0.183	.855	-0.367, 0.441
Coparenting*ASD+ADHD (XM3)	0.015	0.186	0.078	.938	-0.357, 0.386
Child Age (C1)	0.018	0.016	1.134	.261	-0.014, 0.051
Child Cognitive Functioning (C2)	0.003	0.003	1.158	.251	-0.002, 0.009

Note. $N = 74$

Figure 10

Research Question 6c – Statistical Diagram



Note. A pathway diagram of the unstandardized regression coefficients for the moderation of paired parents' coparenting quality on composite family quality by child neurodevelopmental symptomology. X = paired parents' coparenting quality, M1 = child ASD symptomology, M2 = child ADHD symptomology, M3 = child ASD+ADHD symptomology, Y = paired parents' composite FQOL, C1 = child age, and C2 = child cognitive functioning.

Exploratory Research Questions

RQ 7: Coparenting Agreement Across Neurodevelopmental Groups

7a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Coparenting Agreement? A one-way ANOVA was conducted to compare levels of coparenting agreement between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed no significant difference between the neurodevelopmental groups, $F(3, 247) = (2.41)$, $p = .068$. These results are displayed in Appendix H (Table H-7a). For visual depictions of the levels of coparenting components reported by parents across neurodevelopmental groups, see Appendix I.

7b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Coparenting Agreement? A one-way ANOVA was conducted to compare levels of coparenting agreement between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 151) = 19.89$, $p < .001$. These results are displayed in Table 43. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to coparenting quality. Results of the Bonferroni test indicated that the mean coparenting agreement scores differed significantly between the NT group and the ASD group ($p < .001$, 95% C.I. = 0.67, 2.23), the NT group and the ADHD group ($p = .047$, 95% C.I. = 0.01, 1.56), the NT group and the ASD+ADHD group ($p < .001$, 95% C.I. = 1.13, 2.40), and the ADHD group and the ASD+ADHD group ($p = .001$, 95% C.I. = -1.67, -0.29). These groups differ such that the mean for the NT group was significantly higher than the means of all three clinical groups (ASD, ADHD, and ASD+ADHD) and the mean of the ADHD group was significantly higher than the mean of the ASD+ADHD group.

Table 43

RQ 7b – Fathers' Coparenting Agreement Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 27)		ADHD Group (n = 27)		ASD+ADHD Group (n = 66)		$F(3, 151)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Coparenting Agreement	4.26	1.29	2.81	1.15	3.47	1.09	2.49	1.07	19.89^{***}	.28

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

RQ 8: Coparenting Closeness Across Neurodevelopmental Groups

8a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Coparenting Closeness? A one-way ANOVA was conducted to compare levels of coparenting closeness between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 247) = (4.79)$, $p = .003$. These results are displayed in Table 44. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to coparenting closeness. Results of the Bonferroni test indicated that the mean coparenting quality scores differed significantly between the NT group and the ADHD group ($p = .003$, 95% C.I. = [0.18, 1.32]), such that the mean for the NT group was higher than the ADHD group.

Table 44

RQ 8a – Mothers' Coparenting Closeness Across Groups

Measure	NT Group (n = 76)		ASD Group (n = 11)		ADHD Group (n = 96)		ASD+ADHD Group (n = 68)		F(3, 247)	η^2
	M	SD	M	SD	M	SD	M	SD		
Coparenting Closeness	4.54	1.30	4.65	1.38	3.79	1.45	4.00	1.43	4.79**	.06

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

8b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Coparenting Closeness? A one-way ANOVA was conducted to compare levels of coparenting closeness between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed no significant difference between the neurodevelopmental groups, $F(3, 151) = 0.53$, $p = .660$. These results are displayed in Appendix H (Table H-8b).

RQ 9: Exposure to Conflict Across Neurodevelopmental Groups

9a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Exposure to Conflict? A one-way ANOVA was conducted to compare levels of exposure to conflict between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 247) = 2.96$, $p = .033$. These results are displayed in Table 45. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to exposure to conflict. Results of the Bonferroni test indicated that the mean exposure to conflict scores differed significantly between the NT group and the ASD+ADHD group (p = .024, 95% C.I. = -1.01, -0.04), such that the mean for the ASD+ADHD group was higher than the NT group.

Table 45

RQ 9a – Mothers' Exposure to Conflict Across Groups

Measure	NT Group (n = 76)		ASD Group (n = 10)		ADHD Group (n = 97)		ASD+ADHD Group (n = 68)		F(3, 247)	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Exposure to Conflict	0.78	0.75	1.24	1.91	1.08	0.97	1.31	1.35	2.96^{*}	.04

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

9b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Exposure to Conflict? A one-way ANOVA was conducted to compare levels of exposure to conflict between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 150) = 26.34$, $p < .001$. These results are displayed in Table 46. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to exposure to conflict. Results of the Bonferroni test indicated that the mean exposure to conflict scores differed significantly between the NT group and the ASD+ADHD group ($p < .001$, 95% C.I. = -3.93, -2.00), the ASD group and the ASD+ADHD group ($p < .001$, 95% C.I. = -2.92, -0.81), and the ADHD group and the ASD+ADHD group ($p < .001$, 95% C.I. = -3.23, -1.11). These groups differ such that the mean for the ASD+ADHD group was higher than the NT, ASD, and ADHD groups.

Table 46

RQ 9b – Fathers' Exposure to Conflict Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 27)		ADHD Group (n = 27)		ASD+ADHD Group (n = 65)		F(3, 150)	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Exposure to Conflict	0.93	1.12	2.03	1.93	1.72	1.65	3.89	1.92	26.34^{***}	.35

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

RQ 10: Coparenting Support Across Neurodevelopmental Groups

10a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels Coparenting Support? A one-way ANOVA was conducted to compare levels of coparenting support between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed no significant difference between the neurodevelopmental groups, $F(3, 247) = 2.54$, $p = .057$. These results are displayed in Appendix H (Table H-10a).

10b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels Coparenting Support? A one-way ANOVA was conducted to compare levels of coparenting support between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed no significant difference between the neurodevelopmental groups, $F(3, 149) = 2.40$, $p = .071$. These results are displayed in Appendix H (Table H-10b).

RQ 11: Coparenting Undermining Across Neurodevelopmental Groups

11a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Coparenting Undermining? A one-way ANOVA was conducted to compare levels of coparenting undermining between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 247) = 4.36$, $p = .005$. These results are displayed in Table 47. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to coparenting undermining. Results of the Bonferroni test indicated that the mean coparenting undermining scores differed significantly between the NT group and the ASD+ADHD group ($p = .016$, 95% C.I. = -1.26, -0.08), such that the mean for the ASD+ADHD group was higher than the NT group.

Table 47

RQ 11a – Mothers' Coparenting Undermining Across Groups

Measure	NT Group (n = 76)		ASD Group (n = 11)		ADHD Group (n = 96)		ASD+ADHD Group (n = 68)		$F(3, 247)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Coparenting Undermining	0.82	1.00	1.94	2.28	1.28	1.32	1.50	1.46	4.36**	.05

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

11b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Coparenting Undermining? A one-way ANOVA was conducted to compare levels of coparenting undermining between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 149) = 17.17$, $p < .001$. These results are displayed in Table 48. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to coparenting undermining. Results of the Bonferroni test indicated that the mean coparenting undermining scores differed significantly between the NT group and the ASD group ($p < .001$, 95% C.I. = -2.64, -0.50), the

NT group and the ASD+ADHD group ($p < .001$, 95% C.I. = -3.15, -1.39), and the ADHD group and the ASD+ADHD group ($p < .001$, 95% C.I. = -2.39, -0.47). These groups differed such that the mean for the ASD+ADHD group was higher than the NT and ADHD groups, and the mean for the ASD group was higher than the mean for the NT group.

Table 48

RQ 11b – Fathers' Coparenting Undermining Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 27)		ADHD Group (n = 27)		ASD+ADHD Group (n = 64)		$F(3, 149)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Coparenting Undermining	1.69	1.50	3.26	1.51	2.52	1.51	3.96	1.64	17.17***	.26

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

RQ 12: Endorsement of Partner Parenting Across Neurodevelopmental Groups

12a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Endorsement of Partner Parenting? A one-way ANOVA was conducted to compare levels of endorsement of partner parenting between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 248) = 3.59$, $p = .014$. These results are displayed in Table 49. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to endorsement of partner parenting. Results of the Bonferroni test indicated that the mean endorsement of partner parenting scores differed significantly between the NT group and the ASD+ADHD group ($p = .008$, 95% C.I. = 0.12, 1.19), such that the mean for the NT group was higher than the ASD+ADHD group.

Table 49

RQ 12a – Mothers' Endorsement of Partner Parenting Across Groups

Measure	NT Group (n = 76)		ASD Group (n = 11)		ADHD Group (n = 97)		ASD+ADHD Group (n = 68)		$F(3, 248)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Endorsement of Partner Parenting	4.62	1.05	4.23	1.53	4.24	1.20	3.96	1.30	3.59^{*}	.04

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

12b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Endorsement of Partner Parenting? A one-way ANOVA was conducted to compare levels of endorsement of partner parenting between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 150) = 7.17$, $p < .001$. These results are displayed in Table 50. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to endorsement of partner parenting. Results of the Bonferroni test indicated that the mean endorsement of partner parenting scores differed significantly between the NT group and the ASD group ($p = .002$, 95% C.I. = 0.21, 1.38), the NT group and the ADHD group ($p = .008$, 95% C.I. = 0.13, 1.30), and the NT group and the ASD+ADHD group ($p < .001$, 95% C.I. = 0.29, 1.24). These groups differed such that the mean for the NT group was higher than the means for the other neurodevelopmental groups (ASD, ADHD, and ASD+ADHD).

Table 50

RQ 12b – Fathers' Endorsement of Partner Parenting Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 27)		ADHD Group (n = 27)		ASD+ADHD Group (n = 65)		$F(3, 150)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Endorsement of Partner Parenting	4.83	0.94	4.04	0.85	4.12	0.89	4.07	0.79	7.17^{***}	.13

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

RQ 13: Division of Labor Across Neurodevelopmental Groups

13a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Division of Labor? A one-way ANOVA was conducted to compare levels of division of labor between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed no significant difference between the neurodevelopmental groups, $F(3, 246) = 1.03$, $p = .379$. These results are displayed in Appendix H (Table H-13a).

13b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Division of Labor? A one-way ANOVA was conducted to compare levels of division of labor between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 149) = 13.06$, $p < .001$. These results are displayed in Table 51. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to endorsement of partner parenting. Results of the Bonferroni test indicated that the mean endorsement of partner parenting scores differed significantly between the NT group and the ASD+ADHD group ($p < .001$, 95% C.I. = 1.22, 3.17), the ASD group and the ASD+ADHD group (p = .004, 95% C.I. = 0.31, 2.44), and the ADHD group and the ASD+ADHD group (p = .035, 95% C.I. = 0.05, 2.18). These groups differed such that the means for the NT, ASD, and ADHD groups were higher than the mean for the ASD+ADHD group.

Table 51

RQ 13b – Fathers' Division of Labor Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 27)		ADHD Group (n = 27)		ASD+ADHD Group (n = 64)		$F(3, 149)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Division of Labor	3.96	1.61	3.13	1.88	2.87	1.83	1.76	1.70	13.06***	.21

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

RQ 14: Family Interaction Across Neurodevelopmental Groups

14a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Family Interaction? A one-way ANOVA was conducted to compare levels of family interaction between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 285) = 5.62$, $p < .001$. These results are displayed in Table 52. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to family interaction. Results of the Bonferroni test indicated that the mean family interaction scores differed significantly between the NT group and the ADHD group (p = .014, 95% C.I. = 0.39, 0.55) as well as between the NT group and the ASD+ADHD group (p = .002, 95% C.I. = 0.11, 0.66). Specifically, the mean for the NT group was higher than the means for both the ADHD and ASD+ADHD groups. For a visual depiction of the levels of components of FQOL reported by parents across neurodevelopmental groups, see Appendix I.

Table 52

RQ 14a – Mothers' Family Interaction Across Groups

Measure	NT Group (n = 92)		ASD Group (n = 15)		ADHD Group (n = 107)		ASD+ADHD Group (n = 75)		$F(3, 285)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Family Interaction	4.21	0.66	4.18	0.89	3.92	0.65	3.82	0.67	5.62^{***}	.06

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

14b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Family Interaction? A one-way ANOVA was conducted to compare levels of family interaction between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 162) = 3.82$, $p = .011$. These results are displayed in Table 53. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to family interaction. Results of the Bonferroni test indicated that the mean family interaction scores differed significantly between the NT group and the ASD+ADHD group ($p = .022$, 95% C.I. = 0.04, 0.74), such that the mean for the NT group was higher than the mean for the ASD+ADHD group.

Table 53

RQ 14b – Fathers' Family Interaction Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 28)		ADHD Group (n = 30)		ASD+ADHD Group (n = 73)		$F(3, 162)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Family Interaction	4.37	0.59	4.18	0.49	4.18	0.49	3.88	0.75	3.82*	.07

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

RQ 15: Parenting Across Neurodevelopmental Groups

15a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Parenting? A one-way ANOVA was conducted to compare levels of parenting between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 284) = 9.27$, $p < .001$. These results are displayed in Table 54. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to parenting. Results of the Bonferroni test indicated that the mean parenting scores differed significantly between the NT group and the ADHD group ($p = .011$, 95% C.I. = 0.48, 0.57) as well as the between the NT group and the ASD+ADHD group ($p < .001$, 95% C.I. = 0.26, 0.83). Specifically, the mean for the NT group was higher than the means for both the ADHD and ASD+ADHD groups.

Table 54

RQ 15a – Mothers' Parenting Across Groups

Measure	NT Group (n = 92)		ASD Group (n = 15)		ADHD Group (n = 106)		ASD+ADHD Group (n = 75)		$F(3, 284)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Parenting	4.16	0.72	4.09	0.74	3.85	0.63	3.62	0.70	9.27^{***}	.09

$^{*}p < .05.$ $^{**}p < .01.$ $^{***}p < .001$

15b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Parenting? A one-way ANOVA was conducted to compare levels of parenting between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 162) = 3.51$, $p = .017$. These results are displayed in Table 55. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to parenting. Results of the Bonferroni test indicated that the mean parenting scores differed significantly between the NT group and the ASD+ADHD group ($p = .033$, 95% C.I. = 0.02, 0.66), such that the mean for the NT group was higher than the mean for the ASD+ADHD group.

Table 55

RQ 15b – Fathers' Parenting Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 28)		ADHD Group (n = 30)		ASD+ADHD Group (n = 73)		$F(3, 162)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Parenting	4.27	0.58	3.98	0.41	4.21	0.46	3.93	0.68	3.51^{*}	.06

$^{*}p < .05.$ $^{**}p < .01.$ $^{***}p < .001$

RQ 16: Emotional Well-Being Across Neurodevelopmental Groups

16a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Emotional Well-Being? A one-way ANOVA was conducted to compare levels of emotional well-being between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 285) = 15.77$, $p < .001$. These results are displayed in Table 56. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to emotional well-being. Results of the Bonferroni test indicated that the mean parenting scores differed significantly between the NT group and the ADHD group ($p < .001$, 95% C.I. = 0.27, 1.03), the NT group and the ASD+ADHD group ($p < .001$, 95% C.I. = 0.50, 1.33), ASD group and the ADHD group ($p = .003$, 95% C.I. = 0.23, 1.70), and between the ASD group and the ASD+ADHD group ($p < .001$, 95% C.I. = 0.47, 1.98). Specifically, the means for the NT and ASD groups were higher than the means for the ADHD and ASD+ADHD groups.

Table 56

RQ 16a – Mothers' Emotional Well-Being Across Groups

Measure	NT Group (n = 92)		ASD Group (n = 15)		ADHD Group (n = 107)		ASD+ADHD Group (n = 75)		$F(3, 285)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Emotional Well-Being	3.79	1.09	4.11	0.82	3.14	0.97	2.88	0.96	15.77^{***}	.14

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

16b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Emotional Well-Being? A one-way ANOVA was conducted to compare levels of emotional well-being between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed no significant difference between the neurodevelopmental groups, $F(3, 162) = 0.91$, $p = .440$. These results are displayed in Appendix H (Table H-16b).

RQ 17: Physical/Material Well-Being Across Neurodevelopmental Groups

17a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Physical/Material Well-Being? A one-way ANOVA was conducted to compare levels of physical/material well-being between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 283) = 6.82$, $p < .001$. These results are displayed in Table 57. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to physical/material well-being. Results of the Bonferroni test indicated that the mean physical/material well-being scores differed significantly between the NT group and the ASD+ADHD group ($p < .001$, 95% C.I. = 0.20, 0.76), such that the mean for the NT group was higher than the mean for the ASD+ADHD group.

Table 57

RQ 17a – Mothers' Physical/Material Well-Being Across Groups

Measure	NT Group (n = 91)		ASD Group (n = 15)		ADHD Group (n = 106)		ASD+ADHD Group (n = 75)		$F(3, 283)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Physical/Material Well-Being	4.41	0.57	4.24	0.76	4.20	0.62	3.93	0.83	6.82^{***}	.07

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

17b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Physical/Material Well-Being? A one-way ANOVA was conducted to compare levels of physical/material well-being between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 162) = 3.93$, $p = .010$. These results are displayed in Table 58. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to physical/material well-being. Results of the Bonferroni test indicated that the mean physical/material well-being scores differed significantly between the NT group and the ASD group ($p = .035$, 95% C.I. = 0.02, 0.82) and the NT group and the ASD+ADHD group ($p = .011$, 95% C.I. = 0.07, 0.71). These groups differed such that the mean for the NT group was higher than the means for both the ASD and ASD+ADHD groups.

Table 58

RQ 17b – Fathers' Physical/Material Well-Being Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 28)		ADHD Group (n = 30)		ASD+ADHD Group (n = 73)		$F(3, 162)$	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Physical/Material Well-Being	4.36	0.57	3.94	0.45	4.11	0.58	3.98	0.65	3.93^{*}	.07

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

RQ 18: Disability-Related Support Across Neurodevelopmental Groups

18a. Do Mothers of Children with ADHD, ASD, ASD+ADHD, and Mothers of NT Children Differ in their Levels of Disability-Related Support? A one-way ANOVA was conducted to compare levels of disability-related support between mothers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 284) = 11.90$, $p < .001$. These results are displayed in Table 59. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to physical/material well-being. Results of the Bonferroni test indicated that the mean disability-related support scores differed significantly between the NT group and the ADHD group ($p < .001$, 95% C.I. = 0.18, 0.72) and the NT group and the ASD+ADHD group ($p < .001$, 95% C.I. = 0.32, 0.92). Specifically, the mean for the NT group was higher than the mean for both the ADHD and ASD+ADHD groups.

Table 59

RQ 18a – Mothers' Disability-Related Support Across Groups

Measure	NT Group (n = 91)		ASD Group (n = 15)		ADHD Group (n = 107)		ASD+ADHD Group (n = 75)		$F(3, 284)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Disability-Related Support	4.28	0.60	4.18	0.67	3.83	0.68	3.66	0.91	11.90^{***}	.11

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

18b. Do Fathers of Children with ADHD, ASD, ASD+ADHD, and Fathers of NT Children Differ in their Levels of Disability-Related Support? A one-way ANOVA was conducted to compare levels of disability-related support between fathers in the four neurodevelopmental groups. Results of the ANOVA revealed a significant difference between at least two of the neurodevelopmental groups, $F(3, 162) = 3.59$, $p = .015$. These results are displayed in Table 60. The Bonferroni test was used to conduct multiple comparisons and determine which groups differed significantly with regards to physical/material well-being. Results of the Bonferroni test indicated that the mean disability-related support scores differed significantly between the NT group and the ASD+ADHD group ($p = .015$, 95% C.I. = 0.05, 0.72), such that the mean for the NT group was higher than the mean for the ASD+ADHD group.

Table 60

RQ 18b – Fathers' Disability-Related Support Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 28)		ADHD Group (n = 30)		ASD+ADHD Group (n = 73)		$F(3, 162)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Disability-Related Support	4.32	0.57	3.91	0.52	4.06	0.78	3.93	0.58	3.59^{*}	.06

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

RQ 19: Coparenting Agreement Between Paired Mothers and Fathers

19a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Coparenting Agreement? A paired samples *t*-test was performed to determine whether there was a difference between the reported coparenting agreement scores of paired mothers and fathers of NT children. While, on average, mothers (M = 4.71, SD = 0.74) reported higher levels of coparenting agreement than fathers (M = 4.38, SD = 0.90) in the NT group, the results indicated that this difference did not reach statistical significance, $t(14) = 1.01$, $p = .330$. These results are displayed in Appendix H (Table H-19a).

19b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Coparenting Agreement? A paired samples *t*-test was performed to determine whether there was a difference between the reported coparenting agreement scores of paired mothers and fathers of NT children. The results indicated that there was no significant difference in coparenting agreement scores between mothers (M = 3.01, SD = 1.27) and fathers (M = 3.05, SD = 1.36) in the clinical sample, $t(56) = -0.22$, $p = .829$. These results are displayed in Appendix H (Table H-19b).

RQ 20: Coparenting Closeness Between Paired Mothers and Fathers

20a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Coparenting Closeness? A paired samples *t*-test was performed to determine whether there was a difference between the reported coparenting closeness scores of paired mothers and fathers of NT children. The results indicated that there was no significant difference in coparenting closeness scores between mothers (M = 4.85, SD = 0.72) and fathers (M = 4.63, SD = 1.13) in the NT sample $t(14) = 0.69$, $p = .504$. These results are displayed in Appendix H (Table H-20a).

20b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Coparenting Closeness? A paired samples *t*-test was performed to determine whether there was a difference between the reported coparenting closeness scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in coparenting closeness scores between mothers (M = 4.21, SD = 1.16) and fathers (M = 4.21, SD = 1.00) in the clinical sample $t(56) = -0.01$, $p = .995$. These results are displayed in Appendix H (Table H-20b).

RQ 21: Exposure to Conflict Between Paired Mothers and Fathers

21a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Exposure to Conflict? A paired samples *t*-test was performed to determine whether there was a difference between the reported exposure to conflict scores of paired mothers and fathers of NT children. The results indicated that there was no significant difference in exposure to conflict scores between mothers (M = 0.61, SD = 0.29) and fathers (M = 0.60, SD = 0.36) in the NT sample, $t(14) = 0.18$, $p = .860$. These results are displayed in Appendix H (Table H-21a).

21b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Exposure to Conflict? A paired samples *t*-test was performed to determine whether there was a difference between the reported exposure to conflict scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that, while on average fathers (M = 2.39, SD = 1.92) reported higher exposure to conflict scores than mothers (M = 2.10, SD = 1.87) in the clinical sample, the difference did not reach significance, $t(55) = -1.76$, $p = .083$. These results are displayed in Appendix H (Table H-21b).

RQ 22: Coparenting Support Between Paired Mothers and Fathers

22a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Coparenting Support? A paired samples *t*-test was performed to determine whether there was a difference between the reported coparenting support scores of paired mothers and fathers of NT children. The results indicated that mothers ($M = 5.09$, $SD = 0.56$) reported significantly higher levels of coparenting support than fathers ($M = 4.29$, $SD = 0.96$) in the NT sample, $t(14) = 3.25$, $p = .006$. These results are displayed in Table 61.

Table 61

RQ 22a – Coparenting Support of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(14)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Coparenting Support	5.09	0.56	4.29	0.96	3.25	.006	0.839

22b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Coparenting Support? A paired samples *t*-test was performed to determine whether there was a difference between the reported coparenting support scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in coparenting support scores between mothers ($M = 4.57$, $SD = 1.11$) and fathers ($M = 4.63$, $SD = 1.11$) in the clinical sample, $t(55) = -0.35$, $p = .727$. These results are displayed in Appendix H (Table H-22b).

RQ 23: Coparenting Undermining Between Paired Mothers and Fathers

23a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Coparenting Undermining? A paired samples *t*-test was performed to determine whether there was a difference between the reported coparenting undermining scores of paired mothers and fathers of NT children. The results indicated that fathers ($M = 0.99$, $SD = 0.53$) reported significantly higher levels of coparenting undermining than mothers (*M* = 0.49, *SD* = 0.52) in the NT sample, *t*(14) = -3.78, *p* = .002. These results are displayed in Table 62.

Table 62

RQ 23a – Coparenting Undermining of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(14)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Coparenting Undermining	0.49	0.52	0.99	0.53	-3.78	.002	-0.977

23b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Coparenting Undermining? A paired samples *t*-test was performed to determine whether there was a difference between the reported coparenting undermining scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that, while on average fathers (*M* = 2.89, *SD* = 1.90) reported higher levels of coparenting undermining than mothers (*M* = 2.52, *SD* = 1.99) in the clinical sample, this difference did not reach significance, *t*(55) = -1.83, *p* = .072. These results are displayed in Appendix H (Table H-23b).

RQ 24: Endorsement of Partner Parenting Between Paired Mothers and Fathers

24a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Endorsement of Partner Parenting? A paired samples *t*-test was performed to determine whether there was a difference between the reported endorsement of partner parenting scores of paired mothers and fathers of NT children. The results indicated that there was no significant difference in endorsement of partner parenting scores between mothers (*M* = 4.97, *SD* = 0.92) and fathers (*M* = 5.29, *SD* = 0.48) in the NT sample, *t*(14) = -1.12, *p* = .282. These results are displayed in Appendix H (Table H-24a).

24b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Endorsement of Partner Parenting? A paired samples *t*-test was performed to determine whether there was a difference between the reported endorsement of partner parenting scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in endorsement of partner parenting scores between mothers ($M = 4.16$, $SD = 1.09$) and fathers ($M = 4.29$, $SD = 0.96$) in the clinical sample, $t(56) = -0.83$, $p = .408$. These results are displayed in Appendix H (Table H-24b).

RQ 25: Division of Labor Between Paired Mothers and Fathers

25a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Division of Labor? A paired samples *t*-test was performed to determine whether there was a difference between the reported division of labor scores of paired mothers and fathers of NT children. The results indicated that there was no significant difference in division of labor scores between mothers ($M = 4.87$, $SD = 1.22$) and fathers ($M = 4.67$, $SD = 0.99$) in the NT sample, $t(14) = 0.52$, $p = .610$. These results are displayed in Appendix H (Table H-25a).

25b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Division of Labor? A paired samples *t*-test was performed to determine whether there was a difference between the reported division of labor scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in division of labor scores between mothers ($M = 3.13$, $SD = 2.15$) and fathers ($M = 2.97$, $SD = 2.06$) in the clinical sample, $t(53) = 0.70$, $p = .484$. These results are displayed in Appendix H (Table H-25b).

RQ 26: Family Interaction Between Paired Mothers and Fathers

26a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Family Interaction? A paired samples *t*-test was performed to determine whether there was a difference between the reported family interaction scores of paired mothers and fathers of NT children. The results indicated that, while on average mothers (M = 4.37, SD = 0.47) reported higher division of labor scores than fathers (M = 4.11, SD = 0.61) in the NT sample, the difference did not reach significance, $t(19) = 1.87$, $p = .078$. These results are displayed in Appendix H (Table H-26a).

26b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Family Interaction? A paired samples *t*-test was performed to determine whether there was a difference between the reported family interaction scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in family interaction scores between mothers (M = 4.07, SD = 0.60) and fathers (M = 4.02, SD = 0.52) in the NT sample, $t(66) = 0.69$, $p = .494$. These results are displayed in Appendix H (Table H-26b).

RQ 27: Parenting Between Paired Mothers and Fathers

27a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Parenting? A paired samples *t*-test was performed to determine whether there was a difference between the parenting scores of paired mothers and fathers of NT children. The results indicated that there was no significant difference in parenting scores between mothers (M = 4.25, SD = 0.71) and fathers (M = 4.16, SD = 0.61) in the NT sample, $t(18) = 0.67$, $p = .509$. These results are displayed in Appendix H (Table H-27a).

27b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Parenting? A paired samples *t*-test was performed to determine whether there was a difference between the parenting scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in parenting scores between mothers (M = 4.02, SD = 0.69) and fathers (M = 4.03, SD = 0.58) in the clinical sample, $t(66) = -0.14$, $p = .887$. These results are displayed in Appendix H (Table H-27b).

RQ 28: Emotional Well-Being Between Paired Mothers and Fathers

28a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Emotional Well-Being? A paired samples *t*-test was performed to determine whether there was a difference between the emotional well-being scores of paired mothers and fathers of NT children. The results indicated that there was no significant difference in emotional well-being scores between mothers (M = 4.18, SD = 0.89) and fathers (M = 3.99, SD = 0.69) in the NT sample, $t(18) = 1.14$, $p = .271$. These results are displayed in Appendix H (Table H-28a).

28b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Emotional Well-Being? A paired samples *t*-test was performed to determine whether there was a difference between the emotional well-being scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in emotional well-being scores between mothers (M = 3.57, SD = 1.02) and fathers (M = 3.69, SD = 0.93) in the clinical sample, $t(66) = -1.08$, $p = .282$. These results are displayed in Appendix H (Table H-28b).

RQ 29: Physical/Material Well-Being Between Paired Mothers and Fathers

29a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Physical/Material Well-Being? A paired samples *t*-test was performed to determine whether there was a difference between the physical/material well-being scores of paired mothers and fathers of NT children. The results indicated that there was no significant difference in physical/material well-being scores between mothers (M = 4.43, SD = 0.46) and fathers (M = 4.29, SD = 0.49) in the NT sample, $t(18) = 1.11$, $p = .282$. These results are displayed in Appendix H (Table H-29a).

29b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Physical/Material Well-Being? A paired samples t-test was performed to determine whether there was a difference between the physical/material well-being scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in physical/material well-being scores between mothers (M = 4.19, SD = 0.59) and fathers (M = 4.13, SD = 0.64) in the clinical sample, $t(66) = 0.86$, $p = .394$. These results are displayed in Appendix H (Table H-29b).

RQ 30: Disability-Related Support Between Paired Mothers and Fathers

30a. Do Paired Mothers and Fathers of NT Children Differ in their Levels of Disability-Related Support? A paired samples t-test was performed to determine whether there was a difference between the disability-related support scores of paired mothers and fathers of NT children. The results indicated that there was no significant difference in disability-related support scores between mothers (M = 4.33, SD = 0.43) and fathers (M = 4.16, SD = 0.49) in the NT sample, $t(18) = 1.24$, $p = .231$. These results are displayed in Appendix H (Table H-30a).

30b. Do Paired Mothers and Fathers of Children with ASD and/or ADHD Differ in their Levels of Disability-Related Support? A paired samples t-test was performed to determine whether there was a difference between the disability-related support scores of paired mothers and fathers of children with ASD and/or ADHD. The results indicated that there was no significant difference in disability-related support scores between mothers (M = 3.92, SD = 0.76) and fathers (*M* = 3.95, *SD* = 0.68) in the clinical sample, $t(66) = -0.27$, $p = .788$. These results are displayed in Appendix H (Table H-30b).

RQ 31: Associations Between Aspects of Coparenting Quality and FQOL

31a. To What Extent are Aspects of Coparenting Quality Associated with Aspects of FQOL in Mothers of NT Children? Bivariate Pearson Correlation analyses were conducted to determine the extent to which aspects of coparenting (coparenting agreement, coparenting closeness, exposure to conflict, coparenting support, coparenting undermining, endorse partner parenting, and division of labor) were associated with aspects of FQOL (family interaction, parenting, emotional well-being, physical/material well-being, and disability-related support) in mothers of NT children. The results are displayed in Table 63.

Table 63

Correlation Matrix for Aspects of Coparenting Quality and FQOL – Mothers of NT Children

		Family Interaction	Parenting	Emotional Well-Being	Physical/ Material Well-Being	Disability-Related Support
Coparenting Agreement	*r*	0.52^{***}	0.45^{***}	0.31^{**}	0.33^{**}	0.22
	p	< .001	< .001	.006	.004	.064
	n	76	76	76	75	75
Coparenting Closeness	*r*	0.61^{***}	0.47^{***}	0.31^{**}	0.22	0.22
	p	< .001	< .001	.006	.061	.063
	n	76	76	76	75	75
Exposure to Conflict	*r*	-0.25^{*}	-0.27^{*}	-0.36^{**}	-0.02	-0.13
	p	.029	.017	.001	.852	.270
	n	76	76	76	75	75
Coparenting Support	*r*	0.66^{***}	0.58^{***}	0.40^{***}	0.24^{*}	0.33^{**}
	p	< .001	< .001	< .001	.035	.004
	n	76	76	76	75	75
Coparenting Undermining	*r*	-0.51^{***}	-0.41^{***}	-0.29^{*}	-0.16	-0.21
	p	< .001	< .001	.012	.161	.072
	n	76	76	76	75	75
Endorsement of Partner's Parenting	*r*	0.63^{***}	0.51^{***}	0.28^{*}	0.20	0.27^{*}
	p	< .001	< .001	.015	.088	.019
	n	76	76	76	75	75

Division of Labor	r	0.42***	0.33**	0.33**	0.12	0.12
	p	< .001	.004	.004	.325	.304
	n	75	75	75	74	74

*$p < .05$. **$p < .01$. ***$p < .001$

31b. To What Extent are Aspects of Coparenting Quality Associated with Aspects of FQOL in Fathers of NT Children? Bivariate Pearson Correlation analyses were conducted to determine the extent to which aspects of coparenting (coparenting agreement, coparenting closeness, exposure to conflict, coparenting support, coparenting undermining, endorse partner parenting, and division of labor) were associated with aspects of FQOL (family interaction, parenting, emotional well-being, physical/material well-being, and disability-related support) in fathers of NT children. The results are displayed in Table 64.

Table 64

Correlation Matrix for Aspects of Coparenting Quality and FQOL – Fathers of NT Children

		Family Interaction	Parenting	Emotional Well-Being	Physical/ Material Well-Being	Disability-Related Support
Coparenting Agreement	r	.391*	.373*	.278	.322	.394*
	p	.022	.030	.112	.063	.021
	n	34	34	34	34	34
Coparenting Closeness	r	.630***	.588***	.622***	.392*	.619***
	p	< .001	< .001	< .001	.022	< .001
	n	34	34	34	34	34
Exposure to Conflict	r	-.246	-.301	-.149	-.338	-.393*
	p	.160	.083	.401	.050	.022
	n	34	34	34	34	34
Coparenting Support	r	.645***	.654***	.596***	.479**	.556***
	p	< .001	< .001	< .001	.004	< .001
	n	34	34	34	34	34
Coparenting Undermining	r	-.301	-.204	-.165	-.243	-.419*
	p	.084	.247	.350	.167	.014
	n	34	34	34	34	34
Endorsement of Partner's Parenting	r	.370*	.444**	.292	.502**	.406*
	p	.031	.009	.093	.002	.017
	n	34	34	34	34	34

Division of Labor	*r*	.143	.206	.100	.200	.254
	p	.421	.243	.575	.257	.147
	n	34	34	34	34	34

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

31c. To What Extent are Aspects of Coparenting Quality Associated with Aspects of FQOL in Mothers of Children with ASD? Bivariate Pearson Correlation analyses were conducted to determine the extent to which aspects of coparenting (coparenting agreement, coparenting closeness, exposure to conflict, coparenting support, coparenting undermining, endorse partner parenting, and division of labor) were associated with aspects of FQOL (family interaction, parenting, emotional well-being, physical/material well-being, and disability-related support) in mothers of children with ASD. The results are displayed in Table 65.

Table 65

Correlation Matrix for Aspects of Coparenting Quality and FQOL – Mothers of Children with ASD

		Family Interaction	Parenting	Emotional Well-Being	Physical/ Material Well-Being	Disability-Related Support
Coparenting Agreement	*r*	.161	.151	-.024	.240	-.170
	p	.635	.658	.945	.477	.618
	n	11	11	11	11	11
Coparenting Closeness	*r*	$.628^{*}$	$.628^{*}$	.523	$.713^{*}$	.240
	p	.038	.020	.099	.014	.477
	n	11	11	11	11	11
Exposure to Conflict	*r*	-.233	-.186	.194	-.072	-.018
	p	.517	.606	.590	.843	.961
	n	10	10	10	10	10
Coparenting Support	*r*	$.851^{***}$	$.874^{***}$	$.719^{*}$	$.829^{**}$	.528
	p	< .001	< .001	.013	.002	.095
	n	11	11	11	11	11
Coparenting Undermining	*r*	.041	.086	.352	.082	.378
	p	.904	.801	.288	.810	.252
	n	11	11	11	11	11

Endorsement of Partner's Parenting	r	.677*	.650*	.457	.685*	.316
	p	.022	.031	.157	.020	.343
	n	11	11	11	11	11
Division of Labor	r	.141	.105	-.172	.070	-.184
	p	.698	.772	.634	.847	.611
	n	10	10	10	10	10

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

31d. To What Extent are Aspects of Coparenting Quality Associated with Aspects of FQOL in Fathers of Children with ASD? Bivariate Pearson Correlation analyses were conducted to determine the extent to which aspects of coparenting (coparenting agreement, coparenting closeness, exposure to conflict, coparenting support, coparenting undermining, endorse partner parenting, and division of labor) were associated with aspects of FQOL (family interaction, parenting, emotional well-being, physical/material well-being, and disability-related support) in fathers of children with ASD. The results are displayed in Table 66.

Table 66

Correlation Matrix for Aspects of Coparenting Quality and FQOL – Fathers of Children with ASD

		Family Interaction	Parenting	Emotional Well-Being	Physical/ Material Well-Being	Disability-Related Support
Coparenting Agreement	r	-.209	-.243	-.517**	-.331	-.374
	p	.296	.222	.006	.091	.054
	n	27	27	27	27	27
Coparenting Closeness	r	.551**	.584**	.583**	.394*	.305
	p	.003	.001	.001	.042	.121
	n	27	27	27	27	27
Exposure to Conflict	r	-.218	-.088	.004	.027	-.059
	p	.274	.662	.983	.895	.769
	n	27	27	27	27	27
Coparenting Support	r	.614***	.618***	.669***	.535**	.449*
	p	< .001	< .001	< .001	.005	.021
	n	26	26	26	26	26

Coparenting Undermining	*r*	-.082	.109	.020	.087	-.014
	p	.683	.588	.921	.665	.946
	n	27	27	27	27	27
Endorsement of Partner's Parenting	*r*	$.538^{**}$	$.465^{*}$	$.482^{*}$	.360	.261
	p	.004	.015	.011	.065	.189
	n	27	27	27	27	27
Division of Labor	*r*	.154	.165	.126	-.073	.093
	p	.444	.410	.531	.718	.645
	n	27	27	27	27	27

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

31e. To What Extent are Aspects of Coparenting Quality Associated with Aspects of FQOL in Mothers of Children with ADHD? Bivariate Pearson Correlation analyses were conducted to determine the extent to which aspects of coparenting (coparenting agreement, coparenting closeness, exposure to conflict, coparenting support, coparenting undermining, endorse partner parenting, and division of labor) were associated with aspects of FQOL (family interaction, parenting, emotional well-being, physical/material well-being, and disability-related support) in mothers of children with ADHD. The results are displayed in Table 67.

Table 67

Correlation Matrix for Aspects of Coparenting Quality and FQOL – Mothers of Children with ADHD

		Family Interaction	Parenting	Emotional Well-Being	Physical/ Material Well-Being	Disability-Related Support
Coparenting Agreement	*r*	$.425^{***}$	$.363^{***}$	$.317^{**}$	.144	$.286^{**}$
	p	< .001	< .001	.002	.166	.005
	n	95	94	95	94	95
Coparenting Closeness	*r*	$.681^{***}$	$.457^{***}$	$.481^{***}$	$.326^{**}$	$.345^{***}$
	p	< .001	< .001	< .001	.001	< .001
	n	95	94	95	94	95
Exposure to Conflict	*r*	$-.296^{**}$	-.106	-.165	$-.298^{**}$	-.086
	p	.003	.308	.109	.003	.403
	n	96	95	96	95	96

Coparenting Support	*r*	.662***	.419***	.401***	.311**	.386***
	p	< .001	< .001	< .001	.002	< .001
	n	95	94	95	94	95
Coparenting Undermining	*r*	-.472***	-.375***	-.194	-.338***	-.160
	p	< .001	< .001	.060	< .001	.121
	n	95	94	95	94	95
Endorsement of Partner's Parenting	*r*	.497***	.457***	.384***	.210*	.276**
	p	< .001	< .001	< .001	.041	.007
	n	96	95	96	95	96
Division of Labor	*r*	.291**	.374***	.213*	.125	.223**
	p	.004	< .001	.037	.226	.029
	n	96	95	96	95	96

*$p < .05$. **$p < .01$. ***$p < .001$

31f. To What Extent are Aspects of Coparenting Quality Associated with Aspects of FQOL in Fathers of Children with ADHD? Bivariate Pearson Correlation analyses were conducted to determine the extent to which aspects of coparenting (coparenting agreement, coparenting closeness, exposure to conflict, coparenting support, coparenting undermining, endorse partner parenting, and division of labor) were associated with aspects of FQOL (family interaction, parenting, emotional well-being, physical/material well-being, and disability-related support) in fathers of children with ADHD. The results are displayed in Table 68.

Table 68

Correlation Matrix for Aspects of Coparenting Quality and FQOL – Fathers of Children with ADHD

		Family Interaction	Parenting	Emotional Well-Being	Physical/ Material Well-Being	Disability-Related Support
Coparenting Agreement	*r*	.101	.054	.186	.148	.050
	p	.618	.789	.352	.460	.805
	n	27	27	27	27	27
Coparenting Closeness	*r*	.514**	.488**	.011	.253	.210
	p	.006	.010	.958	.203	.294
	n	27	27	27	27	27

Exposure to Conflict	*r*	-.111	-.037	.190	-.117	.002
	p	.580	.853	342	.561	.991
	n	27	27	27	27	27
Coparenting Support	*r*	.566**	.408*	.331	.423*	.556**
	p	.002	.035	.091	.028	.003
	n	27	27	27	27	27
Coparenting Undermining	*r*	-.135	-.048	.149	-.009	.252
	p	.501	.811	.457	.963	.204
	n	27	27	27	27	27
Endorsement of Partner's Parenting	*r*	.549**	.452*	.087	.351	.220
	p	.003	.018	.668	.073	.271
	n	27	27	27	27	27
Division of Labor	*r*	.065	.071	-.325	.069	-.158
	p	.748	.726	.098	.733	.432
	n	27	27	27	27	27

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

31g. To What Extent are Aspects of Coparenting Quality Associated with Aspects of FQOL in Mothers of Children with ASD+ADHD? Bivariate Pearson Correlation analyses were conducted to determine the extent to which aspects of coparenting (coparenting agreement, coparenting closeness, exposure to conflict, coparenting support, coparenting undermining, endorse partner parenting, and division of labor) were associated with aspects of FQOL (family interaction, parenting, emotional well-being, physical/material well-being, and disability-related support) in mothers of children with ASD+ADHD. The results are displayed in Table 69.

Table 69

Correlation Matrix for Aspects of Coparenting Quality and FQOL – Mothers of Children with ASD+ADHD

		Family Interaction	Parenting	Emotional Well-Being	Physical/ Material Well-Being	Disability-Related Support
Coparenting Agreement	r	.410***	.433***	.208	.140	.146
	p	< .001	< .001	.089	.256	.235
	n	68	68	68	68	68
Coparenting Closeness	r	.622***	.524***	.338**	.107	.201
	p	< .001	< .001	.005	.387	.101
	n	68	68	68	68	68
Exposure to Conflict	r	-.529***	-.376**	-.139	-.250	-.074
	p	< .001	.002	.258	.040	.546
	n	68	68	68	68	68
Coparenting Support	r	.476***	.447***	.231	.145	.201
	p	< .001	< .001	.058	.239	.100
	n	68	68	68	68	68
Coparenting Undermining	r	-.492***	-.425***	-.063	-.244*	-.151
	p	< .001	< .001	.608	.045	.220
	n	68	68	68	68	68
Endorsement of Partner's Parenting	r	.463***	.567***	.301*	.245*	.264*
	p	< .001	< .001	.013	.044	.029
	n	68	68	68	68	68
Division of Labor	r	.366**	.271*	.147	.093	.198
	p	.002	.025	.232	.451	.106
	n	68	68	68	68	68

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

31h. To What Extent are Aspects of Coparenting Quality Associated with Aspects of FQOL in Fathers of Children with ASD+ADHD? Bivariate Pearson Correlation analyses were conducted to determine the extent to which aspects of coparenting (coparenting agreement, coparenting closeness, exposure to conflict, coparenting support, coparenting undermining, endorse partner parenting, and division of labor) were associated with aspects of FQOL (family interaction, parenting, emotional well-being, physical/material well-being, and disability-related support) in fathers of children with ASD+ADHD. The results are displayed in Table 70.

Table 70

Correlation Matrix for Aspects of Coparenting Quality and FQOL – Fathers of Children with ASD+ADHD

		Family Interaction	Parenting	Emotional Well-Being	Physical/ Material Well-Being	Disability-Related Support
Coparenting Agreement	r	-.078	-.103	-.246*	-.012	-.176
	p	.538	.414	.049	.926	.160
	n	65	65	65	65	65
Coparenting Closeness	r	.606***	.483***	.302*	.556***	.448***
	p	< .001	< .001	.015	< .001	< .001
	n	65	65	65	65	65
Exposure to Conflict	r	.023	.007	.107	-.038	.058
	p	.857	.958	.399	.767	.647
	n	64	64	64	64	64
Coparenting Support	r	.574***	.527***	.454***	.564***	.475***
	p	< .001	< .001	< .001	< .001	< .001
	n	64	64	64	64	64
Coparenting Undermining	r	.250*	.208	.384**	.182	.312*
	p	.048	.101	.002	.153	.013
	n	63	63	63	63	63
Endorsement of Partner's Parenting	r	.511***	.514***	.158	.578***	.373**
	p	< .001	< .001	.213	< .001	.002
	n	64	64	64	64	64
Division of Labor	r	-.031	-.030	-.259*	.008	-.182
	p	.812	.813	.041	.952	.153
	n	63	63	63	63	63

*p < .05. **p < .01. ***p < .001

Discussion

This study represents the first investigation into the connection between two important family processes, coparenting quality and FQOL, within a sample of mothers and fathers of neurodevelopmentally diverse children. A cross-sectional design was used to investigate the association between coparenting quality and FQOL in families of NT children and families of children with clinically significant symptoms of ASD and/or ADHD, as well as investigating the differences in experiences of coparenting quality and FQOL of mothers and fathers. Attempts were made to take a systemic approach, by recruiting parent dyads (paired mothers and fathers), examining differences between mothers and fathers, and creating collective (composite) coparenting quality and FQOL scores to examine the extent to which collective coparenting quality predicts collective FQOL, as well as the potential moderating role of child ND symptomology.

In the investigation of coparenting quality and FQOL across groups, several key findings emerged for mothers and fathers. Specifically, mothers of NT children experienced higher coparenting quality and FQOL than mothers of children with clinically significant symptoms of ADHD or ASD+ADHD. Mothers of children with ASD alone also had higher FQOL than those with ASD+ADHD. Fathers of NT children experienced higher coparenting quality than fathers of children with ASD and/or ADHD. Fathers of children with ADHD also had higher coparenting quality than fathers of children with ASD+ADHD. Fathers of NT children experienced higher FQOL than fathers of children with ASD+ADHD. Regarding gender differences within parent dyads, there were no significant differences in experiences of coparenting quality or FQOL between mothers and fathers. In a further investigation of coparenting quality and FQOL, higher coparenting quality predicted higher FQOL (above and beyond cognitive functioning and child age) in mothers, fathers, and paired parents of NT children, mothers of children with ADHD, fathers of children with ASD, and mothers and fathers of children with ASD+ADHD. Child ND symptomology did not moderate this association. The following sections provide a detailed discussion of the results of this study. A summary of key findings can be found in Appendix J.

Coparenting Quality Across Neurodevelopmental Groups

Mothers' Coparenting Quality Across Neurodevelopmental Groups

First, mothers' perspectives on their coparenting quality were compared across neurodevelopmental groups. Partially supporting the hypothesis, mothers of NT children reported significantly higher levels of coparenting quality than mothers of children with clinically significant ADHD symptoms and mothers of children with clinically significant ASD+ADHD symptoms. These results can be interpreted as somewhat consistent with FST (Minuchin, 1985) and Feinberg's (2003) ecological model of coparenting, as the individual child characteristics of ADHD and ASD+ADHD symptomology may have had an impact on the coparenting subsystem in these families. It is possible that managing symptoms of ADHD and ASD+ADHD places greater demand on the coparenting relationship, that is not present to the same extent in families of NT children. This is consistent with past research demonstrating that parents of children with ADHD and ASD+ADHD experience higher parenting stress than parents of NT children (Hayes & Watson, 2013; Hong et al., 2021; Theule et al., 2013; Van Steijn et al., 2014). Parents who experience higher levels of stress may lack the resources to engage in coparenting practices that are beneficial but, perhaps, more effortful. Previous research has demonstrated connections between parenting stress and lower coparenting quality (e.g., Bronte-Tinkew et al., 2010; Downes & Cappe, 2021; May et al., 2015; McDaniel et al., 2018; Thullen & Bonsall, 2017). Furthermore, these results are consistent with previous research linking child ADHD symptoms with a poorer quality parenting alliance based on reports from mothers (Williamson & Johnston, 2016). Given that ADHD is thought to have a large degree of heritability (APA, 2022), it is also possible that parents of children with clinically significant levels of ADHD symptomology experience some degree of ADHD symptomology themselves.

Adults with ADHD have been found to be at risk for elevated interpersonal conflict sensitivity to perceived rejection and discord within familial relationships (APA, 2022; Eakin et al., 2004).

Interestingly, mothers of NT children did not report significantly higher levels of coparenting quality than mothers of children with clinically significant ASD symptomology. Several factors may have impacted this finding. First, the subsample of mothers of children with symptoms of ASD only (no co-occurring ADHD) was relatively small (n = 11). Second, the distribution of coparenting scores of mothers of children with symptoms of ASD was not normally distributed, rather appearing bimodal. This may suggest more varied coparenting experiences amongst mothers of children with ASD. For instance, some families may find that the experience of parenting a child with ASD prompts reorganization of roles and increased attention on working together to meet the child's needs and is beneficial to the coparenting relationship (Downes & Cappe, 2021; Hock et al., 2012), while others may find that factors such as elevated parenting stress make it more difficult to share and coordinate surrounding childrearing labour (Downes & Cappe, 2021). In addition, it is important to note that variability in ASD symptomology and presentations may have an influence on parents' coparenting experiences. Notably, while mothers in the ASD group would have endorsed clinical levels of ASD symptomology, the average level of ASD symptomology was lower in the ASD group than the ASD+ADHD group, in which mothers reported lower coparenting quality.

Exploratory Analyses of Aspects of Coparenting Across Neurodevelopmental Groups of Mothers. The pattern of results for mothers' coparenting closeness was somewhat different than that for overall coparenting quality. Mothers of NT children reported higher levels of coparenting closeness than mothers of children with clinically significant levels of ADHD symptomology. These results suggests that mothers of NT children report a greater ability to share the joys of parenting with their coparent than mothers of children with symptoms of ADHD. Research specifically addressing coparenting closeness is scarce; however, this finding is consistent with previous research demonstrating greater levels of parenting stress in parents of children with ADHD than parents of NT children (Theule et al., 2013). Mothers who experience higher levels of parenting stress may find fewer opportunities to engage mindfully in the joys of parenthood and share those joys with their parenting partner. In addition, due the high degree of heritability of ADHD (APA, 2022), parents of children with ADHD may themselves exhibit more symptoms of ADHD, which could present challenges for sharing moments of childrearing joy. For instance, parents with more symptoms of ADHD may have more difficulty attending to positive parenting experiences or their partner's bids for shared attention towards joyful moments. This could affect mothers of children with ADHD if they themselves have greater symptoms of ADHD or if their coparent has greater symptoms of ADHD, as coparenting closeness necessitates shared experiences. In the current study, 23% of mothers in the ADHD group reported having their own diagnoses of ADHD.

Mothers of NT children reported greater levels of endorsement of their partner's parenting and lower levels of coparenting undermining and exposure to conflict than mothers of children with clinically significant levels of ASD+ADHD symptomology. These results suggest that mothers of NT children experience greater levels of endorsement for their partner's parenting, less frequent coparenting behaviours from their partners that compromise their parenting effectiveness or confidence (e.g., criticism, disparagement, blame, or competitiveness), and less conflict in the presence of their child than mothers of children with clinically significant ASD+ADHD symptomology. This could be indicative of coparents engaging in more positive forms of parenting and/or mothers taking a more positive view of their partner's parenting. In either case, these findings are consistent with the suggestions that mothers of NT children tend to experience less parenting stress than mothers of children with NDs (e.g., Hayes & Watson, 2013; Theule et al., 2013). Moreover, some research indicates that children with ASD+ADHD have greater support needs, are at risk for more co-occurring conditions, and are likely to present with the combined hyperactive/impulsive and inattentive presentations of ADHD (Zablotsky et al., 2020), which may contribute to stress. Therefore, parents of children with ASD+ADHD may experience greater demands on their mental and emotional resources, which could make it more difficult to inhibit impulses to engage in undermining or conflictual coparenting behaviours. Furthermore, if a mother's coparent has symptoms of ASD and/or ADHD, they may also find it difficult to inhibit these behaviours. In addition, it is possible that parents of children with significant symptoms of ASD and/or ADHD have greater difficulty finding alone-time to discuss difficult topics that may trigger conflict without their children present, due to their children's greater needs for support or supervision. See Appendix K for discussion of aspects of coparenting for which there were no significant differences between mothers across groups.

Fathers' Coparenting Quality Across Neurodevelopmental Groups

Next, fathers' perspectives on their coparenting quality were compared across neurodevelopmental groups. As hypothesized, fathers of NT children reported higher levels of coparenting quality than fathers in all of the ND groups (fathers of children with clinically significant levels of ASD, ADHD, and ASD+ADHD symptomology). In addition, fathers of children with significant ADHD symptomology reported higher levels of coparenting quality than fathers of children with significant ASD+ADHD symptomology.

These results are consistent with previous research indicating that parents of children with NDs are required to manage more challenging child behaviours (Brobst et al., 2009; Kaiser et al., 2011) and higher levels of parenting stress compared to parents of NT children (Brobst et al., 2009; Estes et al., 2012; Hayes & Watson, 2013; Keen et al., 2010; May et al., 2015; Steijn et al. 2014; Theule et al., 2013; Tomanik et al., 2004). Furthermore, the significant difference in coparenting scores for fathers of children with elevated symptoms of ADHD compared to ASD+ADHD suggests that fathers of children with co-occurring NDs may experience greater demands on the coparenting subsystem. The difference in significant findings between mothers and fathers regarding coparenting in families of children with ASD may be reflective of previous research indicating stronger associations between coparenting quality and parenting stress for fathers than mothers (Downes & Cappe, 2021; May et al., 2015; Thullen & Bonsall, 2017).

Exploratory Analyses of Aspects of Coparenting Across Neurodevelopmental Groups of Fathers. Fathers of NT children reported higher levels of coparenting agreement than fathers in all the ND groups. In addition, fathers of children with significant ADHD symptomology reported higher levels of coparenting agreement than fathers of children with significant ASD+ADHD symptomology. This pattern of results was the same as the pattern for fathers' overall coparenting quality scores. As discussed above within the context of mothers, one possible conceptualization for differences in coparenting agreement amongst fathers of children with different neurodevelopmental profiles lies with previously studied differences in parenting stress. Parents of children with neurodevelopmental disorders have been found to report greater levels of parenting stress than parents of NT children (e.g., Hayes & Watson, 2013; Theule et al., 2013). Therefore, fathers of children with NDs may have greater pressures on their time and mental resources, which may increase the difficulty associated with coordinating childrearing approaches. Additionally, previous research has demonstrated a stronger association between parenting stress and coparenting quality in fathers than mothers

(Downes & Cappe, 2021; May et al., 2015; Thullen & Bonsall, 2017). Therefore, increased parenting stress may have a greater impact on the way fathers perceive their coparenting relationship than it does for mothers.

Fathers of NT children reported greater levels of endorsement of their partner's parenting than fathers in all the ND groups. The pattern of results was similar to that for overall coparenting quality, except for the lack of significant difference between fathers of children with ADHD and ASD+ADHD. These results suggest that fathers of NT children express greater levels of endorsement for their partner's parenting than fathers of children with clinically significant ASD and/or ADHD symptomology. As stated above, this could indicate that their coparents are engaging in higher quality parenting and/or that fathers of NT children view their coparents more positively. This may be due in part to less challenging behaviours and less parenting stress compared to parents of children with NDs (e.g., Brobst et al., 2009; Hayes & Watson, 2013; Kaiser et al., 2011; Theule et al., 2013).

Fathers of children with symptoms of ASD+ADHD reported less satisfaction with division of labor and higher levels of exposure to conflict than fathers in all the other groups. These results suggest that fathers of children with clinically significant symptoms of ASD+ADHD experience lower levels of satisfaction with the way that childrearing responsibilities are shared and more conflict in the presence of their child than fathers of NT children or children with symptoms of ASD or ADHD alone. Differences in division of labor may be reflective of the greater support needs of children with ASD+ADHD (Zablotsky et al., 2020). If there is more childrearing labor to share between coparents, this may increase the perception that one is doing more than their fair share of work. Differences in exposure to conflict are consistent with previous research indicating that parents of children with NDs experience greater levels of parenting stress (e.g., Hayes & Watson, 2013; Theule et al., 2013) and that children with ASD+ADHD tend to have greater support needs, more co-occurring conditions, and often present with the combined hyperactive/impulsive and inattentive subtype of ADHD (Zablotsky et al., 2020), which may increase stress. Of note, the distribution of exposure to conflict scores for the ND groups showed varying degrees of bimodality, which suggests the potential for subgroups of fathers within ND groups that differ with regards to one or more other variables (e.g., symptom severity, parent mental health, or other stressors on the family system).

Fathers of NT children reported lower levels of coparenting undermining than fathers of children with symptom of ASD and ASD+ADHD. Additionally, fathers of children with clinically significant symptoms of ADHD reported less coparenting undermining than fathers of children with clinically significant symptoms of ASD+ADHD. As discussed above, these results can be conceptualized within the context of parents of children with ASD experiencing greater parenting stress (e.g., Hayes & Watson, 2013), which may reduce mental and emotional resources to inhibit coparenting undermining behaviours. Additionally, as discussed above, parents of children with ASD (with or without ADHD) may have more symptoms themselves and may have greater difficulty navigating the coparenting relationship and avoiding behaviours that may be experienced as undermining by their coparent. Again, the finding that fathers of children with ASD+ADHD experience more coparenting undermining than fathers of ADHD alone is consistent with the idea that co-occurring disorders present greater challenges to the parents (Zablotsky et al., 2020), and thus the coparenting relationship. See Appendix K for discussion of aspects of coparenting for which there were no significant differences between fathers across groups.

FQOL Across Neurodevelopmental Groups

Mothers' FQOL Across Neurodevelopmental Groups

To gain a better understanding of FQOL in neurodevelopmentally diverse families, mothers' perspectives on their FQOL was compared across neurodevelopmental groups. Of note, findings discussed in this section resulted from mothers' reports of their family's FQOL. In partial support of the hypothesis, mothers of NT children reported significantly higher levels of FQOL than mothers of children with clinically significant ADHD symptomology and mothers of children with clinically significant ASD+ADHD symptomology. In addition, mothers of children with significant ASD symptomology reported higher levels of FQOL than mothers of children with significant ASD+ADHD symptomology.

These results can be viewed as in partial support of Zuna et al.'s (2010) unified theory of FQOL, in that the individual family-member factor of child ADHD and ASD+ADHD symptoms may have influenced mothers' perspectives on FQOL. Ideally, FQOL is determined collectively by all members of the family. Therefore, these results are interpreted with the caveat that they speak to FQOL on a more individually defined level, as evaluated by mothers. Nevertheless, the approach of having an individual family member, often mothers, report on FQOL has been quite common (e.g., Brown et al., 2006; Gardiner & Iarocci, 2015; Summers et al., 2007), which allows for comparison with findings from previous studies. The pattern of results is consistent with previous research comparing FQOL across families of children with ASD, ADHD, and ASD+ADHD by Green et al. (2016), in which parents of children with ASD+ADHD had the lowest FQOL, followed by families of children with ADHD, and families of NT children had the highest FQOL. The significant difference between mothers of children with symptoms of ASD and mothers of children with symptoms of ASD+ADHD is consistent with previous research suggesting that higher levels of ADHD symptomology in children with ASD is associated with greater affective problems, anxiety problems, pervasive developmental problems, oppositional defiant problems, and parenting stress (Hong et al., 2021), all of which could reasonably impact FQOL.

Similar to the results for mothers' coparenting quality, the nonsignificant difference in FQOL scores between mothers of NT children and children with symptoms of ASD may be in part due to the small subsample size (n = 15). Furthermore, there may be an impact of a self-selection bias in that mothers of children with ASD who have time and energy to complete a survey may experience fewer challenges than what may be typical in the larger population. In addition, symptom severity has been found to be inversely related to FQOL (Wang et al., 2004); therefore, it is possible that if children with more severe symptoms of ASD tended to also meet criteria for ADHD, then children in the ASD only group may have had lower symptom severity, and their mothers may experience higher FQOL. It is also possible that the symptoms of ASD have less impact on the perspectives on FQOL of mothers in this sample than symptoms of ADHD. Specifically, the challenging behaviours associated with hyperactivity and impulsivity may have a greater impact on mothers' views of family life than the social difficulties, rigidity, or repetitive behaviours associated with ASD. Previous research has found higher rates of child externalizing behaviours, which are associated with parenting stress and may impact FQOL, in children with ADHD (Craig et al., 2016). It has been suggested that parents' attributions for challenging child behaviours may play a role in determining the extent to which these behaviours increase parenting stress (Miranda et al., 2015). Specifically, parents of children with symptoms of ADHD may perceive their children as being more capable of controlling challenging behaviours; whereas challenging behaviours associated with ASD may be viewed as more unintentional and/or outside of children's control (Miranda et al., 2015), allowing for greater understanding and compassion. Research on parental attributions for behaviour of children with NDs shows mixed results; however, some research indicates that parents of children with greater ASD symptomology are more likely to attribute behavior problems to characteristics that are more internal, stable, and less controllable by their child (Hartley et al., 2013). In addition, biased child-responsible attributions seem to be associated with elevated child externalizing symptoms and behavior (Kil et al., 2021).

Exploratory Analyses of Aspects of FQOL Across Neurodevelopmental Groups of Mothers. Consistent with mothers' perspectives on overall FQOL, mothers of NT children reported greater satisfaction with family interaction, parenting, and disability-related support than mothers of children with clinically significant levels of ADHD and ASD+ADHD symptomology. This is also consistent with previous research indicating that parents of children with disabilities tend to report concerns with a perceived lack of opportunities to engage positively or participate in activities with family members (Brown et al., 2003; Brown et al., 2006; Poston et al., 2003). Lower satisfaction with parenting in mothers of children with ADHD may be connected to challenges with social skills and aggressive behaviours that are associated with increased ADHD symptomology (Kaiser et al., 2011), higher levels of home chaos (Mokrova et al., 2010), increased parenting stress (Theule et al., 2013), and lower quality parenting alliance (Williamson & Johnston, 2016). Furthermore, in families of children with ASD+ADHD, parenting may be affected by greater affective, anxiety, and oppositional/defiant problems in children (Hong et al., 2021), as well as increased parenting stress (Hong et al., 2021; Van Steijn et al., 2014). Of note, the phrasing the of disability-related support questions were altered to be applicable to parents of all children; therefore, these results speak to a general sense of whether children have the support they need to accomplish goals at school and at home, to make friends, and the nature of the relationship the family has with their child's support service providers. For example, the item "my family member with a disability has support to make friends" was revised to "my family member has support to make friends". Nevertheless, this subscale provides insight into parents' perspectives on FQOL performance concepts, which include the services their families receive, and systemic concepts, such as the education system or specific programs they engage with (Zuna et al., 2010). These results are unsurprising, given that children with ADHD and ASD+ADHD are likely to have greater support needs. While many families of children with NDs may have positive impressions of their services providers, it may be the case that the support they receive is not sufficient (e.g., not enough hours of educational or therapeutic support or insufficient availability of support providers).

There were some deviations from normality within the subsamples' family interaction, parenting, and disability-related support scores. These deviations were generally consistent with the pattern of results; however, as noted above, the small size (n = 15) of the ASD group may have reduced power to detect true differences from other groups. Relatively similar average family interaction and parenting scores between the ASD group and the NT group are also consistent with research indicating that parents of children with disabilities often rate family relationships positively (Brown et al., 2003; Brown et al., 2006; Summers et al., 2007) and some parents of children with ASD feel that their child's ND has brought the family closer and taught them about compassion, tolerance, patience, and joy (Myers et al., 2009).

Similarities in the distributions of disability-related support scores for the ASD and NT groups may indicate that, while children with ASD may have greater support needs, these mothers may be quite satisfied with the performance of their service providers, viewing their children as receiving good support at home, at school, and socially, and having good relationships with their service providers. Again, sampling bias may have played a role here, as mothers of children with ASD who do not feel that their child's support needs are well met may have been less likely to have the time or energy to spend on a survey. In addition to level of support needs, the degree of access to support services between ND groups should be considered. While there seems to be a scarcity of research comparing access to support services, a large national study conducted within the US found that 86.3% of families of children with ASD and 97.7% of families of children with ASD and ID received support services (Zablotsky et al., 2015). While there is less clear evidence documenting rates of support service access for families of children with ADHD, research suggests significant barriers exist for some families (Wright et al., 2015). For instance, one study found that, of children who were screened as at high risk of ADHD, only 23% were receiving current treatment (Bussing et. al., 2003). Another study indicated that 77% of mothers of children with ADHD reported accessing school-related services for their child and 59% accessed counseling services for their child (Kendall et al., 2005). Therefore, it is possible that systemic and performance concepts (i.e., systems, policies, programs, and services; Zuna et al., 2010) may impact families of children with NDs differently. For instance, it may be the case that families of children with ASD have greater access to support services than families of children with ADHD.

Mothers of NT children and children with clinically significant levels of ASD symptomology reported greater satisfaction with emotional well-being than mothers of children with symptoms of ADHD and ASD+ADHD. This pattern of results was somewhat different from mothers' overall FQOL, as mothers of children with symptoms of ASD reported the highest level of satisfaction with emotional well-being within their families. Lower levels of emotional well-being reported by mothers of children with ADHD and ASD+ADHD may be reflective of the need to spend time managing child behaviours (Kaiser et al., 2011) and supporting their child's executive functioning (Schroeder & Kelley, 2009), as well as experiences of increased home chaos (Mokrova et al., 2010) and parenting stress (Theule et al., 2013). Furthermore, in families of children with ASD+ADHD, mothers may spend more time managing affective, anxiety, and oppositional/defiant problems in children (Hong et al., 2021). Attending to these difficulties may take time away from pursuing interests for mothers of children with ADHD or ASD+ADHD. Furthermore, previous research indicates that parents of children with ASD and parents of children with ADHD both experience lower levels of perceived social support than parents of NT children (Pardo-Salamanca et al., 2024). The relatively high degree of emotional well-being reported by mothers in the ASD group may be connected to some of the positive experiences of parents of children with ASD documented in previous research, such as the perspective that their child has enriched their lives (love for the child, enrichment of spiritual life, enrichment of marital life), having taught them about compassion, tolerance, patience, and joy, and increased appreciation for small things and slowing down (Myers et al., 2009).

Mothers of NT children reported greater satisfaction with physical/material well-being than mothers of children with clinically significant symptoms of ASD+ADHD. This finding is consistent with previous research showing that families of children with disabilities perceived low availability of opportunities relating to health (Brown et al., 2003) and research demonstrating higher satisfaction with health and financial well-being for families of NT children than families of children with ASD (Brown et al., 2006). This could be connected to systemic concepts of FQOL (Zuna et al., 2010) in terms of the access families of children with NDs have to appropriate health care services, policies and programs that provide financial assistance for families of children with disabilities, and the performance of these systems. Brown et al. (2006) noted that in their sample, both parents worked outside of the home in only 29% of two-parent families of children with ASD. This may suggest that parents of children with ASD may choose to have one parent stay home with their child to meet their increased support needs, which could reduce their sense of financial security. Within the current study, there was no significant difference in physical/material well-being between mothers of children with symptoms of ASD alone and any other neurodevelopmental groups. This could have been influenced by reduced power/small subsample size of the ASD group or a tendency for children with more severe symptoms of ASD to also present with clinically significant symptoms of ADHD and be placed in the ASD+ADHD group. In addition, this pattern of results and interpretation are consistent with the notions that providing appropriate support services for children can be costly for families (Zablotsky et al., 2014) and children with ASD+ADHD tend to have higher support needs (Zablotsky et al., 2020).

Fathers' FQOL Across Neurodevelopmental Groups

Fathers' perspectives on FQOL were also compared across groups. Again, findings discussed in this section resulted from fathers' reports of their family's FQOL and thus speak to an individually defined evaluation of FQOL. Overall, fathers reported a relatively high level of FQOL. In partial confirmation of the hypothesis, fathers of NT children reported significantly higher levels of FQOL than fathers of children with clinically significant ASD+ADHD symptomology. While the pattern of results was similar to the results for fathers' coparenting quality, with the scores being highest in the NT group, followed by the ADHD group, then the ASD group, and ASD+ADHD group being the lowest, the differences between the NT group and the ASD and ADHD groups were not statistically significant.

This result is partially consistent with previous research on FQOL of parents of children with ASD, ADHD, and ASD+ADHD (Green et al., 2016), as the largest difference in reported FQOL was between fathers of NT children and fathers of children with ASD+ADHD. The generally high FQOL scores are also consistent with previous research by Brown et al. (2003), indicating that families of individuals with disabilities tended to rate their FQOL quite highly. Together, these results may indicate that fathers of neurodevelopmentally diverse children maintain relatively positive perspectives on family life, despite the challenges associated with caring for a child with a disability.

Exploratory Analyses of Aspects of FQOL Across Neurodevelopmental Groups of Fathers. Consistent with their perspectives on overall FQOL, fathers of NT children reported greater satisfaction with family interaction, parenting, and disability-related support than fathers of children with clinically significant levels of ASD+ADHD symptomology. Factors such as greater support needs, affective, anxiety, and oppositional/defiant problems in children (Hong et al., 2021; Zablotsky et al., 2020), as well as increased parenting stress (Hong et al., 2021; Van Steijn et al., 2014) may make challenges to family interaction and parenting most salient for fathers of children with ASD+ADHD. Similarly, the higher support needs of children with ASD+ADHD (Zablotsky et al., 2020) may surpass the support provided by disability-related services. Thus, these results speak to parents' perceptions of the performance concepts, such as services and supports for their children (Zuna et al., 2010). Children with ASD only and ADHD only likely have higher support needs than NT children; however, fathers of children with symptoms of ASD only and ADHD only in this sample seem to be fairly satisfied with the performance of the support/service that their children receive at home, at school, and socially, and that they have good relationships with their support providers.

Interestingly, the distribution of family interaction scores of the ASD+ADHD group was somewhat bimodal, possibly suggesting a small group of fathers who are experiencing particularly impactful challenges to family interaction. The distribution of parenting scores for the ASD+ADHD group seemed to suggest greater variability in parenting experiences. While many fathers of children with ASD+ADHD are quite satisfied with parenting, some fathers perceive notable parenting problems in their families. As discussed previously, sampling and group creation methods may have had some influence on the results for disability-related support. Specifically, fathers of children with ASD or ADHD whose children's support needs are not well met may have been less likely to participate. Furthermore, fathers of children with ASD with greater support needs may have tended to report higher levels ADHD symptomology and to be assigned to the ASD+ADHD group.

Fathers of NT children reported greater satisfaction with physical/material well-being than fathers of children with clinically significant symptoms of ASD and ASD+ADHD. As with mothers, these findings are consistent with previous research (Brown et al., 2003; Brown et al., 2006). In addition, these results are illustrative of the potential impact of performance and systemic concepts on these families' FQOL. Lower levels of satisfaction with physical/material well-being reported by fathers of children with ASD and ASD+ADHD may reflect increased costs associated with support services (Zablotsky et al., 2014), barriers to accessing appropriate health care, lack of financial supports for families of children with NDs, or families choosing to have one parent stay home to provide additional support for their child with ASD or ASD+ADHD (Brown et al., 2006). See Appendix K for discussion of emotional well-being for which there were no significant differences between fathers across groups.

Coparenting Quality Between Paired Mothers and Fathers

While, on average, mothers of NT children reported higher coparenting quality than fathers, contrary to the hypothesis, the difference was not statistically significant. These results are consistent with previous studies that have found similar ratings of coparenting quality between mothers and fathers (Feinberg et al., 2012; Schoppe-Sullivan et al., 2004). It should be noted that the sample size for paired parents of NT children was quite small (n = 15) and may have reduced the power to detect a potentially true difference. Alternatively, it is possible that particular characteristics of the current sample of paired parents of NT children may have influenced the finding. Specifically, this was a sample of paired parents who were able to coordinate such that both parents voluntarily completed a 30–45-minute research survey. Additionally, parents in the NT sample were largely White, highly educated, and married, with annual household incomes above $60,000. Therefore, these findings come from a WEIRD (Western, Educated, Industrialized, Rich, and Democratic; Henrich et al., 2010) population, and perhaps a particularly privileged subset of this population. These dyads represent families in which the parents have the tangible and mental resources to coordinate the completion of nonessential tasks, suggesting that they have relatively good organizational skills, sufficient time, and are not too overwhelmed or stressed to engage in such tasks. In addition, it is possible that this subsample of families may be more egalitarian with regards to gender roles within the family. Previous research has found parental income and education level to be predictors of more egalitarian gender attitudes in parents (Marks et al., 2009).

Similarly, contrary to the hypothesis, there were no significant differences between mothers' and fathers' reports of coparenting quality in the ASD and/or ADHD group. Furthermore, on average, mothers and fathers of children with clinically significant ND symptoms reported very similar levels of coparenting quality. For the purpose of this analysis, parent dyads from the ASD, ADHD, and ASD+ADHD groups were combined into one ND (ASD and/or ADHD) group due to small numbers of dyads in some of the individual groups. Therefore, it is possible that different patterns of results may have emerged in one or more of the individual ND groups. Alternatively, these results may indicate a true lack of difference in perceived coparenting quality between mothers and fathers of children with ASD, ADHD, and ASD+ADHD. It is important to note that similar sampling biases as discussed above regarding the NT sample, were likely factors for the ND sample.

Exploratory Analyses of Aspects of Coparenting Quality Between Paired Mothers and Fathers

Mothers of NT children reported significantly higher coparenting support and lower coparenting undermining than fathers. These results represent deviations from the nonsignificant difference in the overall coparenting quality reported by mothers and fathers of NT children. Furthermore, these results suggest that mothers of NT children feel more support from their coparent (i.e., respect for contributions, affirmations of parenting competency, and upholding of decisions and authority) and experience fewer coparenting behaviours that compromise their parenting effectiveness or confidence (e.g., criticism, disparagement, blame, or competitiveness) from their coparent than fathers. These results are consistent with previous research in which mothers’ average levels of support for their partner’s parenting were lower than that of fathers (Christopher et al., 2015).

This pattern of results may be indicative of mothers often taking on a greater proportion of household and childcare duties (Farr & Patterson, 2013; Raley et al., 2012; Van Egeren, 2004). Therefore, mothers may feel as though fathers have more respect for their childrearing competency and decision making. To some extent, fathers may find themselves falling into a secondary parenting role that involves more provision of support to mothers than active leadership or decision making. For instance, a study by Murphy et al. (2017) found that mothers had greater involvement in parenting decisions, whereas fathers showed greater support for their partner's parenting. In addition, sometimes referred to as maternal "gatekeeping," it has been suggested that mothers may limit paternal involvement or criticize fathers' childrearing attempts due to mothers' beliefs about family roles, high levels of parenting self-efficacy, lower confidence in their coparent's parenting abilities, high standards, perceived relationship instability, fear of losing validation through their role as the primary parent, or poor psychological functioning (i.e., greater neuroticism, anxiety, or depression; Allen & Hawkins, 1999; Fagan & Barnett, 2003; Schoppe-Sullivan et al., 2015). See Appendix K for discussion of aspects of coparenting for which there were no significant differences between paired mothers and fathers.

FQOL Between Paired Mothers and Fathers

While on average, mothers of NT children reported higher FQOL than fathers, contrary to the hypothesis, the difference was not statistically significant in the NT group. Furthermore, as with coparenting quality, the pattern of results was in the opposite direction than what was hypothesized. Similar factors as discussed for the comparison of coparenting quality between mothers and fathers may have impacted this analysis. Again, the sample of paired mothers-father dyads in the NT group was small (n = 19), thus reducing the power of the analysis. Both mothers and fathers in the dyadic sample of NT parents reported relatively high levels of FQOL on average. This is consistent with the interpretation that this subsample of parents was likely high-functioning, socio-economically privileged, and not overly stressed or overwhelmed.

In addition, contrary to the hypothesis, there were no significant differences between mothers' and fathers' reports of FQOL in the ASD and/or ADHD group. On average, mothers and fathers of children with clinically significant ND symptoms reported essentially the same level of FQOL. These results are inconsistent with previous studies in which mothers of children with disabilities reported lower FQOL than fathers (Hsiao, 2018; McStay et al., 2014); however, they are consistent with some previous research that found no significant differences in FQOL based on parent gender (Wang et al., 2006; Zabriskie & McCormick, 2003). See Appendix K for discussion of nonsignificant results for differences in aspects of FQOL between paired mothers and fathers.

Coparenting Quality as a Predictor of FQOL

Results regarding the extent to which perceived coparenting quality predicted perceived FQOL, above and beyond effects of child age and child cognitive functioning were mixed. Specifically, results differed across samples of mothers and fathers in each of the neurodevelopmental groups. Hypotheses were confirmed in the following subsamples: mothers of NT children, fathers of NT children, paired parents of NT children, fathers of children with symptoms of ASD, mothers of children with symptoms of ADHD, mothers of children with symptoms of ASD+ADHD, and fathers of children with symptoms of ASD+ADHD. Coparenting quality did not significantly predict FQOL for mothers of children with symptoms of ASD, fathers of children with symptoms of ADHD, and paired parents of children with symptoms of ASD and/or ADHD. Across all subsamples, the association between coparenting quality and FQOL was positive, such that increases in coparenting quality were connected to increases in FQOL; however, the association was not significant in all cases. While possible paths through which coparenting quality and FQOL may be interconnected (with potential influences on each other) will be discussed, it is crucial to acknowledge that this study was cross-sectional and results are based on correlation, which does not imply causation.

Significant results for parents (mothers, fathers, and dyads) of NT children, fathers of children with symptoms of ASD, mothers of children with symptoms of ADHD, and mothers and fathers of children with symptoms of ASD+ADHD were consistent with both FST (Feinberg, 2003; Minuchin, 1985) and Zuna's (2010) unified theory of FQOL. These results suggest that, within specific neurodevelopmental groups, the functioning of the coparenting subsystem is connected to individual family member's (mothers' and fathers') experiences and perceptions of the family (Feinberg, 2003; Minuchin, 1985). It is possible that the positive functioning within the coparenting relationship may improve FQOL through the benefits it offers for individual family members. For instance, high coparenting quality may have benefited individual parental adjustment for parents in particular neurodevelopmental groups (Feinberg, 2003) such that they have more positive perceptions of FQOL. If parents with positive coparenting relationships experience less parenting stress, fewer symptoms of depression, and greater parenting efficacy, they may feel more positively about FQOL (Solmeyer & Feinberg, 2011). Similarly, if parents with positive coparenting relationships observe positive child adjustment (Teubert & Pinquart, 2010), such as fewer child internalizing and externalizing symptoms, higher levels of social functioning, and secure attachment, coparenting may influence their perceptions of FQOL by way of the individual child. As each family member contributes to the overall FQOL through individual family-member factors (Zuna et al., 2010), this could be a possible way of understanding the ability of coparenting to predict parents' perceptions of FQOL in some families.

In addition to the possible influence of individual-level factors, it is possible that coparenting may influence FQOL as a family-unit factor. The unified theory of FQOL (Zuna et al., 2010) posits that family dynamics, interactions and relationships between family members, are family unit factors that influence FQOL. Therefore, the role of coparenting, which represents the interactions and relationship between parents, in predicting FQOL may be understood in its role as a family dynamic. When parents evaluate overall FQOL, they are likely to consider their level of satisfaction with interactions and relationship between family members, including between themselves and their partners. Through a measurement lens, in considering the FQOL questionnaire used in this study, coparenting quality may directly influence the family interaction subscale and the parenting subscale.

Relatedly, parents' perceptions of coparenting and FQOL may be linked by association with another family process, such as parenting stress. For instance, having a high-quality coparenting relationship may reduce levels of parenting stress (e.g., Abidin & Brunner, 1995; Downes & Cappe, 2021; May et al., 2015), which then improves FQOL. If parents are able to coordinate childrearing responsibilities effectively, receive support from their coparent, and can depend on them to share childrearing labor, they are likely to experience less parenting stress and perceive FQOL more positively. Conversely, poor quality coparenting has been linked to increased parenting stress (Solmeyer & Feinberg, 2011), and parenting stress is associated with lower FQOL (Droogmans et al., 2021; Hsiao et al., 2017; Zeng et al., 2020). When parents cannot count on a partner to support them in their parenting responsibilities, or when their coparent undermines their childrearing efforts, this is likely to increase parenting stress and negatively impact their perception of FQOL.

Nonsignificant results may have been influenced by several factors. First, the sample size of the subsamples of mothers of children with symptoms of ASD and fathers of children with symptoms of ADHD were somewhat small. This may have reduced the power to detect a potential significant effect. Second, violations of assumptions may have had an impact. For mothers of children with symptoms of ASD, the FQOL scores were not normally distributed and there was a considerable degree of heteroscedasticity. For fathers of children with ADHD, child cognitive functioning may have played a role in the results. Specifically, child cognitive functioning had a large, negative association with child age and a medium positive association with FQOL, whereas coparenting had a nonsignificant correlation with FQOL. Furthermore, the inclusion of coparenting quality did not significantly improve the portion of the variance in FQOL that could be predicted. This suggests that child cognitive functioning was more closely connected to FQOL in fathers of children with symptoms of ADHD. After controlling for the predictive effects of child cognitive functioning, there may have been less variance available to be explained by differences in coparenting quality. For the sample of paired parents of children with symptoms of ASD+ADHD, there were only mild deviations from normality.

Overall, fathers of children with symptoms of ADHD had relatively positive perceptions FQOL. Within this subsample, child cognitive functioning was significantly associated with FQOL, while coparenting quality was not. As fathers' reports of cognitive functioning increased, perceived FQOL increased. It is possible that fathers of children with lower cognitive functioning and clinically significant symptoms of ADHD encounter more behavioural challenges. These children may have more difficulty learning about the consequences of their actions and learning strategies to regulate challenging behaviours associated with hyperactivity and impulsivity. Some research suggests that children with both mild IDD and ADHD display more symptoms of conduct disorder than children with ADHD alone or IDD alone (Ahuja, et al., 2013). In the current study, within the subsample of fathers of children with symptoms of ADHD, 53% of fathers reported child conduct problems in the clinically elevated range. This was second only to 68% of fathers in the ASD+ADHD group. These behavioural challenges could have a more significant impact on FQOL than variation in coparenting quality.

Exploratory Analyses of Associations Between Aspects of Coparenting Quality and FQOL

Coparenting Agreement

Coparenting agreement shared significant, positive associations with family interaction and parenting for parents of NT children, as well as mothers of children with ADHD and ASD+ADHD. This association may suggest that shared values and communications skills that allow for agreement to be reached also apply to many family and parenting interactions. Coparenting agreement also shared significant, positive associations with emotional well-being for mothers of NT children, mothers of children with ADHD, and fathers of children with ASD. Perhaps parents who share values feel more emotionally fulfilled and may share common interests that they can engage with. Interestingly, coparenting agreement was negatively associated with emotional well-being for fathers of children with ASD+ADHD. This association is conceptually inconsistent and may have been influenced by deviations from normality in the distributions of scores. Coparenting agreement was associated with disability-related support for mothers of children with ADHD and fathers of NT children. Shared values and communication skills that allow for agreement to be reached may aid some parents in completing the tasks needed to choose and access supports for their children. Finally, coparenting agreement was associated with physical/material well-being for mothers of NT children, although the reason for this relation is less conceptually clear. See Appendix K for discussion of nonsignificant results relating to coparenting agreement.

Coparenting Closeness

For all parents, endorsement of partner's parenting shared significant, positive associations with family interaction and parenting. It is unsurprising that parents who share joys of parenting with their coparent tend to be satisfied with the family interactions and parenting within their families, as these are relational aspects of FQOL. Coparenting closeness was also associated with emotional well-being for parents of NT children and children with symptoms of ASD+ADHD, mothers of children with ADHD, and fathers of children with ASD. This is conceptually consistent, as both variables have connections to parents' emotions. Interestingly, coparenting closeness was associated with physical/material well-being for parents of children with ASD, fathers of NT children and children with ASD+ADHD, and mothers of children with ADHD. While the reason for this association is less conceptually clear, it is possible that parents with less financial stress experience fewer barriers to connecting emotionally with their coparent. Finally, coparenting closeness shared associations with the full range of FQOL components for fathers of NT children and children with ASD+ADHD, as well as mothers of children with ADHD, suggesting broader qualities of connection that extend to many domains of family life.

Exposure to Conflict

Exposure to conflict shared a significant, negative association with family interaction for mothers of NT children and mothers of children with ADHD and ASD+ADHD. Similarly, there was a negative association with parenting for mothers of NT children and mothers of children with ASD+ADHD. In addition, exposure to conflict was negatively associated with emotional well-being for mothers of NT children. The negative associations between exposure to conflict and family interaction, parenting, and emotional well-being are quite understandable, as conflict would likely have a negative impact on relational and emotional aspects of FQOL. Exposure to conflict was also negatively associated with physical/material well-being for mothers of children with ADHD. It may be that conflict leads mothers of children with ADHD to feel less safe at home. Alternatively, there may be stressors or individual characteristics that create pressure on families and lead to both increases in negative forms of coparenting and create barriers to physical/material well-being. Interestingly, exposure to conflict was negatively associated with disability-related support for fathers of NT children. While this result suggests that fathers who experience more coparenting conflict tend to be less satisfied with the level of support their children have to achieve their goals, the reasons for this are less conceptually clear. See Appendix K for discussion of nonsignificant results relating to exposure to conflict.

Coparenting Support

For all parents (mothers and fathers of children with and without ND symptomology), coparenting support shared significant, positive associations with family interaction and parenting. This is unsurprising, as these variables share common themes of support, understanding, communication, teamwork, and positive relational functioning (including parenting). In addition, coparenting support was associated with emotional well-being, and physical/material well-being of mothers of children with ASD, and physical/material well-being, and disability-related support of fathers of children with ADHD. For parents of NT children, mothers of children of ADHD, fathers of children with ASD, and fathers of children with ASD+ADHD, coparenting support shared significant, positive associations with all FQOL components (family interaction, parenting, emotional well-being, physical/material well-being, and disability-related support). For parents of NT children, children with ADHD, children with

ASD, and fathers of children with ASD+ADHD, coparenting support was the most (or amongst the most) closely connected to the widest range of aspects of FQOL. For these parents, when they feel supported in their parenting by their partner, they also seem to have positive perceptions of nearly all aspects of FQOL. This may indicate broader qualities of support, respect for contributions, and affirmations of competency that affect many domains of family life.

Coparenting Undermining

Coparenting undermining shared significant, negative associations with family interaction and parenting for mothers of NT children and mothers of children with ADHD and ASD+ADHD. These connections are conceptually consistent, as these are relational aspects of FQOL. In addition, coparenting undermining was negatively associated with emotional well-being for mothers of NT children, which is unsurprising as undermining behaviour would likely have a negative impact on emotional aspects of FQOL. In addition, coparenting undermining was negatively associated with physical/material well-being for mothers of children with ADHD and ASD+ADHD. As with exposure to conflict, undermining behaviour may lead some mothers to feel less safe at home, or it may be exacerbated by stressors or individual characteristics that also create barriers to physical/material well-being. Again, like exposure to conflict, coparenting undermining was negatively associated with disability-related support for fathers of NT children. This may be connected to a sense of less support for their children from within the family. Interestingly, coparenting undermining shared significant, positive associations with family interaction, emotional well-being, and disability-related support for fathers of children with ASD+ADHD. These associations are conceptually inconsistent and may have been influenced by deviations from normality in the distribution of scores, including a subgroup of fathers who reported especially high levels of undermining. See Appendix K for discussion of nonsignificant results relating to coparenting undermining.

Endorsement of Partner's Parenting

For all parents, endorsement of partner's parenting shared significant, positive associations with family interaction and parenting. It is unsurprising that parents who perceive their coparent as a capable parent tend to be satisfied with the family interactions and parenting within their families, as these are relational aspects of FQOL. Endorsement of partner's parenting was also associated with emotional well-being for mothers of NT children, children with ADHD, and ASD+ADHD, as well as fathers of children with ASD. Perhaps having a capable coparent allows some parents the time to connect with friends or family who support them, or to pursue their interests. Endorsement of partner's parenting was associated with physical/material well-being for parents of children ASD+ADHD, mothers of children with ASD, mothers of children with ADHD, and fathers of NT children. Furthermore, there was an association with disability-related support for parents of NT children and children with ASD+ADHD, as well as mothers of children with ADHD. Connections between endorsement of partner's parenting and physical/material well-being and disability-related support are less conceptually clear; however, these connections could indicate associations between capable parenting and competence in general qualities of resourcefulness, aspects of SES (e.g., education or income), securing support for children, or the absence of barriers that could interfere with these aspects of functioning or well-being. For mothers of children with ADHD and ASD+ADHD, endorsement of partner's parenting was associated with all the FQOL components.

Division of Labor

Division of labor shared significant, positive associations with family interaction and parenting for mothers of NT children and mothers of children with ADHD and ASD+ADHD. It is unsurprising that mothers who are satisfied with the division of childrearing labor tend to be happy with the family interactions and parenting in their families. Division of labor was positively associated with emotional well-being for mothers of NT children and children with ADHD, but it was negatively associated with emotional well-being for fathers of children with ASD+ADHD. It is reasonable to expect that mothers who receive sufficient support to relieve stress and have more time to pursue their own interests tend to be more satisfied with the division of labor in their families. The negative association for fathers of children with ASD+ADHD is somewhat surprising and may have been influenced by deviations from normality in the distributions of scores. For mothers of children with ADHD, division of labor was associated with disability-related support. It may be the case that being able to share labor effectively with a coparent allows mothers of children with ADHD to complete the tasks needed to choose and access supports for their children. See Appendix K for discussion of nonsignificant results relating to division of labor.

Child ND Symptomology, Coparenting Quality, and FQOL

To further investigate the impact of child ND symptomology on parents' perceptions of functioning within the family system, the moderating role of child symptoms of ASD, ADHD, and ASD+ADHD in the association between coparenting quality and FQOL was examined. For mothers and fathers, child age, child cognitive functioning, coparenting quality, and child neurodevelopmental symptomology predicted a significant proportion of the variation in FQOL (41% and 25%, respectively). Main effects were found for coparenting quality, indicating a positive connection between parents' coparenting quality and FQOL. Main effects were also found for mothers' reports of ADHD, and ASD+ADHD symptomology, indicating that mothers of NT children report higher FQOL than mothers of children with ADHD and those with children of ASD+ADHD. However, none of the child ND symptomology variables significantly moderated the association between parents' coparenting quality and FQOL.

In considering these results, further support is provided for the perspective, based in FST and the unified theory of FQOL, that coparenting quality and FQOL are related processes. In addition, the aspects of this analysis associated with the comparison of FQOL across mothers in neurodevelopmental groups found results consistent with previous findings that mothers of NT children report higher levels of FQOL than mothers of children with disabilities (Brown et al., 2006; Poston et al., 2003). As discussed previously, the small sample size and abnormal shape of the distribution of FQOL scores for mothers of children with ASD may have contributed to the lack of significant difference between this group and the NT group. This analysis did not indicate any differences in FQOL between fathers in the different neurodevelopmental groups. The nonsignificant moderating role of child ND symptomology suggests that there is no notable difference in the strength of the association between coparenting quality and FQOL between parents of children with ASD, ADHD, ASD+ADHD, and NT children when effects of child age and child cognitive functioning are controlled for.

For paired parents, child age, child cognitive functioning, collective coparenting quality, and child neurodevelopmental symptomology predicted a nonsignificant proportion (20%) of the variation in collective FQOL. Within the group of paired parents, collective coparenting quality did not play a significant role in predicting collective FQOL. In terms of group differences, paired parents of NT children reported higher levels of collective FQOL than paired parents of children with ASD+ADHD. However, none of the child ND symptomology variables significantly moderated the association between collective coparenting quality and collective FQOL.

These results are partially consistent with research demonstrating lower FQOL in parents of children with disabilities (Brown et al., 2006; Poston et al., 2003). The lack of significant connection between perceived coparenting quality and FQOL is in line with results examining the role of coparenting quality in predicting FQOL of parents of children with ASD and/or ADHD. The sample size (n = 74), which was smaller than the sizes of the samples of mothers and fathers, may have reduced the power for detecting significant effects within the context of a model with an independent variable, two control variables, and a categorical moderator with four levels. In addition, if parents had discrepant perspectives on coparenting quality and FQOL, then there may have been fewer clear patterns that could be discerned when considering their collective perceptions. However, based on the analyses associated with RQs 3 and 4, there appeared to be significant, positive correlations between paired mothers' and fathers' coparenting and FQOL scores.

Interestingly, the distribution of collective coparenting scores for paired parents appeared to be bimodal, suggesting the existence of subgroups of couples with different coparenting experiences. This could represent differences between the neurodevelopmental subgroups. Based on the distributions of scores, it appears that the paired parents of NT children in this sample tended to have relatively positive coparenting relationships, while the paired parents of children with ASD and/or ADHD had more varied coparenting relationships. Similarly, paired parents of NT children generally reported very positive perspectives on FQOL, while paired parents of children with ASD and/or ADHD reported a wider range of experiences with FQOL; however, both distributions of FQOL scores appeared more normally distributed and there was less evidence of subgroups within either group. Taken together, these differences in patterns within the distributions of coparenting and FQOL scores may have contributed to a weaker ability for coparenting quality to predict FQOL within the dyads in this sample. Further, this may suggest a more complex relationship between dyadic coparenting and FQOL, or perhaps differing patterns within the smaller neurodevelopmental groups (ASD, ADHD, ASD+ADHD, and NT).

Summary

This study investigated differences in experiences of coparenting quality and FQOL across parents of children with different neurodevelopmental profiles. Findings indicate that mothers of children with symptoms of ADHD and ASD+ADHD and fathers of children with ASD and/or ADHD may be at greater risk for lower overall coparenting quality. In some cases, parents of children with NDs reported similar coparenting quality to parents of NT children. For instance, mothers of children with ASD reported similar levels of coparenting quality to mothers of NT children. Exploratory investigations into aspects of coparenting quality suggest that mothers of children with ASD+ADHD may be at risk for lower levels of endorsement of partner parenting, as well as higher levels of coparenting undermining and exposure to conflict. Mothers of children with ADHD may be at risk for lower levels of coparenting closeness. Fathers of children with ASD+ADHD may be at risk for lower levels of coparenting agreement, endorsement of partner parenting, satisfaction with the division of labor, as well as increased exposure to conflict and coparenting undermining. Fathers of children with ADHD may be at risk for lower levels of coparenting agreement and endorsement of partner parenting. Additionally, fathers of children with ASD may be at risk for lower levels of coparenting agreement and endorsement of partner parenting, as well as higher levels of coparenting undermining.

Regarding FQOL, findings indicate that mothers of children with ADHD and ASD+ADHD and fathers of children with ASD+ADHD may be at greater risk for lower overall experiences of FQOL. More specifically, mothers of children with ASD+ADHD may be at risk for lower satisfaction with family interactions, parenting, emotional well-being, physical/material well-being, and disability-related support. Mothers of children with ADHD may be at risk for lower satisfaction with family interactions, parenting, emotional well-being, and disability-related support. Fathers of children with ASD+ADHD may be at risk for lower satisfaction with family interactions, parenting, physical/material well-being, and disability-related support. Fathers of children with ASD may be at risk for lower satisfaction with their family's physical/material well-being. Overall, parents of children with ASD reported similar levels of FQOL to parents of NT children. Likewise, fathers of children with ADHD tended to report similar levels of FQOL to fathers of NT children.

No significant differences were found between paired mothers and fathers in terms of overall coparenting quality or FQOL, regardless of neurodevelopmental profile. When considering specific components of coparenting, mothers of NT children may experience greater coparenting support and less coparenting undermining than fathers.

To better understand the interplay of these family processes, the ability of perceived coparenting quality to predict perceived FQOL was examined. Coparenting quality predicted FQOL above and beyond child age and cognitive functioning for parents of NT children and parents of children with symptoms of ASD+ADHD, mothers of children with symptoms of ADHD, and fathers of children with symptoms of ASD. Furthermore, the strength of this association does not seem to differ depending on child ND. In addition, many components of coparenting quality and FQOL were correlated. Specifically, coparenting agreement, coparenting closeness, coparenting support, endorsement of partner's parenting, and satisfaction with division of labor were significantly associated with all, or nearly all, components of FQOL for mothers of children with ADHD. Closeness, support, and endorsement were associated with the widest range of components of FQOL for fathers of NT children and children with ASD+ADHD. Coparenting support and agreement were associated with the widest range of components of FQOL for mothers of NT children. Support was most associated with components of FQOL for mothers of children with ASD and fathers of children with ADHD, while endorsement was most closely connected with FQOL components for mothers of children with ASD+ADHD.

Study Strengths

This study builds on existing research on coparenting quality and FQOL within neurodevelopmentally diverse families and extends this research in several novel ways. First, this study is among the first to examine differences in coparenting quality and FQOL across groups of parents of children with clinically significant symptoms of ASD, ADHD, and ASD+ADHD, and NT children. Second, this study is among the first to compare perspectives on coparenting quality and FQOL between paired mothers and fathers of neurodevelopmentally diverse children. Third, this is the first study to examine the extent to which coparenting quality is associated with FQOL in parents of neurodevelopmentally diverse children. Furthermore, this study specifically examined the potential moderating effect of child neurodevelopmental disorder symptomology on the association between coparenting quality and FQOL. The use of moderation provided a deeper level of insight into the dynamics between coparenting quality and FQOL in parents of neurodevelopmentally diverse children.

There has been considerable growth within the field of coparenting research, including studies on coparenting quality within families of children with ASD and families of children with ADHD. This study has been able to build on this existing research by including a neurodevelopmentally diverse sample and comparing reported coparenting quality across families of NT children as well as children with clinically significant symptoms of ASD, ADHD, and ASD+ADHD. This allowed for examination of differences in the reported coparenting quality of mothers and fathers across neurodevelopmental groups. Similarly, FQOL has been studied within the context of families of children with various disabilities. This represents a valuable contribution in comparing levels of perceived FQOL across groups of mothers and fathers of NT children as well as children with clinically significant symptoms of ASD, ADHD, and ASD+ADHD.

In addition to allowing for comparison in coparenting quality and FQOL levels across neurodevelopmental groups, this study allowed for comparisons in perceptions of coparenting quality and FQOL between mothers and fathers. Historically, much of the research on parenting has only included mothers as research participants. Inclusion of both mothers and fathers allowed for the creation of subsamples of mothers and fathers, which increased the specificity within the analyses. Given that parenting tends to be a gendered experience, this approach increases the confidence with which specific findings can be generalized to mothers and fathers within the larger population. Furthermore, even when more current research may include fathers or parents of all genders, it is rare for studies to include both parents from the same family. By including a dyadic sample, this design facilitated comparisons between mothers' and fathers' perspectives on coparenting and FQOL. This is a considerable strength, as FST suggests that family processes are best understood within the context of the family system.

When it came to the examination of the association between coparenting quality and FQOL, efforts were made to account for additional confounding factors. Due to the understanding that parents face different demands depending on the developmental level and corresponding support needs of their child, child age and cognitive functioning was controlled for. This is important as intellectual developmental disorder can co-occur with ADHD and frequently co-occurs with ASD.

Another strength of the current study came with the inclusion of exploratory analyses focusing on the components of coparenting quality and FQOL. While there was insufficient previous research to inform specific hypotheses, the more detailed examination of aspects of coparenting quality and FQOL allowed for deepened insight into the differing experiences of mothers and fathers of children with neurodevelopmentally diverse children. Specifically, this approached allowed for a more targeted understanding of which aspects of parents' perceived coparenting and FQOL may be impacted by childhood NDs, as well the domains in which parents of children with NDs tend to have experiences that are quite similar to parents of NT children.

Study Limitations

This study sought to gain insight into the coparenting and FQOL experiences of mothers and fathers of children with ASD, ADHD, and ASD+ADHD, and NT children. The approach of examining these constructs within subsamples of mothers and fathers (grouped by gender) and parents of children in different neurodevelopmental presentations (grouped by ND symptomology) was selected based on the understanding that both individual parent characteristics (gender) and child characteristics (ND symptomology) may impact parents' experiences of coparenting and FQOL. Furthermore, experiences of paired parents (dyads) of children with clinically significant ND symptomology and NT children were examined to gain a more holistic perspective of the dynamics between coparenting quality and FQOL. These goals required the creation of many subsamples. Therefore, some of the primary limitations of this study relate to the size of some of the subsamples used for analysis.

It would have been ideal to form neurodevelopmental groups that were confirmed by both parent-reported child diagnoses and symptom levels; however, this was not feasible in the current study. Using this method, a large number of participants would have been eliminated from the groups on the basis of symptom levels that did not align with reported diagnoses (i.e., sub-clinical levels of symptomology associated with diagnoses that were reported and/or the presence of clinical levels of symptomology for NDs that were not reported). Proceeding using this method would have reduced the power to detect true effects within the neurodevelopmental subgroups. Therefore, given that the perspective was taken that symptomology is more observable by parents and more likely to impact coparenting and FQOL experiences than the label of a diagnosis, the approach of forming groups based on ND symptomology levels was taken. This approach reduced the number of participants being cut from the study; however, it may have created more noise within the groups, particularly if there were any biases in the way that parents completed the questions associated with ND symptomology.

Further, even after adopting an approach for grouping parents that would avoid cutting an excessive number of participants, some of the neurodevelopmental groups were quite small. For example, the subsample of mothers of children with clinically significant symptoms of ASD included 15 mothers. The groups of groups of fathers of children with ASD, ADHD, and NT children were slightly larger, but still smaller than the planned 55 parents per group. Interestingly, for both mothers and fathers, the ASD+ADHD groups were larger than the ASD only groups, which may speak to the frequent co-occurrence of these disorders. Having low numbers of participants in some groups likely reduced the power to detect true effects in these subsamples. Additionally, small subsamples likely contributed to some of the violations of the assumptions of analyses, such as normality.

The sample of paired parents (dyads) was particularly difficult to recruit. Therefore, the total sample of dyads was smaller than planned for and dividing parents into subgroups became problematic. These numbers would have been further reduced if any parents had not completed all the required measures for the analysis. To avoid conducting analyses in small groups where possible, the ND groups (ASD, ADHD, and ASD+ADHD) were combined into an ASD and/or ADHD group. Even using this approach, the NT group remained small, which may have reduced power. Additionally, some specificity was lost in the ASD and/or ADHD group. Within the subsamples of mothers and fathers in the total sample (including paired and unpaired parents), different patterns of results emerged between the ASD, ADHD, and ASD+ADHD groups, suggesting different patterns of results may have emerged within different neurodevelopmental subsamples of paired parents.

In addition to sample sizes, there are other complexities associated with dyadic or family-level research questions and analyses. As stated previously, it would be ideal to include all family members' perspectives in explorations of FQOL. For logistical reasons, children's perspectives were not included in the current study. Some research questions in the current study involved comparisons across neurodevelopmental groups (i.e., mothers of children with ASD, ADHD, ASD+ADHD, and NT children, or fathers of children with ASD, ADHD, ASD+ADHD, and NT children). Within the context of these research questions, the measure of FQOL represents the mother's or father's perspective on FQOL, and thus represents an individual perspective on a family-level construct. While this is common in FQOL literature, it places limitations on the interpretation and generalizability of the results. With the inclusion of dyads, attempts were made to gain more insight into FQOL on a family-level. The approach to analysis of creating dyadic, composite scores by taking the average of coparenting and FQOL scores of mothers and fathers was adopted due to its conceptual consistency with the goal of creating scores that represented combined (equally weighted) perspectives of mothers and fathers, simplicity within the context of a project with multiple goals and research questions, and use in previous coparenting and FQOL research (May et al., 2015; Park et al., 2003). Nevertheless, this relatively simple approach limited the ability to investigate the intricacies of the potential connections between paired mothers' and fathers' perspectives on coparenting quality and FQOL.

An additional limitation relates to the unintended bias towards heterosexual couples within the dyadic sample. There was an insufficient number of same-sex couples within the dyadic sample to create separate groups for same-sex paired mothers and fathers. Parents who identified as nonbinary were included if they endorsed identifying as either a mother or a father and had a partner that identified as the parent of the other gender.

Similarly, a more general limitation of the study is that overall, the sample was largely composed of parents who were White, highly educated, and earning at or above median income. While this is common in Western psychology research, it creates limitations for the generalizability of this research. While these results may be representative of individuals from these or similar populations, the results may not generalize well to parents from different racial or ethnic groups, parents with less formal education, or lower-income families. These sample characteristics may have also influenced some results, as lower SES may impact experiences within families. For instance, lower household income may create financial stress, which in turn may increase general stress levels, worsen parents' mental health, or reduce access to supports and services. Lower income is also likely to affect the physical/material well-being component of FQOL.

In addition to limitations regarding the sample, it is important to note that the study design brings with it some inherent limitations. First, because a cross-sectional design was used, the associations found within this study cannot be used as evidence of causal relations. Second, the use of an online survey that was shared broadly and required participants to elect to spend time completing the survey independently introduces the potential for selection biases. As addressed throughout the discussion, this approach may have resulted in an over-representation of parents who are thriving, with relatively low levels of stress. Recruitment methods involved sending study advertisement materials to service agencies and posting materials on social media pages for parents. This method may have also resulted in recruitment of parents who are actively receiving formal or social support. Third, all measures were self-report (or parent-report regarding child ND symptomology). This approach was appropriate in the sense that the study focuses on parents' experiences of coparenting and FQOL; however, self-report data does involve inherent biases. While the anonymity in this study hopefully allowed parents to feel comfortable responding openly, many factors may impact individual parents' perspectives on family dynamics, thus impacting their reports. Finally, while some of the small sample sizes may have increased chances of a Type II error (not finding a significant association that exists in reality), the large number of comparisons conducted increases the chance of a Type I error (finding a statistically significant association that does not exist in reality).

Implications

Research Implications

This study has implications for future research on family functioning within families of neurodevelopmentally diverse children. Generally, this study provides support for a systemic view of coparenting quality and FQOL, wherein individual characteristics or behaviours may impact other family members' perceptions of family life and relational dynamics between family members, as suggested by FST. More specifically, this research provides support for a systems-based understanding of coparenting quality, such as Feinberg's (2003) ecological model of coparenting, as it suggests an interplay between child characteristics (child ND symptomology) and parents' experiences of coparenting quality. Similarly, the findings of this research provide support for the unified theory of FQOL proposed by Zuna et al. (2010), as there appear to be connections between individual family-member factors (child ND symptomology) and parents' perceptions of FQOL. The finding that coparenting quality is linked to FQOL for parents of children with at least some neurodevelopmental profiles demonstrates the importance of the coparenting relationship within families. Furthermore, it provides partial support for the unified theory of FQOL (Zuna et al., 2010), as it demonstrates an association between a family-unit factor (experiences of coparenting quality) and experiences of FQOL. This suggests that there could be important contributions of other family-unit factors, such as marital or romantic relationship satisfaction between parents, as previous research has indicated a significant association between marital satisfaction and coparenting quality (Ronaghan et al., 2024). Taken together, the successful application of FST, the ecological model of coparenting (Feinberg, 2003), and the unified theory of FQOL (Zuna et al., 2010) within this research suggests that these theories may provide useful theoretical frameworks for future research concerning coparenting quality or FQOL.

This research provides information on perceptions of coparenting quality and FQOL across parents of children with different neurodevelopmental profiles, which may provide a useful base upon which future research may build. Understanding which NDs may represent greater challenges to parents' ability to work effectively together as parents or their experiences of FQOL may inform future research on other aspects of family functioning within families of neurodevelopmentally diverse children. Relatedly, the pattern of findings in which parents of children with co-occurring ASD and ADHD reported the lowest levels of coparenting quality and FQOL among the neurodevelopmental groups suggests the significance of co-occurring neurodevelopmental disorders. Based on these findings, it may be important for researchers studying issues pertaining to neurodevelopmentally diverse families to consider the presence of co-occurring disorders. Furthermore, the exploratory analyses deepened this understanding by breaking parents' experiences of coparenting quality and FQOL down into components and comparing levels of satisfaction across parents of neurodevelopmentally diverse children. These findings may inform future research into the ways that parenting a child with an ND may impact coparenting quality and FQOL. Specifically, findings regarding which coparenting components parents differed in depending on child ND symptomology could have implications for research on specific components of coparenting that could be supported in parents of children with NDs, as well as strengths amongst these parents that can be built upon.

This study has been able to provide some empirical evidence for the connection between parents' experiences of coparenting quality and FQOL. While this association is conceptually reasonable, it had been previously unconfirmed. Demonstrating this connection also serves to provide further validation for the importance of coparenting research, as a factor that may impact overall FQOL. Furthermore, the lack of significant moderating effects of child ND symptomology on the associations between experiences of coparenting quality and FQOL may be viewed as evidence that coparenting is similarly important for the FQOL of parents of children with ASD, ADHD, ASD+ADHD, and NT children. Exploratory analyses examining the associations between aspects of coparenting quality and aspects of FQOL also provides further insight into which specific coparenting qualities or behaviours may be more closely tied to particular aspects of FQOL. This may be useful in informing research with more specific focuses. For instance, these findings could be helpful for research aiming to understand how specific aspects of FQOL can be improved for parents of neurodevelopmentally diverse children.

Clinical Implications

This research offers several insights that have implications for the supports and services offered to parents of children with NDs. First, findings suggest that parents of children with NDs would benefit from support to increase well-being within the family system. In particular, parents of children with co-occurring ASD and ADHD may have especially high support needs. It is possible that a variety of types of supports and services may be helpful in increasing experiences of family functioning of parents of children with NDs, as these families are at risk for greater levels of parenting stress and parenting demands (e.g., Brobst et al., 2009; Hayes & Watson, 2013; Kaiser et al., 2011; Theule et al., 2013). Therefore, services such as increased respite, individual therapeutic supports for parents and children, parenting resources (e.g., parent training programs), family-focused interventions (e.g., structural family therapy [Pennant, 2025], Triple P, Parent–Child Interaction Therapy, or other interventions with goals such as improving communication, supporting relationship building and learning through play/connection activities, addressing challenging behaviours using structure and reinforcement, collaborative problem solving), and increased opportunities for social support (e.g., specialized parent support groups) may be beneficial. In addition, community activities and events that are ND-friendly and support satisfaction with relationships and emotional well-being in families may benefit overall experiences of FQOL. More specific targets for support may be further informed by the exploratory analyses.

Exploratory investigations into aspects of FQOL suggest that parents of children with NDs may benefit from greater support targeting the FQOL domains of family interactions, parenting, emotional-wellbeing, physical/material well-being, and disability-related support. Specifically, findings suggest that mothers of children with ADHD and ASD+ADHD and fathers of children with ASD+ADHD may be at risk for lower satisfaction with family interactions, parenting, and disability-related support. Mothers of children with ADHD and ASD+ADHD may also be at risk for lower satisfaction with their families' emotional well-being. Mothers of children with ASD+ADHD and fathers of children with ASD and ASD+ADHD may be at risk for lower satisfaction with their families' physical/material well-being. Therefore, these results highlight the range of support needs of families of children with NDs, as well as the broad range of domains in which parents of children with co-occurring disorders may benefit from increased support. Furthermore, although there were general patterns of lower levels of satisfaction across parents in many of the ND groups, the different patterns that emerged for mothers and fathers in the various neurodevelopmental groups emphasizes the importance of considering the convergence of individual parent and child factors that may shape the experience of each parent and thus shape their support needs. While this research may be useful in alerting service providers to the potential support needs of parents of children with NDs, it is likely that there are other individual, family, and extrafamilial factors that will shape the challenges that families experience and must be considered in directing them to appropriate resources or developing a suitable treatment plan.

Second, this research suggests that families of children with NDs may benefit from coparenting supports. Specifically, findings that mothers of children with clinically significant symptoms of ADHD and ASD+ADHD and fathers of children with ASD and/or ADHD experience lower coparenting quality than parents of NT children suggest that these parents may be encountering barriers to more effective forms of coparenting. Again, parents of children with co-occurring ASD and ADHD may be at risk for particularly high coparenting support needs relative to the other neurodevelopmental groups. Therefore, it may be beneficial for clinicians diagnosing NDs, especially co-occurring NDs, to recommend coparenting supports for families.

Helpful coparenting supports may include therapeutic work with both parents, focusing on improving various aspects of coparenting. For instance, encouraging coparenting agreement (i.e., identifying common values and deciding on behavioural expectations, consequences, approaches to caring for children's emotional needs, educational priorities, safety issues, and peer relations), closeness (e.g., shared mindfulness or gratitude exercises), support (e.g., expressing appreciation and implementing consistent boundaries), taking steps to reduce exposure to conflict (e.g., using time-outs when conflict begins to escalate), reducing undermining (e.g., practicing positive communication strategies), and facilitating cooperative decision-making regarding division of labor. A number of coparenting interventions have been developed based on empirical evidence (Eira Nunes et al, 2021). Programs such as Family Foundations (Feinberg & Kan, 2008), Tuning in to Kids Together (Ambrosi et al., 2023), and the Young Parenthood Program (Florsheim et al., 2012) show promise for having beneficial impacts on coparenting. Evidence-based coparenting interventions typically involve a combination of psychoeducation, skills training, and planning (Eira Nunes et al, 2021). Due to the known association between marital/romantic relationship satisfaction and coparenting (Ronaghan et al., 2024) couples therapy may also offer benefits that are shared with the coparenting relationship (Liekmeier et al., 2023).

Results of the exploratory analyses of aspects of coparenting suggest that parents of children with NDs may benefit from coparenting supports, while also highlighting the potential for variability in the coparenting experiences of parents depending on their children's neurodevelopmental profile. Furthermore, as many parents of neurodevelopmentally diverse children have relatively positive perspectives on their coparenting quality, this research also has implications for supports aiming to build on parents' existing coparenting strengths. Some coparenting programs for parents of children with NDs are being developed and are beginning to show promising outcomes (Hock et al., 2022).

Future Directions

While this study represents an important extension within the field of coparenting and FQOL research, it also illuminates several important directions for future research. Although over 900 participants were recruited, after the sample was reduced to the participants who met inclusion criteria, the sample size placed limitations on the current study. Therefore, future studies that include a larger sample would be able to take further steps toward solidifying and extending current findings. Specifically, a larger sample would allow for larger subsamples within groups of mothers and fathers of children with specific NDs. This would increase the power to detect true effects and thus improve the confidence one can have with regards to findings.

Having a larger sample size would have also allowed for the application of more stringent criteria for the creation of subgroups. Specifically, future research in which groups are created based on a combination of both parent-reported diagnoses and scores on symptom severity measures would allow for greater confidence regarding diagnosis-specific results. In addition, future research may investigate possible coparenting and FQOL differences between families of children with diagnosed and undiagnosed NDs (i.e., children who have not been formally diagnosed but who present with clinical levels of symptomology).

Further research on parent dyads and the coparenting and FQOL dynamics between them would be beneficial. A larger sample of dyads would allow for more powerful examination of potential differences in coparenting and FQOL experiences between mothers and fathers. In addition, more complex designs and statistical methodology for dyadic analysis may be helpful. Specifically, using an actor-partner interdependence model or multilevel structural equation modeling (MSEM) would allow for a deeper understanding of the potential effects of each parent’s coparenting experiences on their own and their partner’s experiences of FQOL. This may be beneficial to increase understanding of how women’s and men’s gendered parenting roles may impact their parenting experiences. Furthermore, this may help inform clinicians and service providers working with mothers, fathers, or families. Future research should also consider coparenting dynamics within same-sex or nonbinary-identifying parent dyads. This would be a helpful direction for future research, as gender roles may impact these families differently and coparenting dynamics may differ from the dynamics that are typical of heterosexual coparents.

In general, future research involving a more diverse sample may be beneficial. This sample was largely White, educated, heterosexual, and married. While these demographics allow for direct generalization to these types of families within the population, they are not reflective of the entire population of parents in Canada and the US. Increased diversity within a larger study may be beneficial. Alternatively, future research may examine coparenting and FQOL dynamics in specific cultural groups, in families with differing SES, or in families of same-sex or gender-diverse families. These more targeted samples may allow for research that can speak more directly to these different populations and inform clinicians or service providers who work with specific populations.

Future research on coparenting and FQOL using different methods may also strengthen the body of research. For instance, it may be beneficial for researchers to carefully consider methods for recruiting parents experiencing more varied levels of coparenting quality and FQOL. This is a challenge for survey-based research using mostly online recruitment, as many parents who experience lower coparenting quality and FQOL may also experience other stressors that create barriers to engagement. The ability to include these families in such research would improve the generalizability of findings. Perhaps for future studies researchers may attempt partnering with school districts to reach a wider range of parents, or engaging with support agencies using intentional strategies, such as collecting data prior to or early in service provision. Another methodological approach that would expand upon the current study is the use of interviews or open-ended questions with qualitative analysis. A qualitative study on coparenting quality and FQOL in families of neurodevelopmentally diverse children would add richness to the understanding of these parenting experiences and may provide further insight into associated individual or family factors.

As the current study demonstrated the association between coparenting quality and FQOL for mothers and fathers of children with several neurodevelopmental profiles, it has created a basis from which future research may investigate other associated factors. Specifically, future research may investigate the extent to which coparenting quality is directly associated with FQOL, or aspects of FQOL, as well as the extent to which other individual or family factors may mediate the association. For instance, future research may inquire directly into the potential mediating effects of parenting stress. Furthermore, the body of coparenting and FQOL research may benefit from investigation of other potential moderating factors, such as parental NDs or parental mental health conditions (Feinberg, 2003; Joseph et al., 2022; Tissot et al., 2017; Wymbs et al., 2015). This would allow for greater understanding of the extent to which parents' own neurodiversity or mental health may impact their experiences of coparenting quality and FQOL. Both parental neurodiversity and mental health have the potential to impact these family processes, as they shape the way parents experience and think about their family environment, as well as possibly affecting their behaviour (e.g., Feinberg, 2003; Lovejoy et al., 2000; Paulson et al., 2006; Tissot et al., 2017; Williamson & Johnston, 2016). Introducing these individual parent characteristics would facilitate a more complete perspective on the interplay between coparenting and FQOL within the context of families of neurodevelopmentally diverse children, as well as informing parenting and parent mental health supports. While this study has made an important contribution to the field of research and parenting experience, it also raises several interesting questions to be addressed by future research so that clinicians and service providers may be better informed about the experiences of the families they serve.

Conclusions

This study extends the existing research on parents' experiences of coparenting quality and FQOL by illuminating differences across families of children with neurodevelopmentally diversities and between mothers and fathers. Importantly, it demonstrated that many parents of neurodevelopmentally diverse children report strong coparenting quality and great satisfaction with their FQOL. Nevertheless, findings that mothers and fathers of children with clinically significant symptoms of some NDs experienced lower coparenting quality and FQOL emerged. In contrast, mothers and fathers in the same families were not found to differ significantly with regards to their perspectives on coparenting quality or FQOL. In addition to examining coparenting quality and FQOL separately, this study served to elucidate the connections between experiences of coparenting quality and FQOL among parents of neurodevelopmentally diverse children. While this study demonstrated significant associations between experiences of coparenting quality and FQOL for parents of children with a variety of neurodevelopmental profiles, nonsignificant results for mothers and fathers of children with symptoms of particular NDs raise questions for future study. Despite some differences in the strength of associations across mothers and fathers of children with symptoms of different NDs, these differences were found to be nonsignificant. Finally, steps were taken to gain a deeper understanding of the components of coparenting quality and FQOL, including several significant differences across neurodevelopmental groups, limited differences between paired mothers and fathers, and associations between components of the two constructs. This research provides support for theoretical frameworks including FST (Minuchin, 1985), the ecological model of coparenting (Feinberg, 2003), and the unified theory of FQOL (Zuna et al., 2010) and expands upon the existing body of knowledge pertaining to coparenting quality and FQOL. Furthermore, this study raises interesting questions for further exploration of coparenting quality and FQOL in neurodevelopmentally diverse families. Importantly, by gaining greater understanding of the experiences of parents of neurodevelopmentally diverse children, research such as this may inform clinicians and support providers as they work to support parents' strengths and foster greater quality of life for families.

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Appendix A

Exploratory Analysis Research Questions

7. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **coparenting agreement**?
    a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **coparenting agreement**?
    b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **coparenting agreement**?
8. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **coparenting closeness**?
    a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **coparenting closeness**?
    b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **coparenting closeness**?
9. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **exposure to conflict**?
    a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **exposure to conflict**?
    b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **exposure to conflict**?
10. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **coparenting support**?
    a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **coparenting support**?
    b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **coparenting support**?
11. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **coparenting undermining**?
    a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **coparenting undermining**?

   b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **coparenting undermining**?

12. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **endorsement of partner parenting**?
    a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **endorsement of partner parenting**?
    b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **endorsement of partner parenting**?
13. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **division of labor**?
    a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **division of labor**?
    b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **division of labor**?
14. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **family interaction**?
    a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **family interaction**?
    b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **family interaction**?
15. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **parenting**?
    a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **parenting**?
    b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **parenting**?
16. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **emotional well-being**?
    a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **emotional well-being**?

   b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **emotional well-being**?

17. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **physical/material well-being**?
   a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **physical/material well-being**?
   b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **physical/material well-being**?
18. Do parents of children with ADHD, ASD, ASD+ADHD, and parents of NT children differ in their levels of **disability-related support**?
   a. Do *mothers* of children with ADHD, ASD, ASD+ADHD, and *mothers* of NT children differ in their levels of **disability-related support**?
   b. Do *fathers* of children with ADHD, ASD, ASD+ADHD, and *fathers* of NT children differ in their levels of **disability-related support**?
19. Do paired mothers and fathers differ in their levels of **coparenting agreement**?
   a. Do paired mothers and fathers of *NT* children differ in their levels of **coparenting agreement**?
   b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **coparenting agreement**?
20. Do paired mothers and fathers differ in their levels of **coparenting closeness**?
   a. Do paired mothers and fathers of *NT* children differ in their levels of **coparenting closeness**?
   b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **coparenting closeness**?
21. Do paired mothers and fathers differ in their levels of **exposure to conflict**?
   a. Do paired mothers and fathers of *NT* children differ in their levels of **exposure to conflict**?
   b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **exposure to conflict**?
22. Do paired mothers and fathers differ in their levels of **coparenting support**?

   a. Do paired mothers and fathers of *NT* children differ in their levels of **coparenting support**?
   b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **coparenting support**?

23. Do paired mothers and fathers differ in their levels of **coparenting undermining**?
    a. Do paired mothers and fathers of *NT* children differ in their levels of **coparenting undermining**?
    b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **coparenting undermining**?
24. Do paired mothers and fathers differ in their levels of **endorsement of partner parenting**?
    a. Do paired mothers and fathers of *NT* children differ in their levels of **endorsement of partner parenting**?
    b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **endorsement of partner parenting**?
25. Do paired mothers and fathers differ in their levels of **division of labor**?
    a. Do paired mothers and fathers of *NT* children differ in their levels of **division of labor**?
    b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **division of labor**?
26. Do paired mothers and fathers differ in their levels of **family interaction**?
    a. Do paired mothers and fathers of *NT* children differ in their levels of **family interaction**?
    b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **family interaction**?
27. Do paired mothers and fathers differ in their levels of **parenting**?
    a. Do paired mothers and fathers of *NT* children differ in their levels of **parenting**?
    b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **parenting**?
28. Do paired mothers and fathers differ in their levels of **emotional well-being**?

   a. Do paired mothers and fathers of *NT* children differ in their levels of **emotional well-being**?
   b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **emotional well-being**?

29. Do paired mothers and fathers differ in their levels of **physical/material well-being**?
    a. Do paired mothers and fathers of *NT* children differ in their levels of **physical/material well-being**?
    b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **physical/material well-being**?
30. Do paired mothers and fathers differ in their levels of **disability-related support**?
    a. Do paired mothers and fathers of *NT* children differ in their levels of **disability-related support**?
    b. Do paired mothers and fathers of children with *ASD and/or ADHD* differ in their levels of **disability-related support**?
31. To what extent are **aspects of coparenting** (coparenting agreement, coparenting closeness, exposure to conflict, coparenting support, coparenting undermining, endorse partner parenting, and division of labor) associated with **aspects of FQOL** (family interaction, parenting, emotional well-being, physical/material well-being, and disability-related support)?
    a. To what extent are **aspects of coparenting** associated with **aspects of FQOL** in *mothers of NT children*?
    b. To what extent are **aspects of coparenting** associated with **aspects of FQOL** in *fathers of NT children*?
    c. To what extent are **aspects of coparenting** associated with **aspects of FQOL** in *mothers of children with ASD*?
    d. To what extent are **aspects of coparenting** associated with **aspects of FQOL** in *fathers of children with ASD*?
    e. To what extent are **aspects of coparenting** associated with **aspects of FQOL** in *mothers of children with ADHD*?
    f. To what extent are **aspects of coparenting** associated with **aspects of FQOL** in *fathers of children with ADHD*?

g. To what extent are **aspects of coparenting** associated with **aspects of FQOL** in *mothers of children with ASD+ADHD*?
h. To what extent are **aspects of coparenting** associated with **aspects of FQOL** in *fathers of children with ASD+ADHD*?

Appendix B

Demographic Questionnaire

Please Note:
This demographic questionnaire is a sample template. Some of these questions will be worded and branched to fit the responses of each participant (e.g., a parent responding about a child without ASD will not be asked to discuss subsequent ASD diagnostic information). In addition, this questionnaire includes items that will be used for other studies.

General Demographics:

Q1 What is your gender?
- o Male
- o Female
- o I do not identify with the genders listed above
- o I prefer not to answer

Q2 What is your age? __________

Q3 What is your marital status?
- o Single
- o Common-law
- o Married
- o Separated/divorced
- o Widowed

Q4 What is your average household income?
- o 0-40k
- o 40-60k
- o 60-90k
- o 90-125k
- o 125k+

Q5 What is the highest level of education that you have received?
(Post-secondary education includes trade training, College, University Certificate, Diploma, and University degree)
- o Less than high school
- o High school
- o Some post-secondary education
- o Completed post-secondary education

Q6 What ethnicity do you identify with?
- o Asian
- o Black
- o Indigenous

- White
- Other (please specify) _____________

Q7 What country do you currently live in?

- Canada
- United States
- Other (please specify) _________

Q8 What state, province, or territory do you currently live in (please specify)?

Please specify: _______________________

Q9 How did you hear about this survey?

- Social Media (e.g., Facebook, Twitter) (please specify) ____________
- Webpage Posting (please specify) __________
- ASD Service Organization (please specify) __________
- ADHD Service Organization (please specify) __________
- Community posting (e.g., in school, community centre, doctor's office) (please specify) ___________
- Participation in previous research (please specify where) __________
- U of M Participant Subpool
- Other (please specify) _____________

ASD/ADHD Demographics:

Q10 Have you ever received a diagnosis of autism spectrum disorder (or Asperger's Disorder, Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specified)?

- Yes
- No

Q11 What autism spectrum diagnosis have you received?

Please specify: ____________

Q12 Who did you receive this diagnosis from?

- Family physician
- Paediatrician
- Psychiatrist
- Clinical Psychologist
- School Psychologist
- Other (please specify) _______________

Q13 At what age were you diagnosed with ASD?

Please specify: _______________

Q14 Have you ever received a diagnosis of attention-deficit/hyperactivity disorder (or attention-deficit disorder)?

- Yes

- No

Q15 Who did you receive this diagnosis from?
- Family physician
- Paediatrician
- Psychiatrist
- Clinical Psychologist
- School Psychologist
- Other (please specify) _______________

Q16 At what age were you diagnosed with ADHD/ADD?
Please specify _______________

Child Demographics

Q17 How many children do you have?
- 1
- 2
- 3
- 4
- 5
- 6 or more

Q18 Do you have a child between 2 and 18 years of age?
- Yes
- No

Q19 How old is your child between 2and 18 years of age? (if more than one child in this age range, please check multiple)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18

Q20 Do you have a child (aged 2-18) who has been diagnosed with autism spectrum disorder (or Asperger's Disorder, Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specified)?
- o Yes
- o No

Q21 How many of your children (age 2-18) have been diagnosed with autism spectrum disorder?
- o 1
- o 2
- o 3
- o 4
- o 5 or more

Q22 Do you have a child (aged 2-18) who has been diagnosed with attention-deficit/hyperactivity disorder (ADHD or ADD)?
- o Yes
- o No

Q23 How many of your children (age 2-18) have been diagnosed with ADHD or ADD?
- o 1
- o 2
- o 3
- o 4
- o 5 or more

<u>NOTE:</u>

To allow for parents to adequately respond to questions and measures, parents will be prompted to consider the following questions based on a target child using Qualtrics formatting and branching. The following guidelines will be used:

a) Child aged 2-18 (in families with no children with ASD or ADHD) **OR** *oldest* child aged 2-18 (in families with no children with ASD or ADHD)
b) Child with ASD aged 2-18 (in families with one child with ASD) **OR** *oldes*t child with ASD aged 2-18 (in families with more than one child with ASD)
c) Child with ADHD aged 2-18 (in families with one child with ADHD) **OR** *oldest* child with ADHD aged 2-18 (in families with more than one child with ADHD)
d) Child with ASD and ADHD aged 2-18 (in families with one child with ASD and ADHD) **OR** *oldest* child with ASD and ADHD aged 2-18 (in families with more than one child with ASD and ADHD)

Parents will be prompted to create a deidentified nickname to assist with orienting the questions towards the target child:

Please provide a nickname for this child. Try to pick something that will help you, but won't identify the child to others (e.g., "Pumpkin," "Little Man," or you can use your child's first and middle initial).

Target Child Diagnostic Questions

Q24 How many years old is __________? ________________

Q25 What month was _______ born in? ____________

Q26 What is your relationship to __________?
- Biological mother
- Biological father
- Adoptive mother
- Adoptive father
- Foster mother
- Foster father
- Step-mother
- Step-father
- Other (please specify) _______________

If foster parent or step-parent, how long has ________ lived with you? ________________

Q27 What is your custodial arrangement for _____________?
- Primary caregiver
- Shared custody
- Non-custodial caregiver

Q28 How many days a week does ____________ live with you?
- 1
- 2
- 3
- 4
- 5
- 6
- 7

Q29 Who diagnosed ___________ with autism spectrum disorder?
- Family physician
- Paediatrician
- Psychiatrist
- Clinical Psychologist
- School Psychologist
- Other (please specify) _______________

Q30 How old was __________ when he/she was diagnosed with autism spectrum disorder?
Please specify_____________

Q31 Who diagnosed ___________ with attention-deficit/hyperactivity disorder (ADHD or ADD)?

- Family physician
- Paediatrician
- Psychiatrist
- Clinical Psychologist
- School Psychologist
- Other (please specify) _______________

Q32 How old was __________ when he/she was diagnosed with attention-deficit/hyperactivity disorder (ADHD or ADD)?
Please specify_____________

Q33 Has _____ received any interventions for their ADHD symptoms? If yes, select which:
- Medications
- Psychosocial interventions
- Both

Q34 Please describe the type of psychosocial intervention ________ has been receiving?

Q35 Has ________ been **prescribed** any medication for their ADHD symptoms? Please select which medication ______ has been **prescribed**: (Brand name/Drug name)
- Adderall/Dextroamphetamine and amphetamine
- Biphentin/Methylphenidate
- Concerta/Methylphenidate
- Dexedrine/Dextroamphetamine
- Focalin/Dexmethylphenidate
- Intuniv/Guanfacine
- Ritalin/Methylphenidate
- Strattera/Atomoxetine
- Vyvanse/Lisdexamfetamine dimesylate
- Zenzedi/Dextroamphetamine

Q36 Which medication has ______ been **taking** for their ADHD symptoms? (Brand name/Drug name)
- Adderall/Dextroamphetamine and amphetamine
- Biphentin/Methylphenidate
- Concerta/Methylphenidate
- Dexedrine/Dextroamphetamine
- Focalin/Dexmethylphenidate
- Intuniv/Guanfacine
- Ritalin/Methylphenidate
- Strattera/Atomoxetine
- Vyvanse/Lisdexamfetamine dimesylate
Zenzedi/Dextroamphetamine

Q37 Has ___________ been diagnosed with an intellectual disability (and/or ID, developmental delay, global developmental delay, mental retardation, cognitive disability)?

- Yes
- No

Q38 Who diagnosed __________ with an intellectual disability?

- Family physician
- Paediatrician
- Psychiatrist
- Clinical Psychologist
- School Psychologist
- Other (please specify) _______________

Q39 Has ___________ been diagnosed with any of the following mental health or developmental conditions?

- Prenatal Alcohol Exposure/Fetal Alcohol Spectrum Disorder (FASD)/Fetal Alcohol Syndrome (FAS)
- Anxiety Disorder
- Obsessive Compulsive Disorder (OCD)
- Depression
- Specific Learning Disability (reading, writing, and/or math, also known as dyslexia, dyscalculia)
- Social (Pragmatic) Communication Disorder
- Language Disorder
- Developmental Coordination Disorder
- Feeding Disorder (e.g., avoidant/restrictive food intake disorder)
- Oppositional Defiant Disorder
- Conduct Disorder
- Other: _________________

Qualitative Questions:
Q40. If you wish, please feel free to use the space below to report on any of your personal experiences with parenting.

Q41. Is there anything else you would like to add?

Appendix C

Summary of Cut-Off Scores

Table C-1

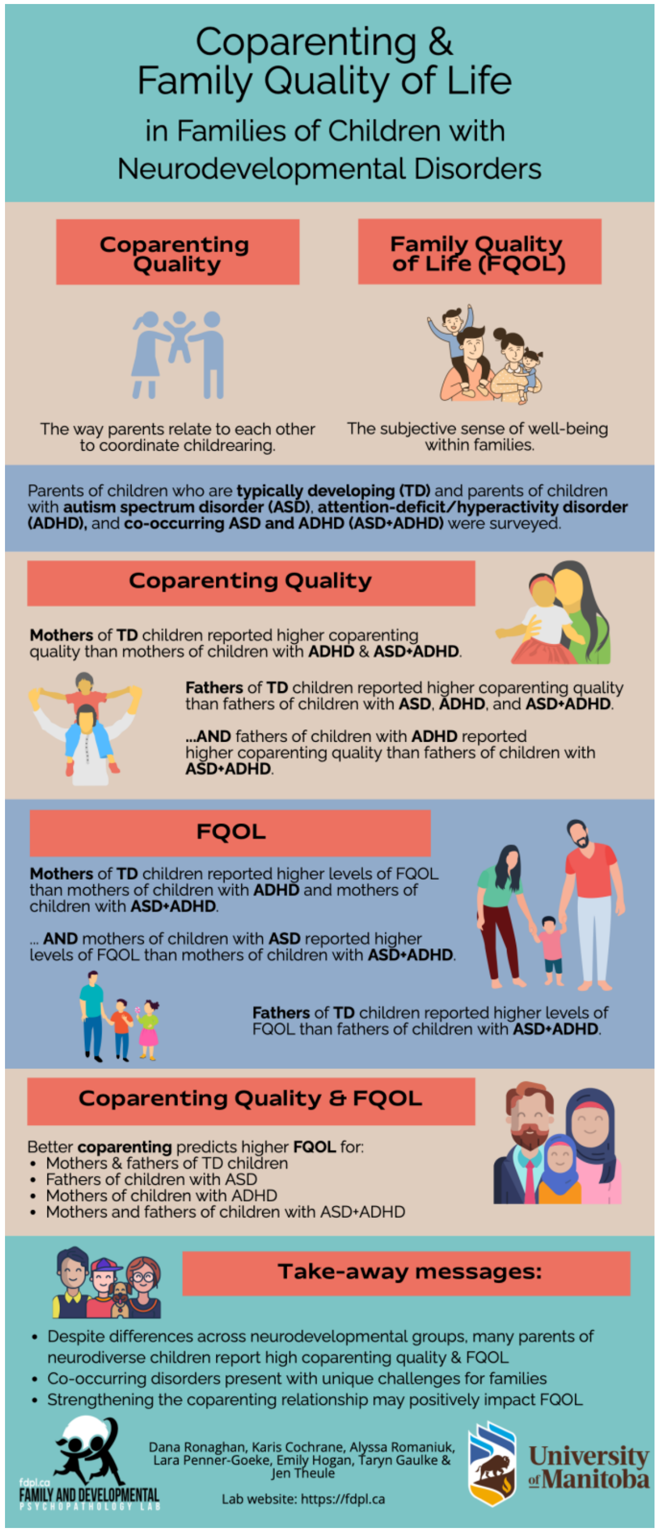
Summary of Cut-Off Scores

Measure	Cut-Off Score	Qualitative Category
Social Communication Questionnaire (SCQ)[1]	≥ 15	clinically significant ASD symptomology
ADHD Rating Scale-5 (ADHD-RS-5)[2]	≥ 80th percentile	clinically significant ADHD symptomology

Note. [1] SCQ (Rutter et al., 2003); [2] ADHD-RS-5 (DuPaul et al., 2016a)

Appendix D

Summary of Study Results



Appendix E

Assumption Testing

Research Question 1a.

Figure E-1a.1

Research Question 1a – Normality Histogram for NT Group

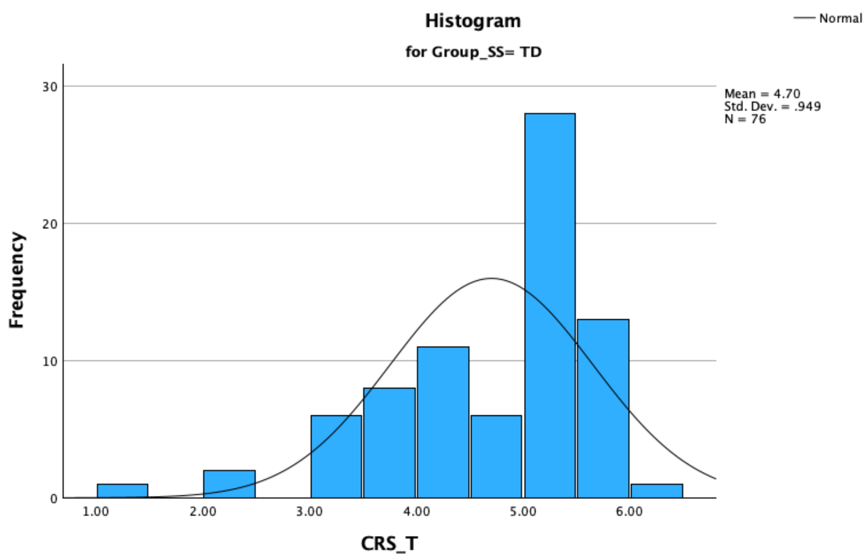


Figure E-1a.2

Research Question 1a – Normality Histogram for ASD Group

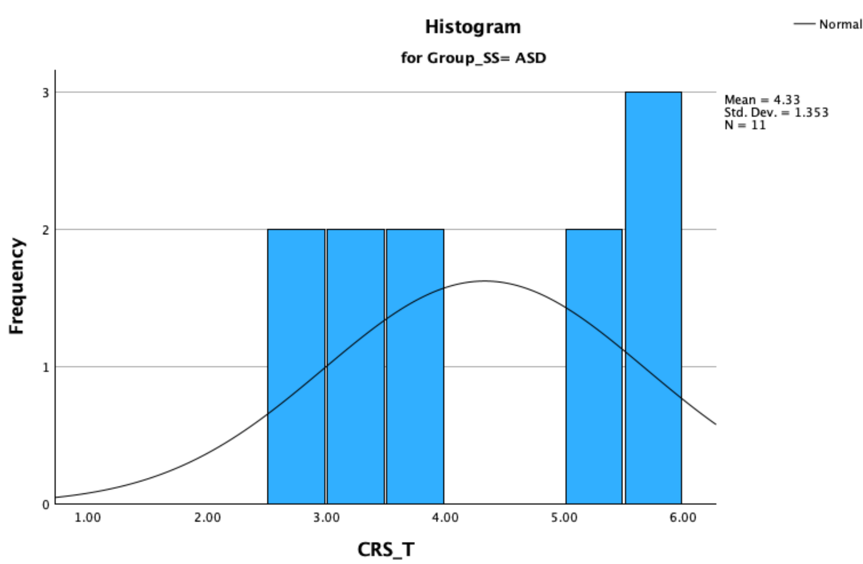


Figure E-1a.3

Research Question 1a – Normality Histogram for ADHD Group

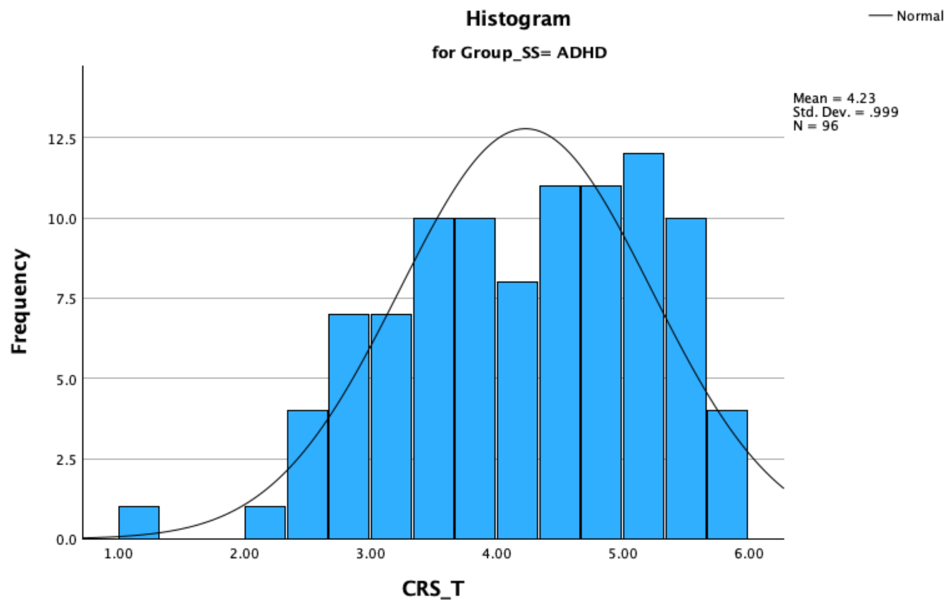


Figure E-1a.4

Research Question 1a – Normality Histogram for ASD+ADHD Group

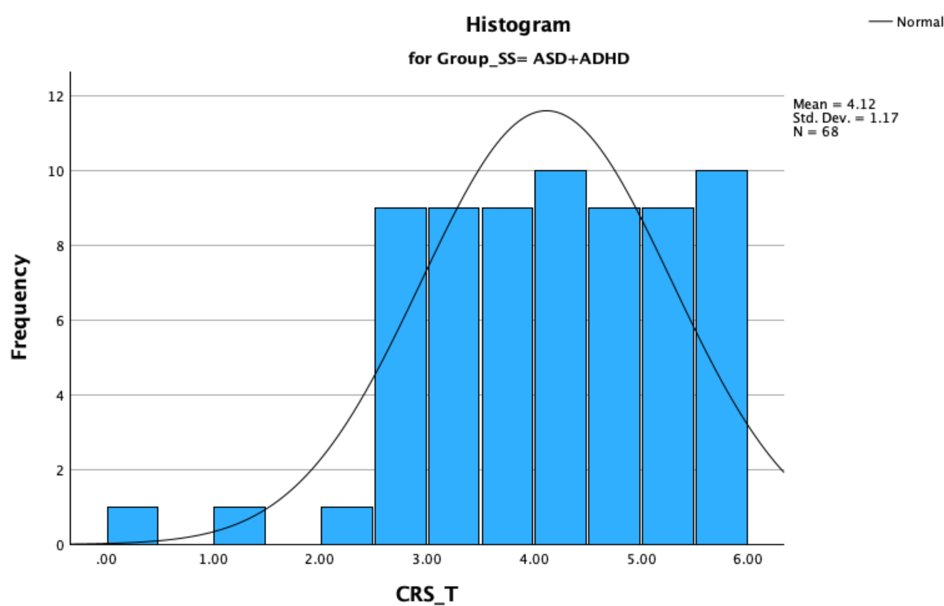


Figure E-1a.5

Research Question 1a – Expected Normal Probability Plot for NT Group

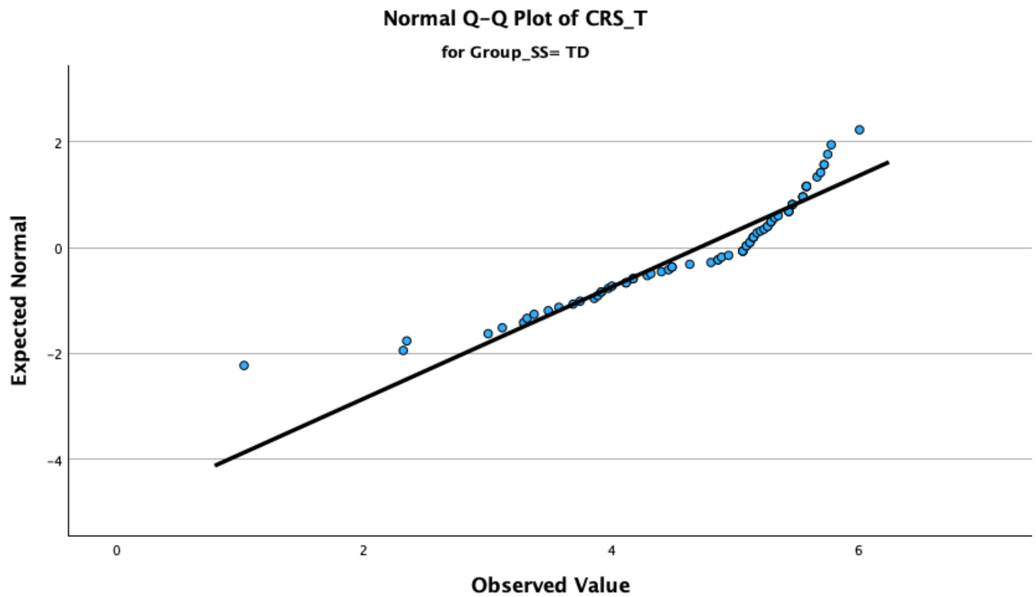


Figure E-1a.6

Research Question 1a – Expected Normal Probability Plot for ASD Group

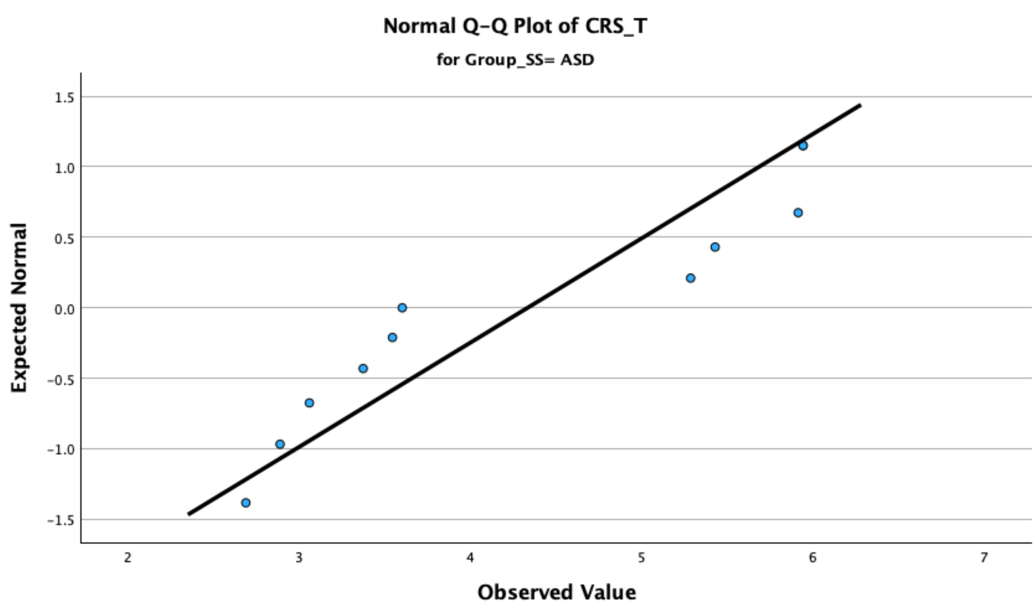


Figure E-1a.7

Research Question 1a – Expected Normal Probability Plot for ADHD Group

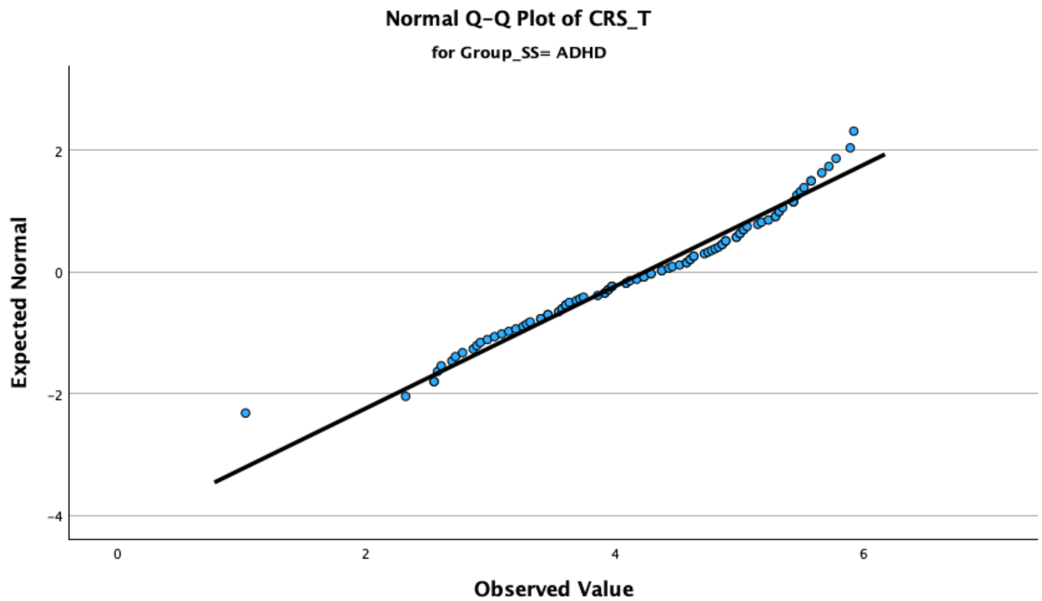
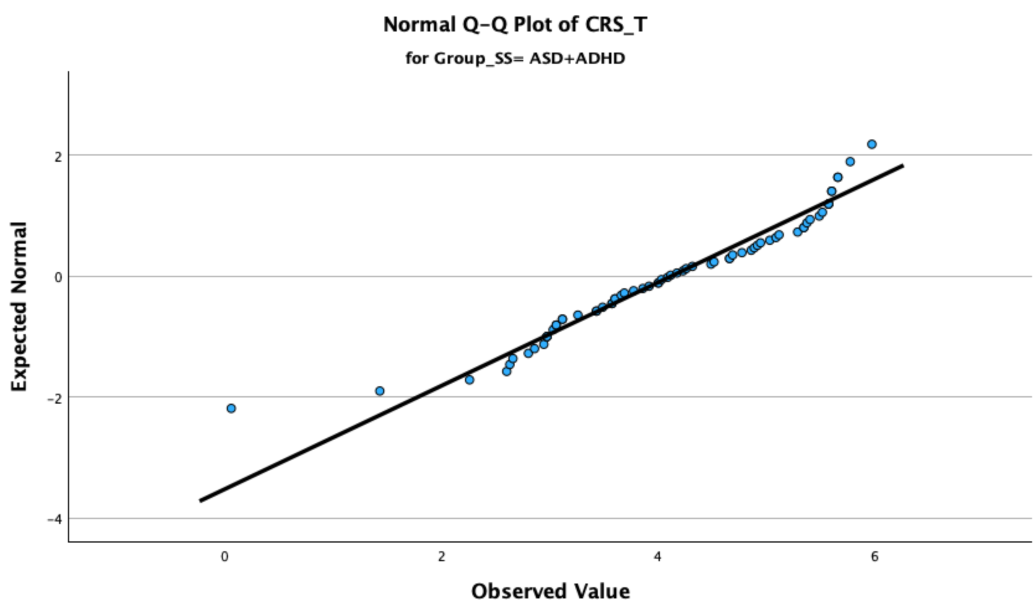


Figure E-1a.8

Research Question 1a – Expected Normal Probability Plot for ASD+ADHD Group



Research Question 1b.

Figure E-1b.1

Research Question 1b – Normality Histogram for NT Group

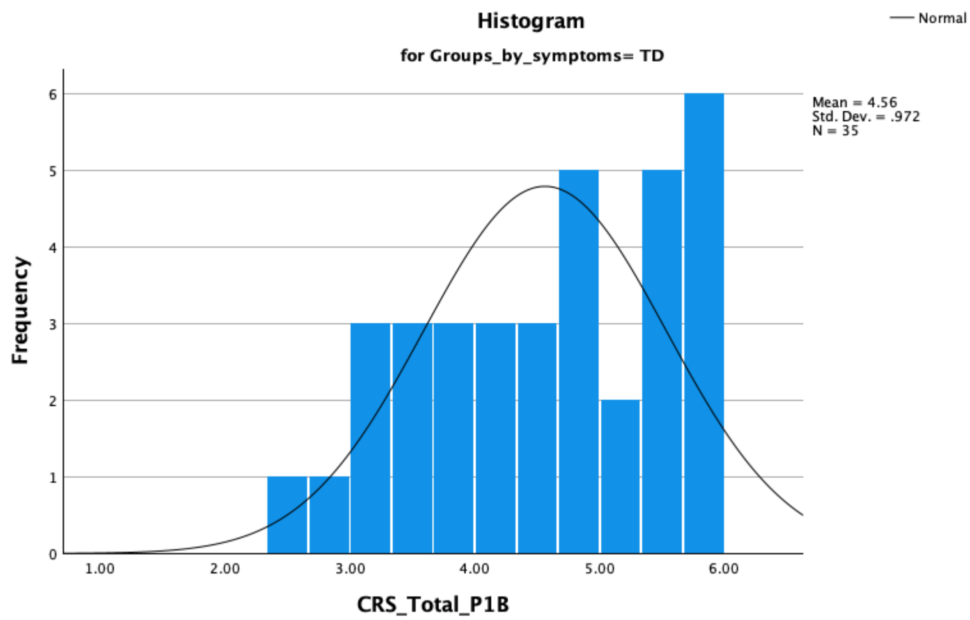


Figure E-1b.2

Research Question 1b – Normality Histogram for ASD Group

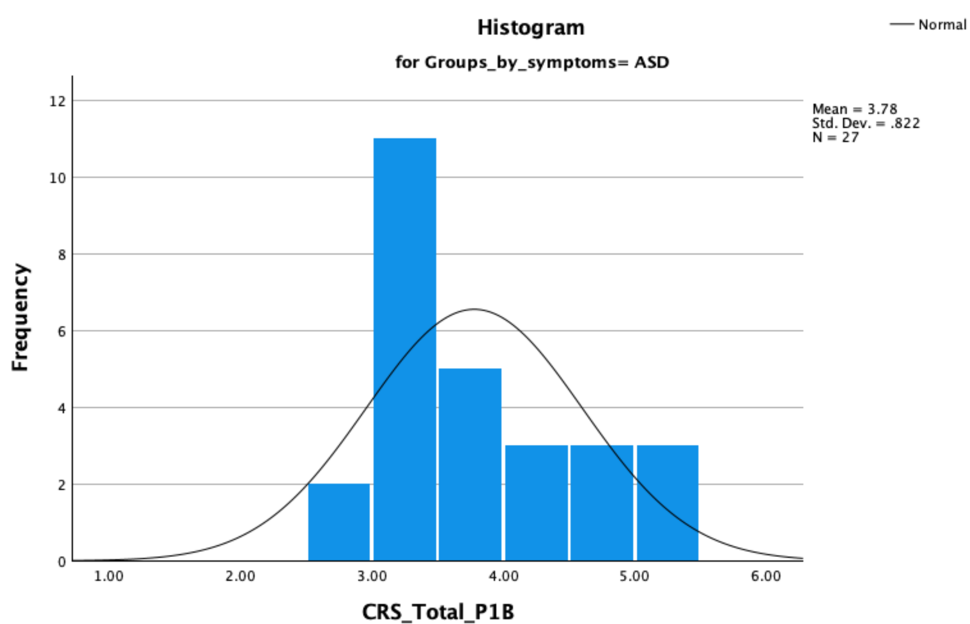


Figure E-1b.3

Research Question 1b – Normality Histogram for ADHD Group

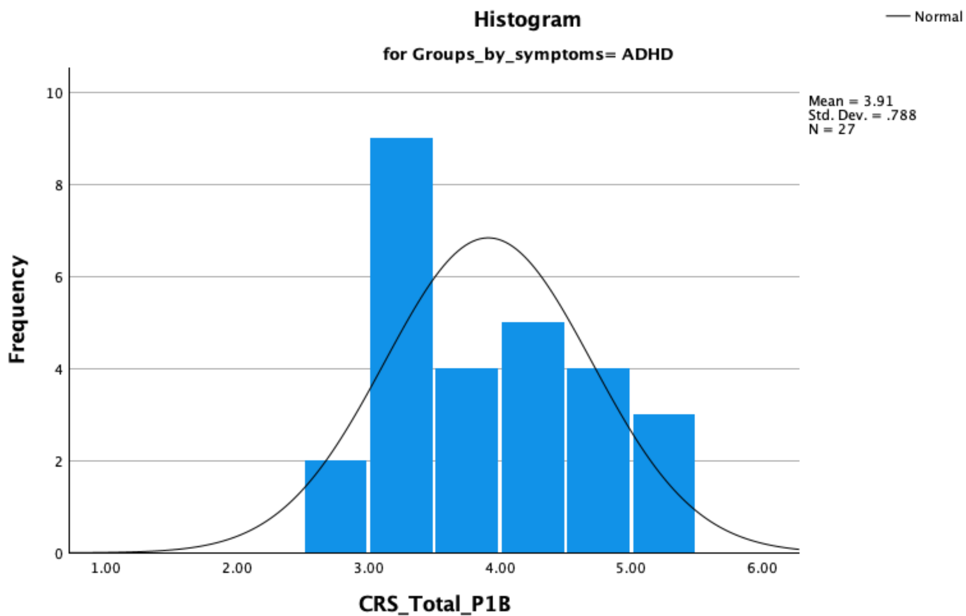


Figure E-1b.4

Research Question 1b – Normality Histogram for ASD+ADHD Group

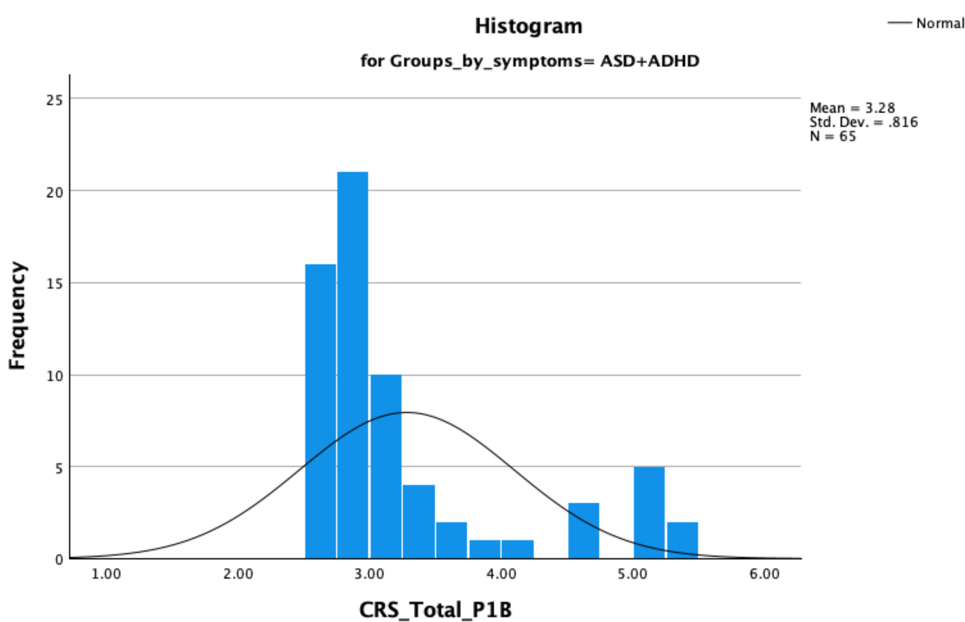


Figure E-1b.5

Research Question 1b – Expected Normal Probability Plot for NT Group

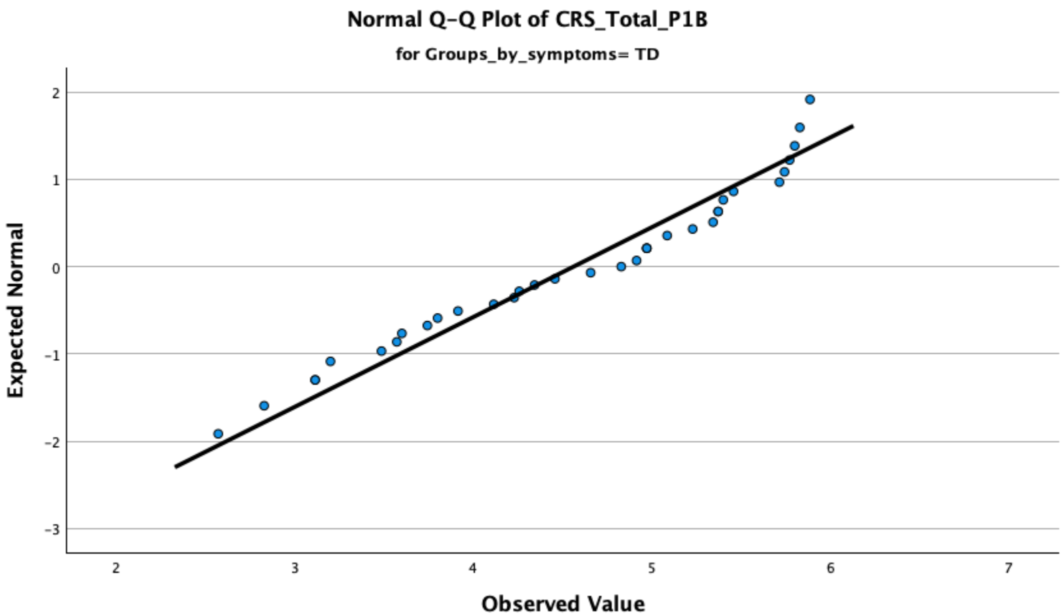


Figure E-1b.6

Research Question 1b – Expected Normal Probability Plot for ASD Group

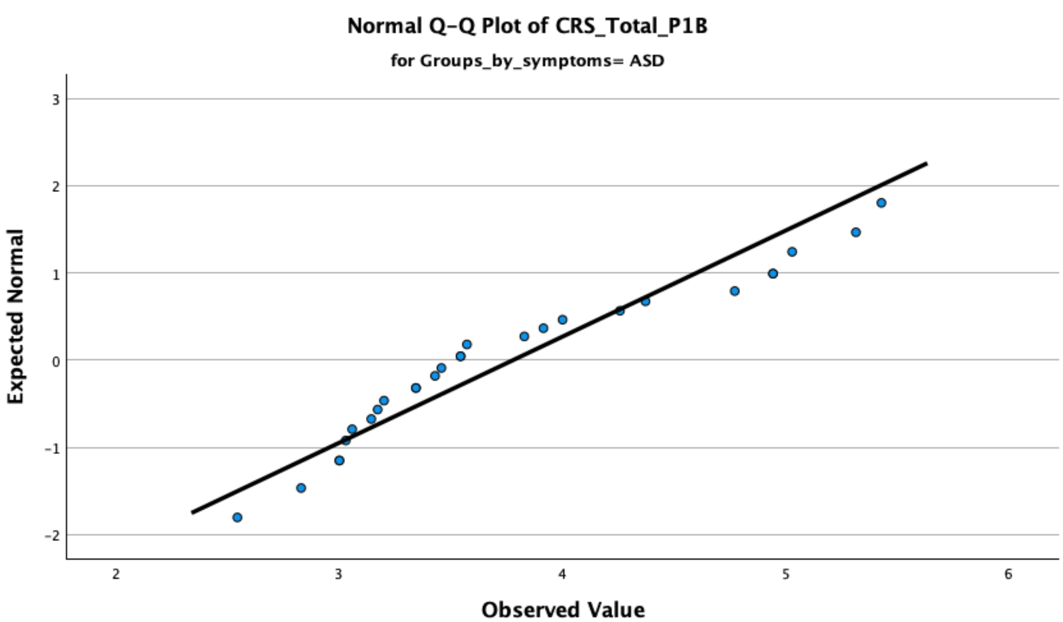


Figure E-1b.7

Research Question 1b – Expected Normal Probability Plot for ADHD Group

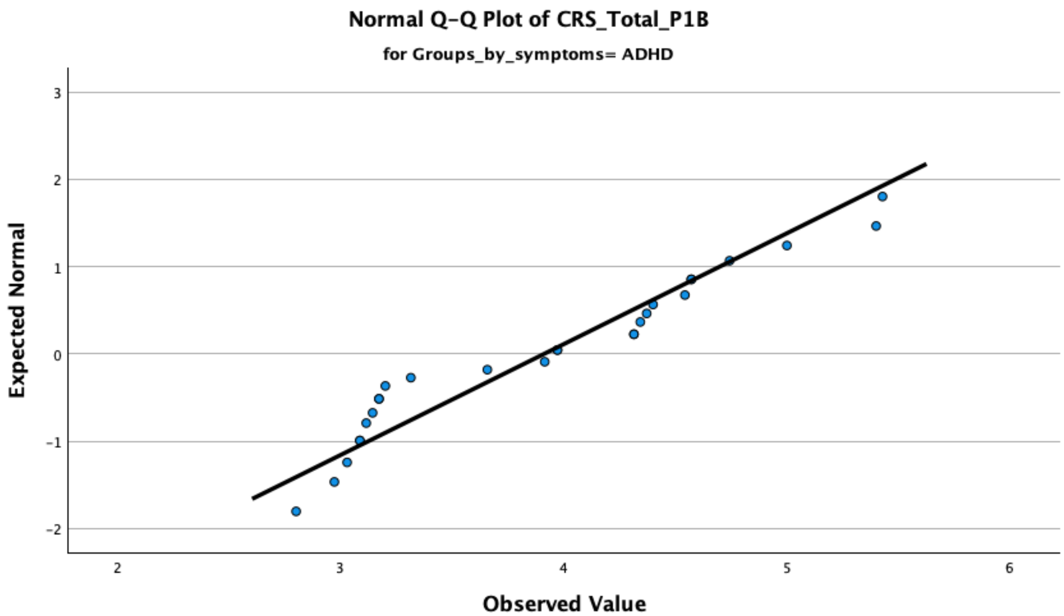
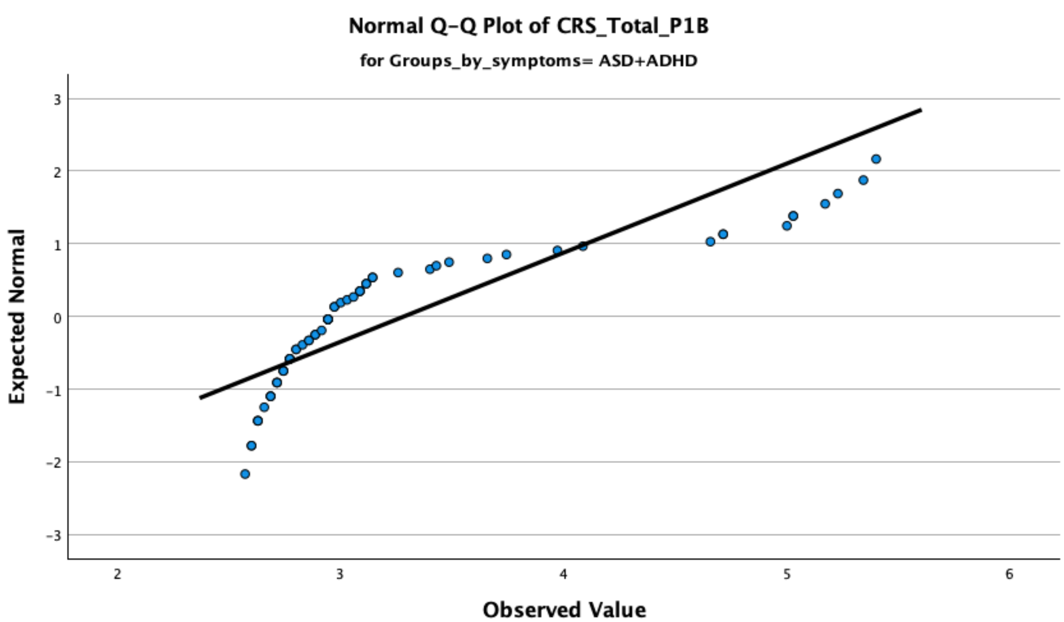


Figure E-1b.8

Research Question 1b – Expected Normal Probability Plot for ASD+ADHD Group



Research Question 2a.

Figure E-2a.1

Research Question 2a – Normality Histogram for NT Group

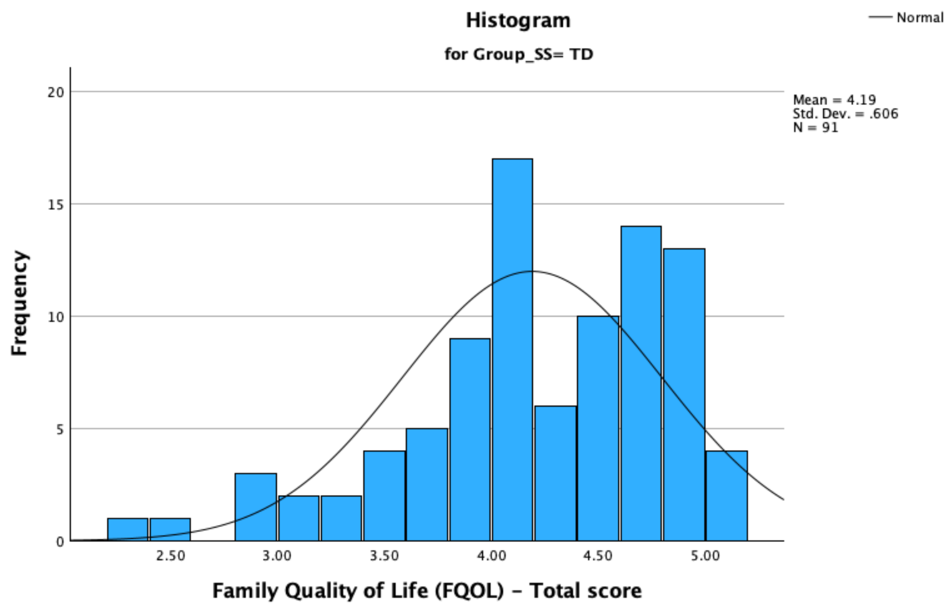


Figure E-2a.2

Research Question 2a – Normality Histogram for ASD Group

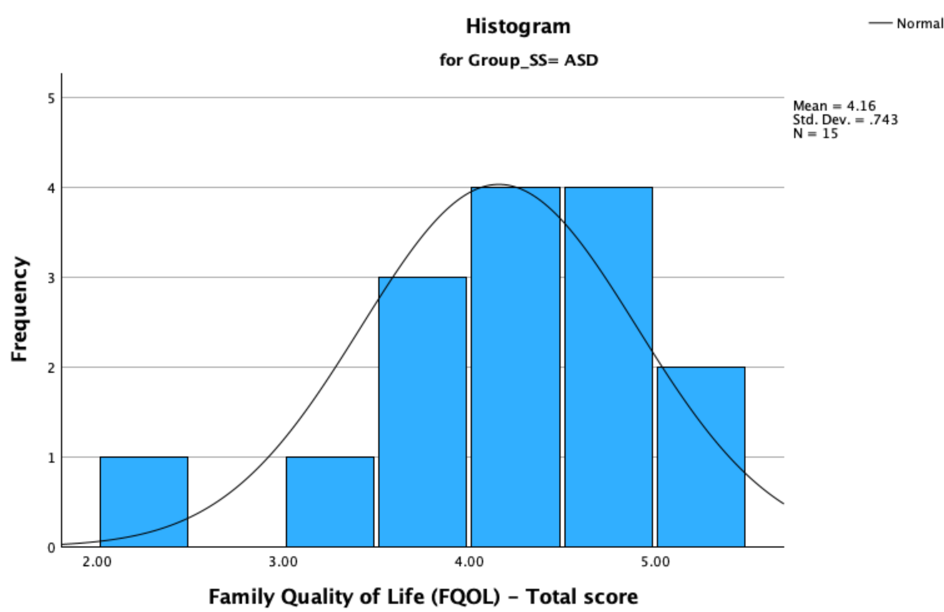


Figure E-2a.3

Research Question 2a – Normality Histogram for ADHD Group

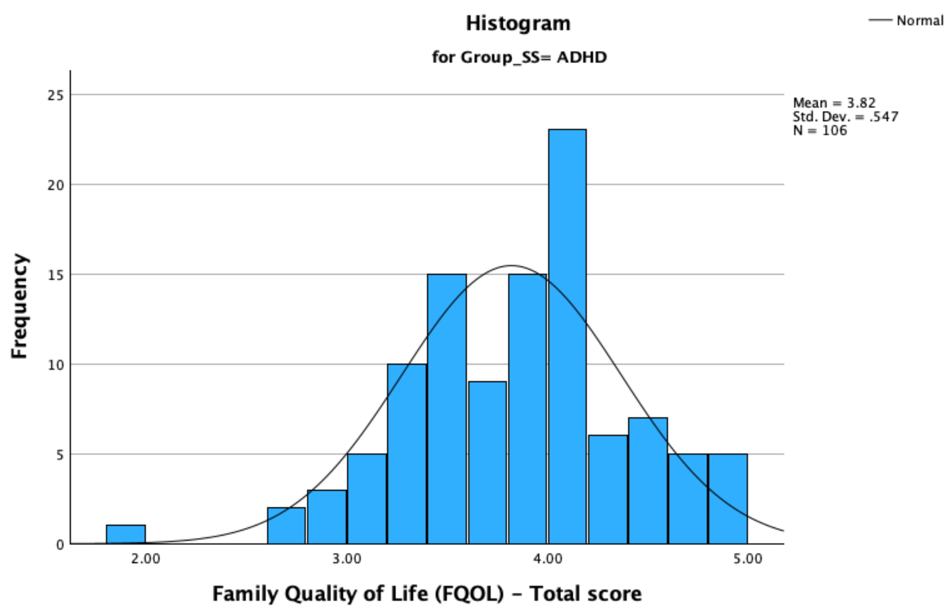


Figure E-2a.4

Research Question 2a – Normality Histogram for ASD+ADHD Group

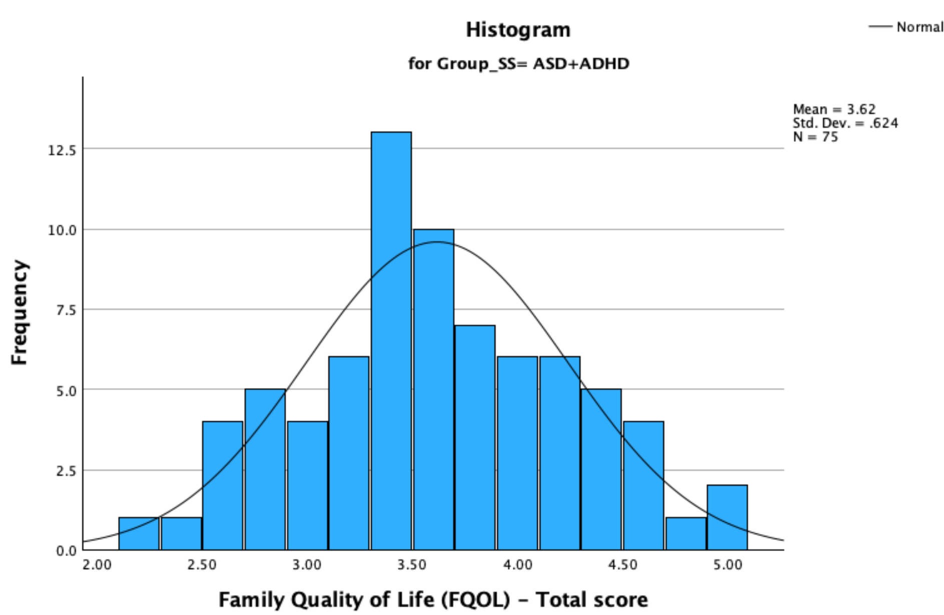


Figure E-2a.5

Research Question 2a – Expected Normal Probability Plot for NT Group

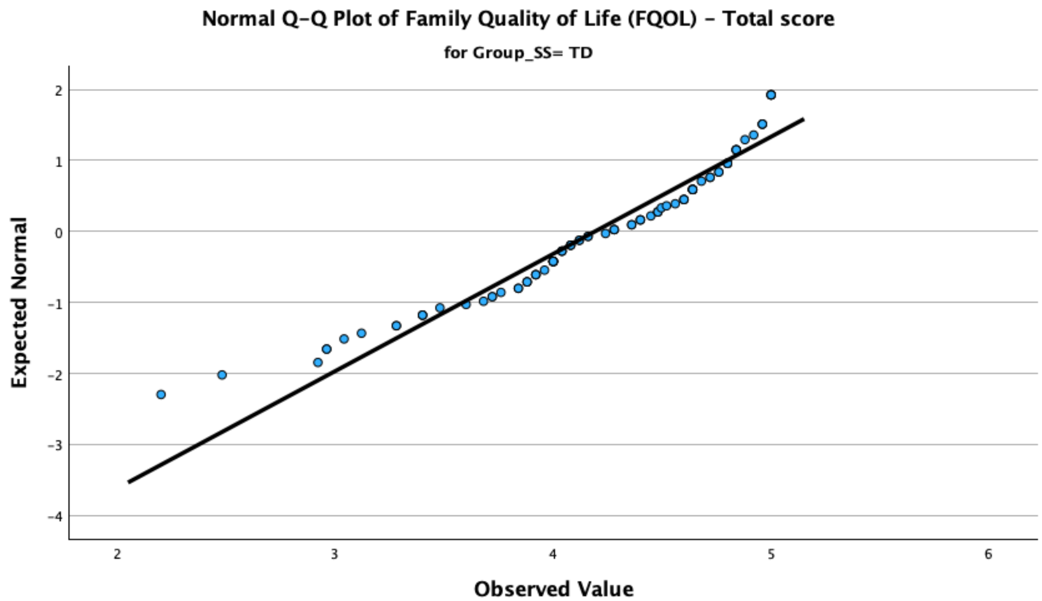


Figure E-2a.6

Research Question 2a – Expected Normal Probability Plot for ASD Group

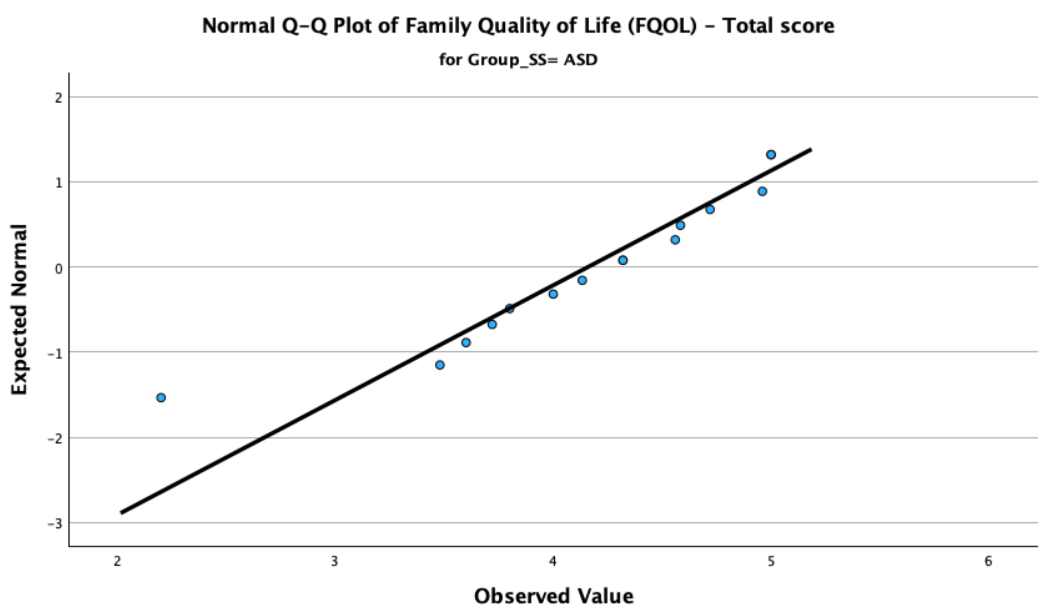


Figure E-2a.7

Research Question 2a – Expected Normal Probability Plot for ADHD Group

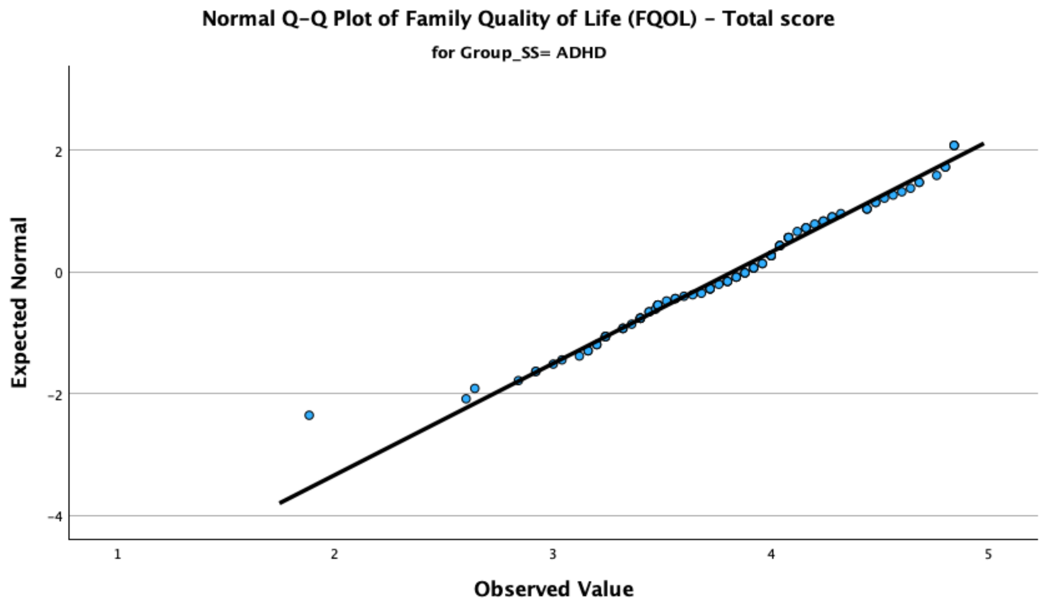
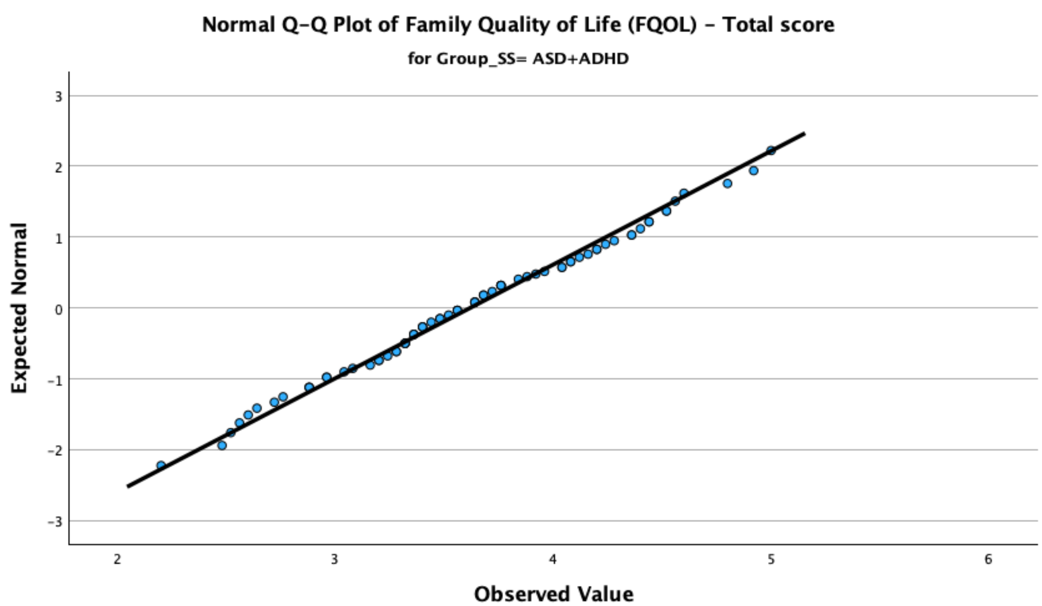


Figure E-2a.8

Research Question 2a – Expected Normal Probability Plot for ASD+ADHD Group



Research Question 2b.

Figure E-2b.1

Research Question 2b – Normality Histogram for NT Group

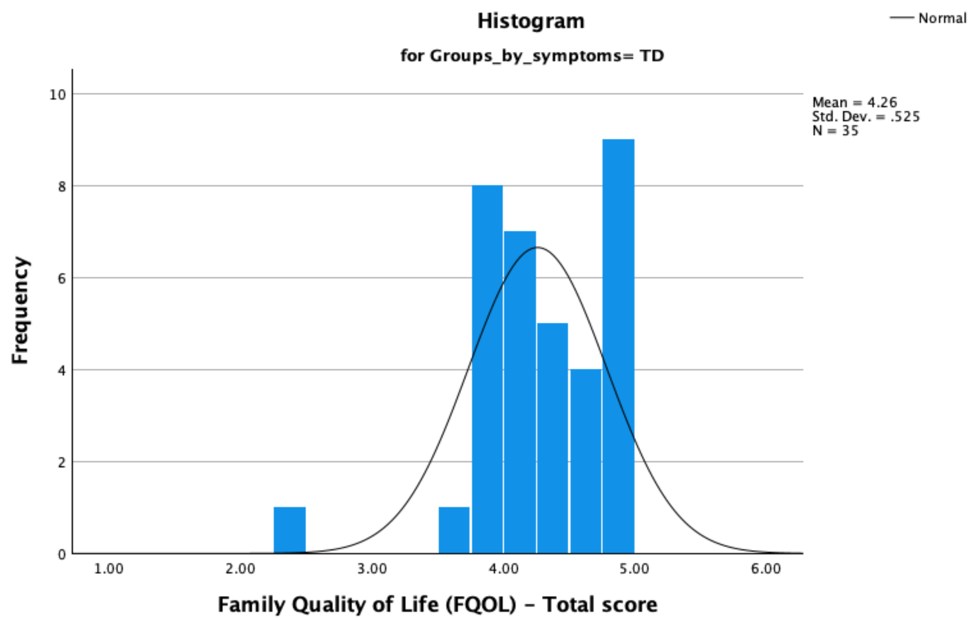


Figure E-2b.2

Research Question 2b – Normality Histogram for ASD Group

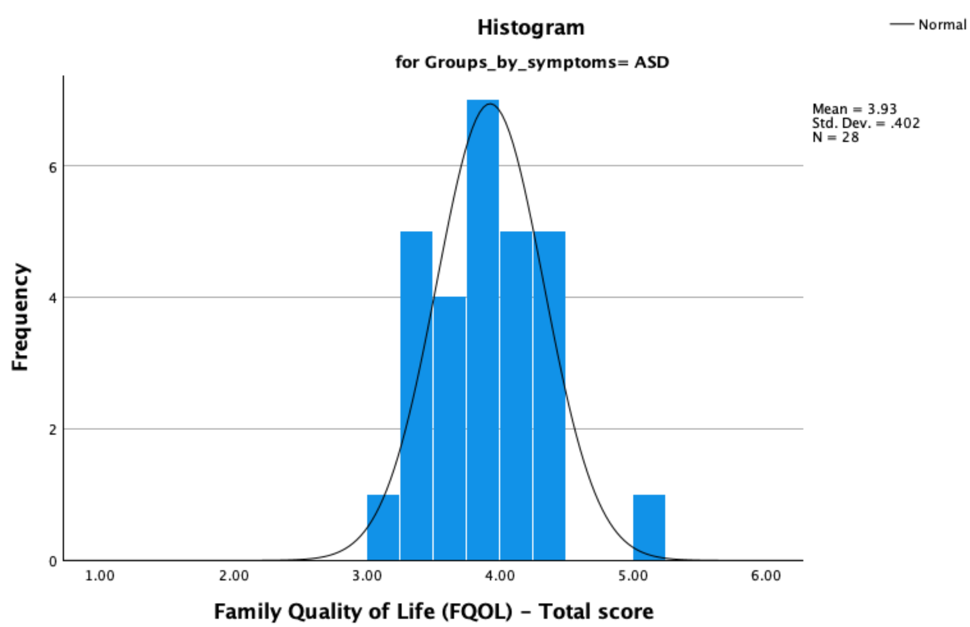


Figure E-2b.3

Research Question 2b – Normality Histogram for ADHD Group

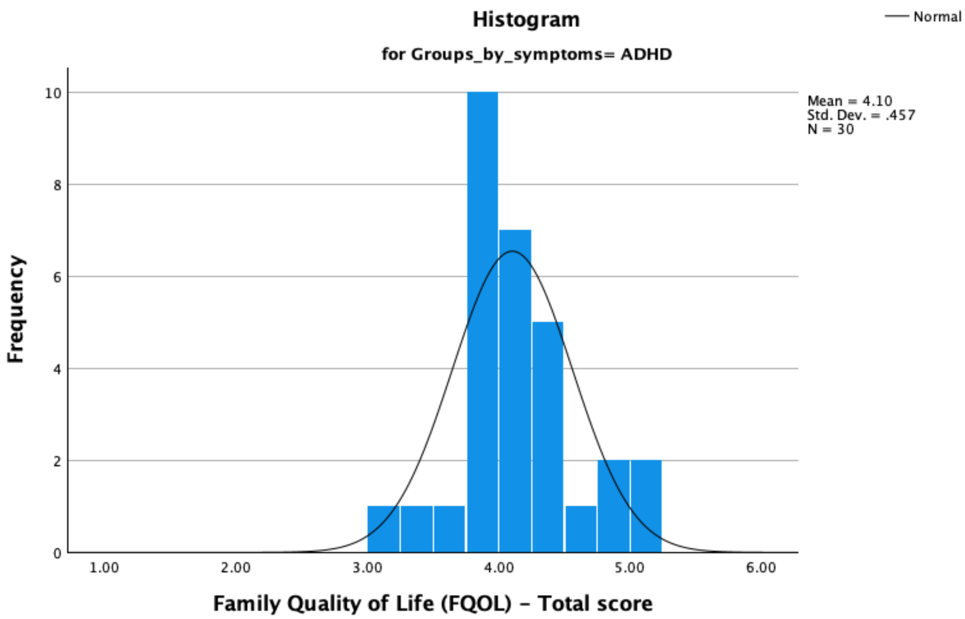


Figure E-2b.4

Research Question 2b – Normality Histogram for ASD+ADHD Group

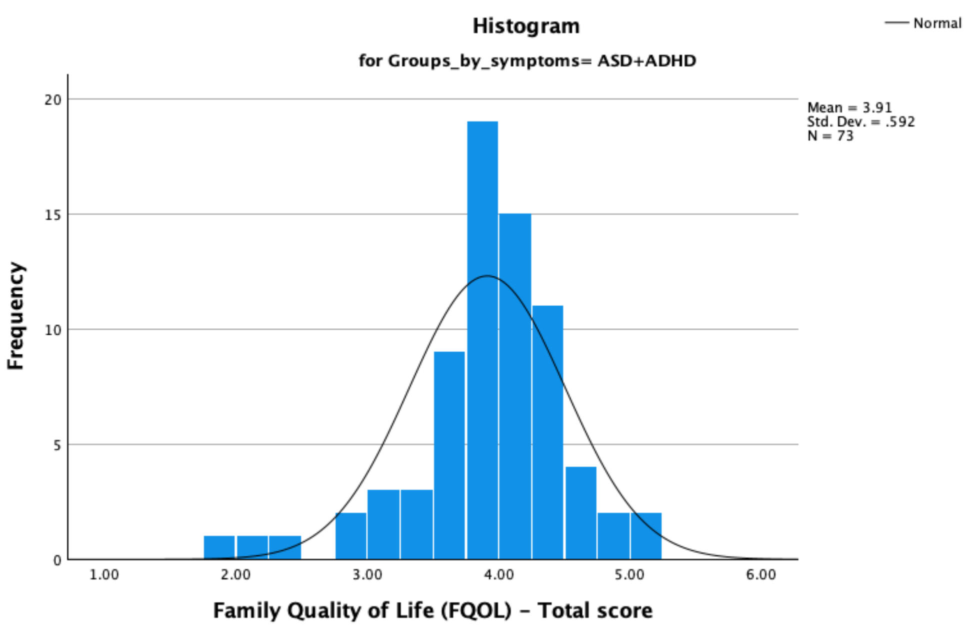


Figure E-2b.5

Research Question 2b – Expected Normal Probability Plot for NT Group

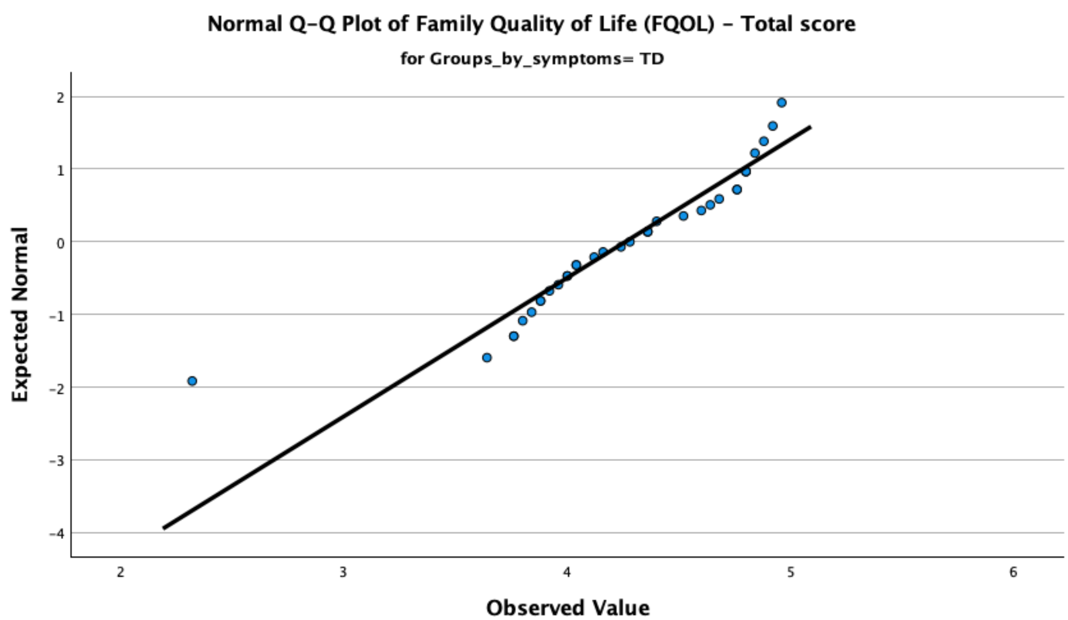


Figure E-2b.6

Research Question 2b – Expected Normal Probability Plot for ASD Group

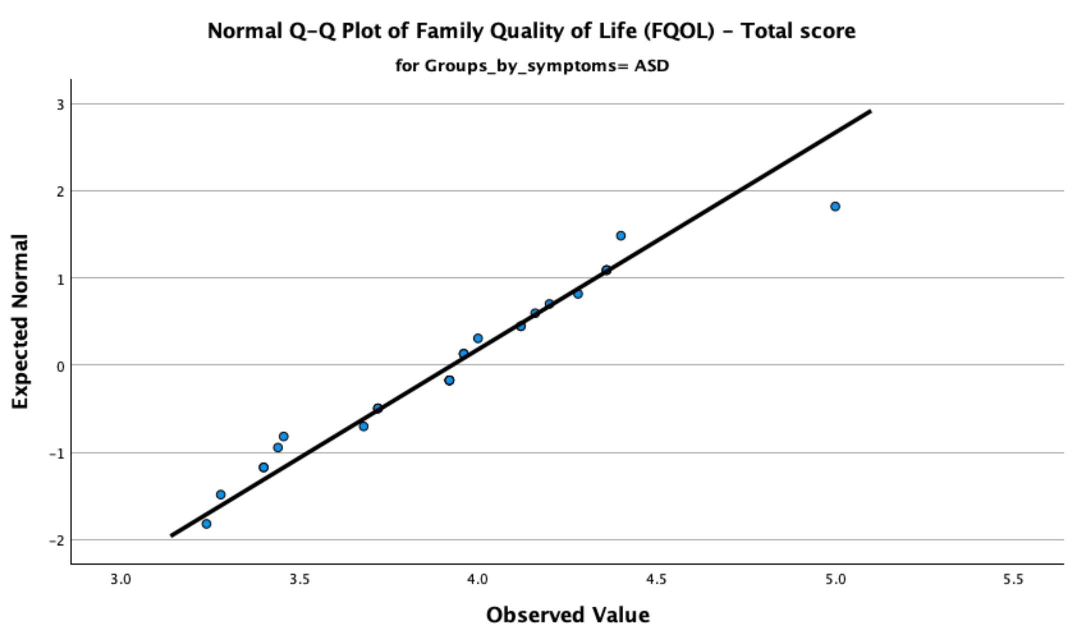


Figure E-2b.7

Research Question 2b – Expected Normal Probability Plot for ADHD Group

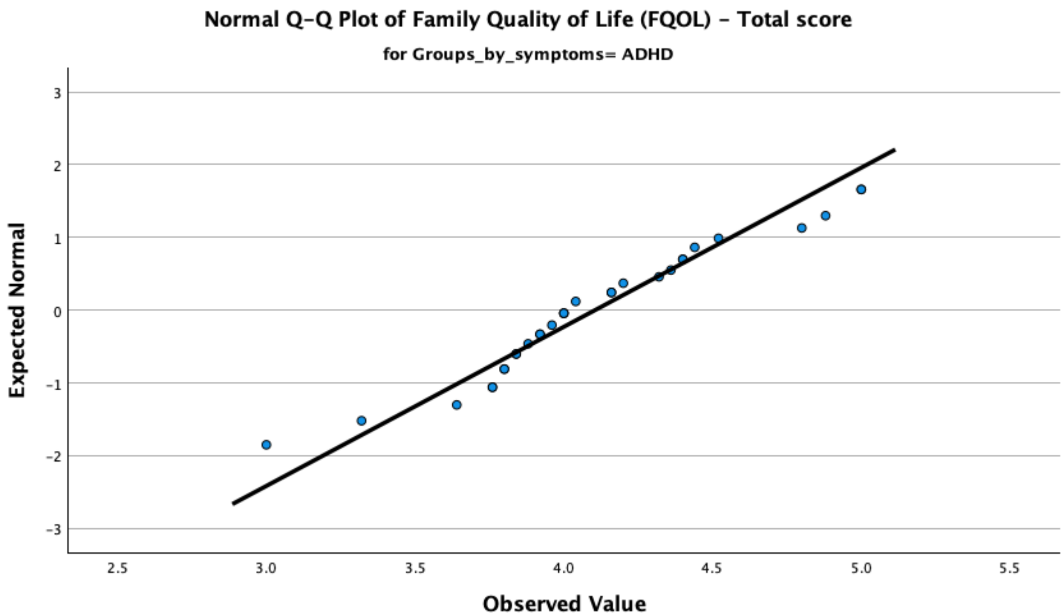
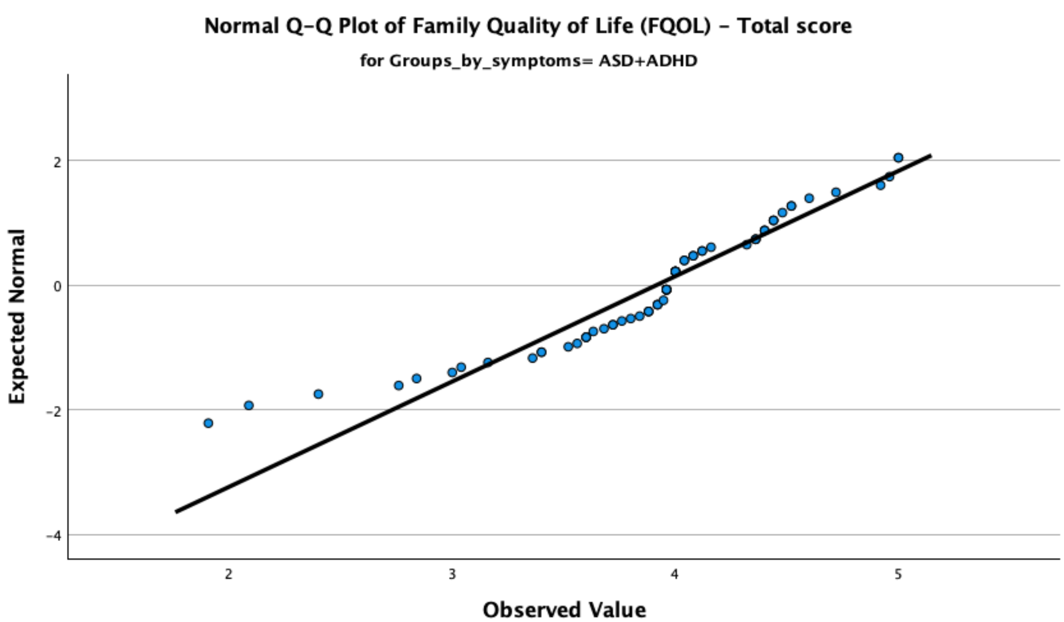


Figure E-2b.8

Research Question 2b – Expected Normal Probability Plot for ASD+ADHD Group



Research Question 3a.

Figure E-3a.1

Research Question 3a – Normality Histogram

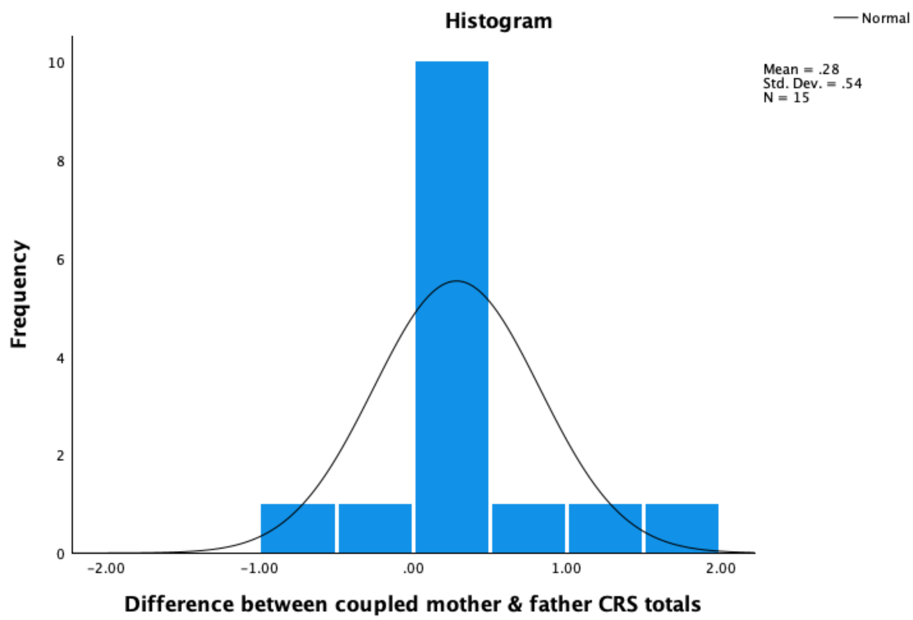
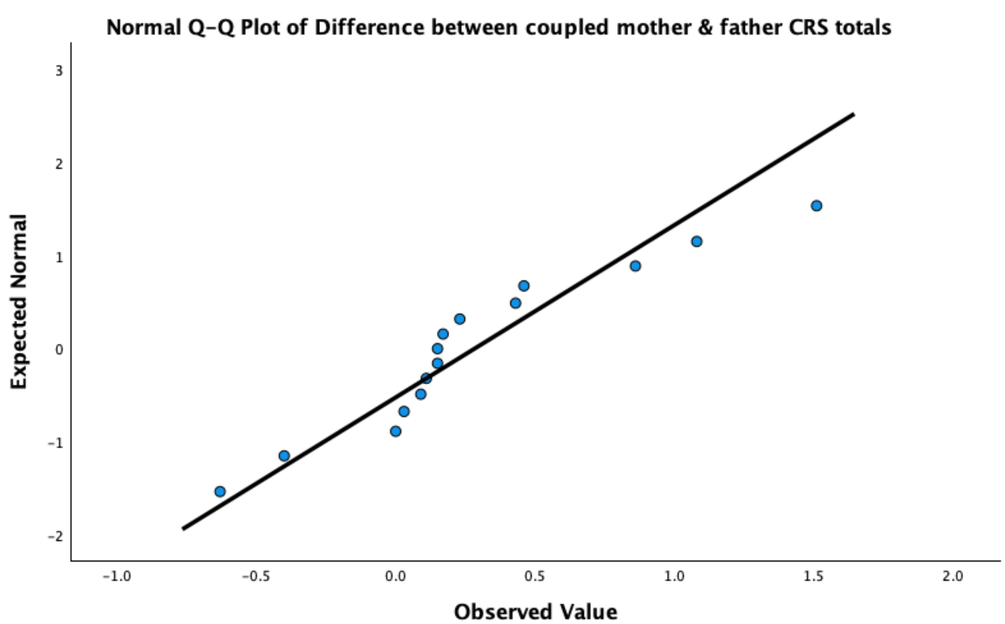


Figure E-3a.2

Research Question 3a – Expected Normal Probability Plot



Research Question 3b.

Figure E-3b.1

Research Question 3b – Normality Histogram

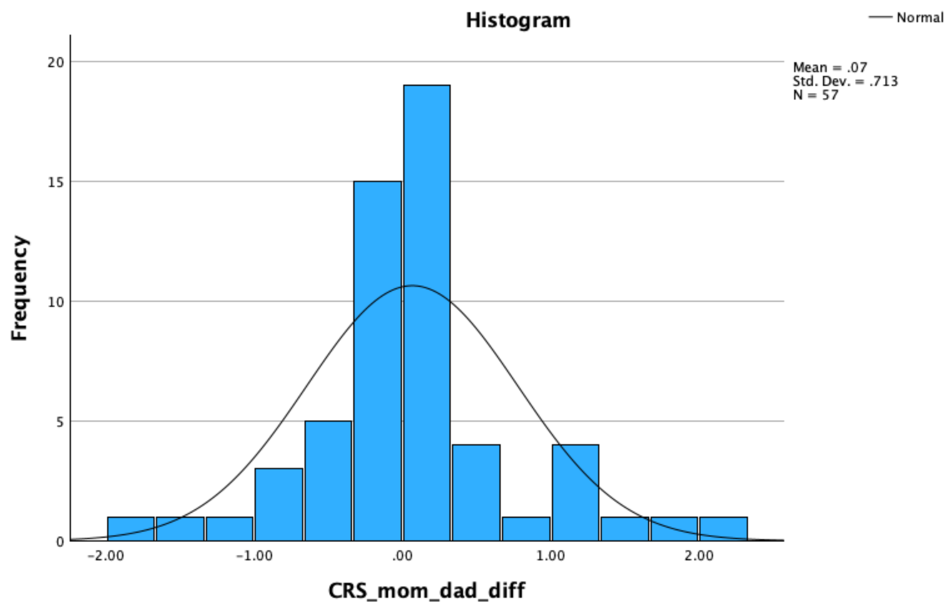
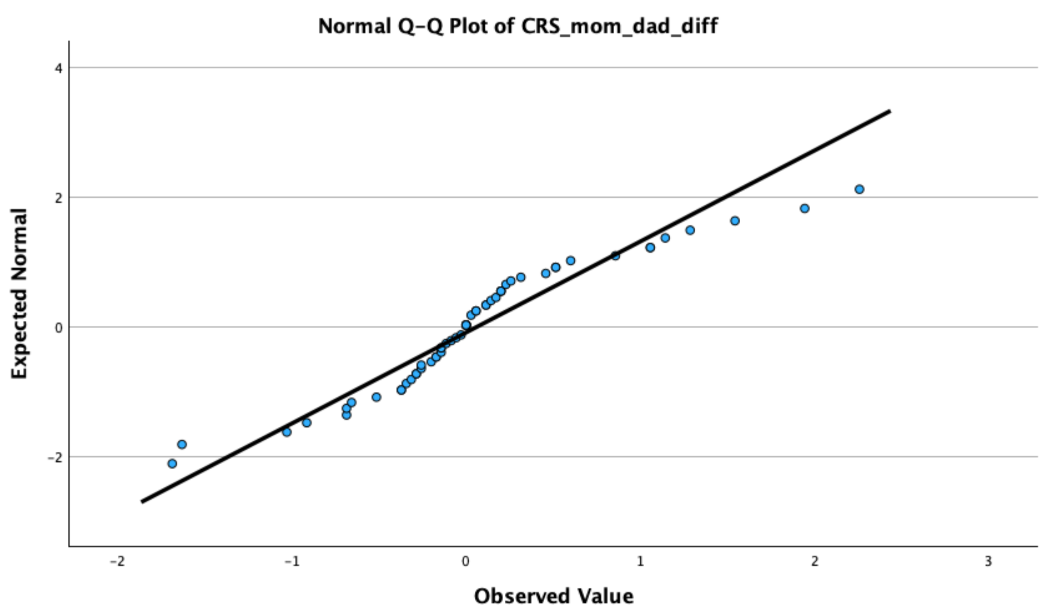


Figure E-3b.2

Research Question 3b – Expected Normal Probability Plot



Research Question 4a.

Figure E-4a.1

Research Question 4a – Normality Histogram

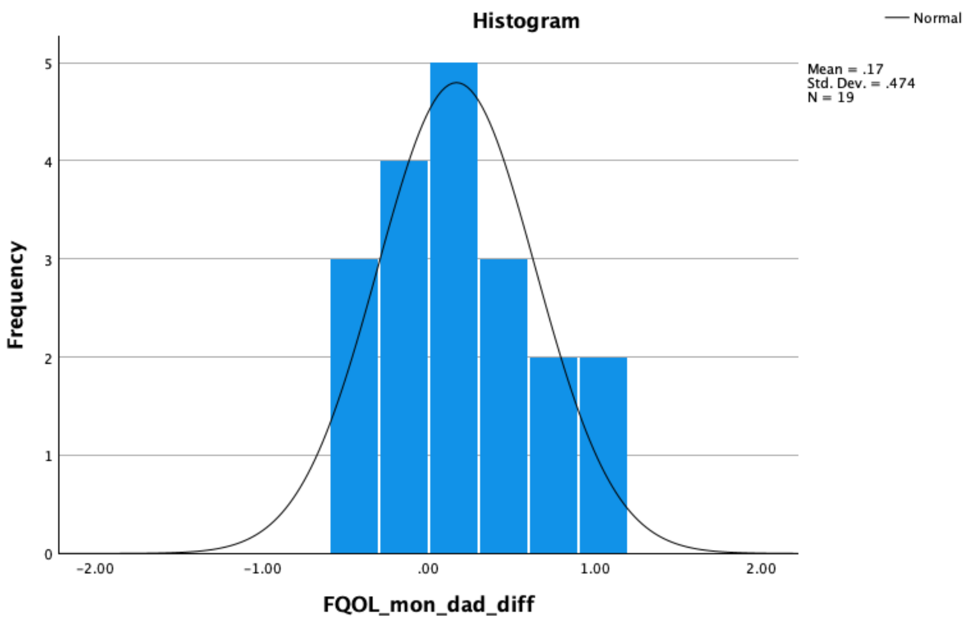
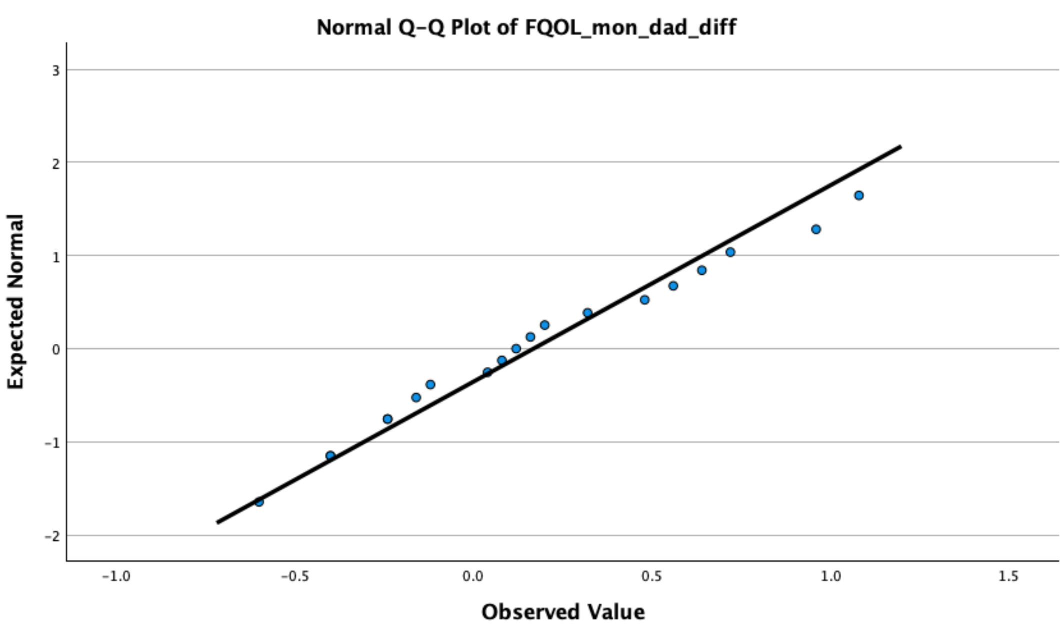


Figure E-4a.2

Research Question 4a – Expected Normal Probability Plot



Research Question 4b.

Figure E-4b.1

Research Question 4b – Normality Histogram

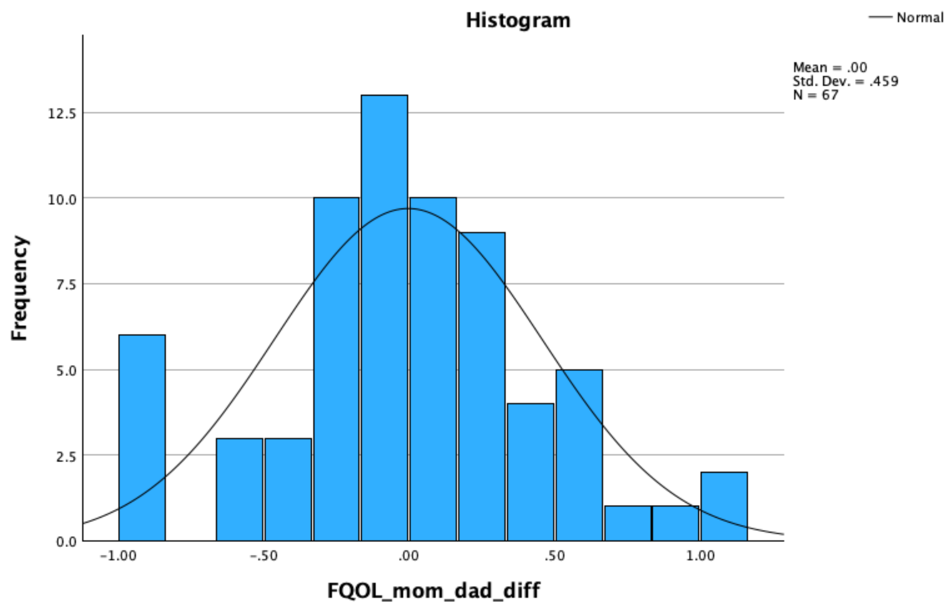
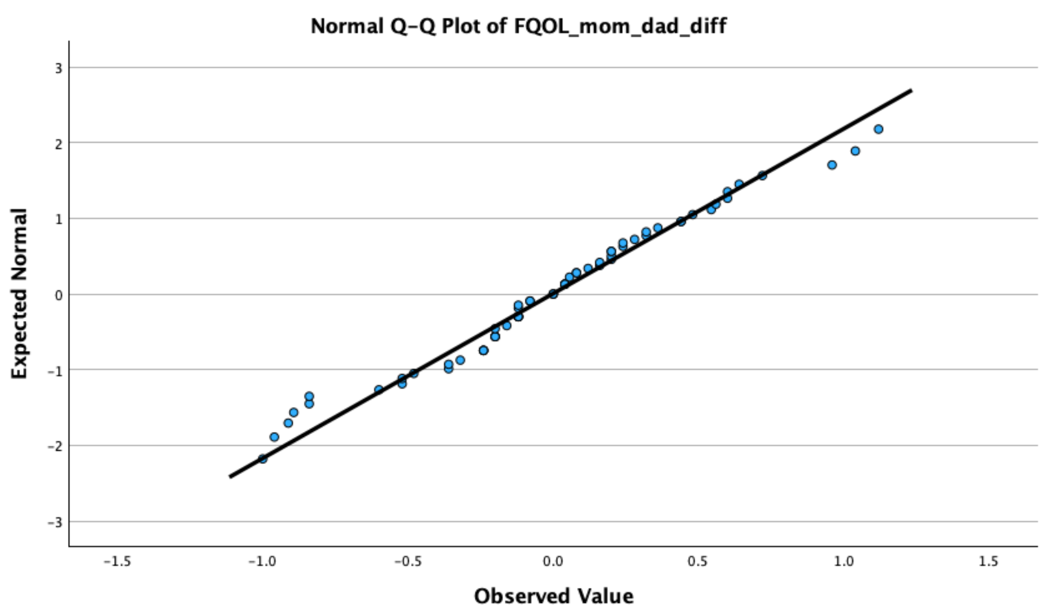


Figure E-4b.2

Research Question 4b – Expected Normal Probability Plot



Research Question 5a.

Figure E-5a.1

Research Question 5a – Expected Normal Probability Plot

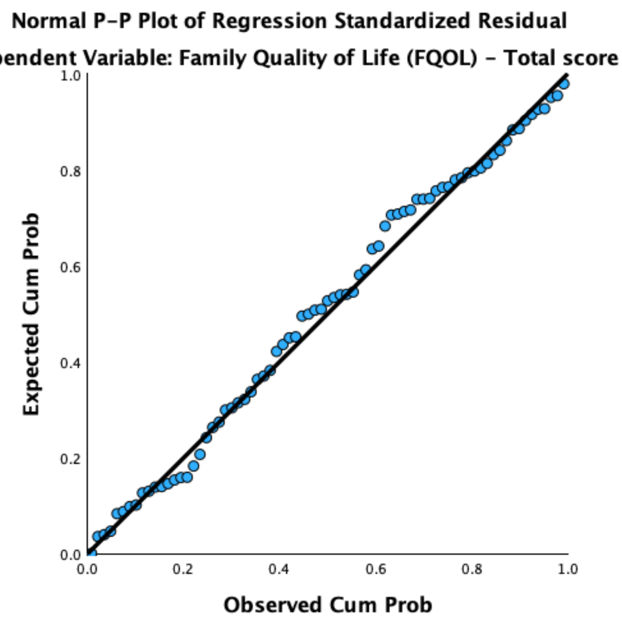
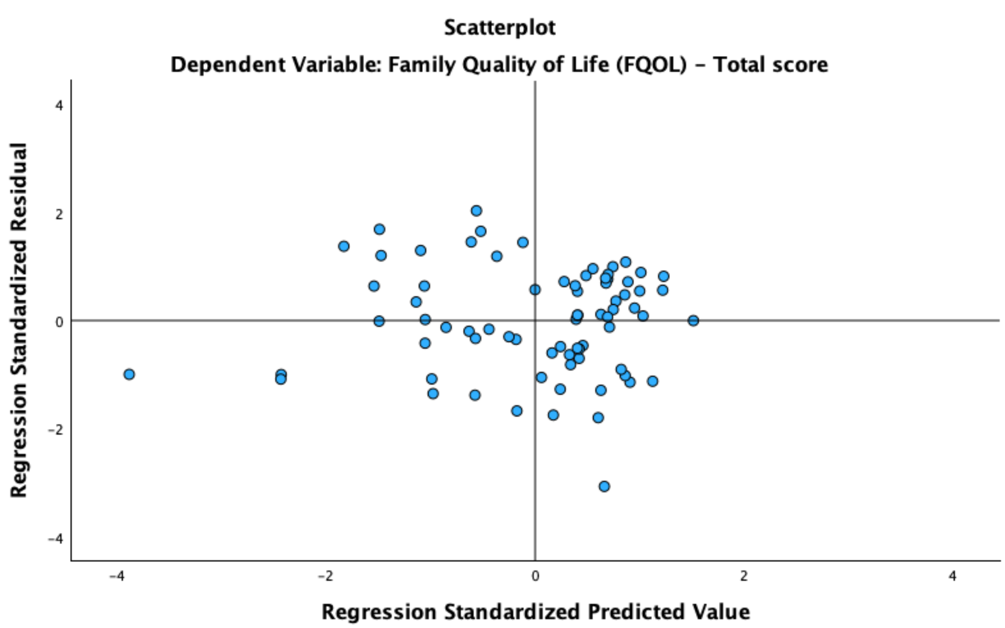


Figure E-5a.2

Research Question 5a – Scatterplot of Residuals



Research Question 5b.

Figure E-5b.1

Research Question 5b – Expected Normal Probability Plot

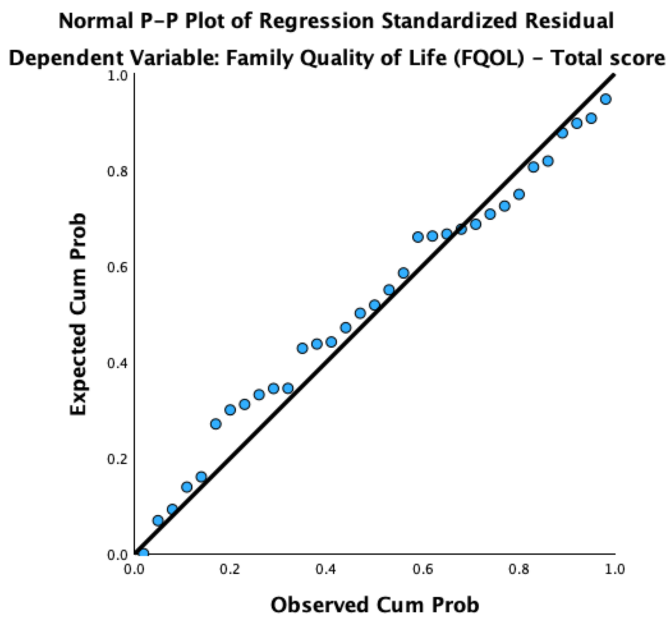
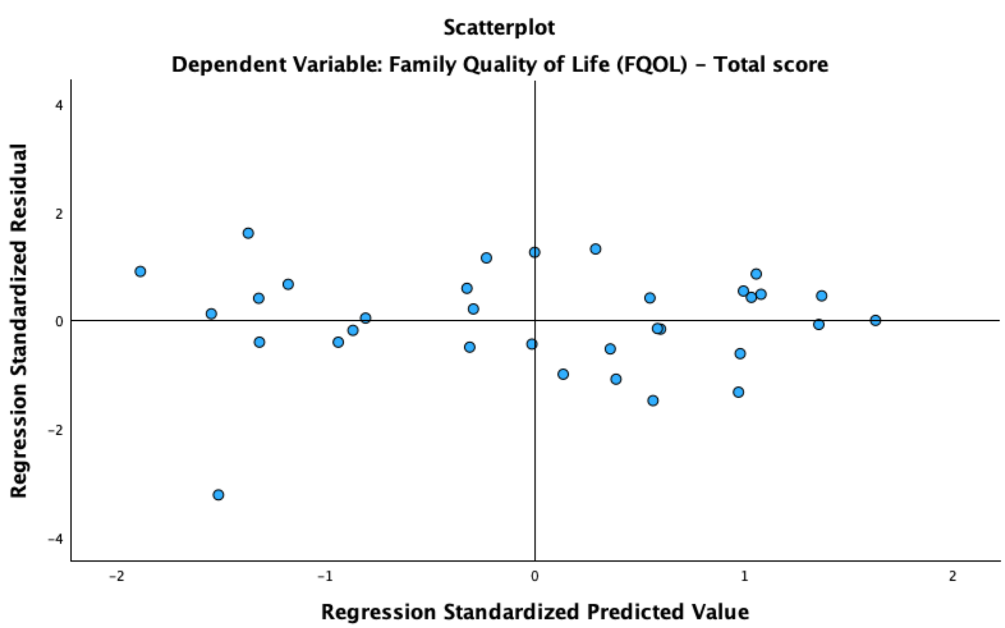


Figure E-5b.2

Research Question 5b – Scatterplot of Residuals



Research Question 5c.

Figure E-5c.1

Research Question 5c – Expected Normal Probability Plot

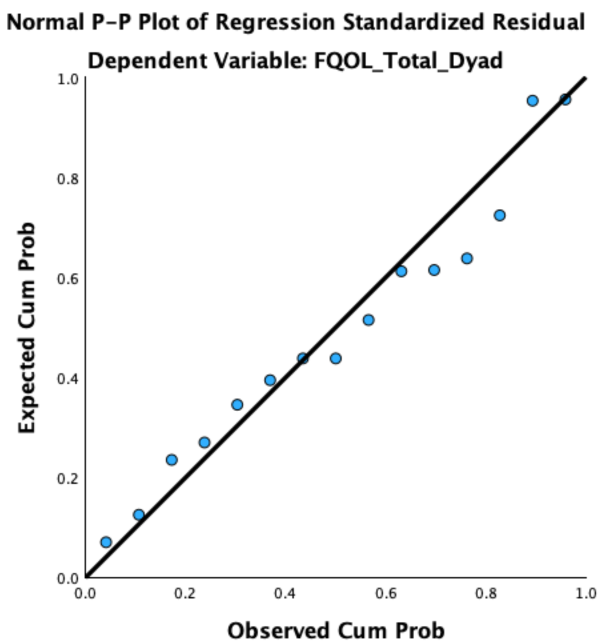
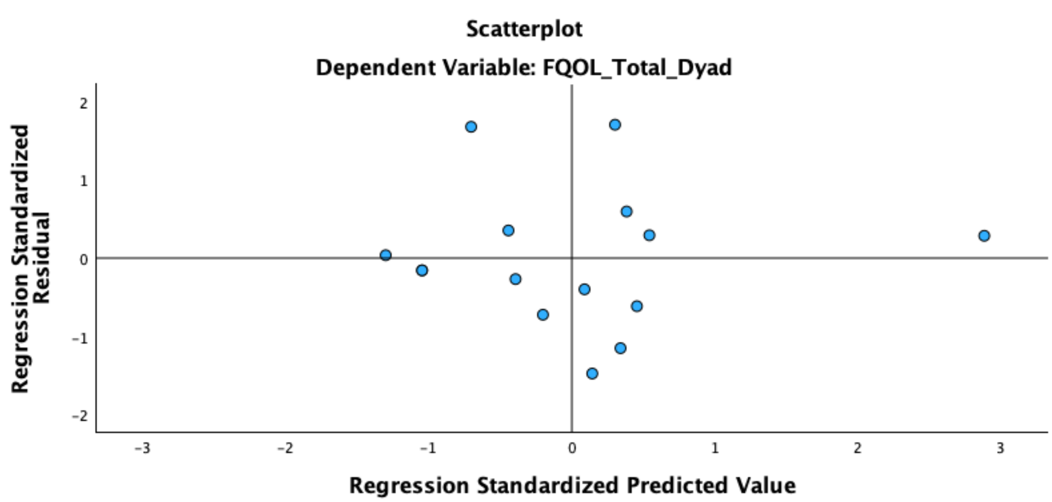


Figure E-5c.2

Research Question 5c – Scatterplot of Residuals



Research Question 5d.

Figure E-5d.1

Research Question 5d – Expected Normal Probability Plot

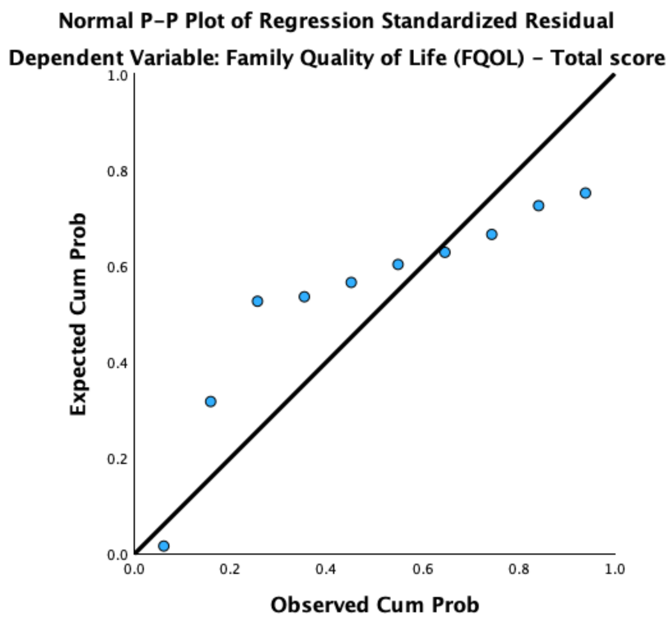
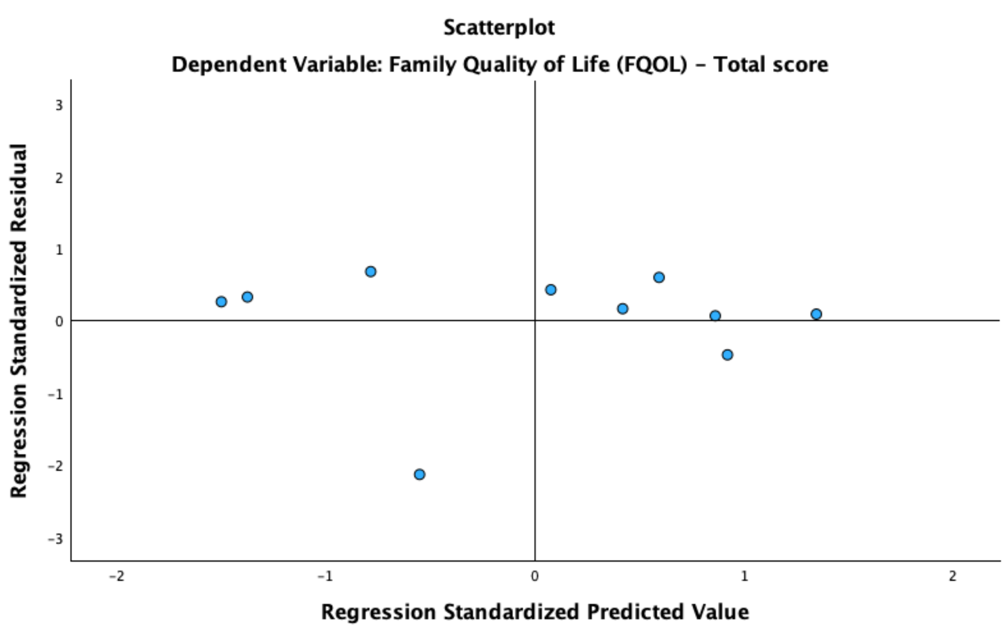


Figure E-5d.2

Research Question 5d – Scatterplot of Residuals



Research Question 5e.

Figure E-5e.1

Research Question 5e – Expected Normal Probability Plot

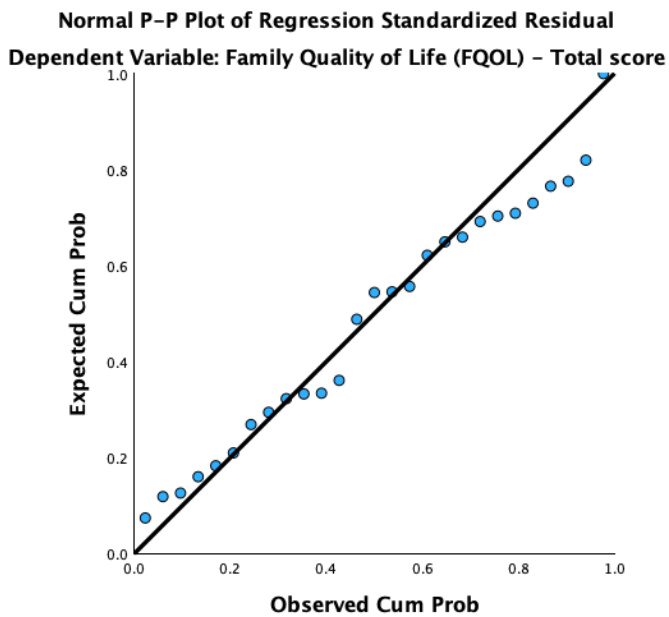
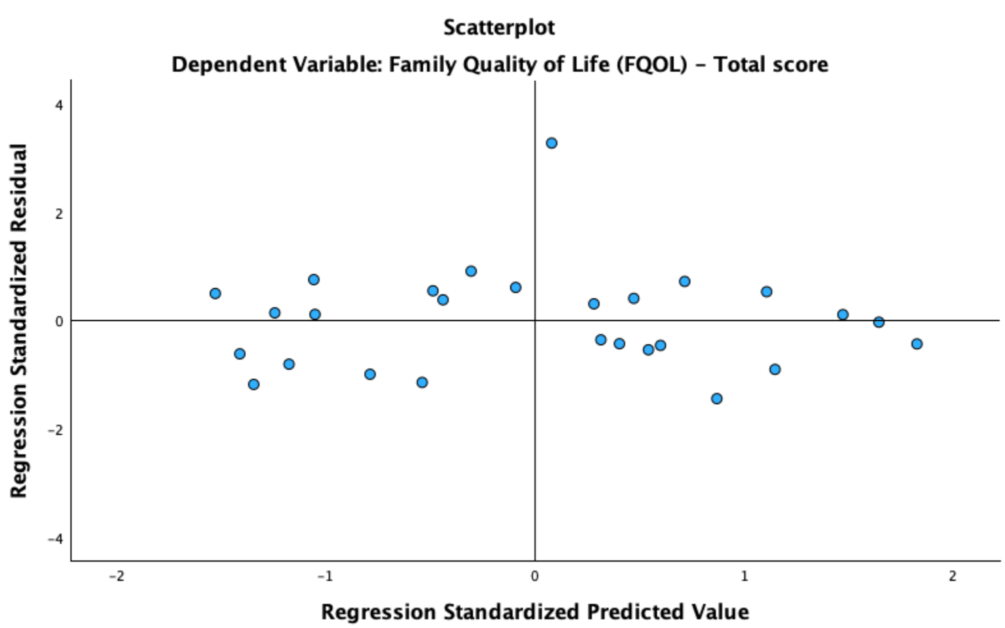


Figure E-5e.2

Research Question 5e – Scatterplot of Residuals



Research Question 5f.

Figure E-5f.1

Research Question 5f – Expected Normal Probability Plot

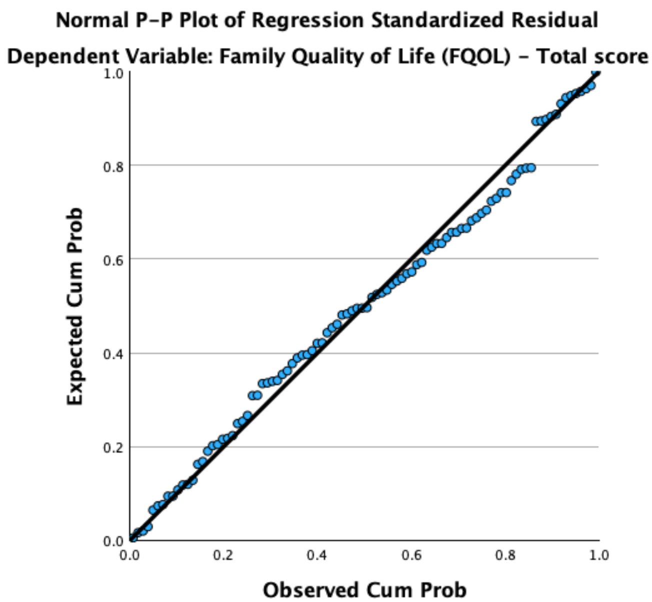
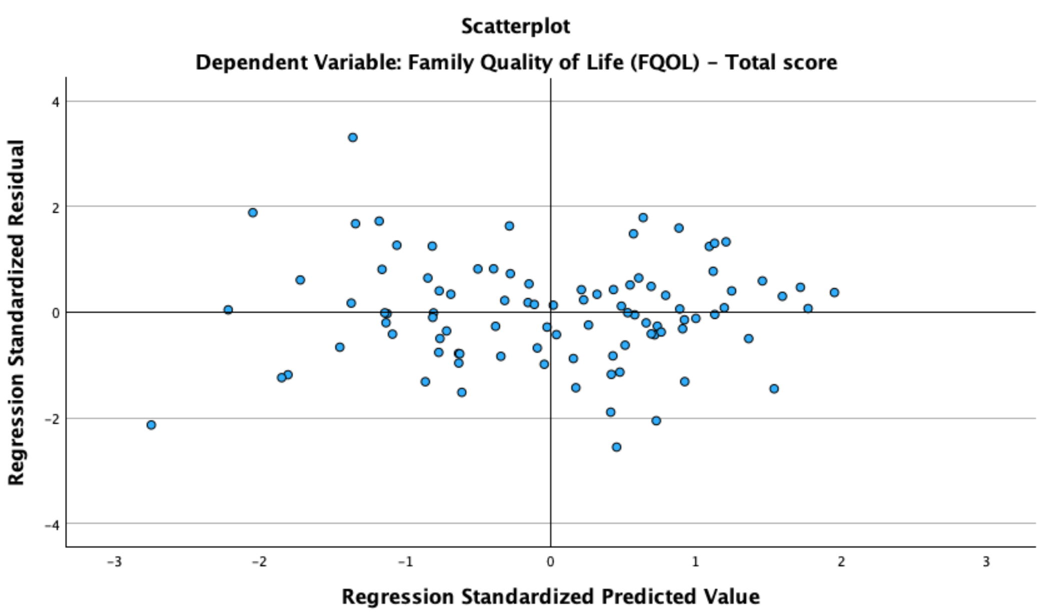


Figure E-5f.2

Research Question 5f – Scatterplot of Residuals



Research Question 5g.

Figure E-5g.1

Research Question 5g – Expected Normal Probability Plot

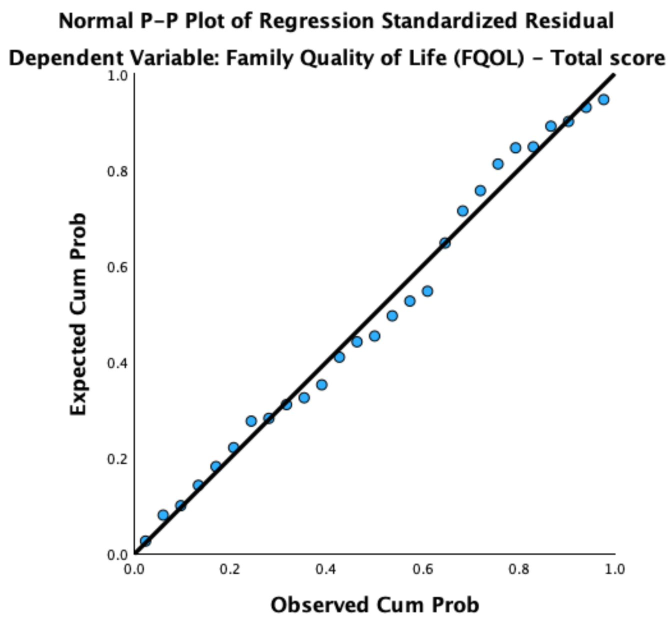
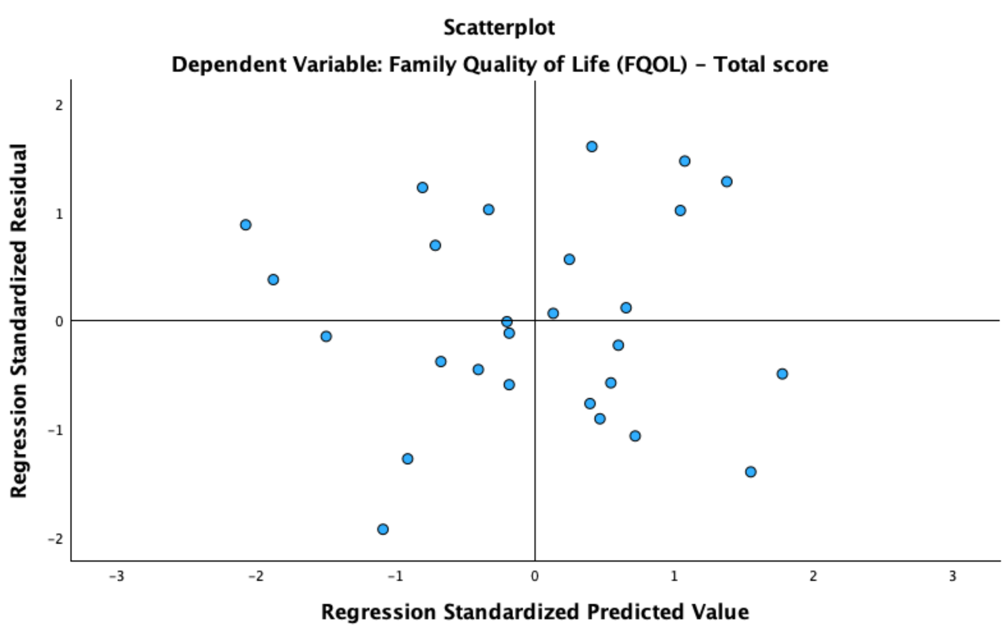


Figure E-5g.2

Research Question 5g – Scatterplot of Residuals



Research Question 5h.

Figure E-5h.1

Research Question 5h – Expected Normal Probability Plot

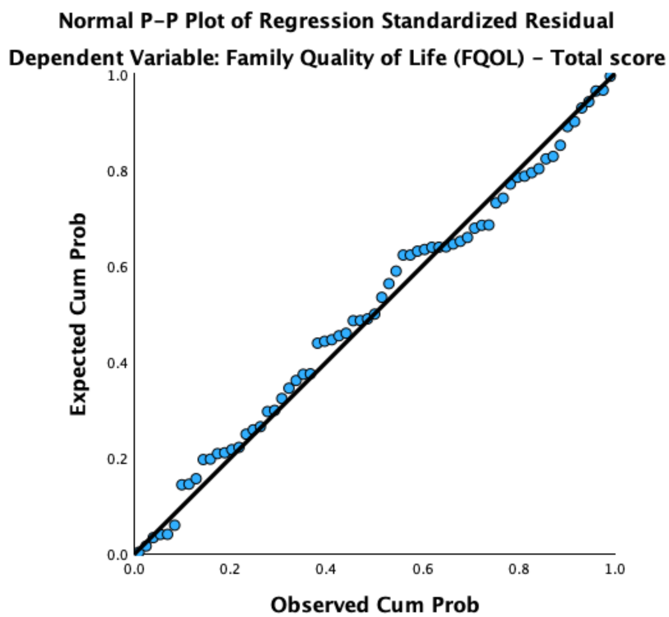
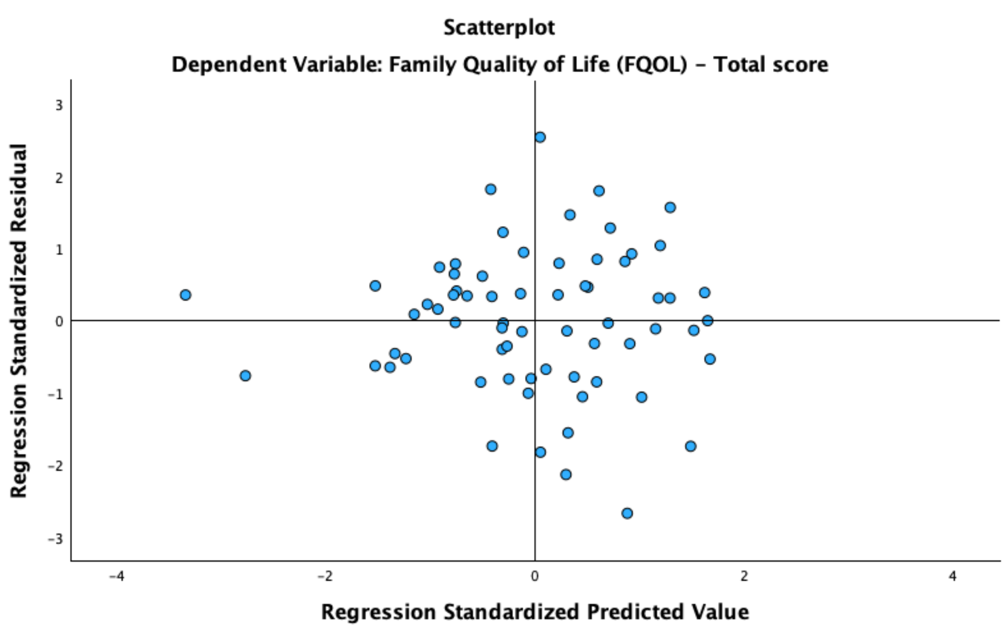


Figure E-5h.2

Research Question 5h – Scatterplot of Residuals



Research Question 5i.

Figure E-5i.1

Research Question 5i – Expected Normal Probability Plot

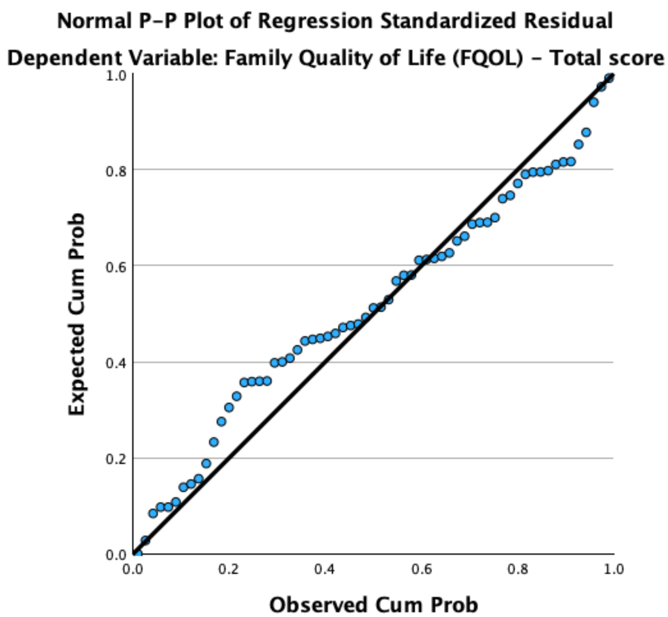
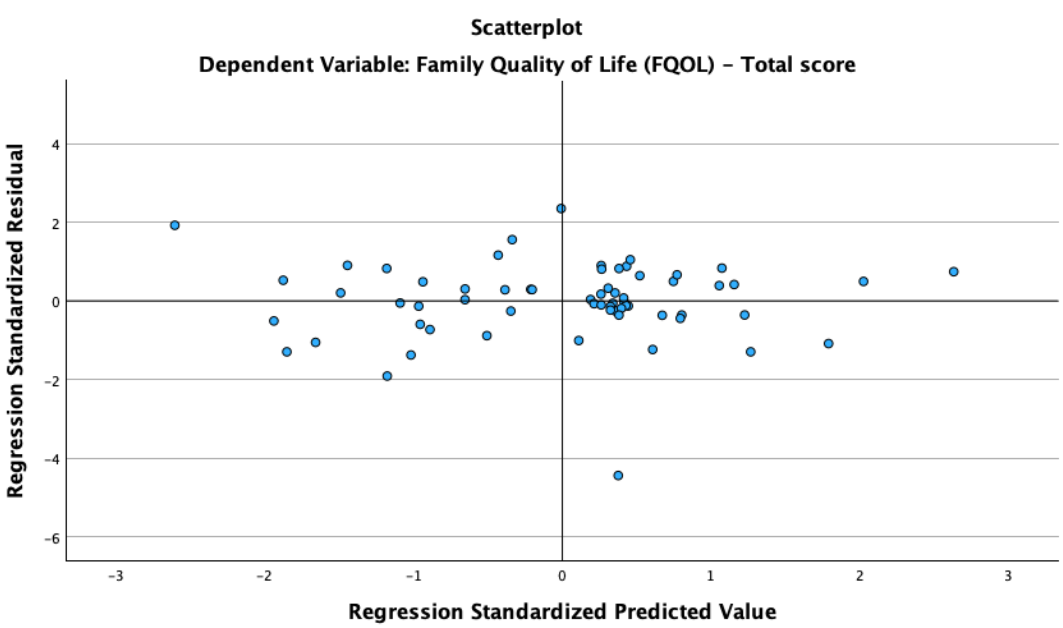


Figure E-5i.2

Research Question 5i – Scatterplot of Residuals



Research Question 5j.

Figure E-5j.1

Research Question 5j – Expected Normal Probability Plot

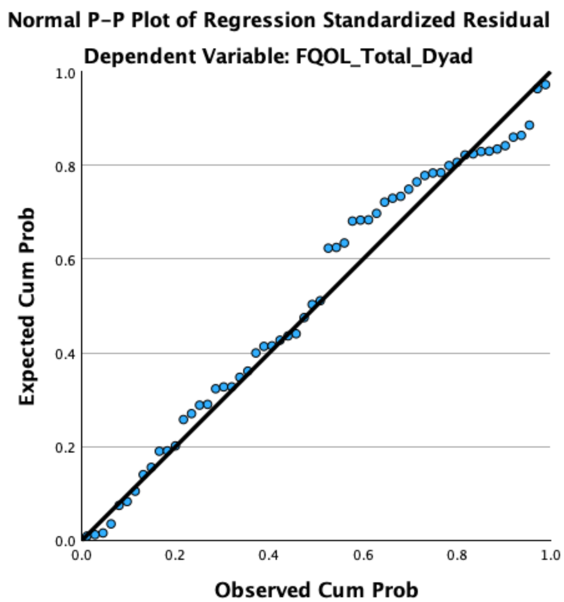
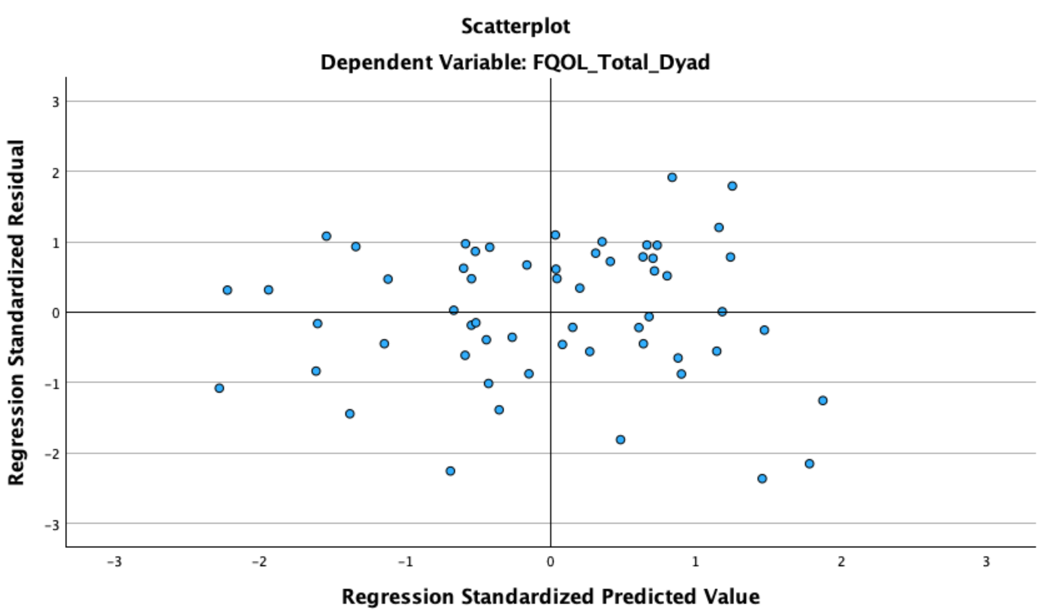


Figure E-5j.2

Research Question 5j – Scatterplot of Residuals



Research Question 6a.

Figure E-6a.1

Research Question 6a – Expected Normal Probability Plot

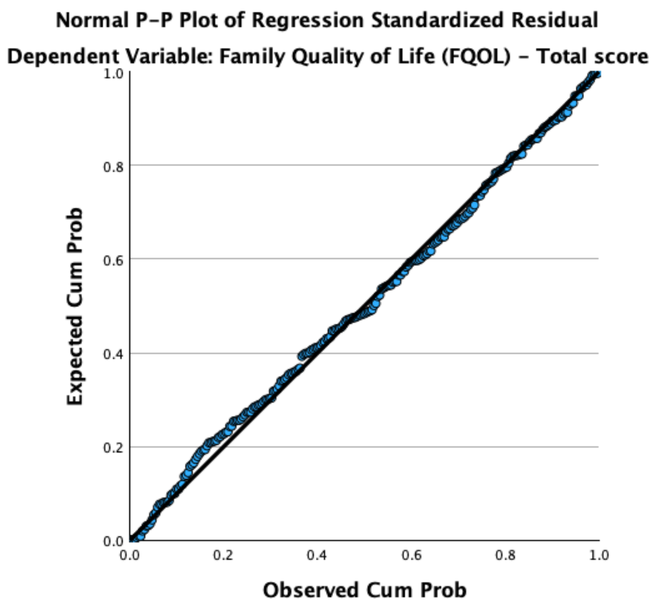
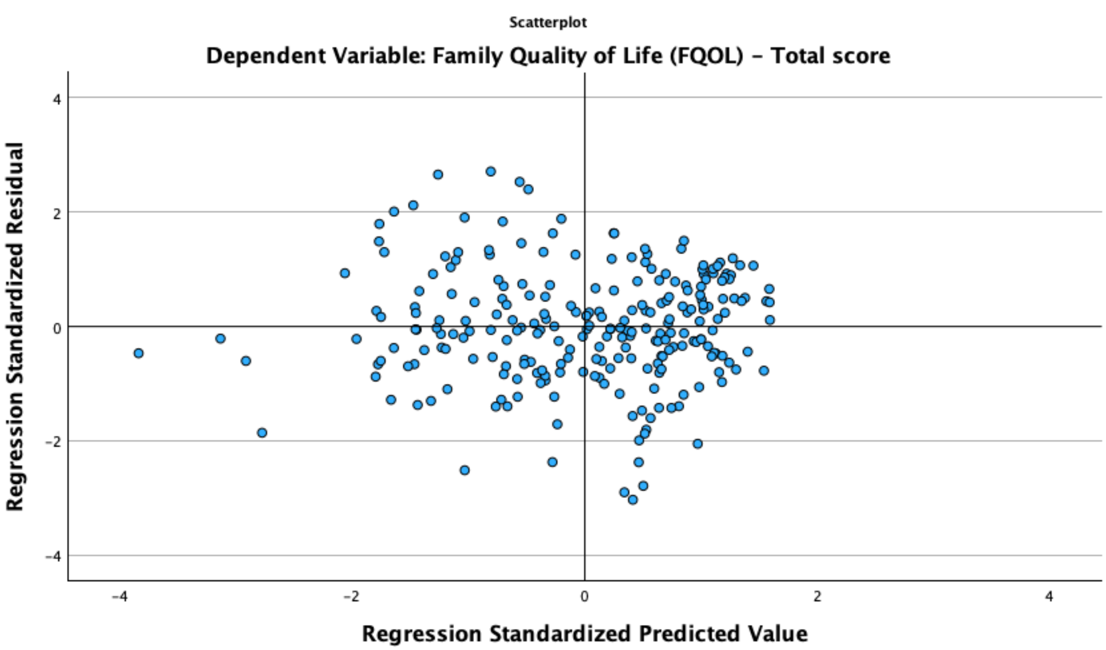


Figure E-6a.2

Research Question 6a – Scatterplot of Residuals



Research Question 6b.

Figure E-6b.1

Research Question 6b – Expected Normal Probability Plot

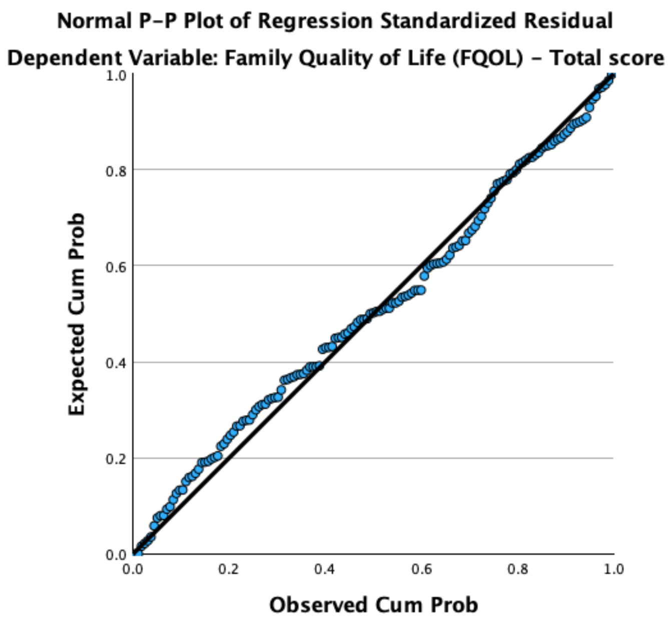
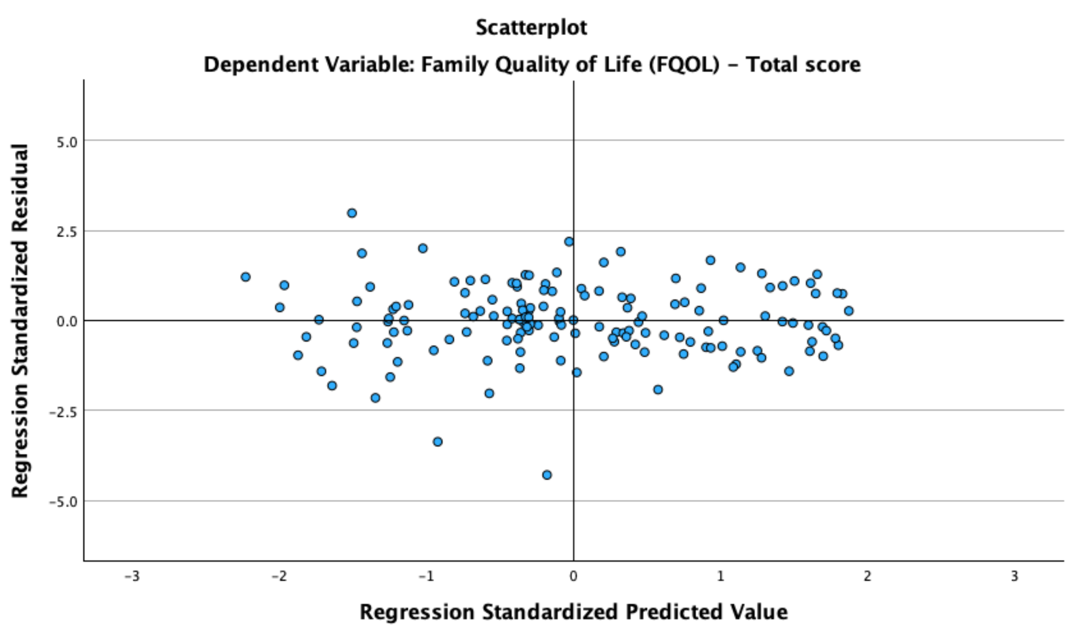


Figure E-6b.2

Research Question 6b – Scatterplot of Residuals



Research Question 6c.

Figure E-6c.1

Research Question 6c – Expected Normal Probability Plot

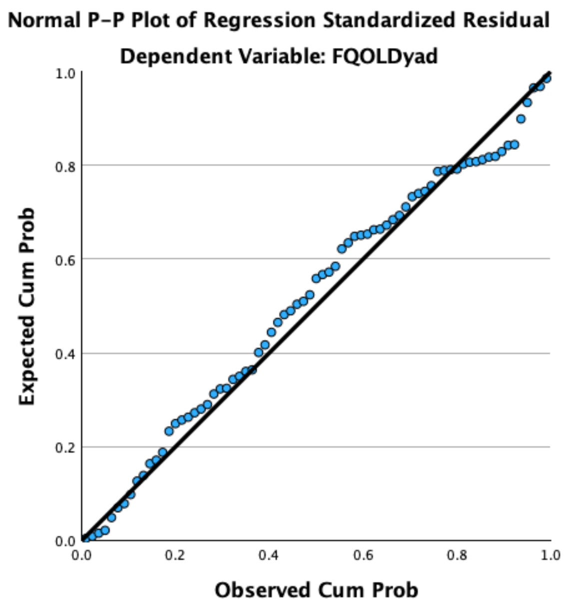
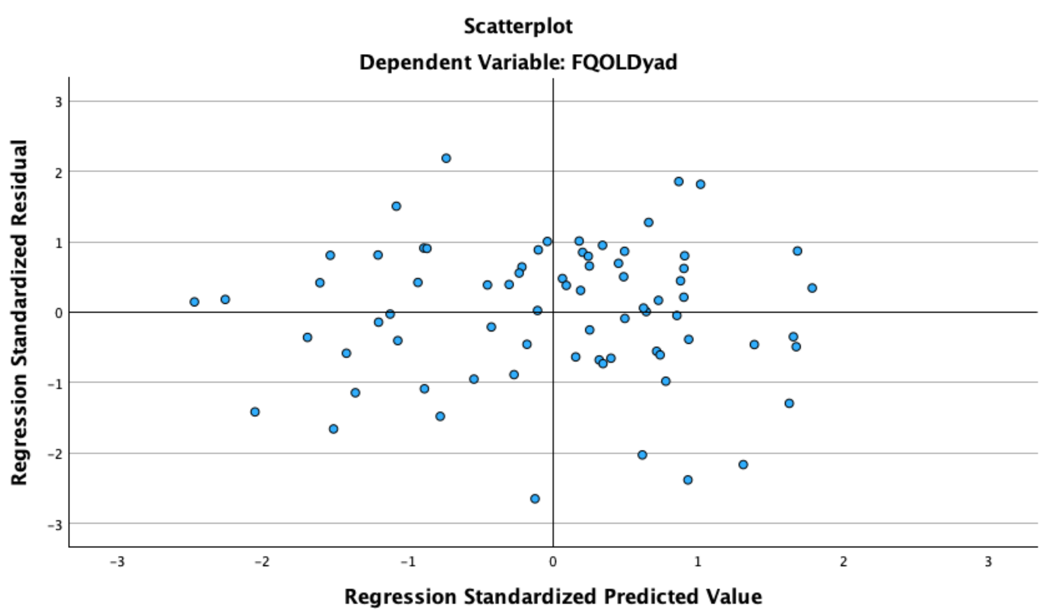


Figure E-6c.2

Research Question 6c – Scatterplot of Residuals



Appendix F

Assumption Testing for Exploratory Analyses

Exploratory Research Question 7

Table F-7

Assumption Testing – RQ 7: Coparenting Agreement Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 7a: Mothers				$F(3,247) = .90$, $p = .444$
NT Group	-0.98 (.28)	0.46 (0.55)	$W(76) = .91$, $p < .001$	
ASD Group	-0.05 (0.66)	-1.37 (1.28)	$W(11) = .88$, $p = .115$	
ADHD Group	-0.28 (0.25)	-0.52 (0.49)	$W(96) = .97$, $p = .038$	
ASD+ADHD Group	-0.32 (0.29)	-0.56 (0.57)	$W(68) = .97$, $p = .058$	
RQ 7b: Fathers				$F(3,151) = .88$, $p = .45$
NT Group	-0.35 (0.40)	-0.83 (0.78)	$W(35) = .94$, $p = .043$	
ASD Group	0.17 (0.45)	-1.38 (0.87)	$W(27) = .91$, $p = .023$	
ADHD Group	0.44 (0.45)	-0.01 (0.87)	$W(27) = .98$, $p = .741$	
ASD+ADHD Group	1.13 (0.30)	1.22 (0.58)	$W(66) = .91$, $p < .001$	

Exploratory Research Question 7a.

Figure F-7a.1

Exploratory Research Question 7a – Normality Histogram for NT Group

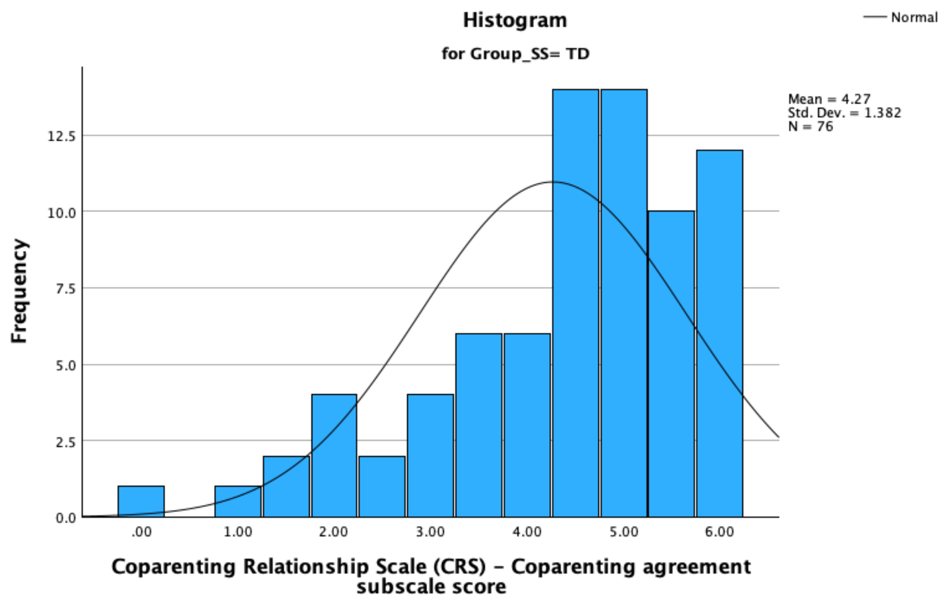


Figure F-7a.2

Exploratory Research Question 7a – Normality Histogram for ASD Group

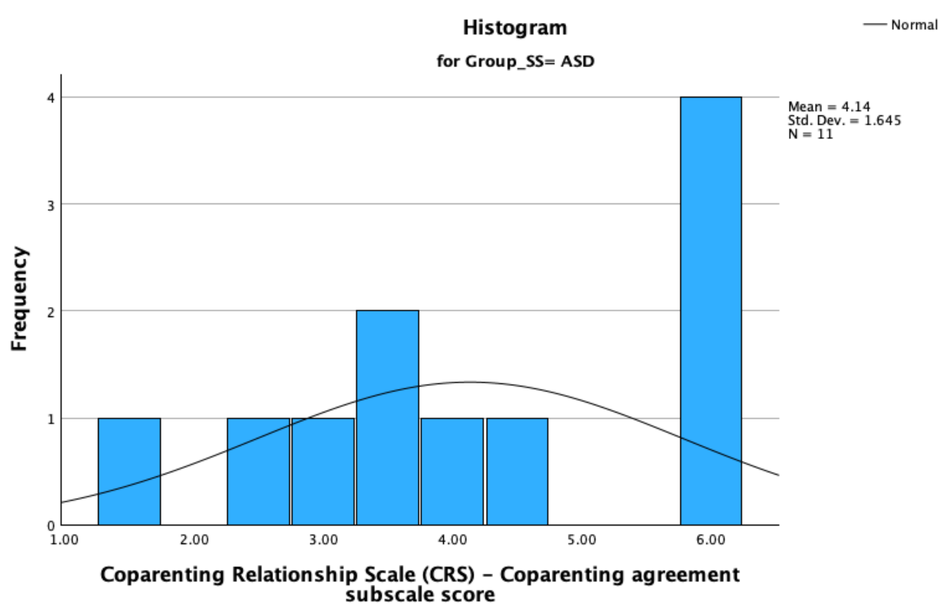


Figure F-7a.3

Exploratory Research Question 7a – Normality Histogram for ADHD Group

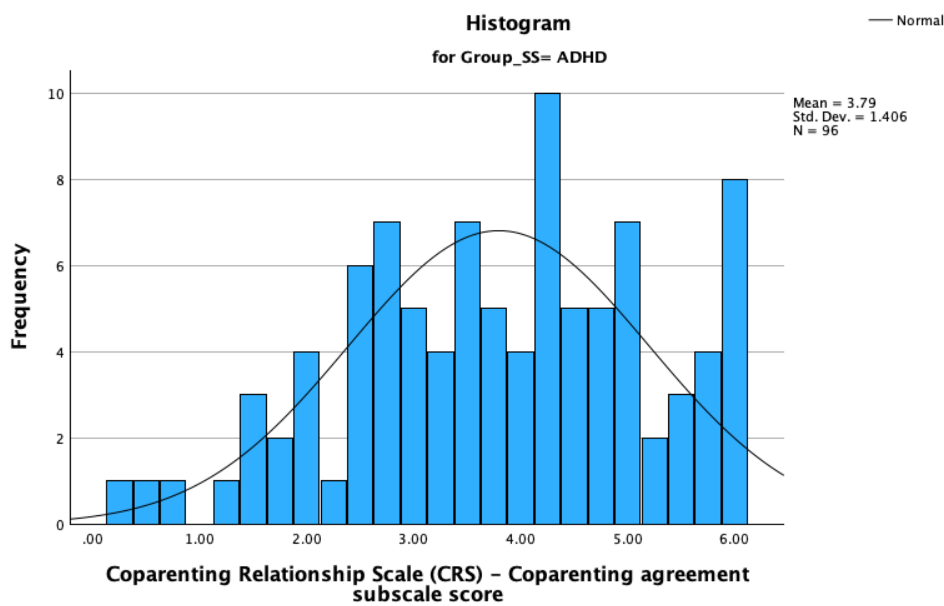


Figure F-7a.4

Exploratory Research Question 7a – Normality Histogram for ASD+ADHD Group

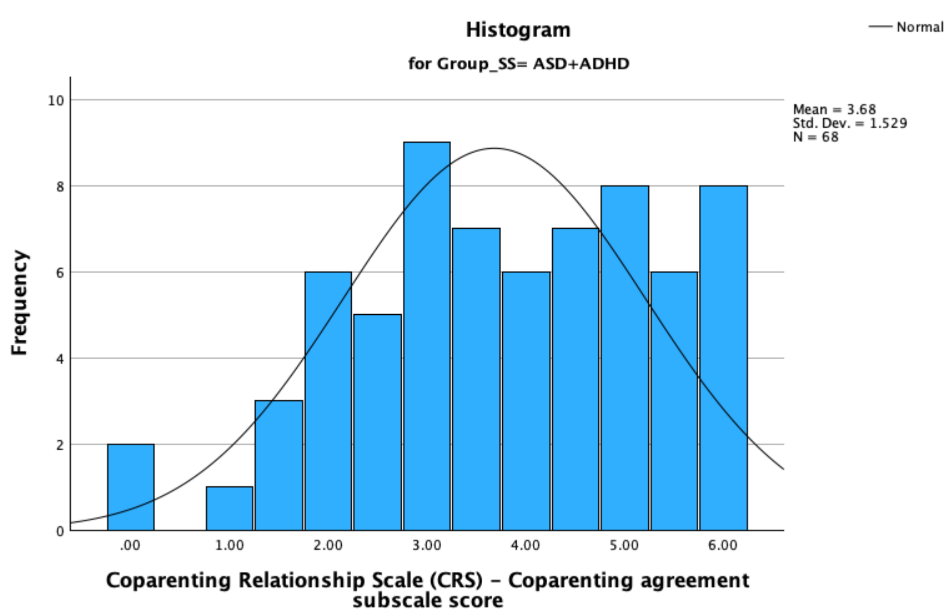


Figure F-7a.5

Exploratory Research Question 7a – Expected Normal Probability Plot for NT Group

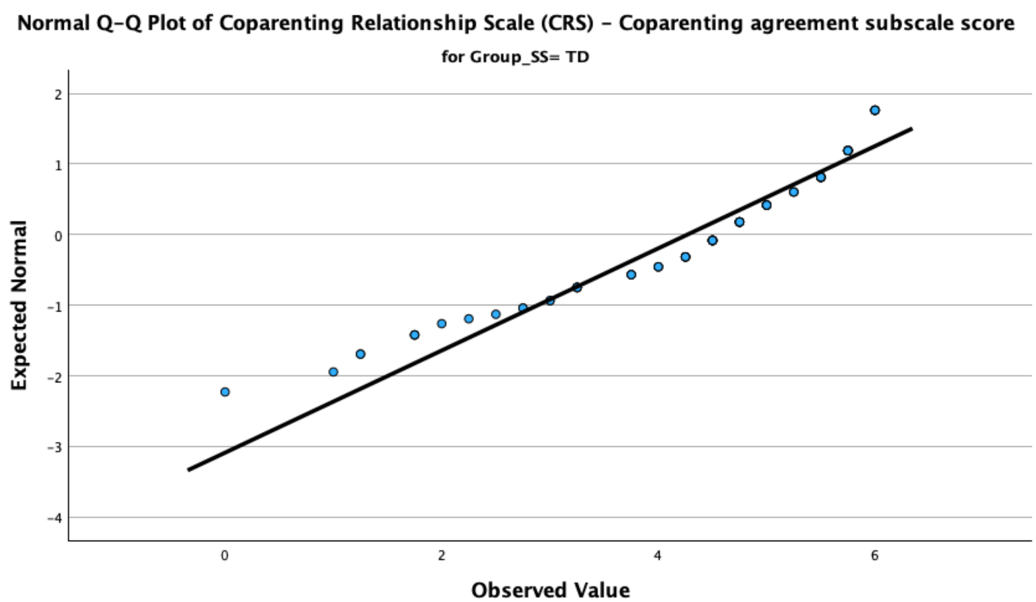


Figure F-7a.6

Exploratory Research Question 7a – Expected Normal Probability Plot for ASD Group

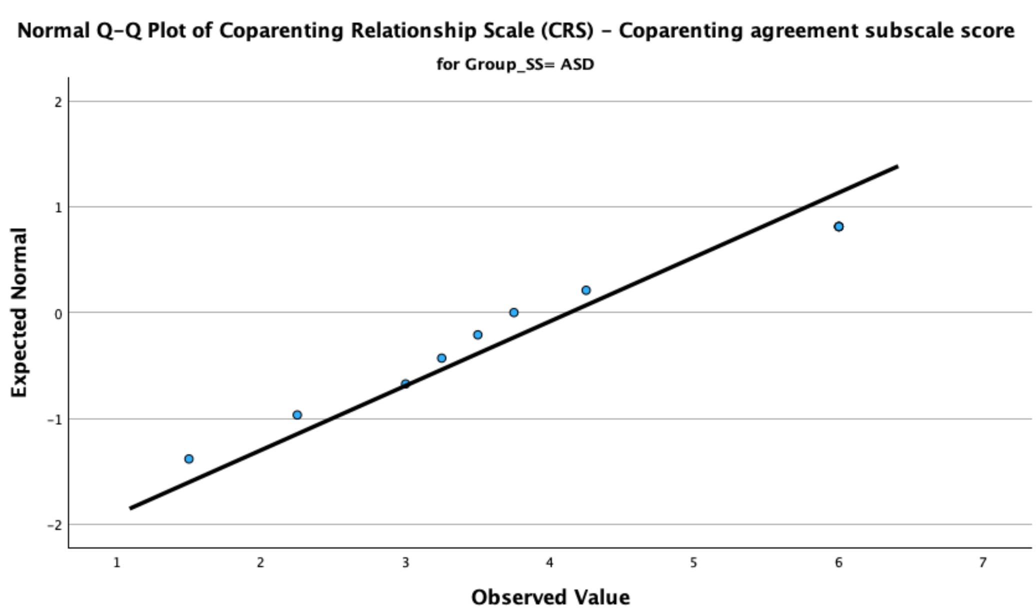


Figure F-7a.7

Exploratory Research Question 7a – Expected Normal Probability Plot for ADHD Group

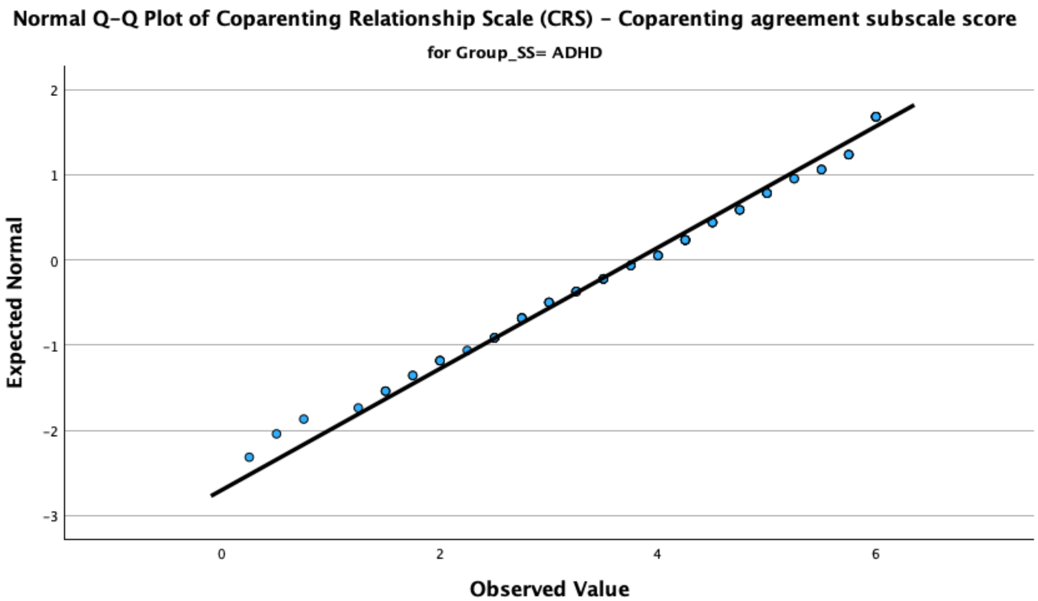
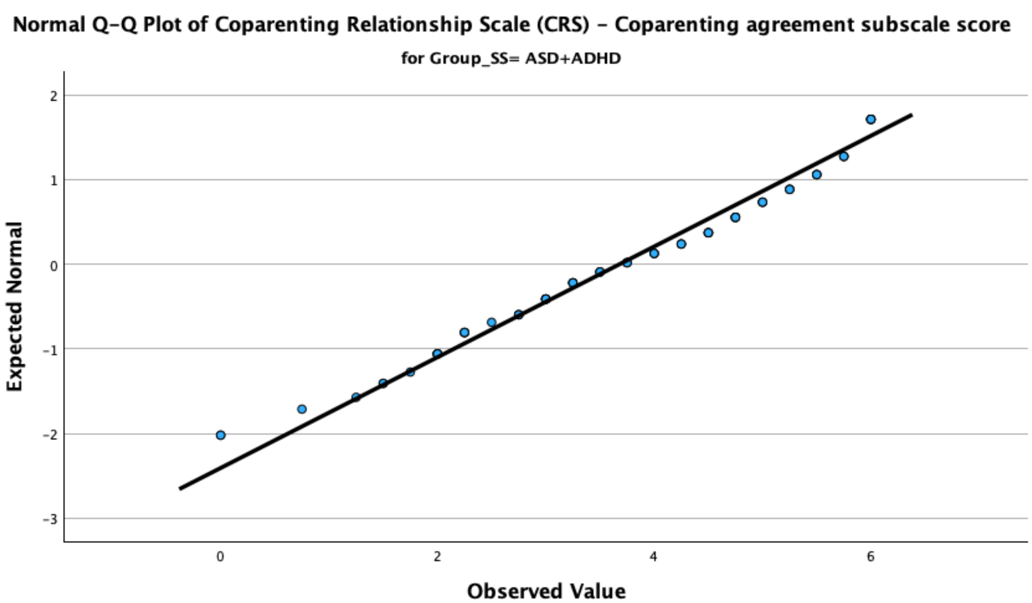


Figure F-7a.8

Exploratory Research Question 7a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 7b.

Figure F-7b.1

Exploratory Research Question 7b – Normality Histogram for NT Group

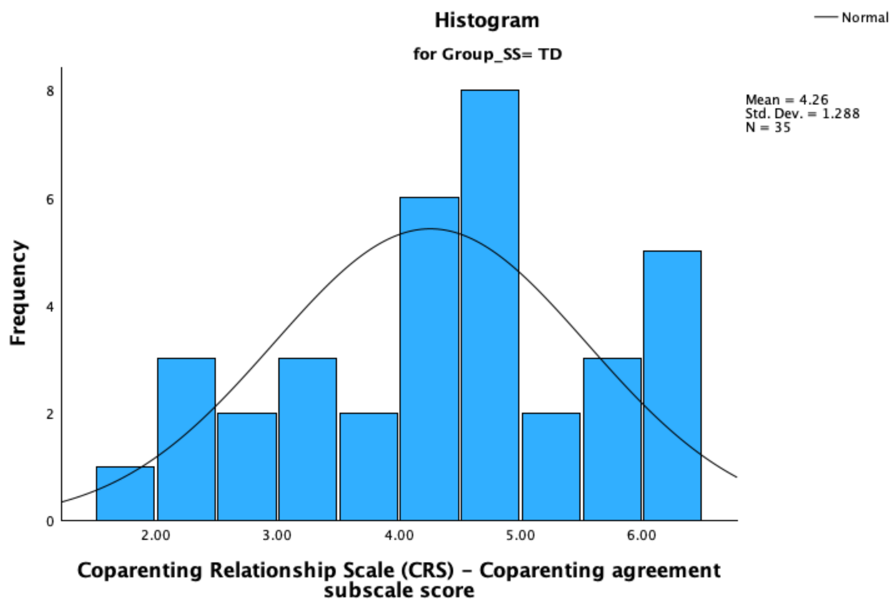


Figure F-7b.2

Exploratory Research Question 7b – Normality Histogram for ASD Group

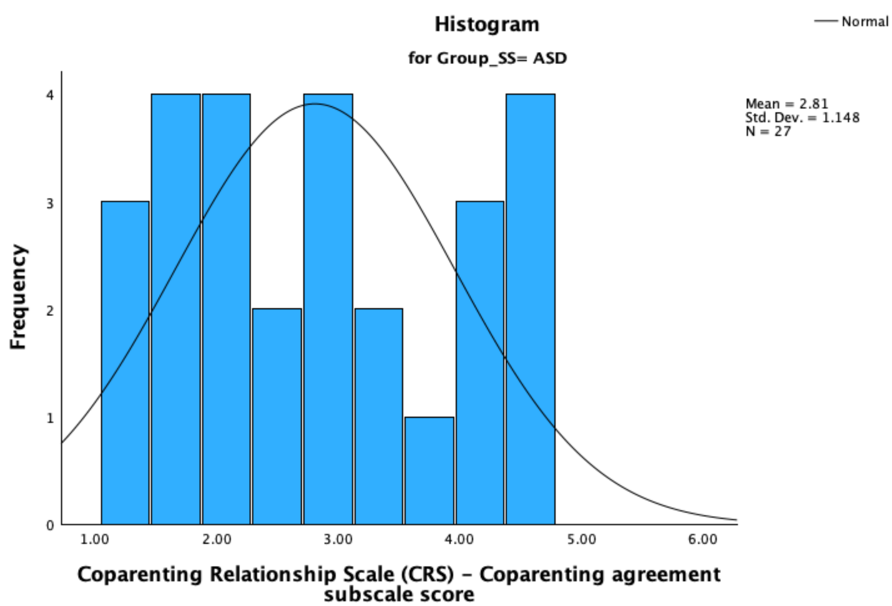


Figure F-7b.3

Exploratory Research Question 7b – Normality Histogram for ADHD Group

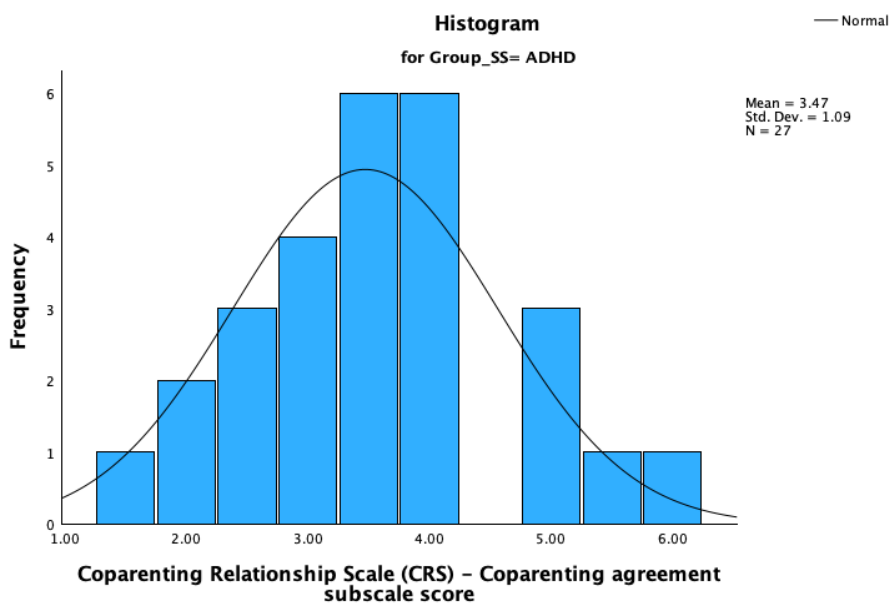


Figure F-7b.4

Exploratory Research Question 7b – Normality Histogram for ASD+ADHD Group

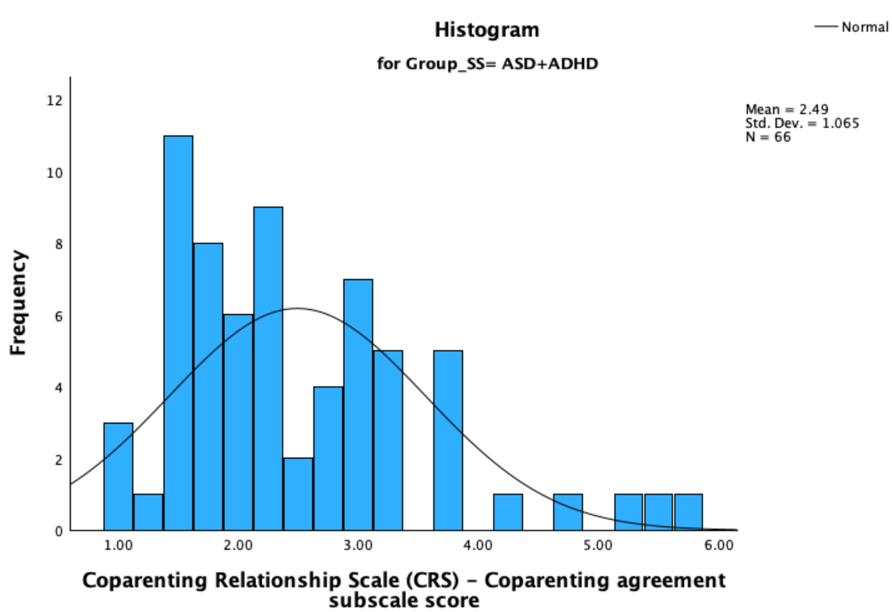


Figure F-7b.5

Exploratory Research Question 7b – Expected Normal Probability Plot for NT Group

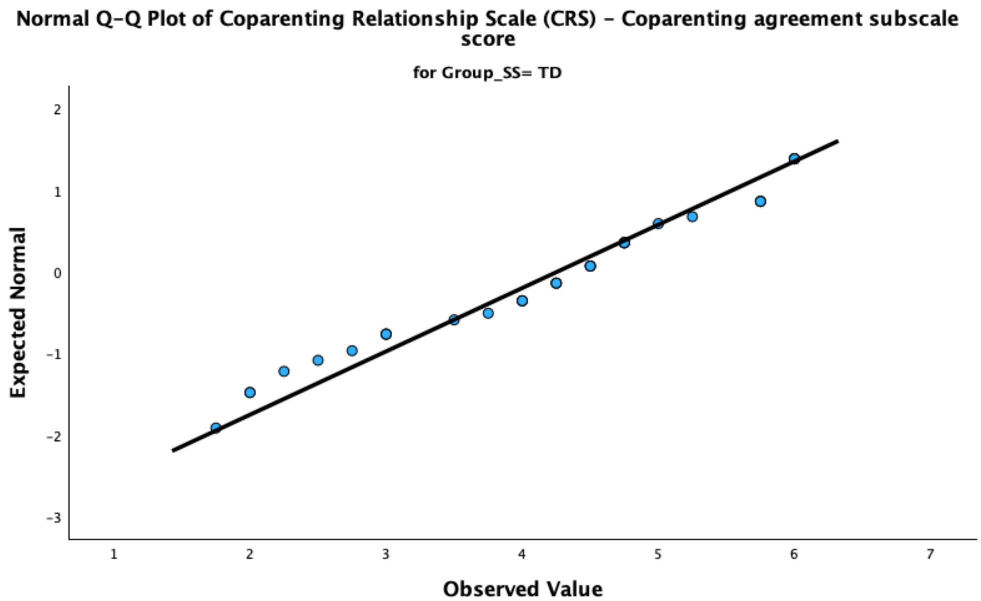


Figure F-7b.6

Exploratory Research Question 7b – Expected Normal Probability Plot for ASD Group

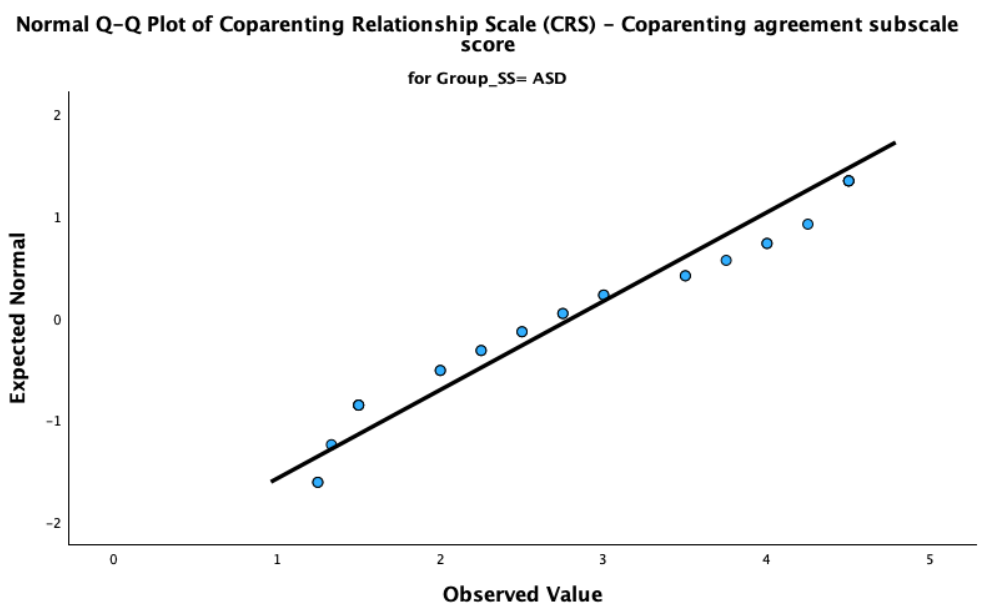


Figure F-7b.7

Exploratory Research Question 7b – Expected Normal Probability Plot for ADHD Group

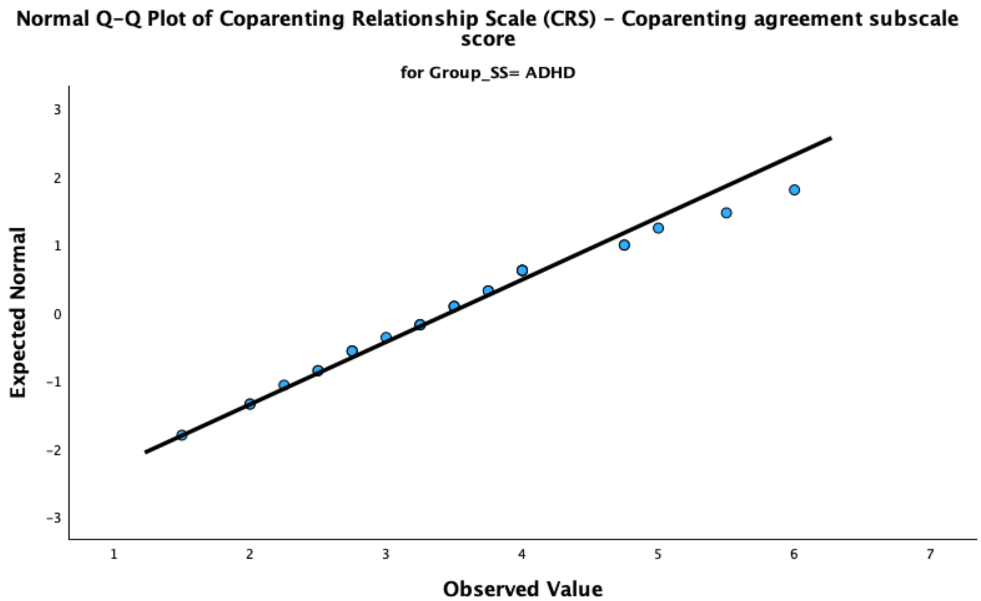
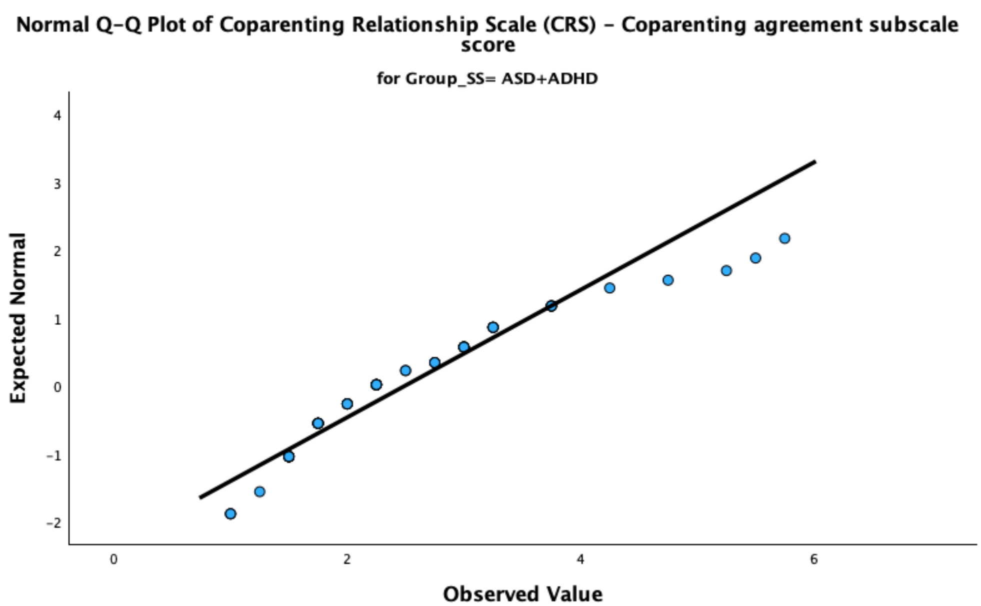


Figure F-7b.8

Exploratory Research Question 7b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 8

Table F-8

Assumption Testing – RQ 8: Coparenting Closeness Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 8a: Mothers				$F(3,247) = .97$, $p = .408$
NT Group	-1.36 (0.28)	1.88 (0.55)	$W(76) = .87$, $p < .001$	
ASD Group	-0.43 (0.66)	-1.58 (1.28)	$W(11) = .85$, $p = .037$	
ADHD Group	-0.58 (0.25)	-0.50 (0.49)	$W(96) = .95$, $p = .001$	
ASD+ADHD Group	-0.53 (0.29)	0.03 (0.57)	$W(68) = .95$, $p = .007$	
RQ 8b: Fathers				$F(3,151) = 4.70$, $p = .004$
NT Group	-0.66 (0.40)	-0.21 (0.78)	$W(35) = .90$, $p = .004$	
ASD Group	0.47 (0.45)	-0.54 (0.87)	$W(27) = .94$, $p = .123$	
ADHD Group	0.44 (0.45)	0.03 (0.87)	$W(27) = .96$, $p = .276$	
ASD+ADHD Group	-0.37 (0.30)	-0.24 (0.58)	$W(66) = .96$, $p = .046$	

Exploratory Research Question 8a.

Figure F-8a.1

Exploratory Research Question 8a – Normality Histogram for NT Group

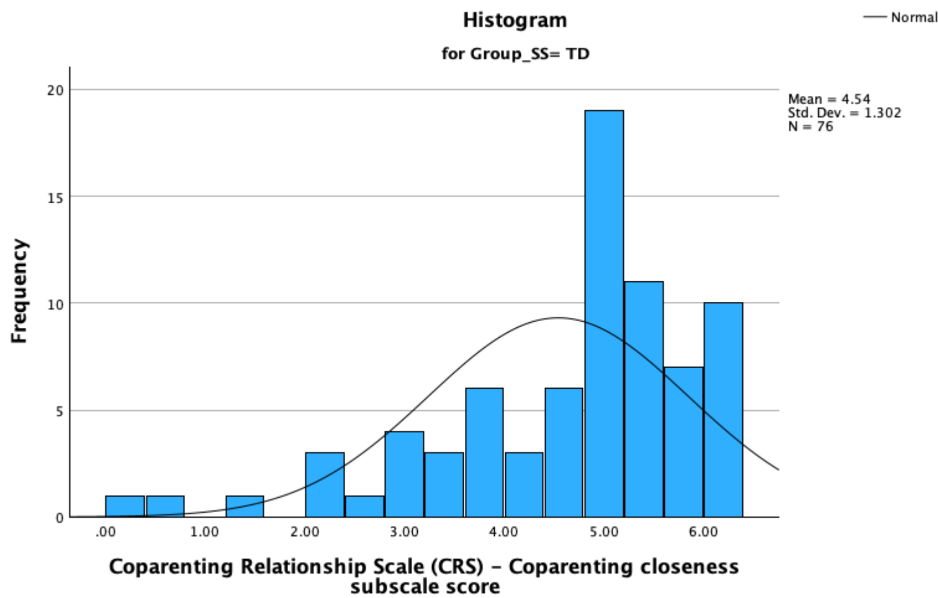


Figure F-8a.2

Exploratory Research Question 8a – Normality Histogram for ASD Group

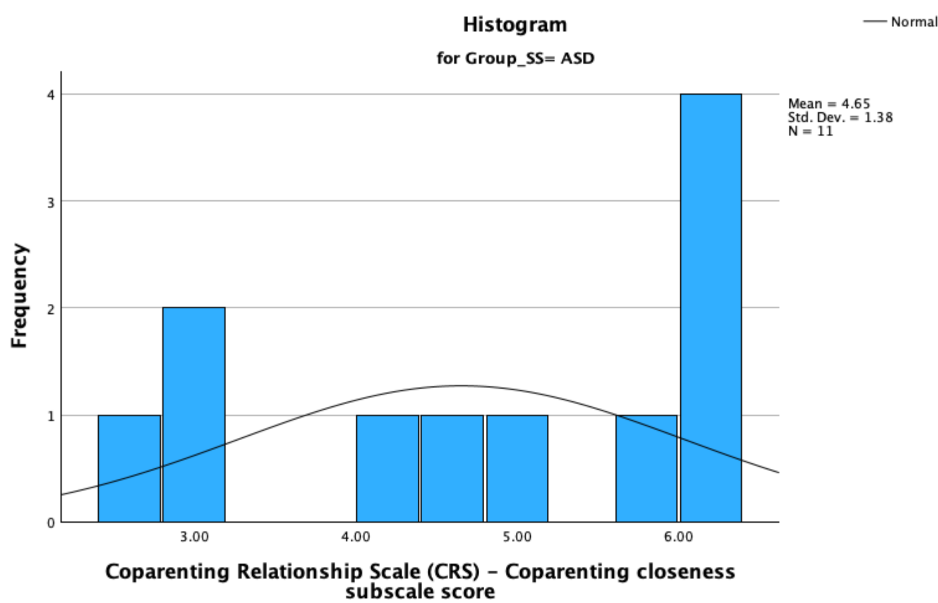


Figure F-8a.3

Exploratory Research Question 8a – Normality Histogram for ADHD Group

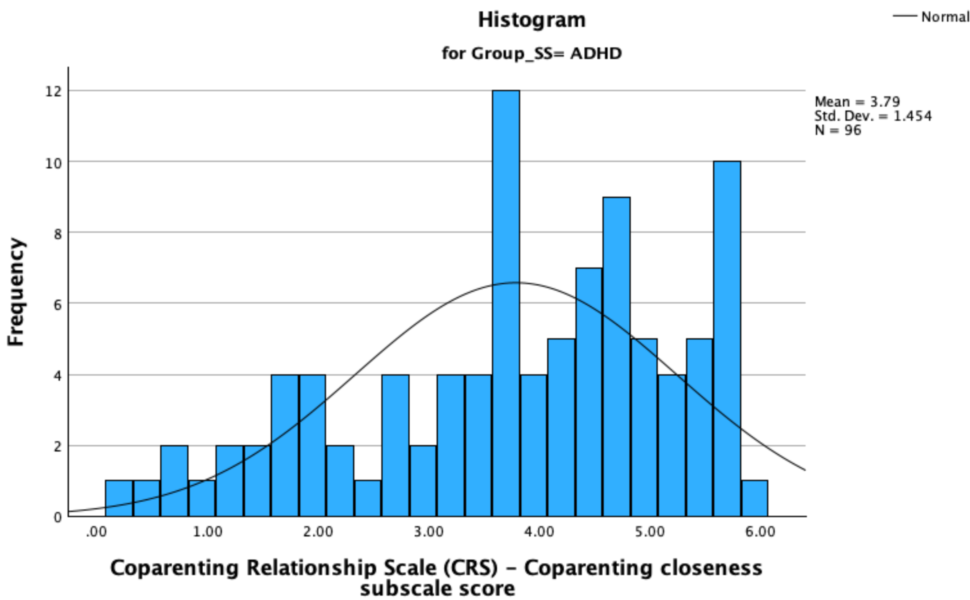


Figure F-8a.4

Exploratory Research Question 8a – Normality Histogram for ASD+ADHD Group

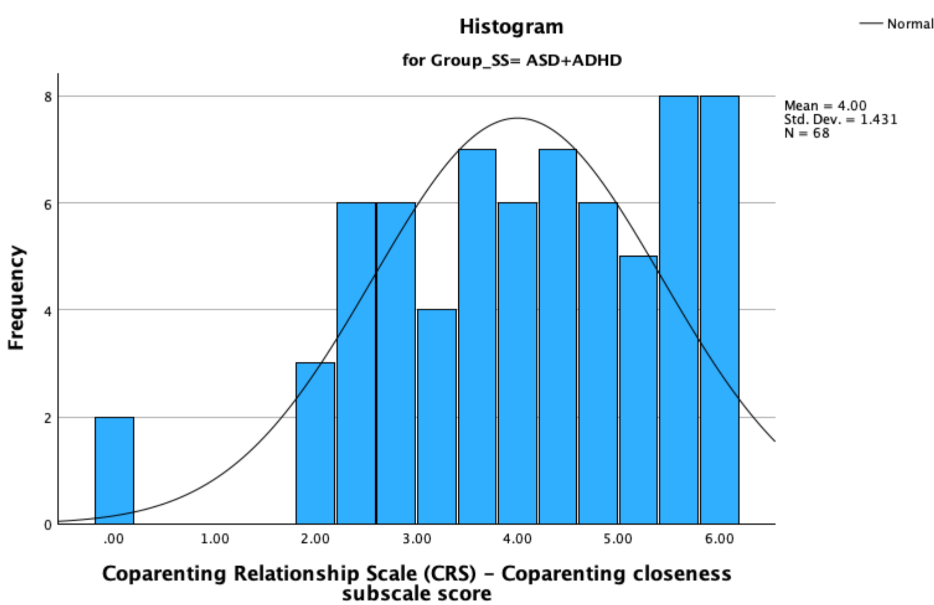


Figure F-8a.5

Exploratory Research Question 8a – Expected Normal Probability Plot for NT Group

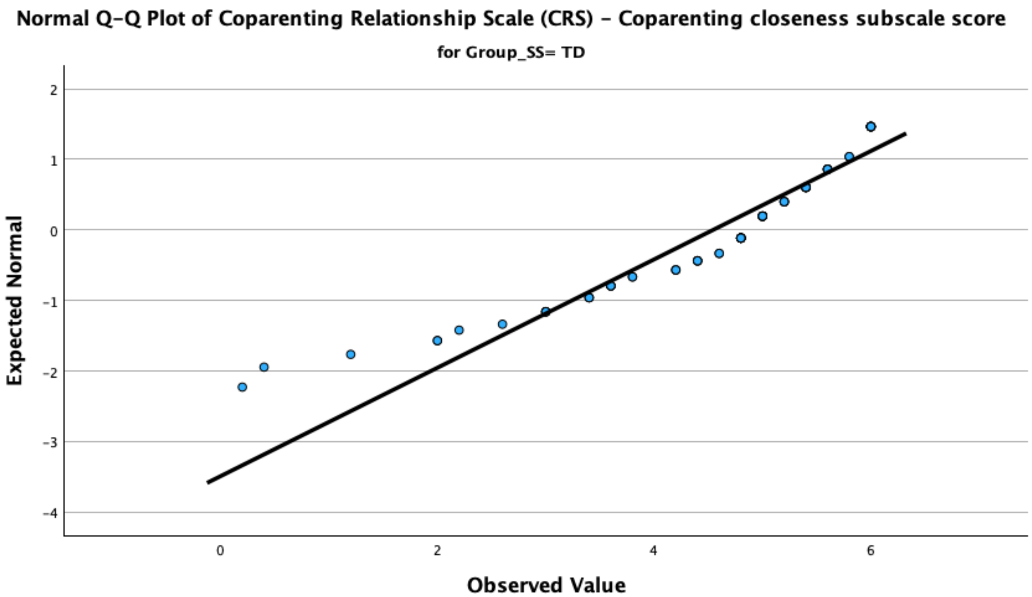


Figure F-8a.6

Exploratory Research Question 8a – Expected Normal Probability Plot for ASD Group

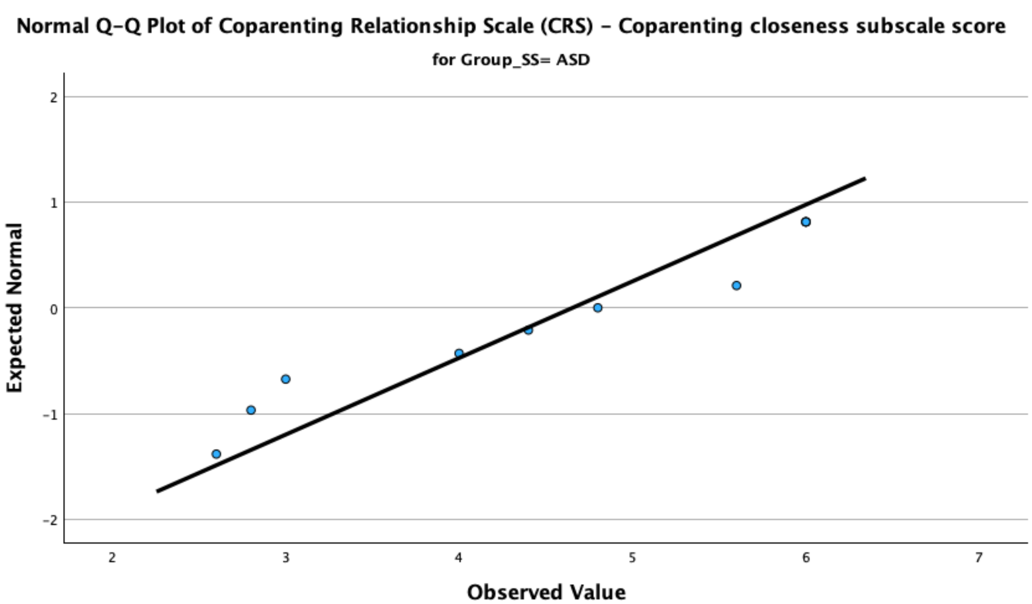


Figure F-8a.7

Exploratory Research Question 8a – Expected Normal Probability Plot for ADHD Group

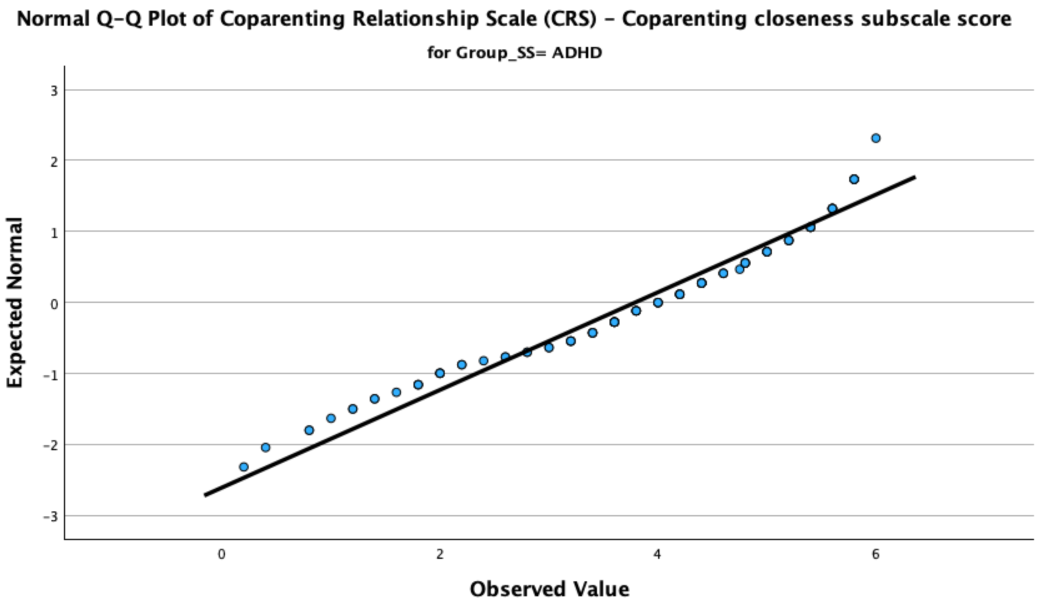
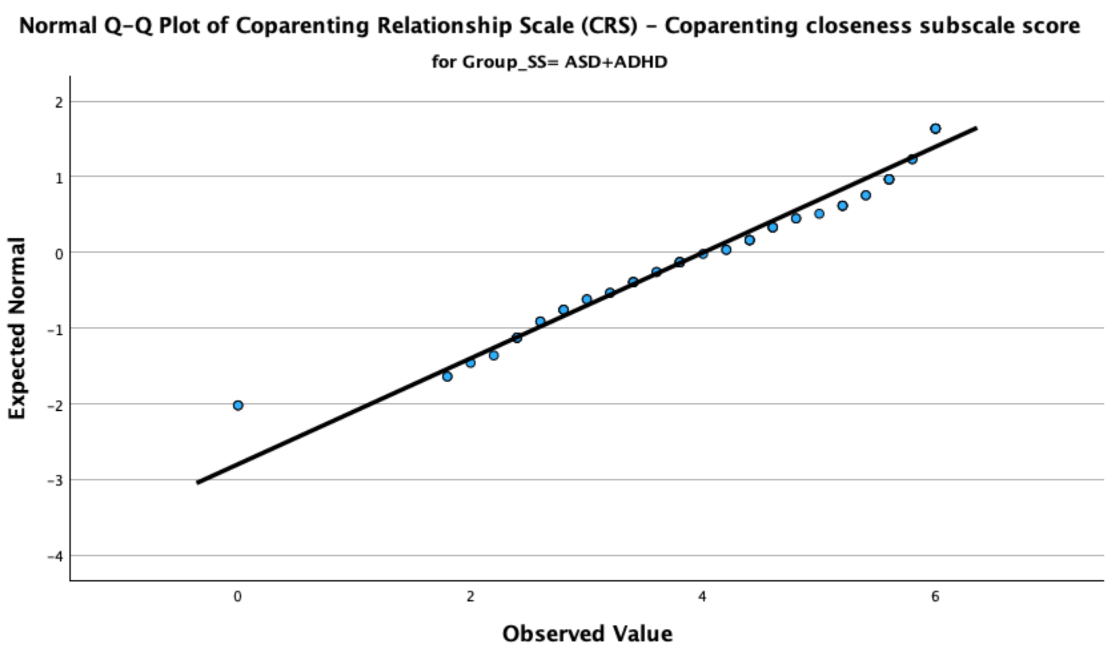


Figure F-8a.8

Exploratory Research Question 8a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 8b.

Figure F-8b.1

Exploratory Research Question 8b – Normality Histogram for NT Group

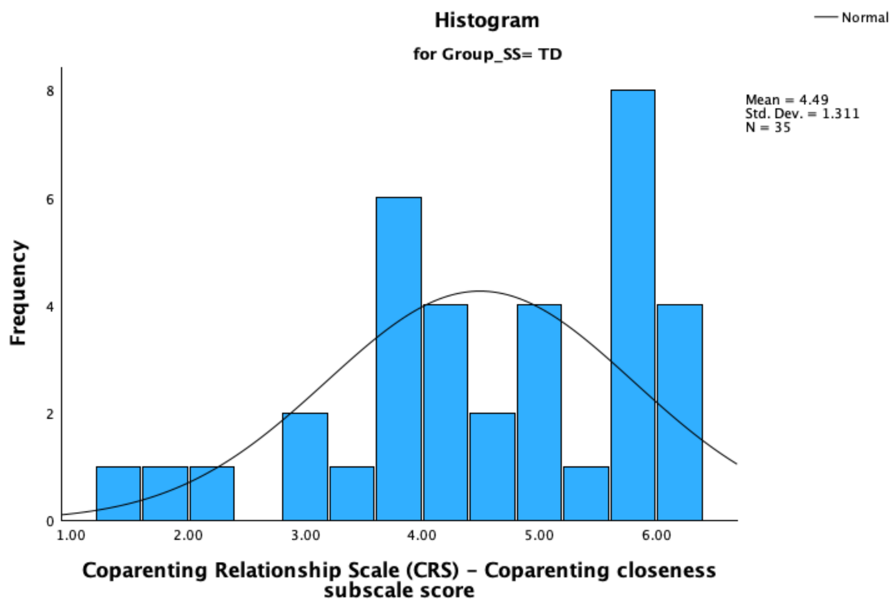


Figure F-8b.2

Exploratory Research Question 8b – Normality Histogram for ASD Group

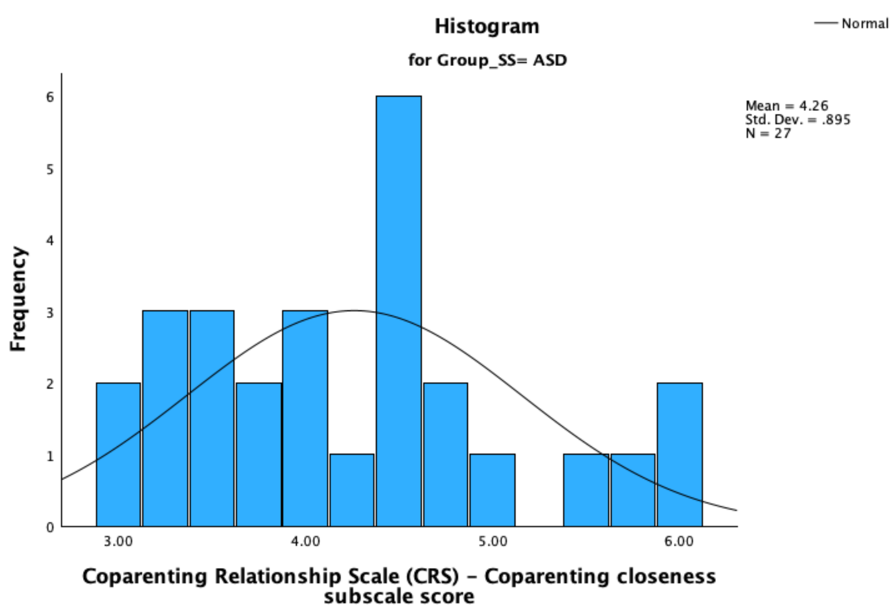


Figure F-8b.3

Exploratory Research Question 8b – Normality Histogram for ADHD Group

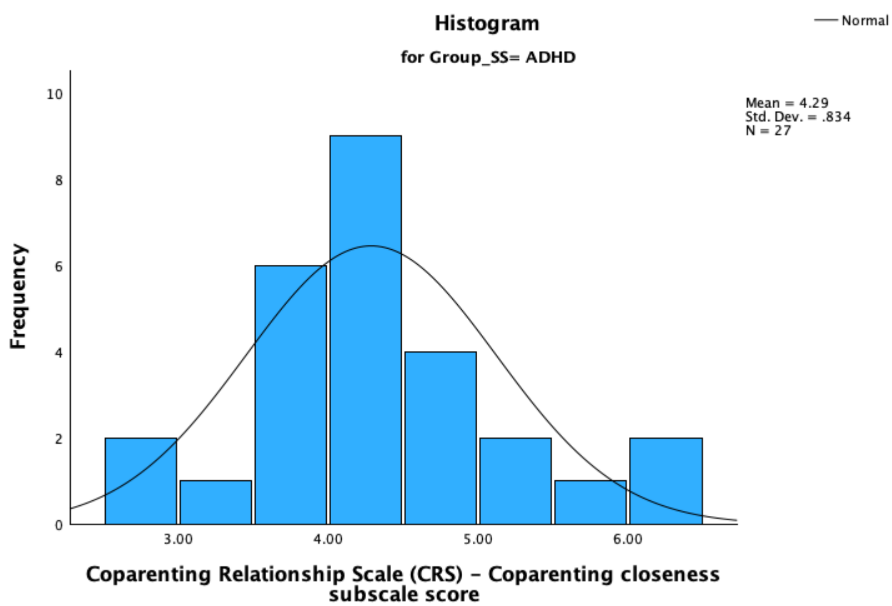


Figure F-8b.4

Exploratory Research Question 8b – Normality Histogram for ASD+ADHD Group

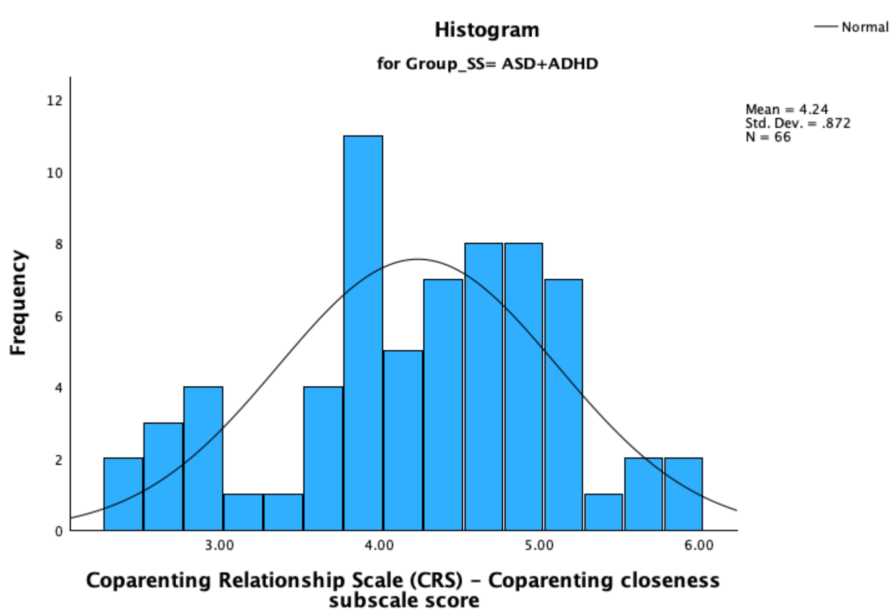


Figure F-8b.5

Exploratory Research Question 8b – Expected Normal Probability Plot for NT Group

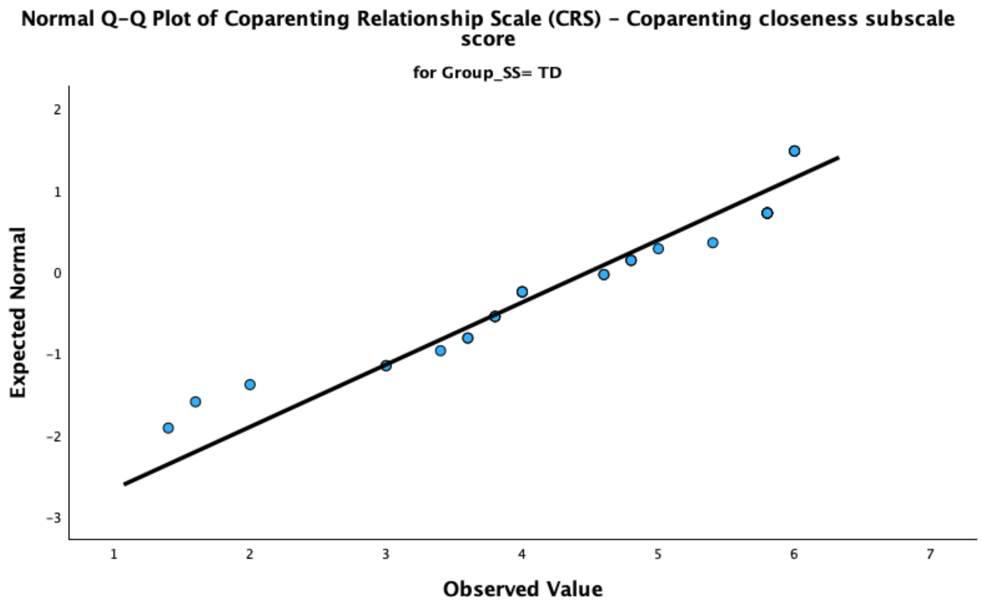


Figure F-8b.6

Exploratory Research Question 8b – Expected Normal Probability Plot for ASD Group

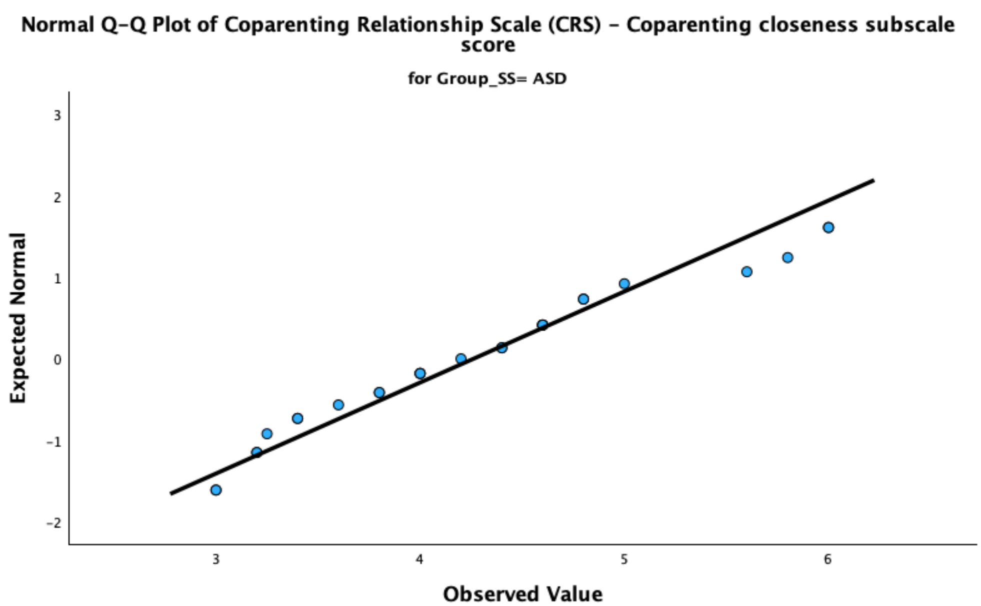


Figure F-8b.7

Exploratory Research Question 8b – Expected Normal Probability Plot for ADHD Group

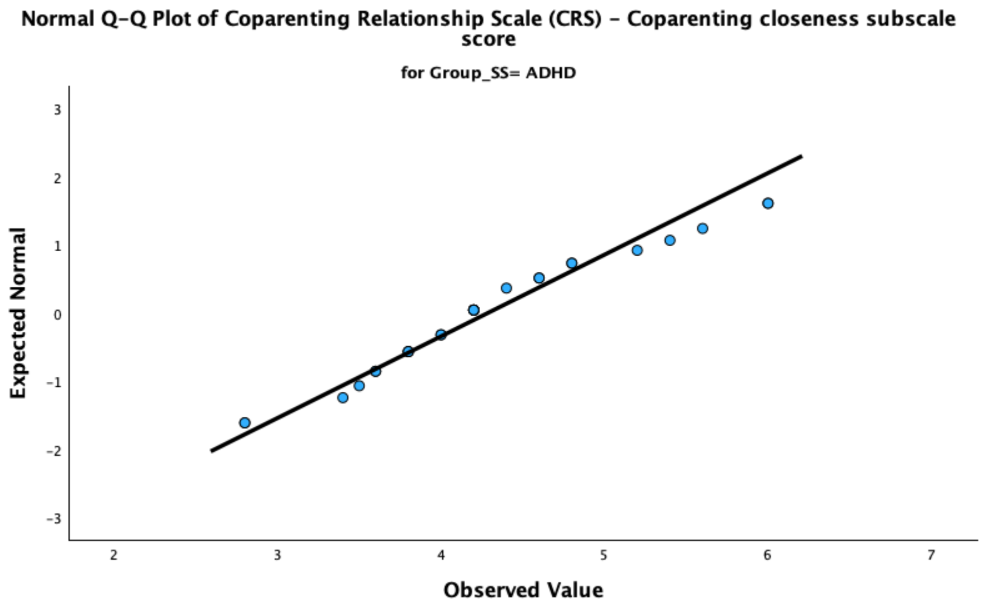
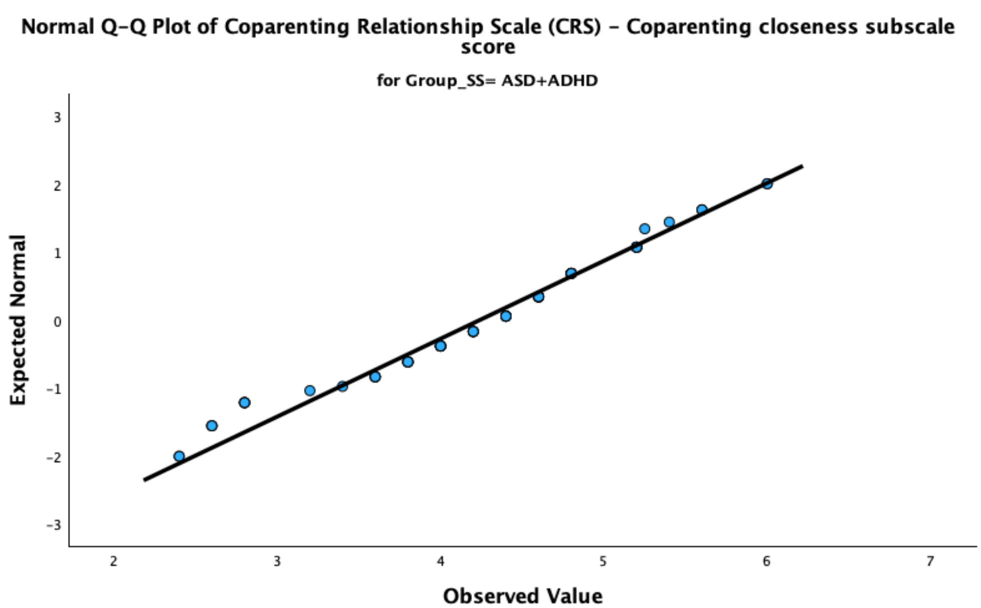


Figure F-8b.8

Exploratory Research Question 8b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 9

Table F-9

Assumption Testing – RQ 9: Exposure to Conflict Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 9a: Mothers				$F(3,247) = 8.96$, $p < .001$
NT Group	0.84 (0.28)	-0.27 (0.55)	$W(76) = .89$, $p < .001$	
ASD Group	1.84 (0.69)	2.49 (1.33)	$W(10) = .69$, $p < .001$	
ADHD Group	1.50 (0.25)	2.81 (0.49)	$W(97) = .87$, $p < .001$	
ASD+ADHD Group	1.32 (0.29)	1.44 (0.57)	$W(68) = .85$, $p < .001$	
RQ 9b: Fathers				$F(3,150) = 11.30$, $p < .001$
NT Group	2.62 (0.40)	8.65 (0.78)	$W(35) = .72$, $p < .001$	
ASD Group	0.29 (0.45)	-1.71 (0.87)	$W(27) = .83$,. $p < .001$	
ADHD Group	0.85 (0.45)	-0.45 (0.87)	$W(27) = .88$, $p = .004$	
ASD+ADHD Group	-0.63 (0.30)	-0.99 (0.59)	$W(65) = .88$, $p < .001$	

Exploratory Research Question 9a.

Figure F-9a.1

Exploratory Research Question 9a – Normality Histogram for NT Group

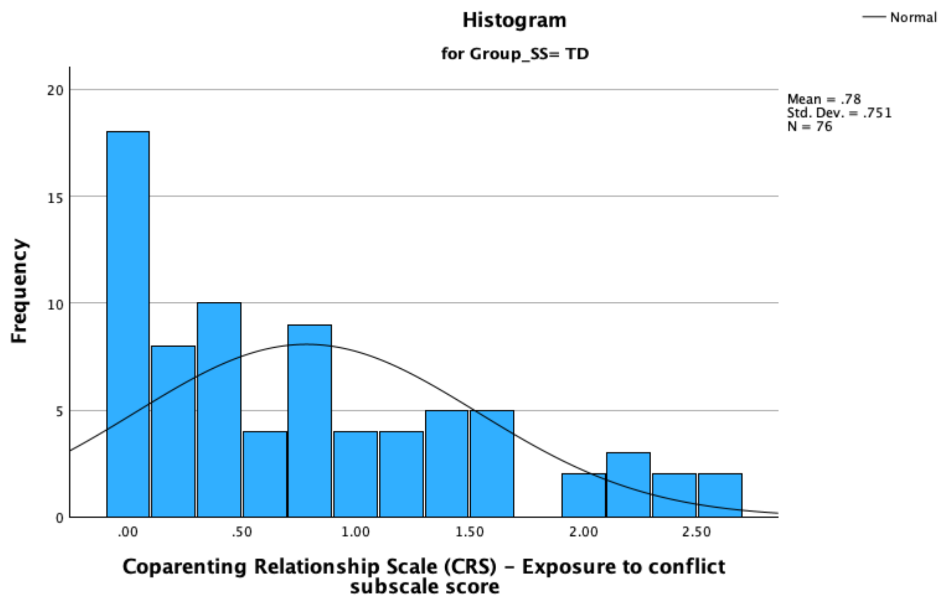


Figure F-9a.2

Exploratory Research Question 9a – Normality Histogram for ASD Group

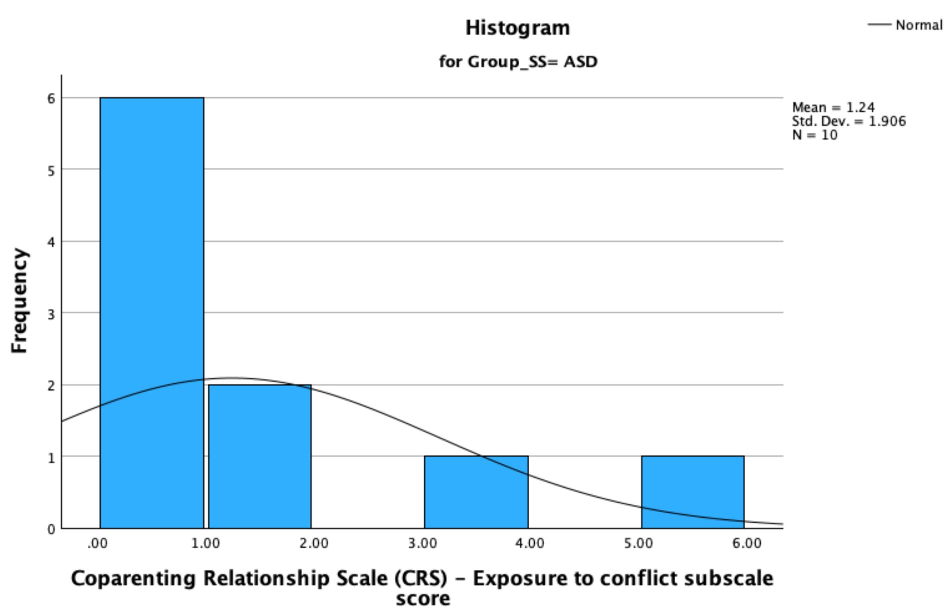


Figure F-9a.3

Exploratory Research Question 9a – Normality Histogram for ADHD Group

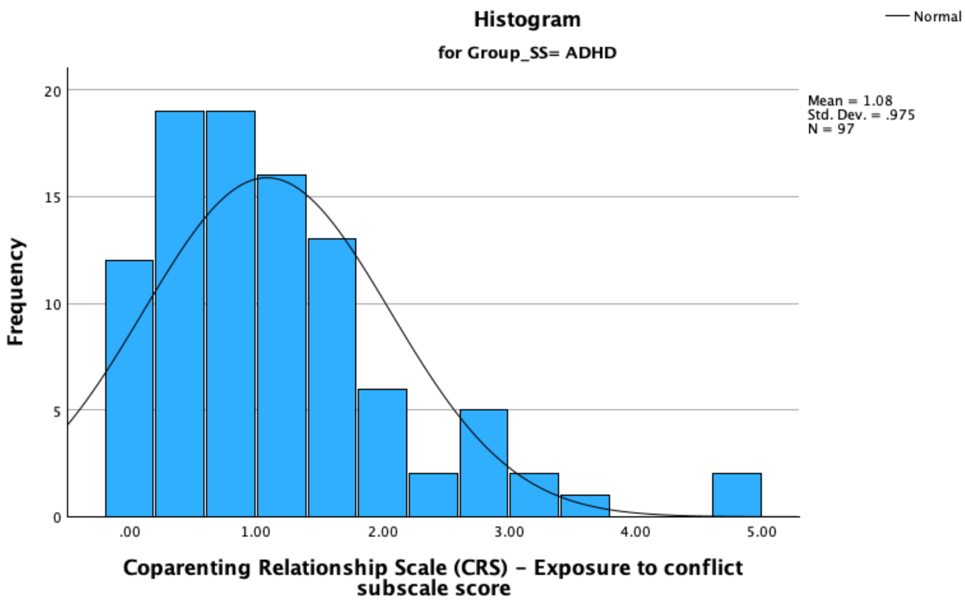


Figure F-9a.4

Exploratory Research Question 9a – Normality Histogram for ASD+ADHD Group

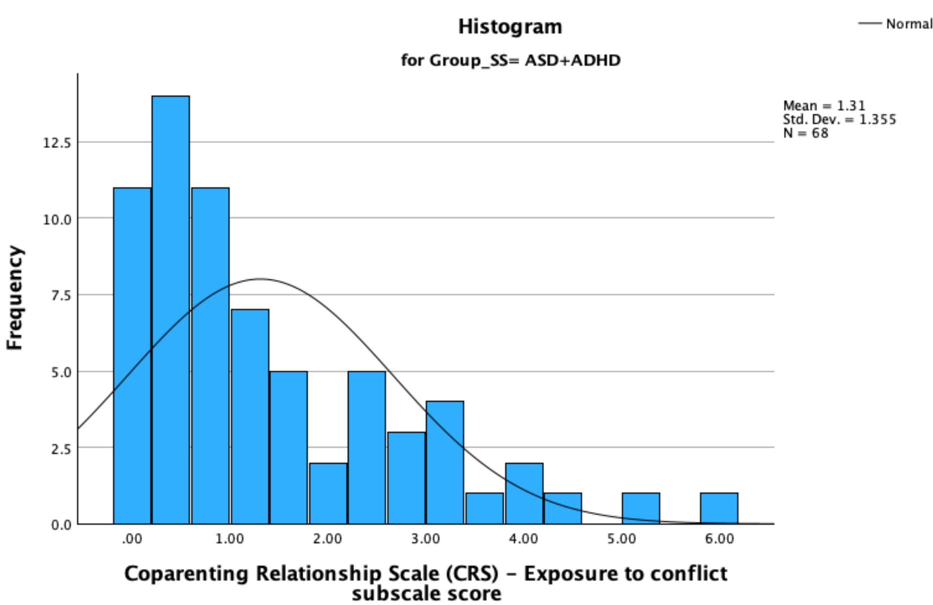


Figure F-9a.5

Exploratory Research Question 9a – Expected Normal Probability Plot for NT Group

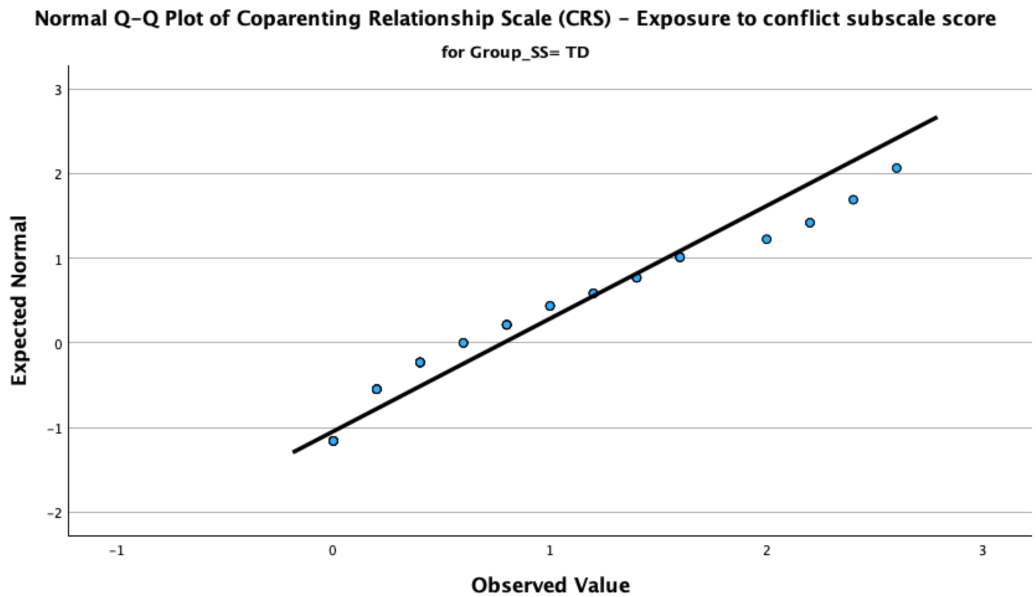


Figure F-9a.6

Exploratory Research Question 9a – Expected Normal Probability Plot for ASD Group

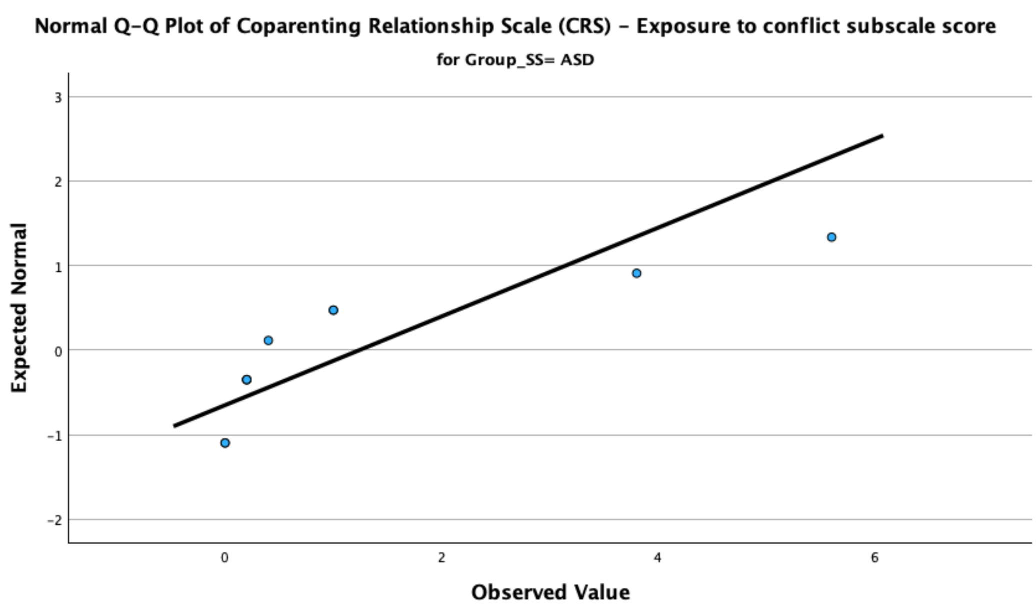


Figure F-9a.7

Exploratory Research Question 9a – Expected Normal Probability Plot for ADHD Group

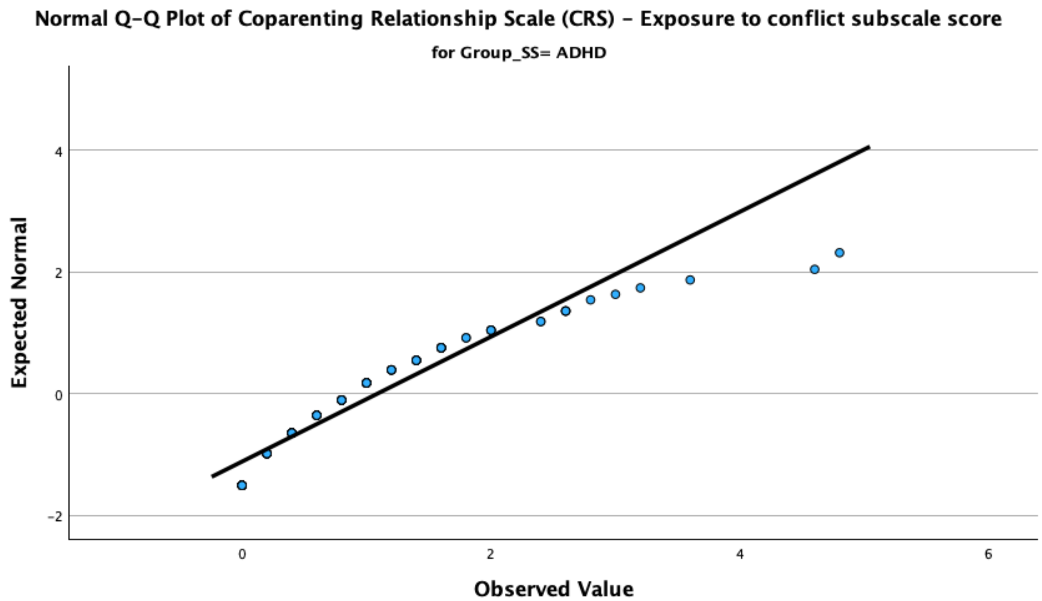


Figure F-9a.8

Exploratory Research Question 9a – Expected Normal Probability Plot for ASD+ADHD Group

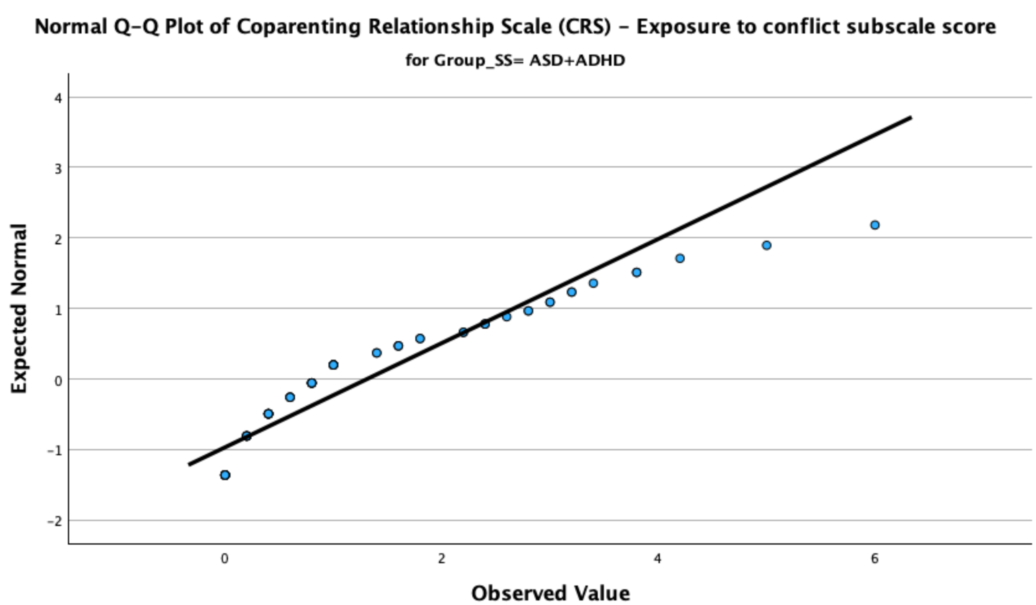


Figure F-9b.1

Exploratory Research Question 9b – Normality Histogram for NT Group

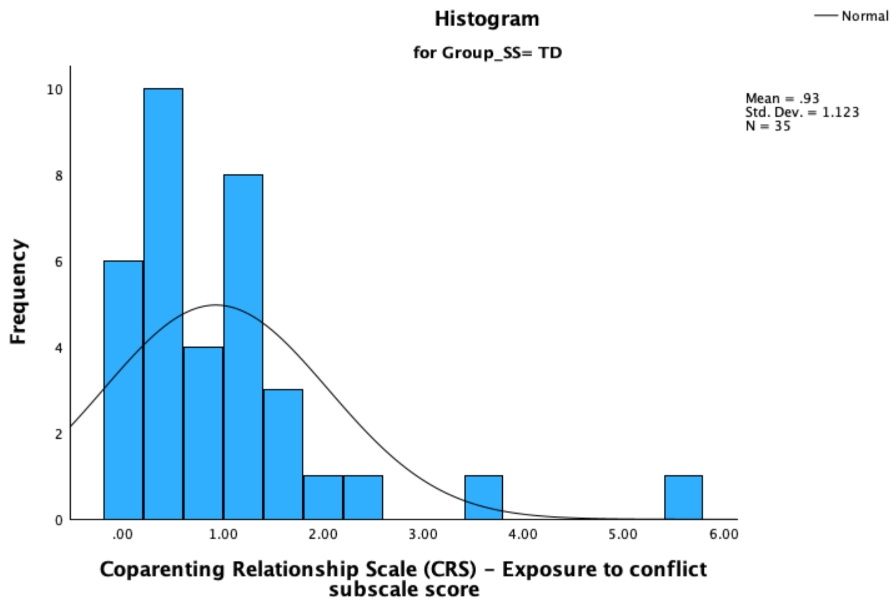


Figure F-9b.2

Exploratory Research Question 9b – Normality Histogram for ASD Group

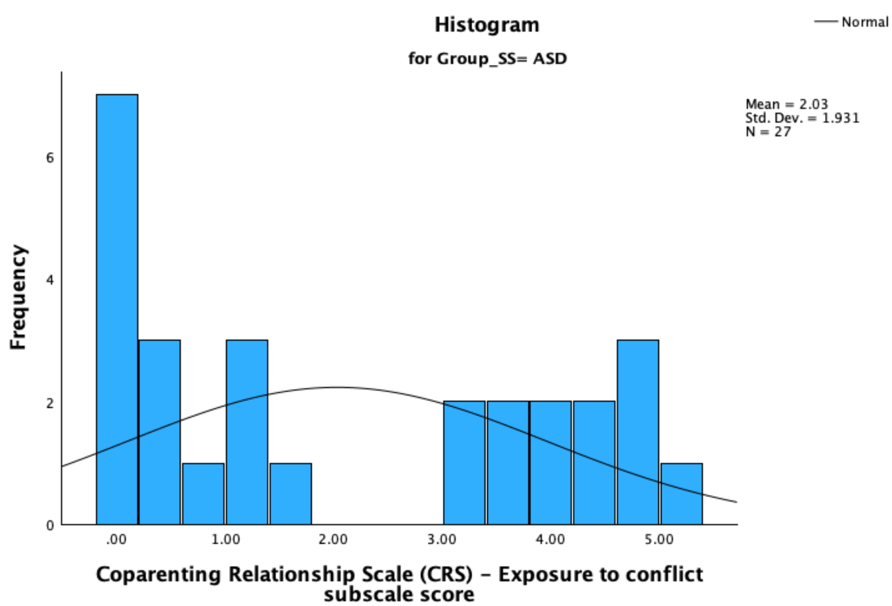


Figure F-9b.3

Exploratory Research Question 9b – Normality Histogram for ADHD Group

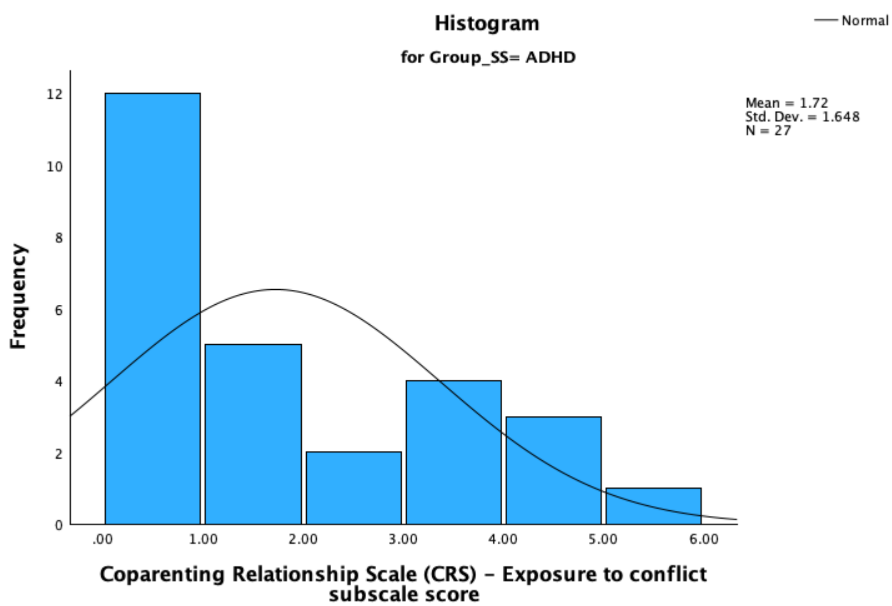


Figure F-9b.4

Exploratory Research Question 9b – Normality Histogram for ASD+ADHD Group

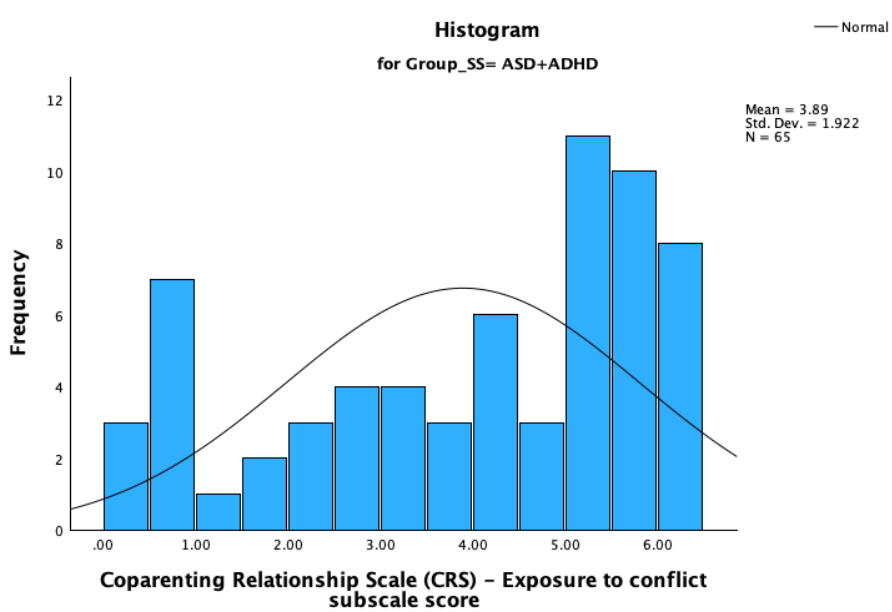


Figure F-9b.5

Exploratory Research Question 9b – Expected Normal Probability Plot for NT Group

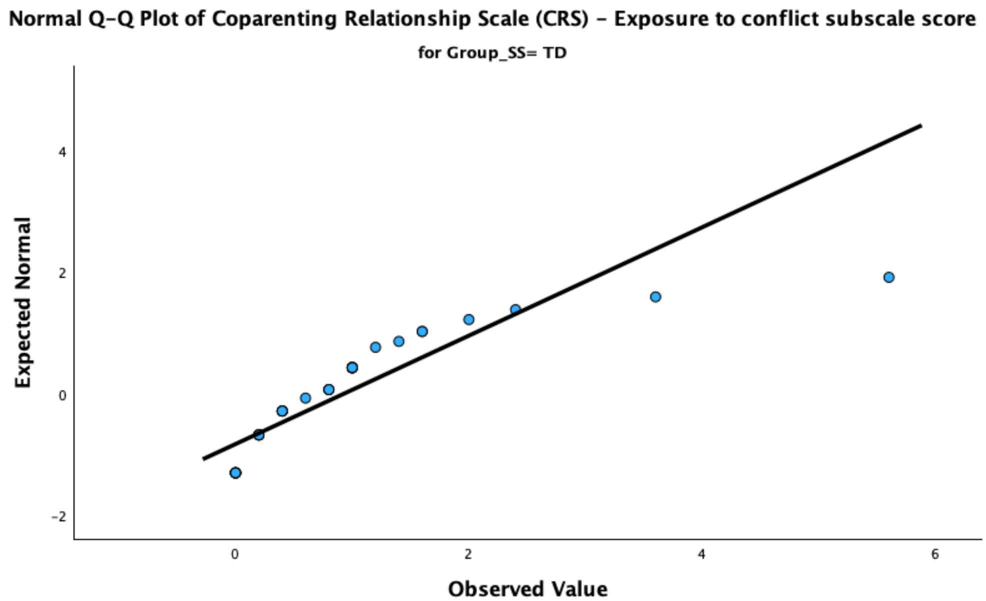


Figure F-9b.6

Exploratory Research Question 9b – Expected Normal Probability Plot for ASD Group

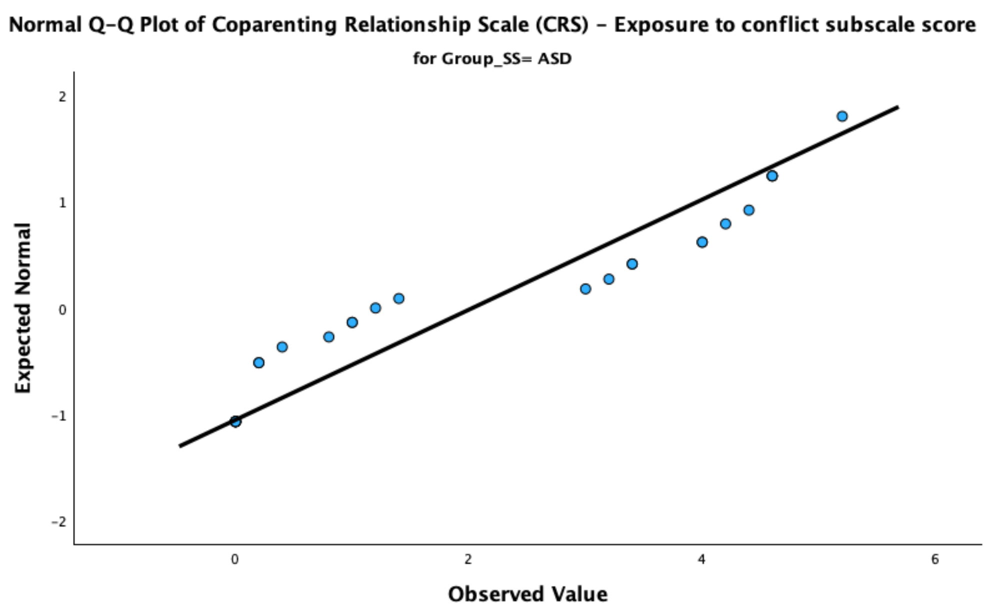


Figure F-9b.7

Exploratory Research Question 9b – Expected Normal Probability Plot for ADHD Group

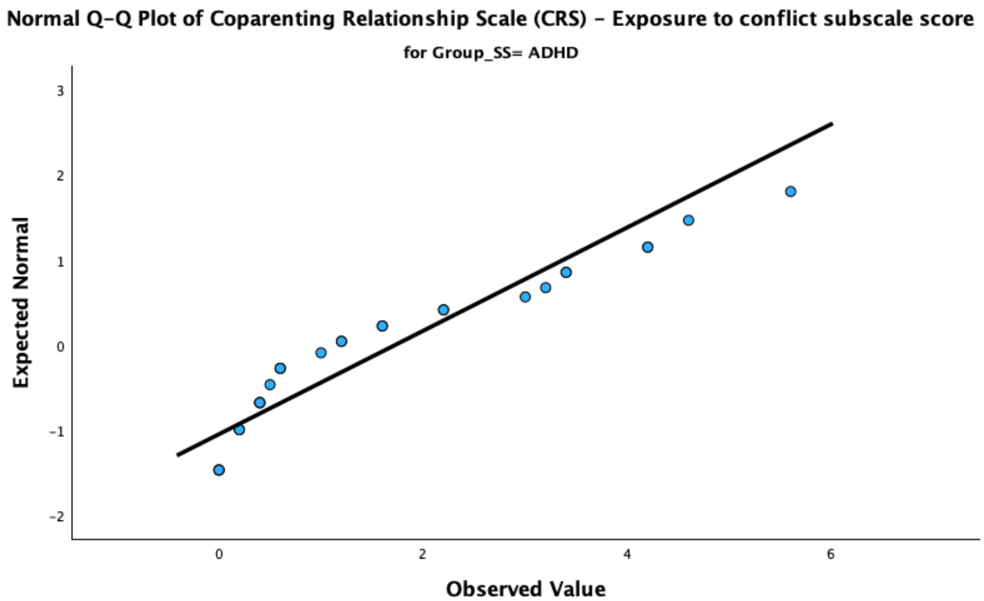
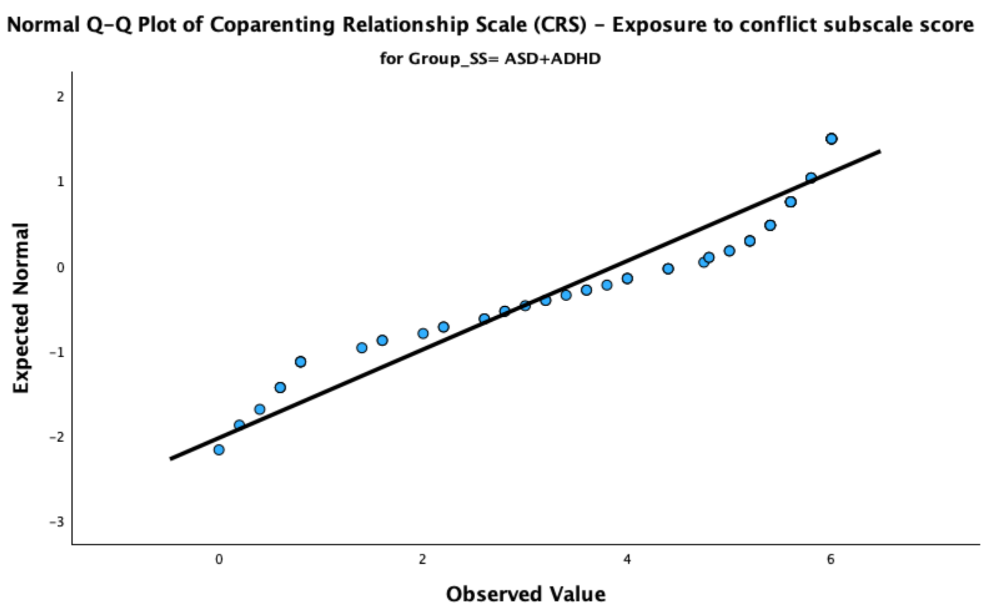


Figure F-9b.8

Exploratory Research Question 9b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 10

Table F-10

Assumption Testing – RQ 10: Coparenting Support Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 10a: Mothers				$F(3, 247) = 0.74$, $p = .530$
NT Group	-1.13 (0.28)	0.54 (0.55)	$W(76) = .87$, $p < .001$	
ASD Group	-0.76 (0.66)	-1.32 (1.28)	$W(11) = .79$, $p = .008$	
ADHD Group	-0.67 (0.25)	-0.25 (0.49)	$W(96) = .94$, $p < .001$	
ASD+ADHD Group	-0.56 (0.29)	-0.37 (0.57)	$W(68) = .94$, $p = .002$	
RQ 10b: Fathers				$F(3, 150) = 1.37$, $p < .25$
NT Group	-0.73 (0.40)	-0.78 (0.78)	$W(35) = .88$, $p < .001$	
ASD Group	-0.84 (0.46)	-0.09 (0.89)	$W(26) = .88$,. $p = .007$	
ADHD Group	-0.50 (0.45)	-0.02 (0.87)	$W(27) = .96$, $p = .433$	
ASD+ADHD Group	-0.43 (0.30)	-1.00 (0.59)	$W(65) = .92$, $p < .001$	

Exploratory Research Question 10a.

Figure F-10a.1

Exploratory Research Question 10a – Normality Histogram for NT Group

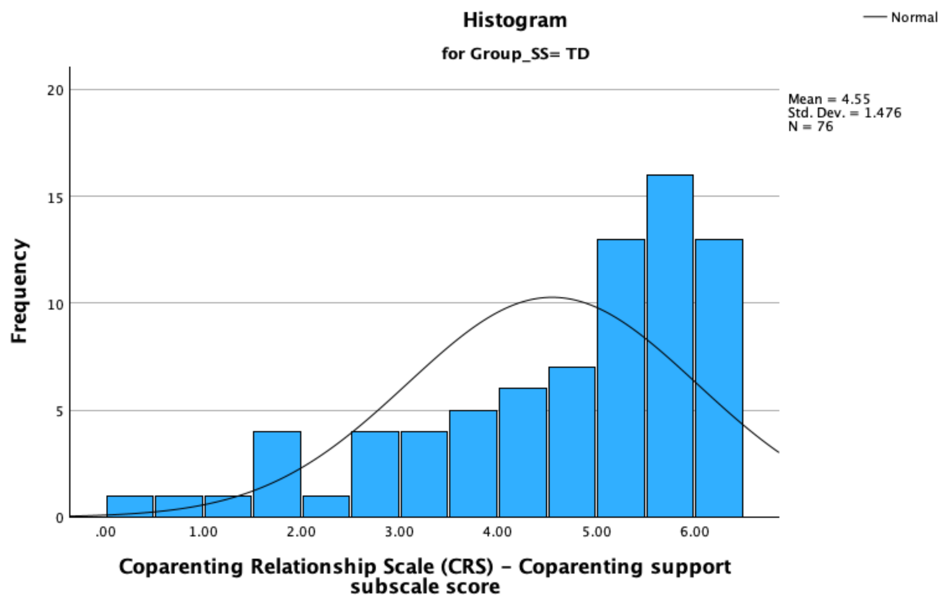


Figure F-10a.2

Exploratory Research Question 10a – Normality Histogram for ASD Group

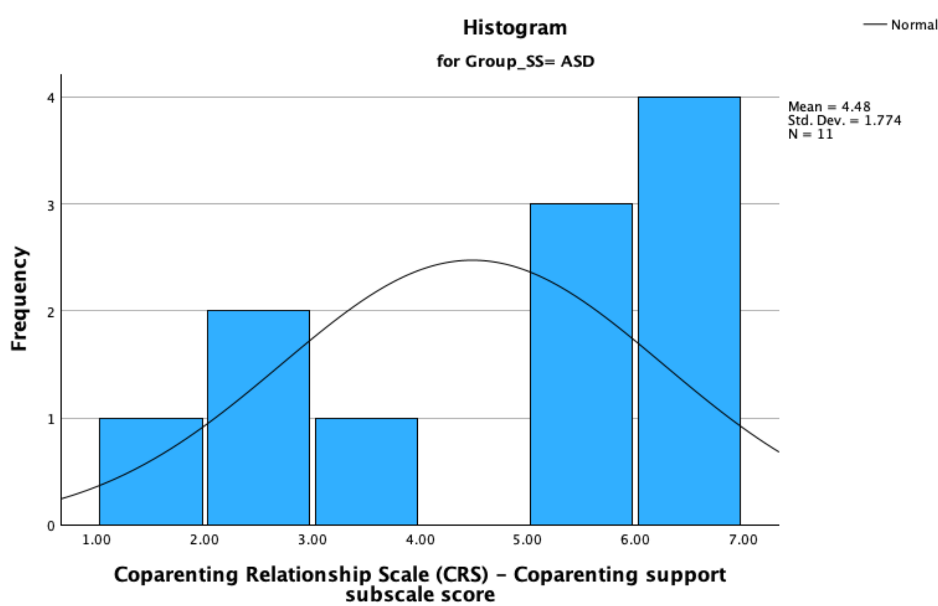


Figure F-10a.3

Exploratory Research Question 10a – Normality Histogram for ADHD Group

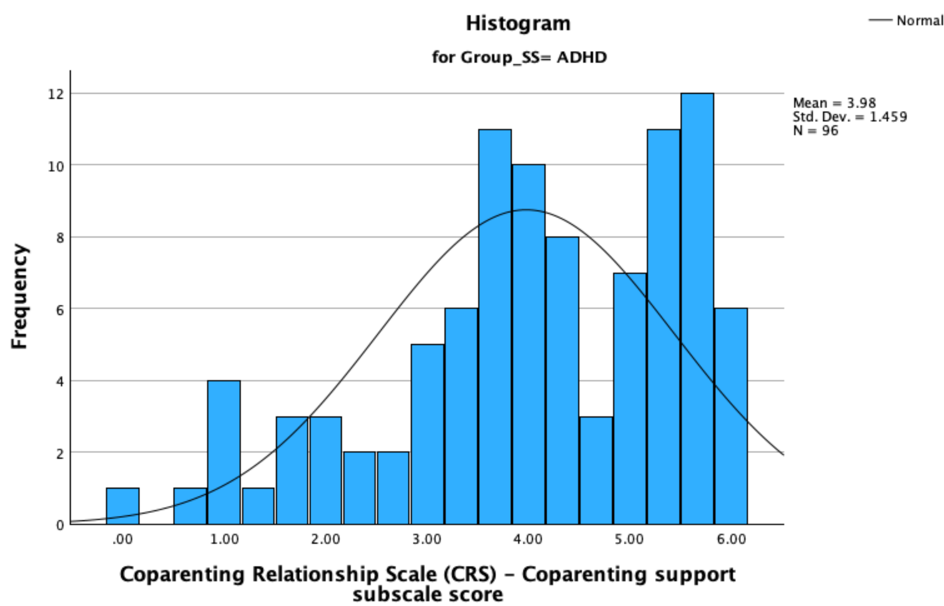


Figure F-10a.4

Exploratory Research Question 10a – Normality Histogram for ASD+ADHD Group

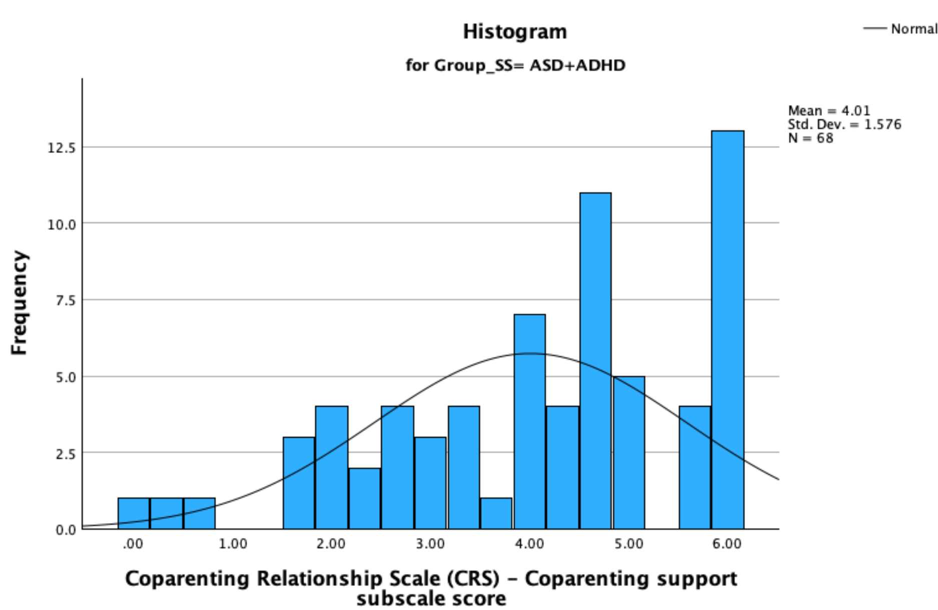


Figure F-10a.5

Exploratory Research Question 10a – Expected Normal Probability Plot for NT Group

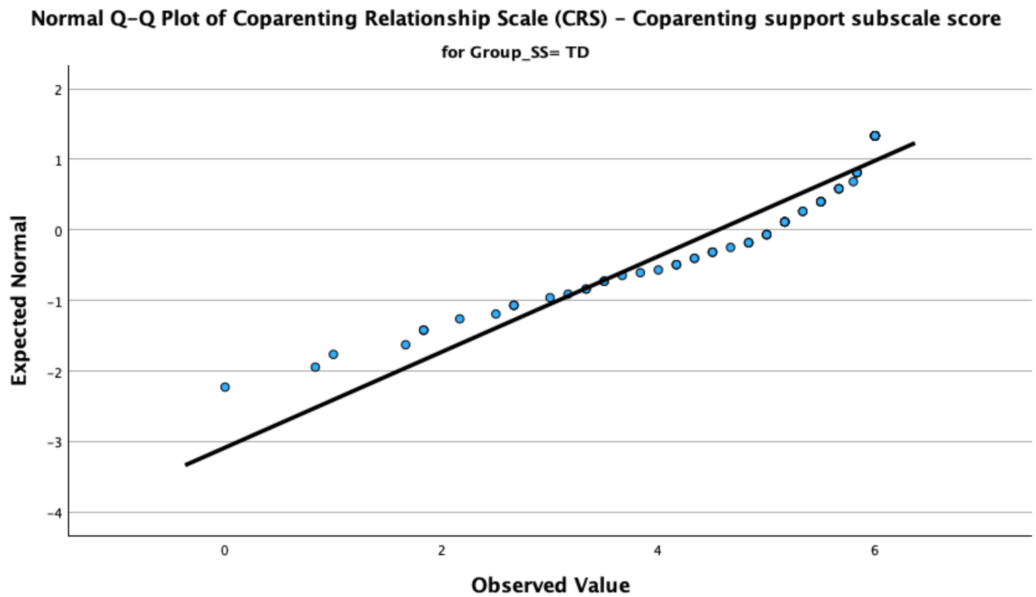


Figure F-10a.6

Exploratory Research Question 10a – Expected Normal Probability Plot for ASD Group

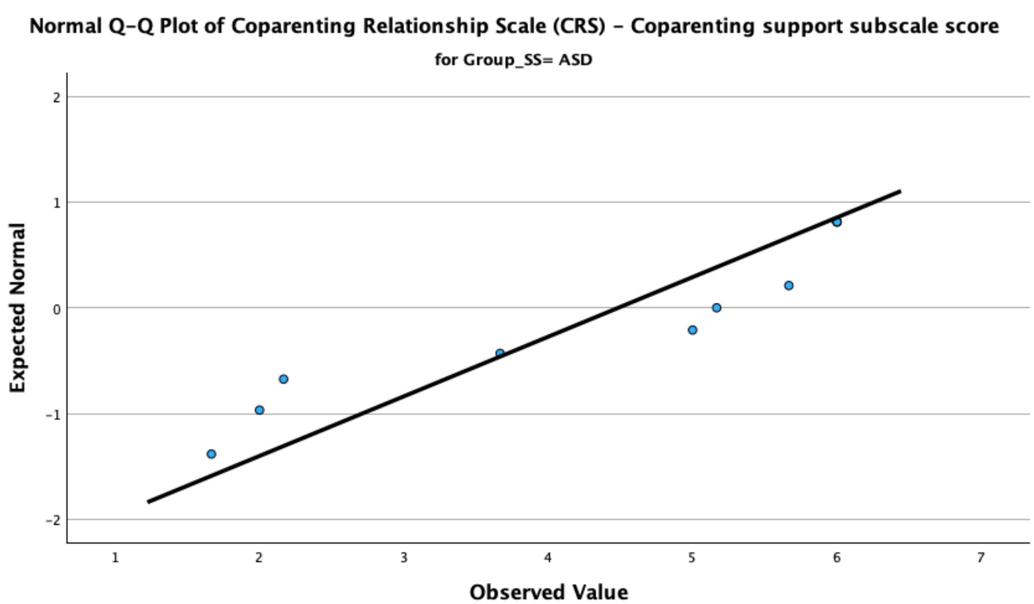


Figure F-10a.7

Exploratory Research Question 10a – Expected Normal Probability Plot for ADHD Group

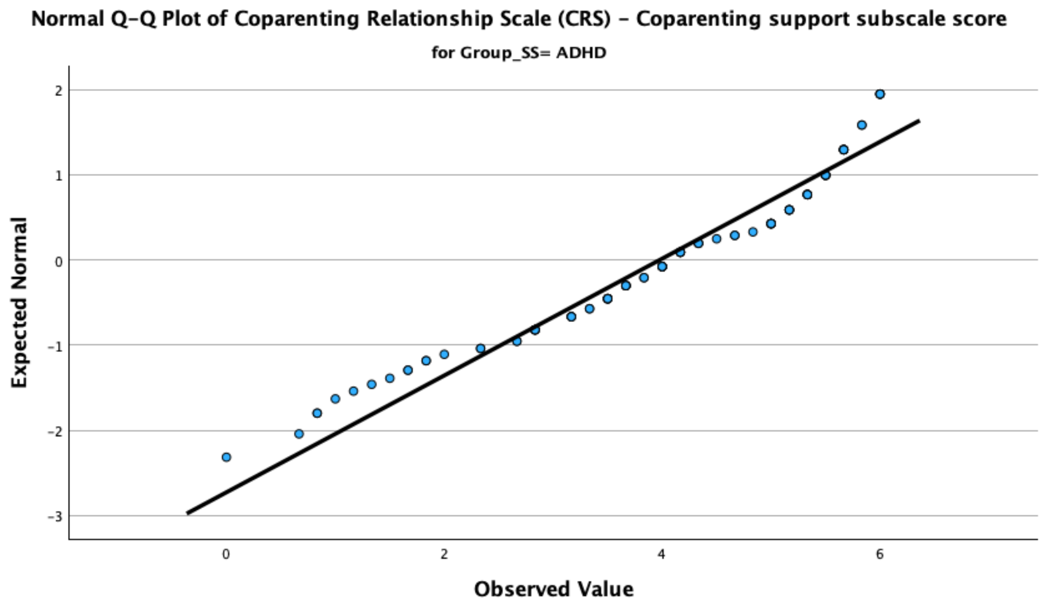
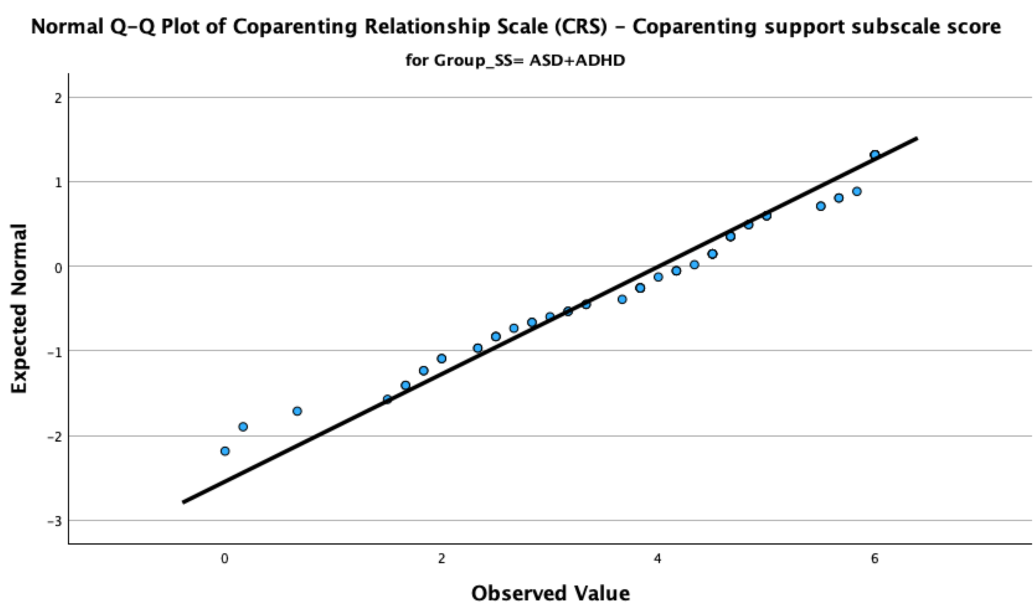


Figure F-10a.8

Exploratory Research Question 10a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 10b.

Figure F-10b.1

Exploratory Research Question 10b – Normality Histogram for NT Group

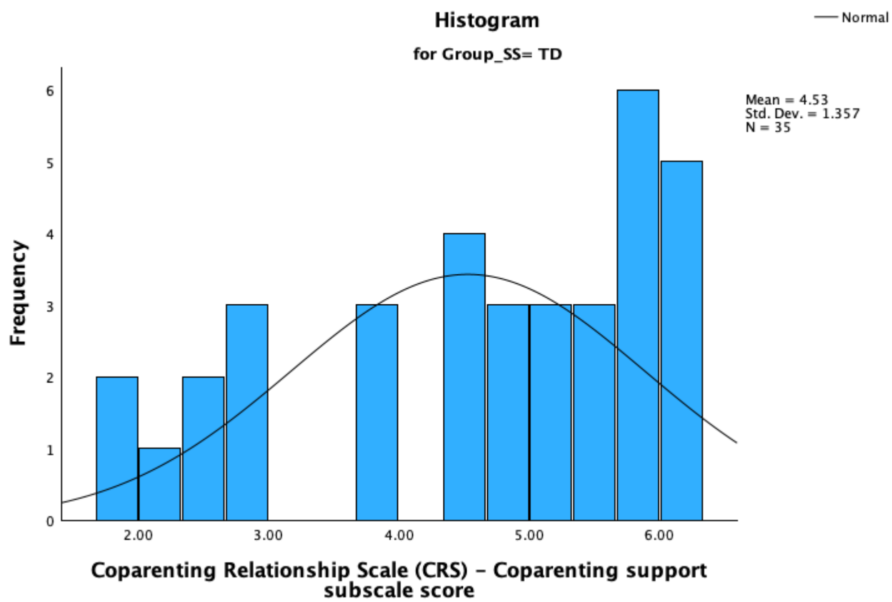


Figure F-10b.2

Exploratory Research Question 10b – Normality Histogram for ASD Group

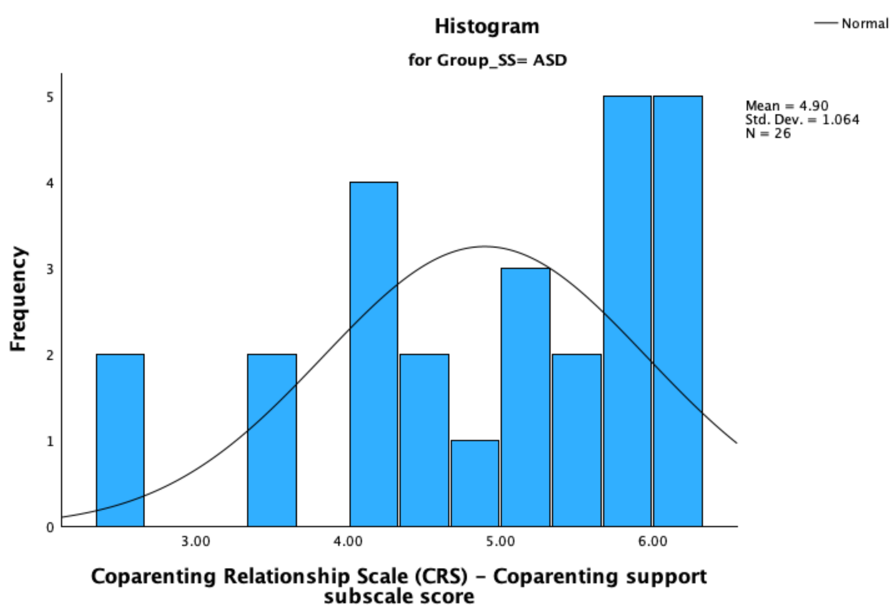


Figure F-10b.3

Exploratory Research Question 10b – Normality Histogram for ADHD Group

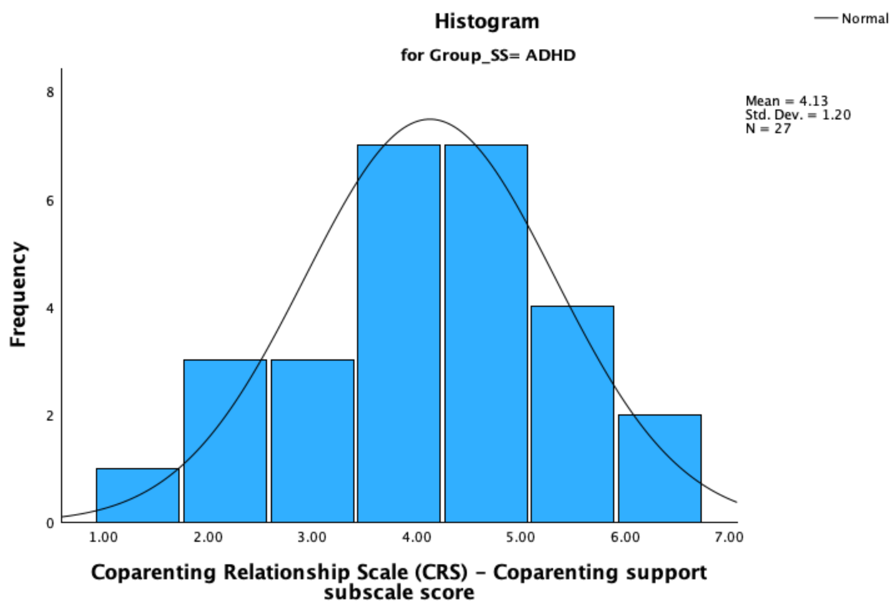


Figure F-10b.4

Exploratory Research Question 10b – Normality Histogram for ASD+ADHD Group

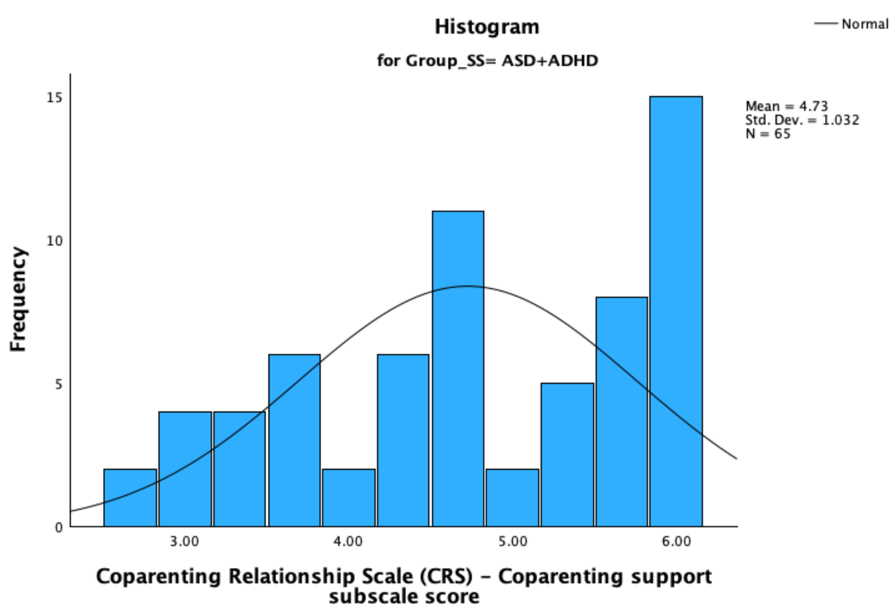


Figure F-10b.5

Exploratory Research Question 10b – Expected Normal Probability Plot for NT Group

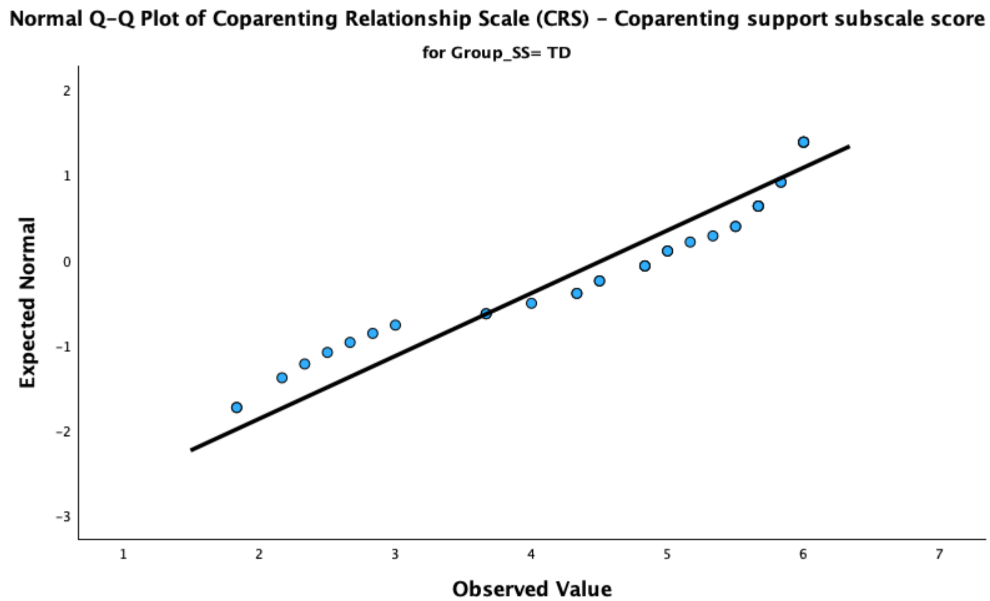


Figure F-10b.6

Exploratory Research Question 10b – Expected Normal Probability Plot for ASD Group

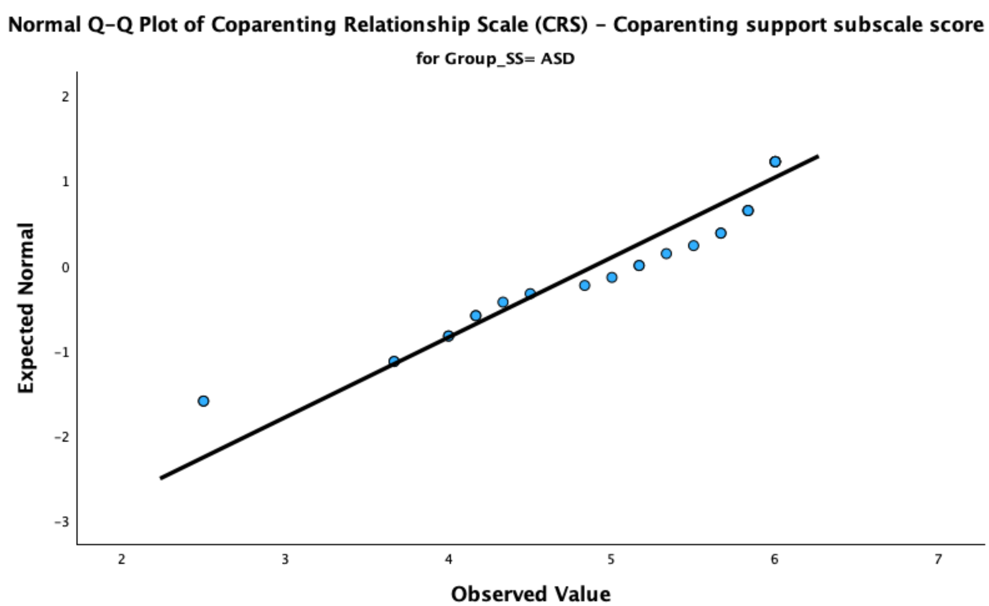


Figure F-10b.7

Exploratory Research Question 10b – Expected Normal Probability Plot for ADHD Group

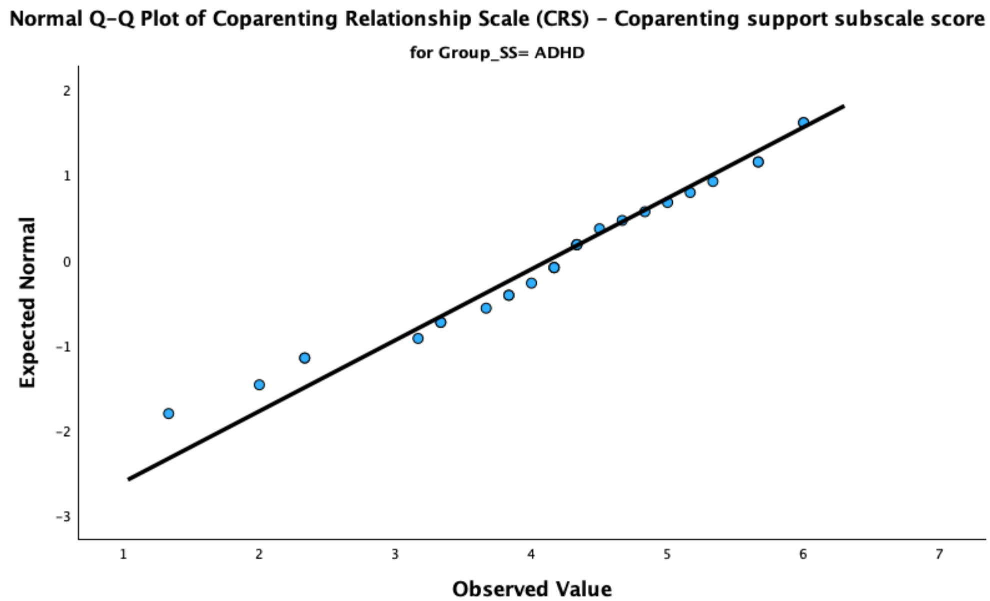
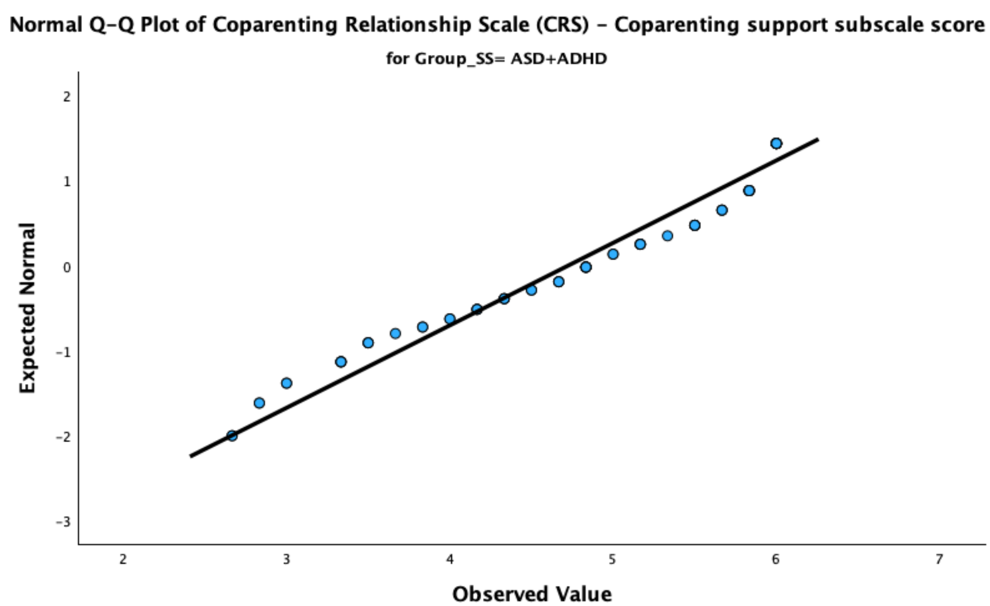


Figure F-10b.8

Exploratory Research Question 10b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 11

Table F-11

Assumption Testing – RQ 11: Coparenting Undermining Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 11a: Mothers				$F(3, 247) = 7.20$, $p < .001$
NT Group	1.61 (0.28)	2.55 (0.55)	$W(76) = .80$, $p < .001$	
ASD Group	0.92 (0.66)	-0.56 (1.28)	$W(11) = .82$, $p = .017$	
ADHD Group	1.47 (0.25)	1.68 (0.49)	$W(96) = .83$, $p < .001$	
ASD+ADHD Group	1.22 (0.29)	0.84 (0.57)	$W(68) = .87$, $p < .001$	
RQ 11b: Fathers				$F(3, 150) = 1.37$, $p < .25$
NT Group	0.86 (0.40)	0.36 (0.78)	$W(35) = .91$, $p = .009$	
ASD Group	-0.24 (0.45)	-0.82 (0.87)	$W(27) = .97$,. $p = .632$	
ADHD Group	0.47 (0.45)	-0.55 (0.87)	$W(27) = .96$, $p = .281$	
ASD+ADHD Group	-0.67 (0.30)	-0.58 (0.59)	$W(64) = .92$, $p < .001$	

Exploratory Research Question 11a.

Figure F-11a.1

Exploratory Research Question 11a – Normality Histogram for NT Group

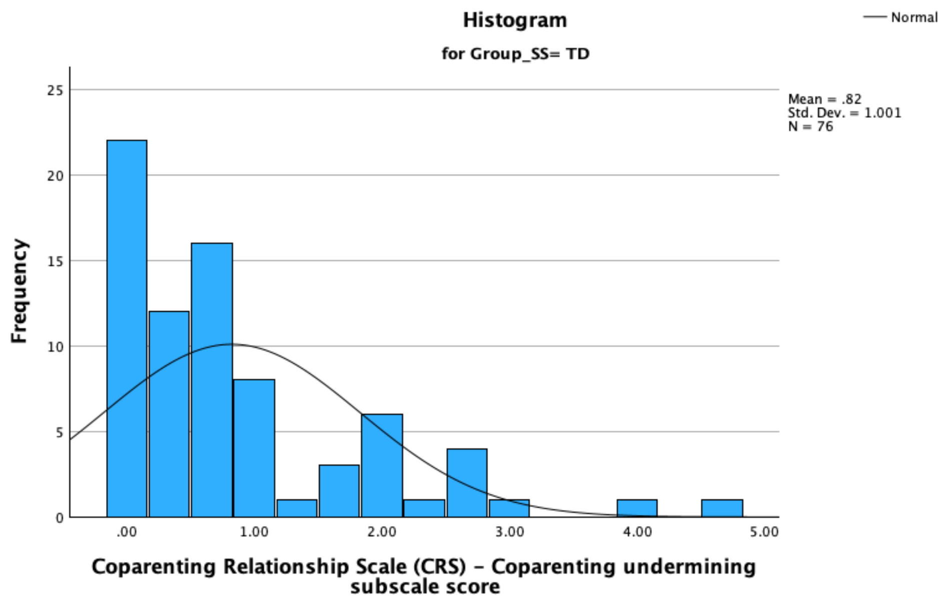


Figure F-11a.2

Exploratory Research Question 11a – Normality Histogram for ASD Group

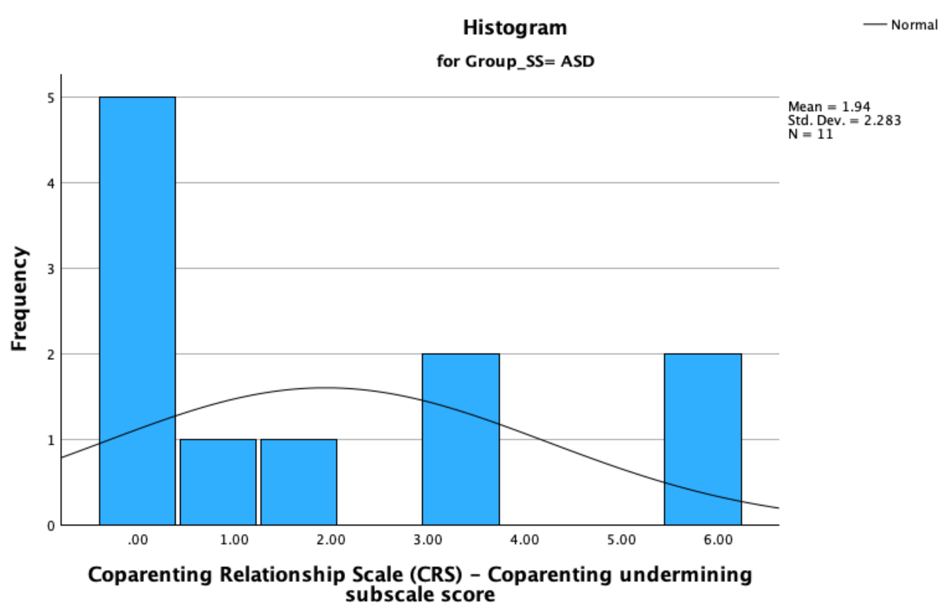


Figure F-11a.3

Exploratory Research Question 11a – Normality Histogram for ADHD Group

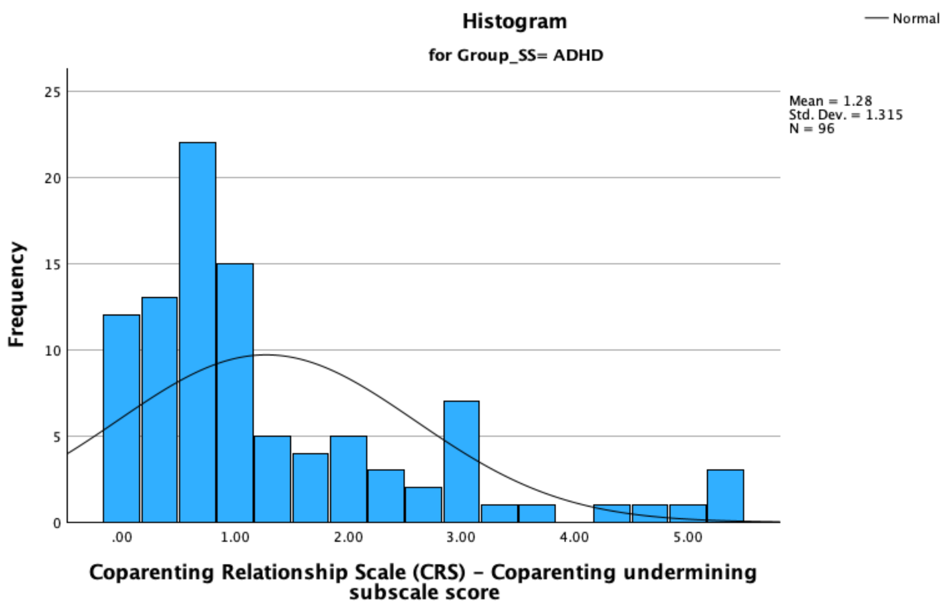


Figure F-11a.4

Exploratory Research Question 11a – Normality Histogram for ASD+ADHD Group

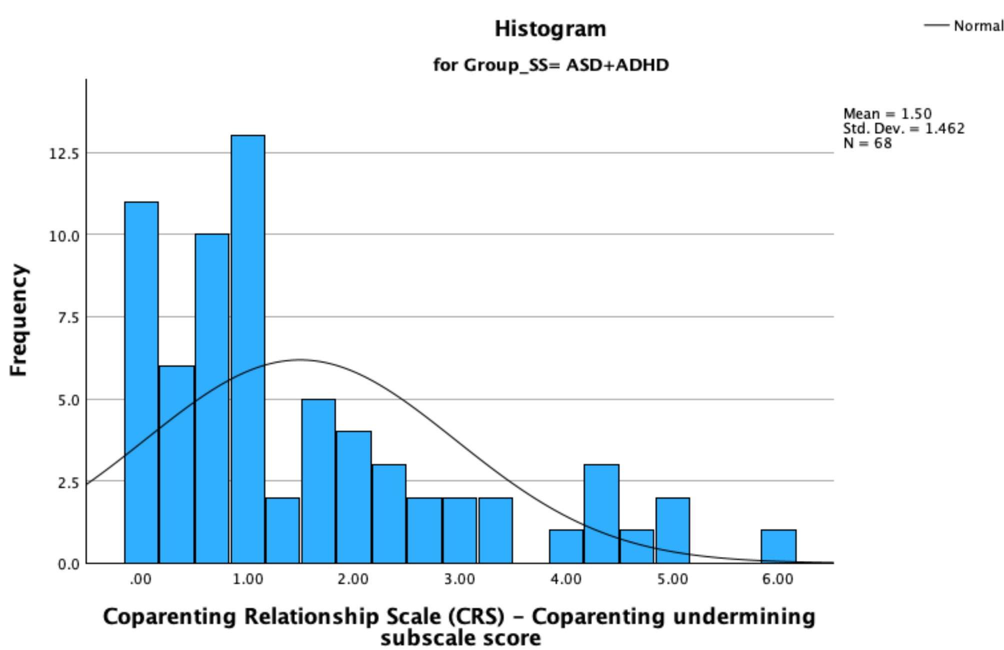


Figure F-11a.5

Exploratory Research Question 11a – Expected Normal Probability Plot for NT Group

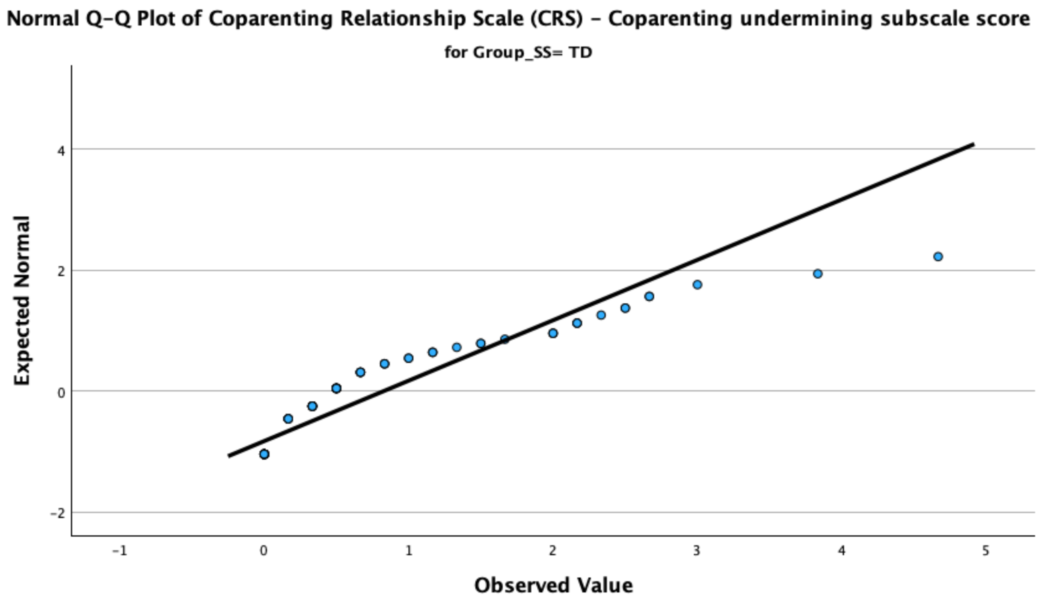


Figure F-11a.6

Exploratory Research Question 11a – Expected Normal Probability Plot for ASD Group

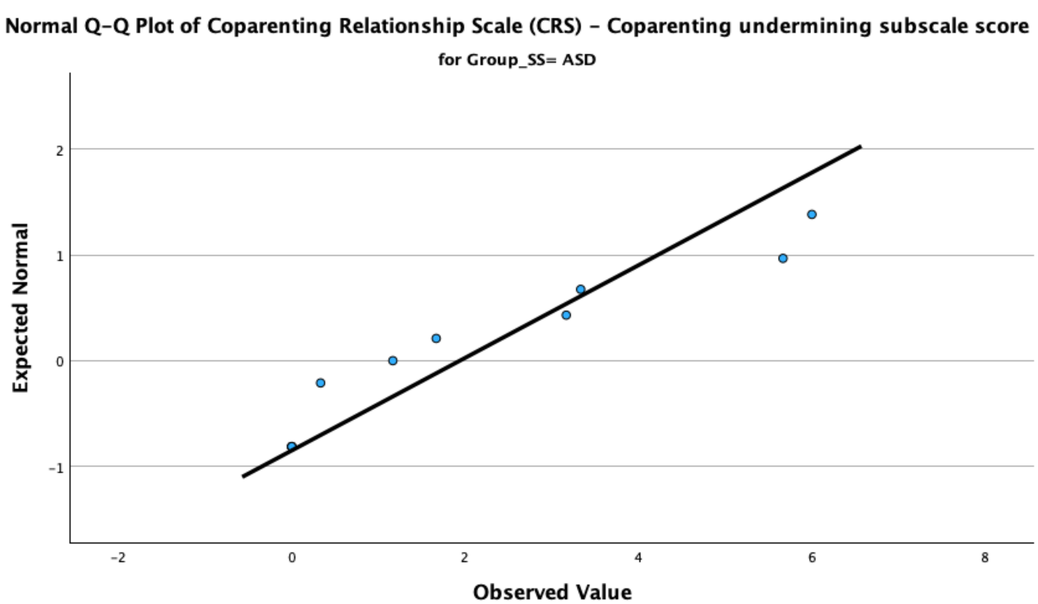


Figure F-11a.7

Exploratory Research Question 11a – Expected Normal Probability Plot for ADHD Group

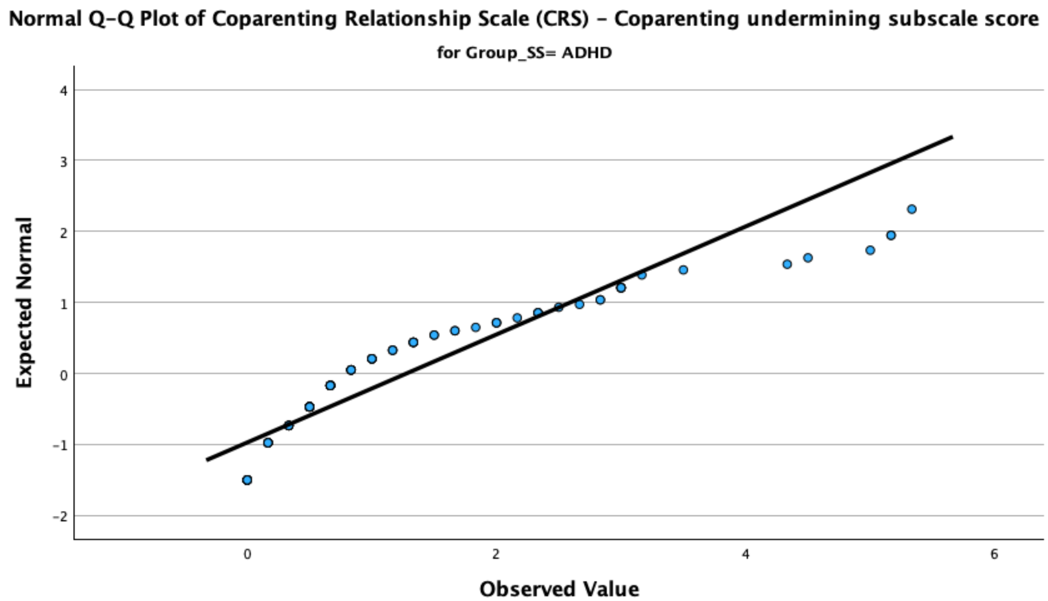
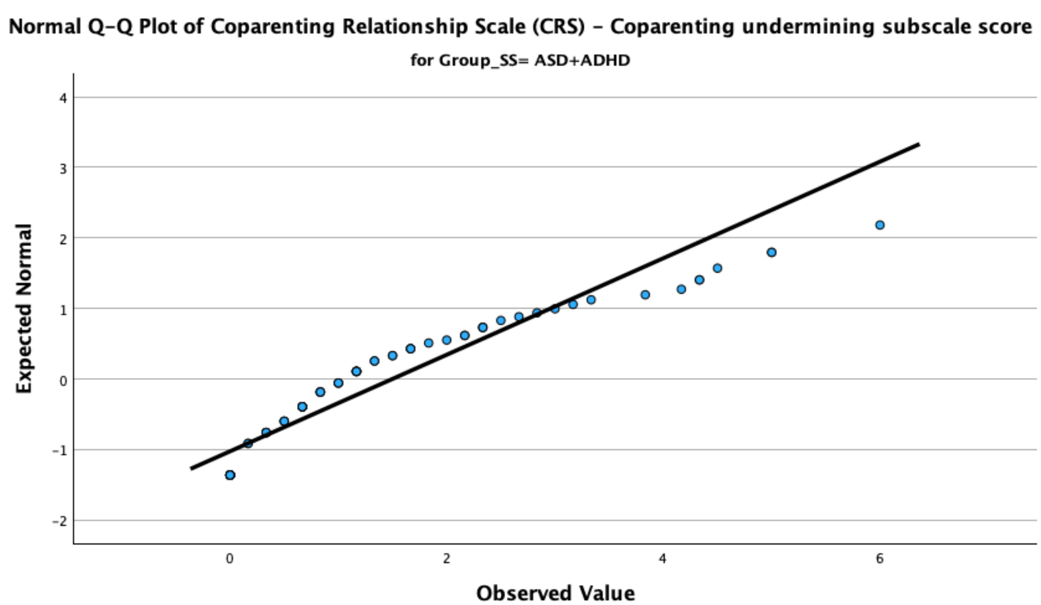


Figure F-11a.8

Exploratory Research Question 11a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 11b.

Figure F-11b.1

Exploratory Research Question 11b – Normality Histogram for NT Group

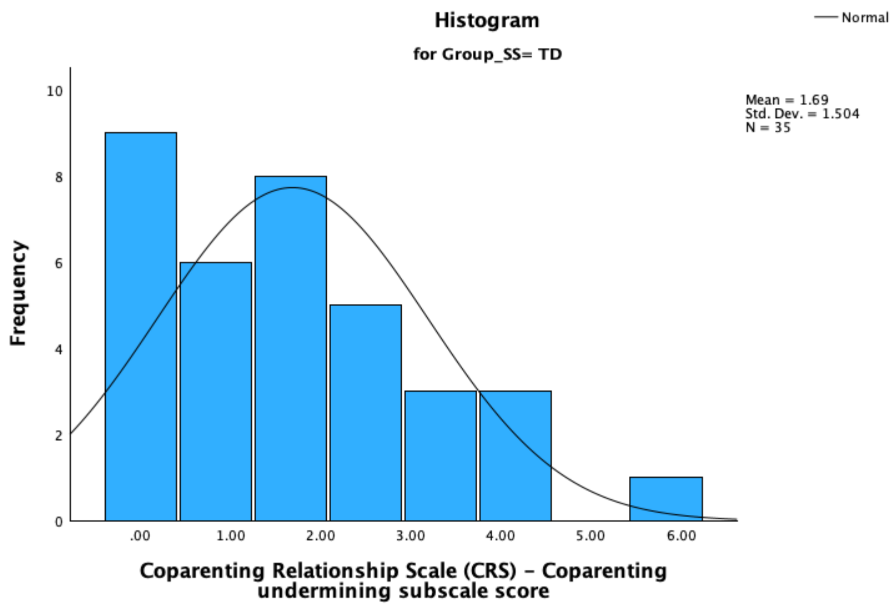


Figure F-11b.2

Exploratory Research Question 11b – Normality Histogram for ASD Group

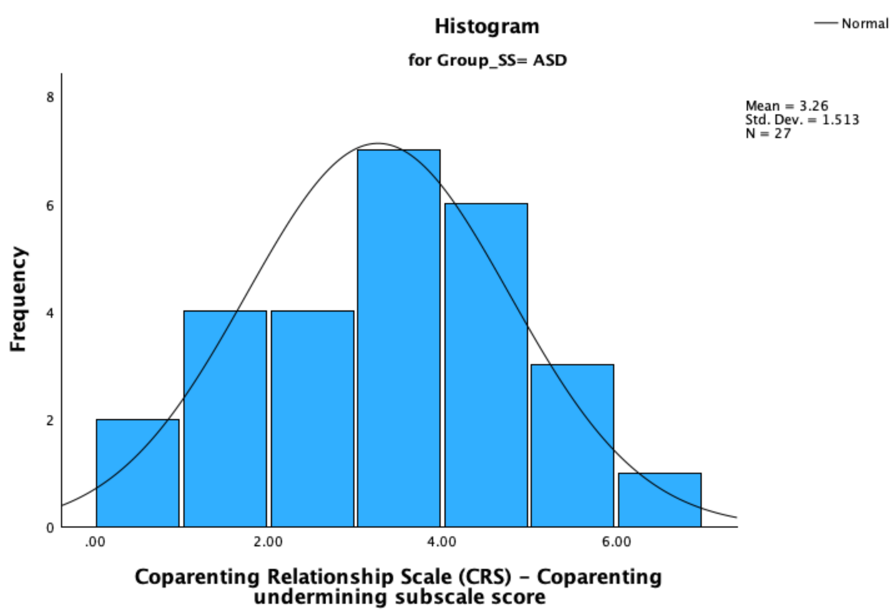


Figure F-11b.3

Exploratory Research Question 11b – Normality Histogram for ADHD Group

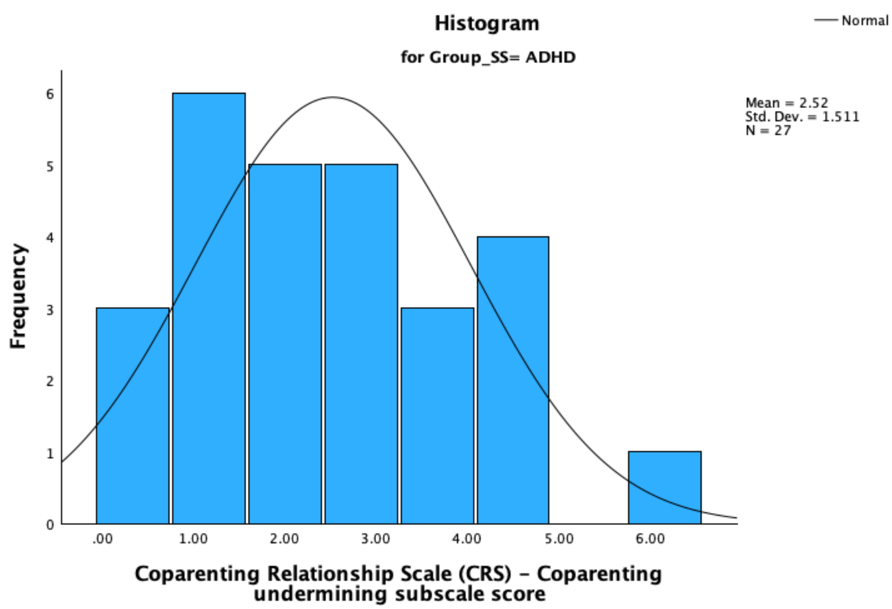


Figure F-11a.4

Exploratory Research Question 11b – Normality Histogram for ASD+ADHD Group

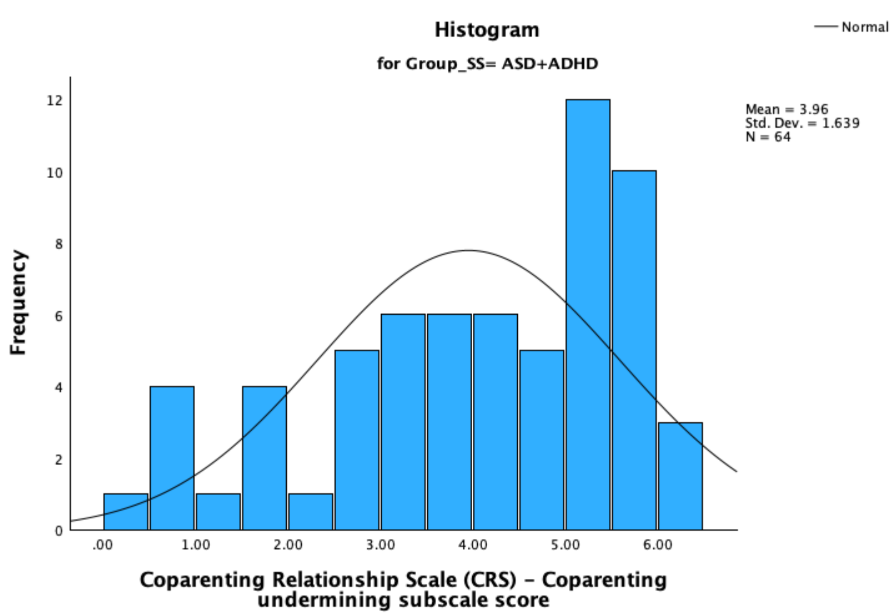


Figure F-11b.5

Exploratory Research Question 11b – Expected Normal Probability Plot for NT Group

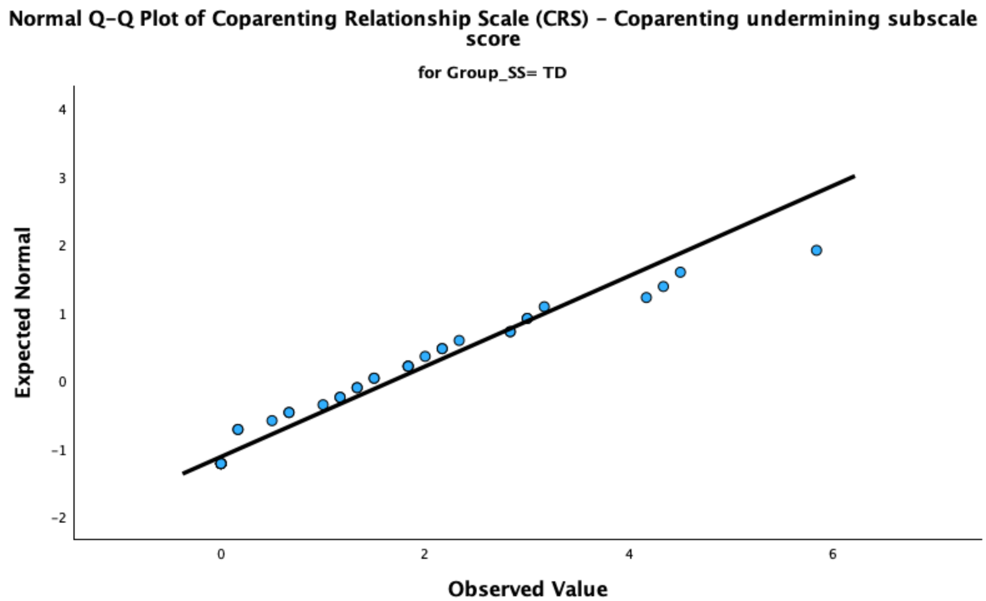


Figure F-11b.6

Exploratory Research Question 11b – Expected Normal Probability Plot for ASD Group

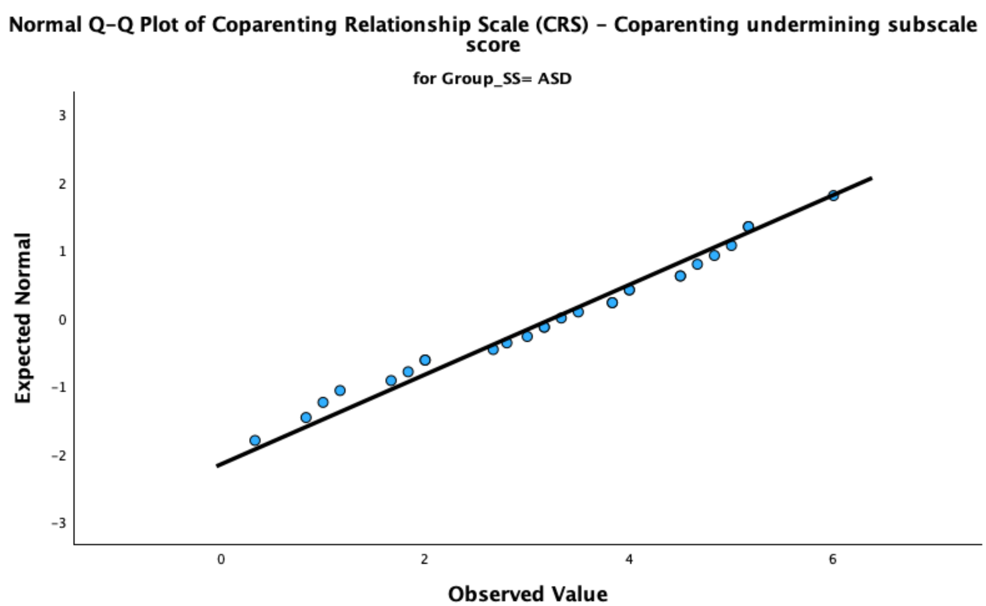


Figure F-11b.7

Exploratory Research Question 11b – Expected Normal Probability Plot for ADHD Group

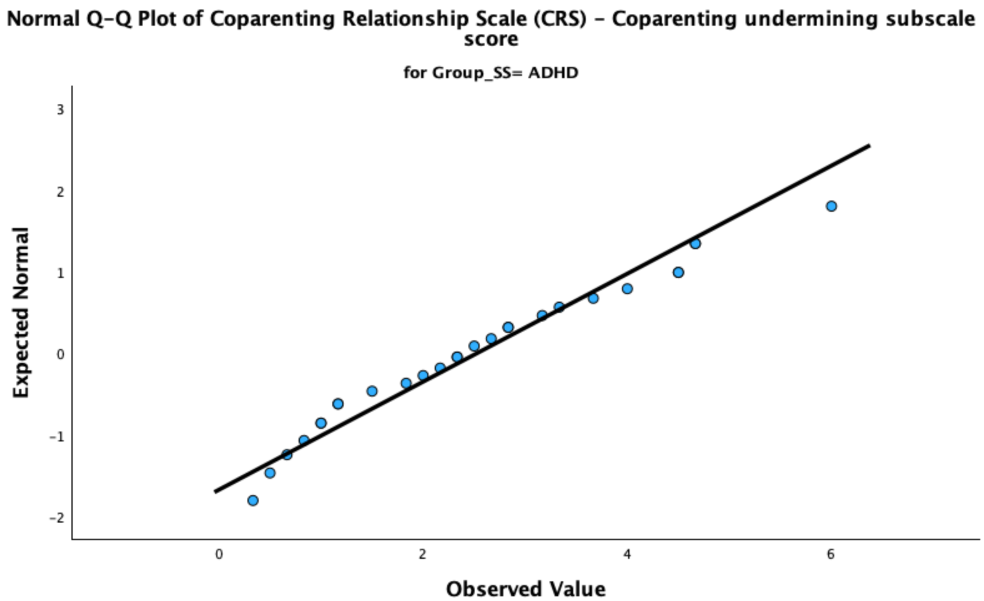
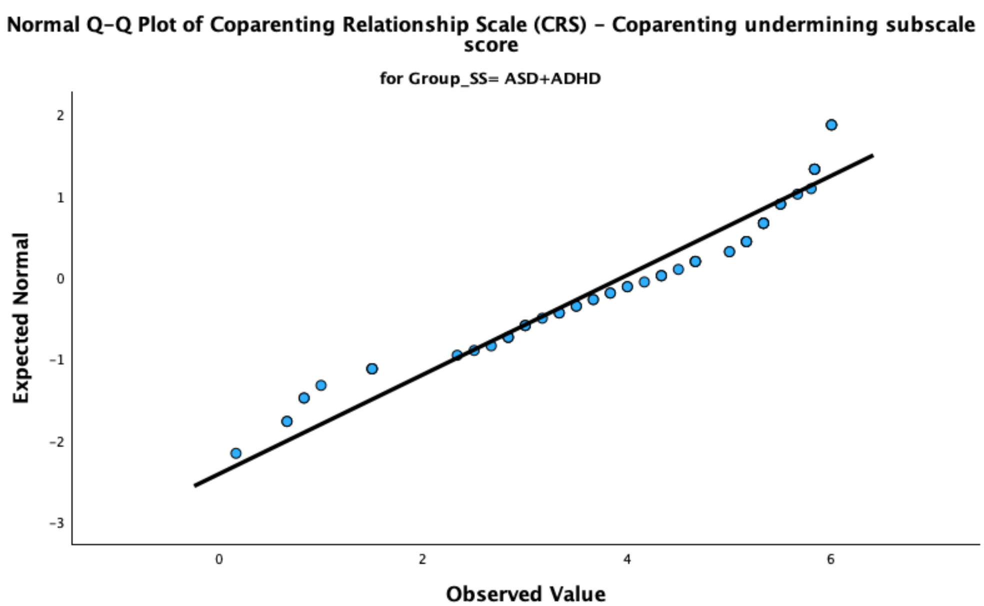


Figure F-11b.8

Exploratory Research Question 11b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 12

Table F-12

Assumption Testing – RQ 12: Endorsement of Partner Parenting Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 12a: Mothers				$F(3, 248) = 1.77$, $p = .155$
NT Group	-1.34 (0.28)	2.69 (0.55)	$W(76) = .90$, $p < .001$	
ASD Group	-0.37 (0.66)	-1.17 (1.28)	$W(11) = .88$, $p = .101$	
ADHD Group	-0.43 (0.24)	-0.47 (0.49)	$W(97) = .96$, $p = .005$	
ASD+ADHD Group	-0.46 (0.29)	0.04 (0.57)	$W(68) = .97$, $p = .058$	
RQ 12b: Fathers				$F(3, 150) = 0.99$, $p = .399$
NT Group	-0.41 (0.40)	-0.99 (0.78)	$W(35) = .92$, $p = .013$	
ASD Group	0.67 (0.45)	0.34 (0.87)	$W(27) = .95$, $p = .265$	
ADHD Group	0.11 (0.45)	-0.49 (0.87)	$W(27) = .99$, $p = .954$	
ASD+ADHD Group	0.38 (0.30)	-0.01 (0.59)	$W(65) = .96$, $p = .049$	

Exploratory Research Question 12a.

Figure F-12a.1

Exploratory Research Question 12a – Normality Histogram for NT Group

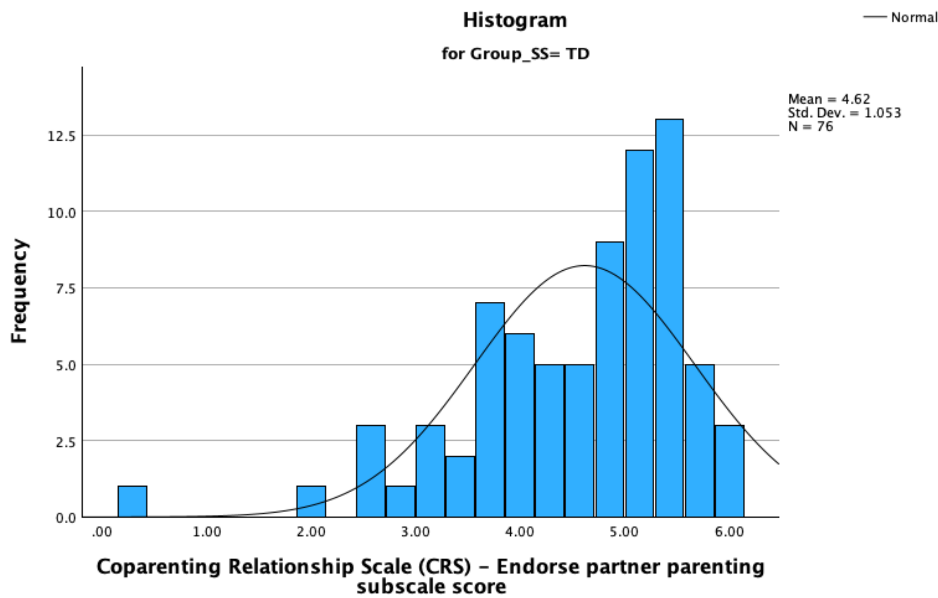


Figure F-12a.2

Exploratory Research Question 12a – Normality Histogram for ASD Group

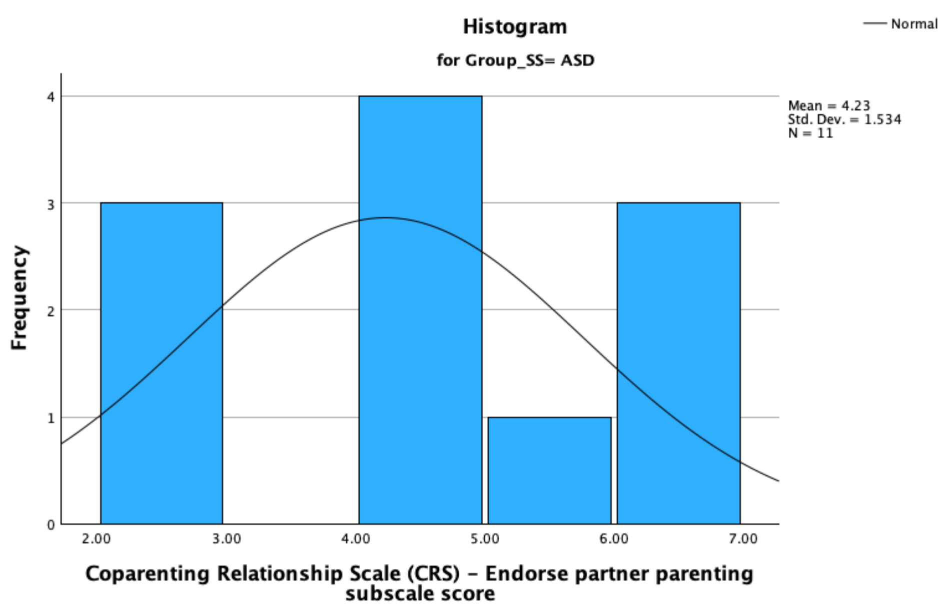


Figure F-12a.3

Exploratory Research Question 12a – Normality Histogram for ADHD Group

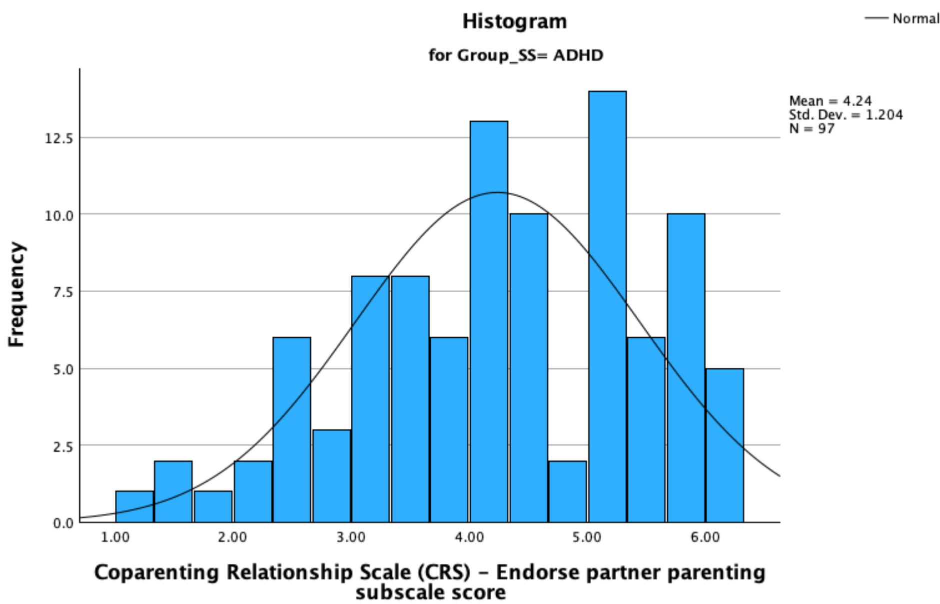


Figure F-12a.4

Exploratory Research Question 12a – Normality Histogram for ASD+ADHD Group

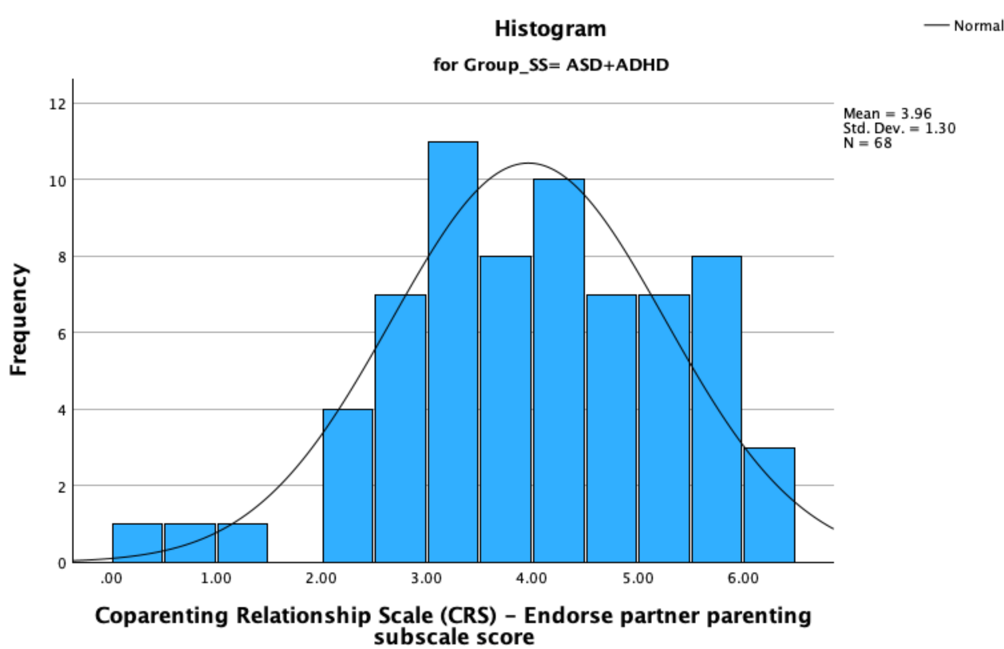


Figure F-12a.5

Exploratory Research Question 12a – Expected Normal Probability Plot for NT Group

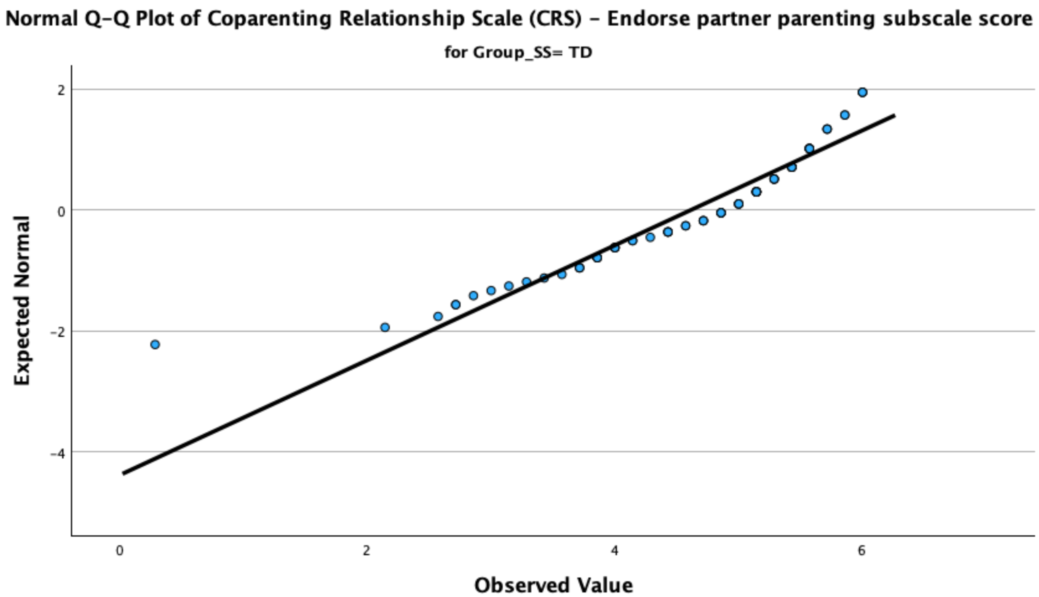


Figure F-12a.6

Exploratory Research Question 12a – Expected Normal Probability Plot for ASD Group

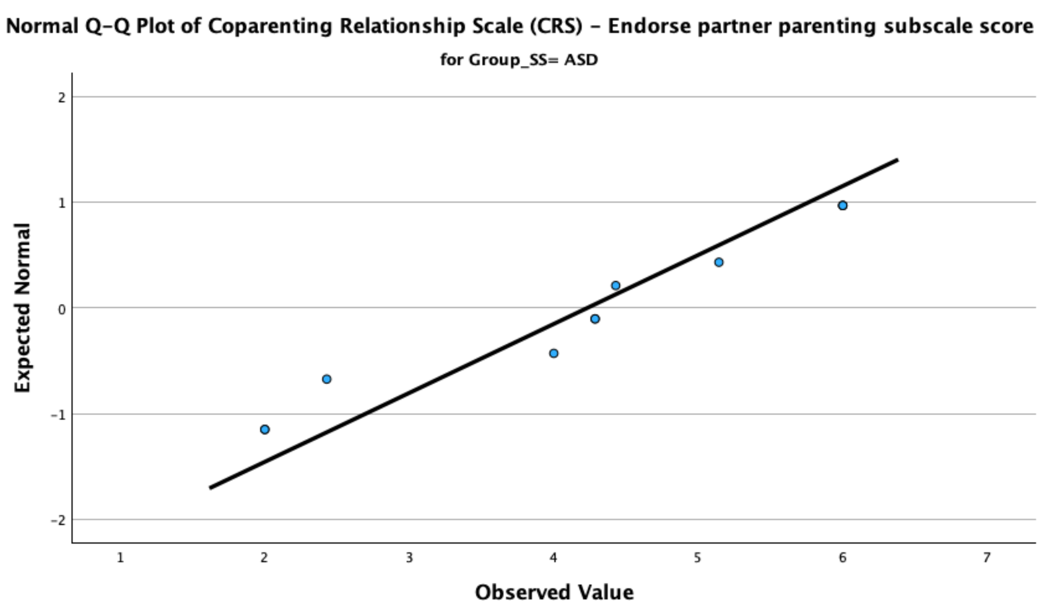


Figure F-12a.7

Exploratory Research Question 12a – Expected Normal Probability Plot for ADHD Group

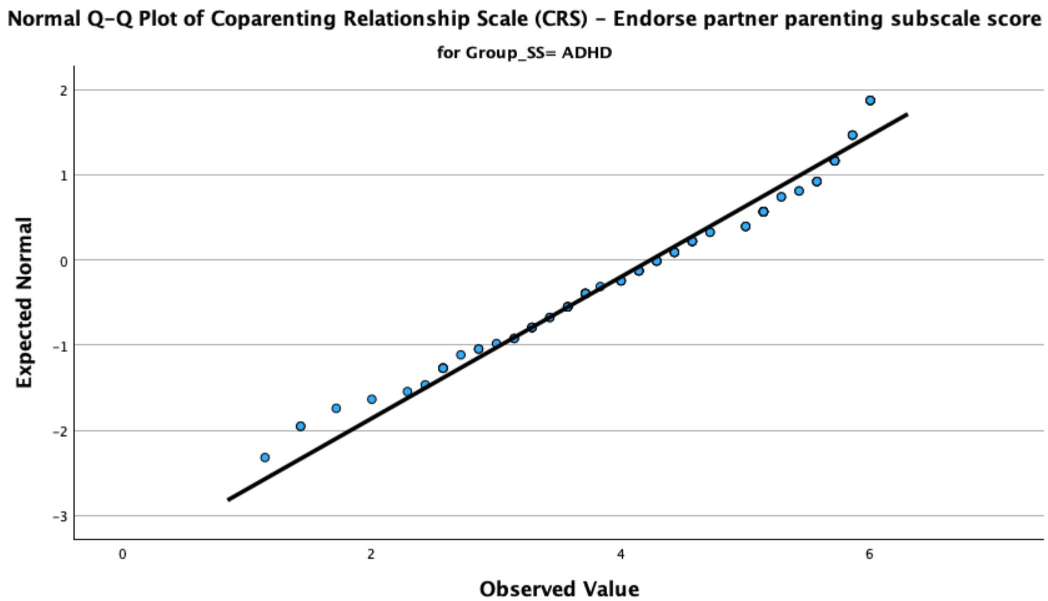
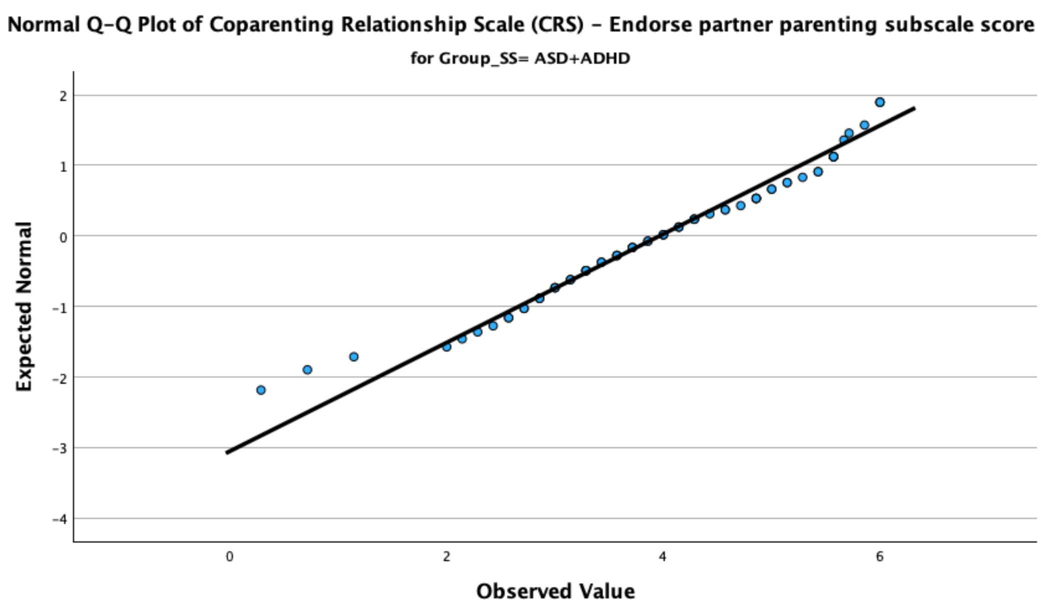


Figure F-12a.8

Exploratory Research Question 12a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 12b.

Figure F-12b.1

Exploratory Research Question 12b – Normality Histogram for NT Group

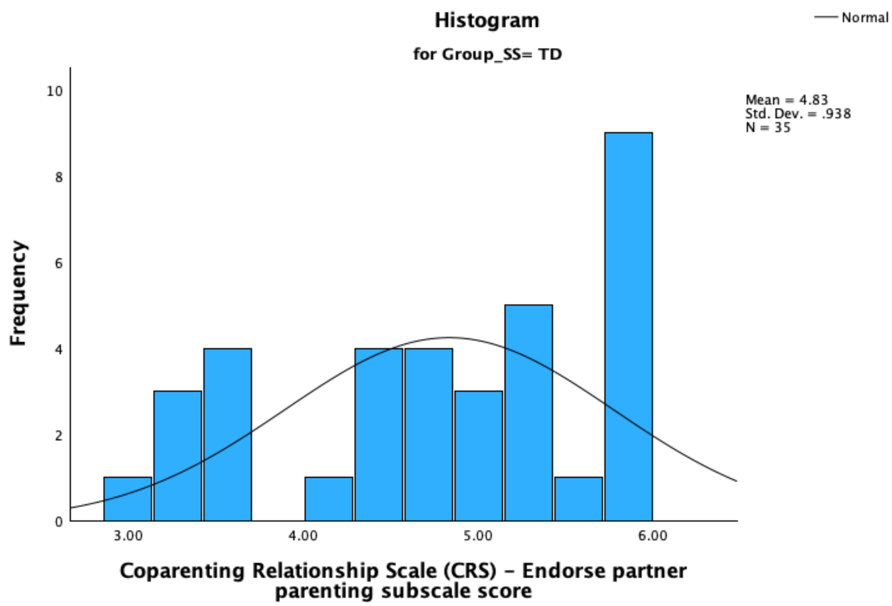


Figure F-12b.2

Exploratory Research Question 12b – Normality Histogram for ASD Group

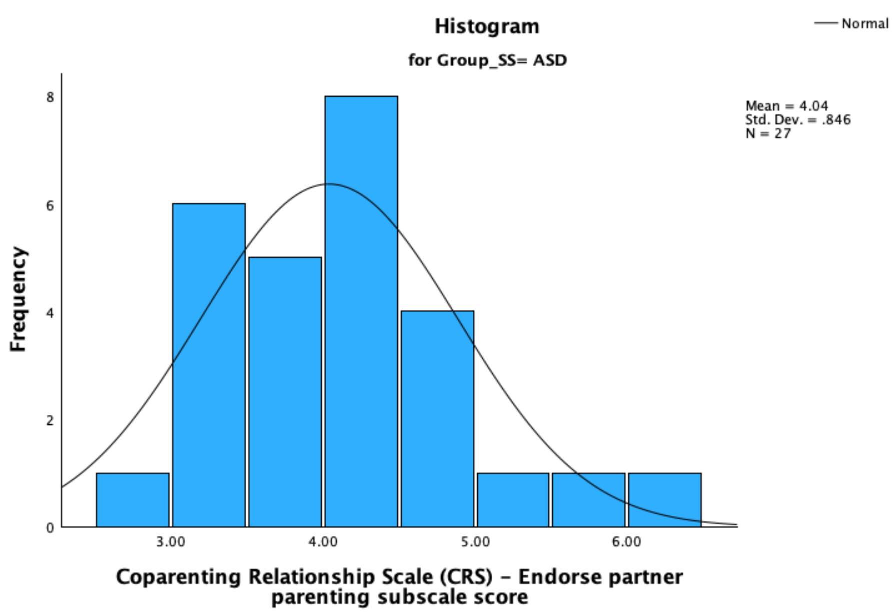


Figure F-12b.3

Exploratory Research Question 12b – Normality Histogram for ADHD Group

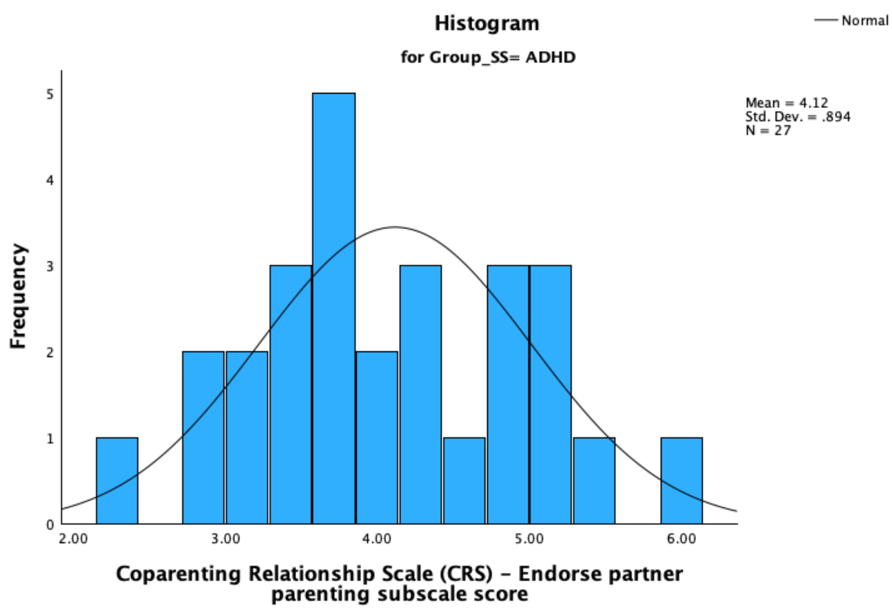


Figure F-12b.4

Exploratory Research Question 12b – Normality Histogram for ASD+ADHD Group

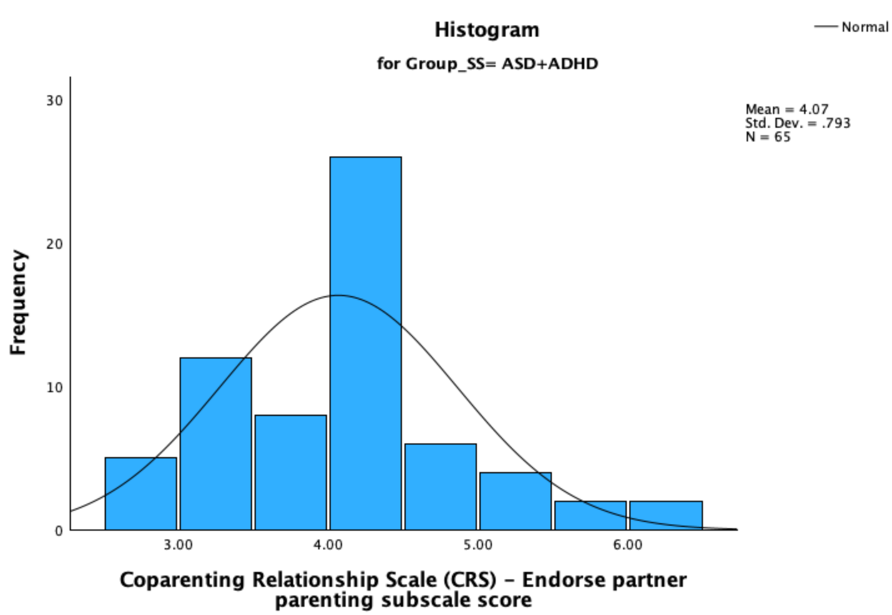


Figure F-12b.5

Exploratory Research Question 12b – Expected Normal Probability Plot for NT Group

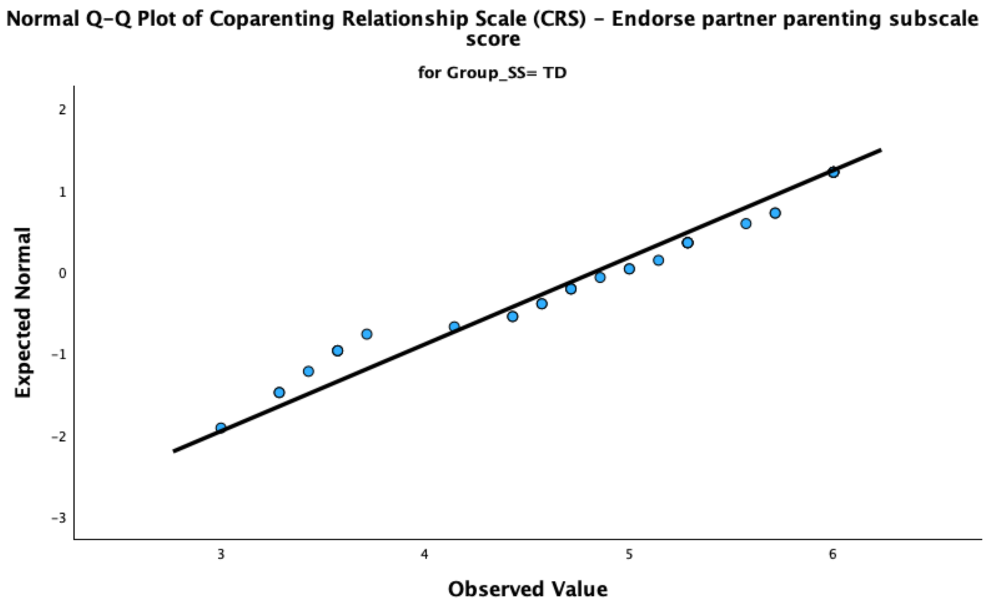


Figure F-12b.6

Exploratory Research Question 12b – Expected Normal Probability Plot for ASD Group

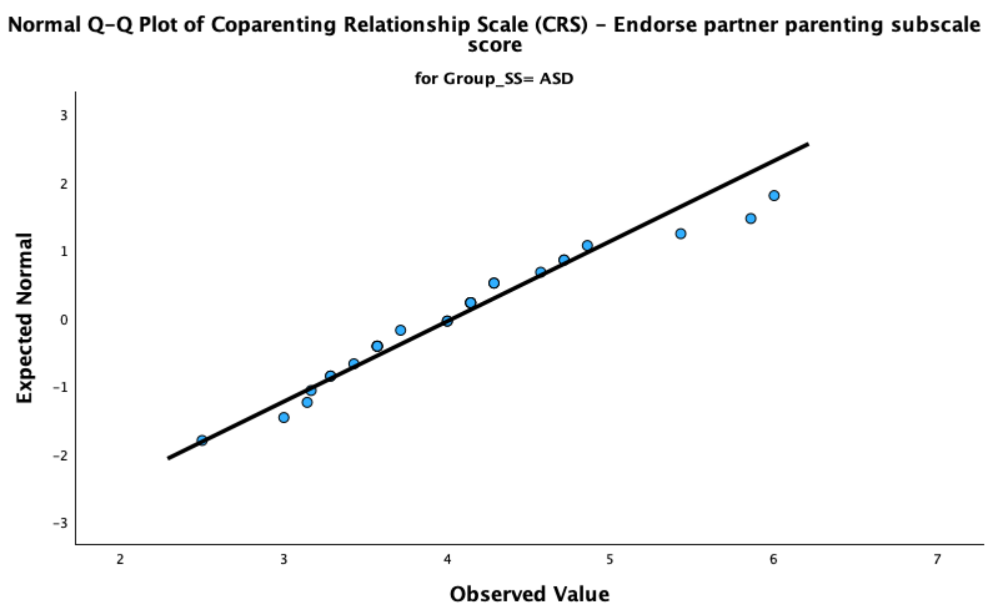


Figure F-12b.7

Exploratory Research Question 12b – Expected Normal Probability Plot for ADHD Group

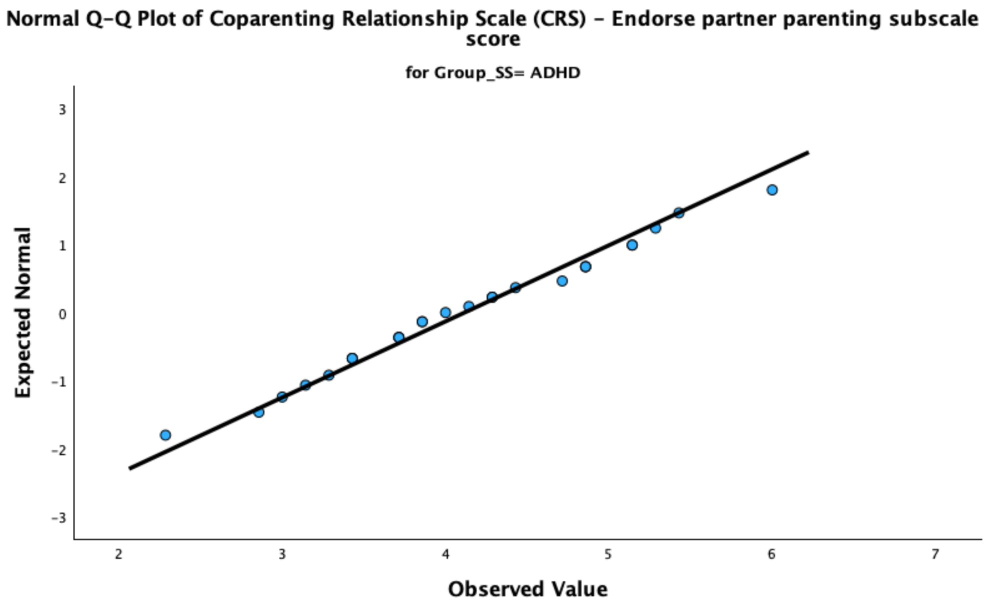
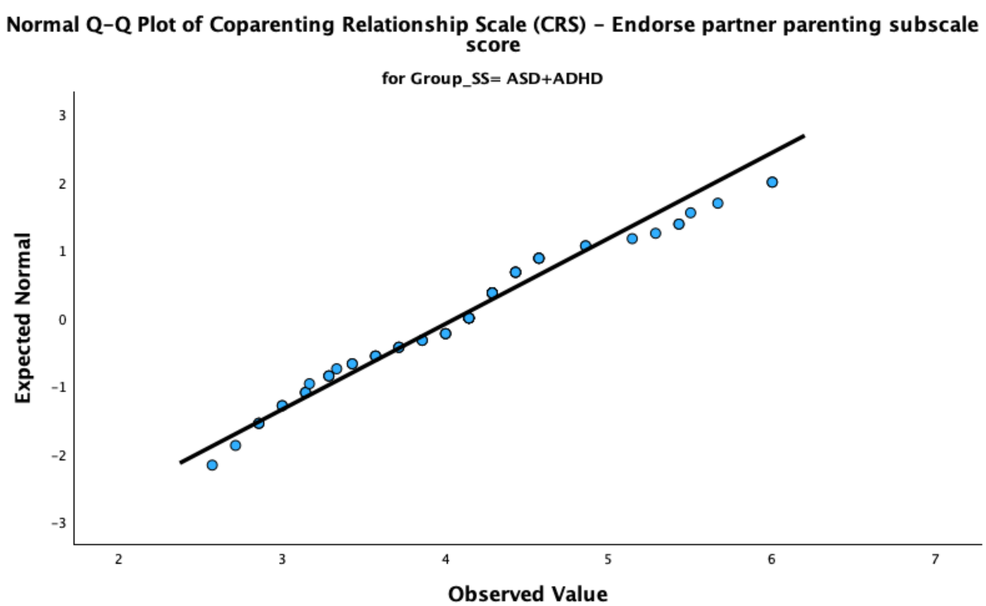


Figure F-12b.8

Exploratory Research Question 12b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 13

Table F-13

Assumption Testing – RQ 13: Division of Labor Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 13a: Mothers				$F(3, 246) = 1.04$, $p = .375$
NT Group	-0.66 (0.28)	-0.38 (0.55)	$W(75) = .91$, $p < .001$	
ASD Group	-0.39 (0.69)	-1.24 (1.33)	$W(10) = .92$, $p = .343$	
ADHD Group	-0.40 (0.25)	-0.95 (0.49)	$W(97) = .92$, $p < .001$	
ASD+ADHD Group	-0.34 (0.29)	-0.70 (0.57)	$W(68) = .95$, $p = .005$	
RQ 13b: Fathers				$F(3,149) = .37$, $p = .776$
NT Group	-0.42 (0.40)	-0.47 (0.78)	$W(35) = .93$, $p = .030$	
ASD Group	0.39 (0.45)	-0.90 (0.87)	$W(27) = .90$, $p = .012$	
ADHD Group	0.09 (0.45)	-0.96 (0.87)	$W(27) = .95$, $p = .188$	
ASD+ADHD Group	1.03 (0.30)	0.17 (0.59)	$W(64) = .87$, $p < .001$	

Exploratory Research Question 13a.

Figure F-13a.1

Exploratory Research Question 13a – Normality Histogram for NT Group

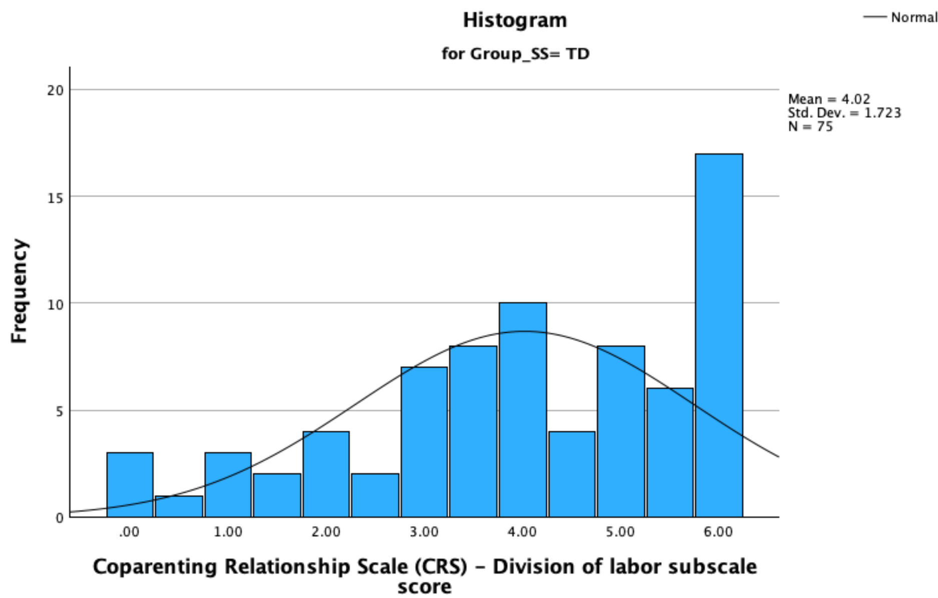


Figure F-13a.2

Exploratory Research Question 13a – Normality Histogram for ASD Group

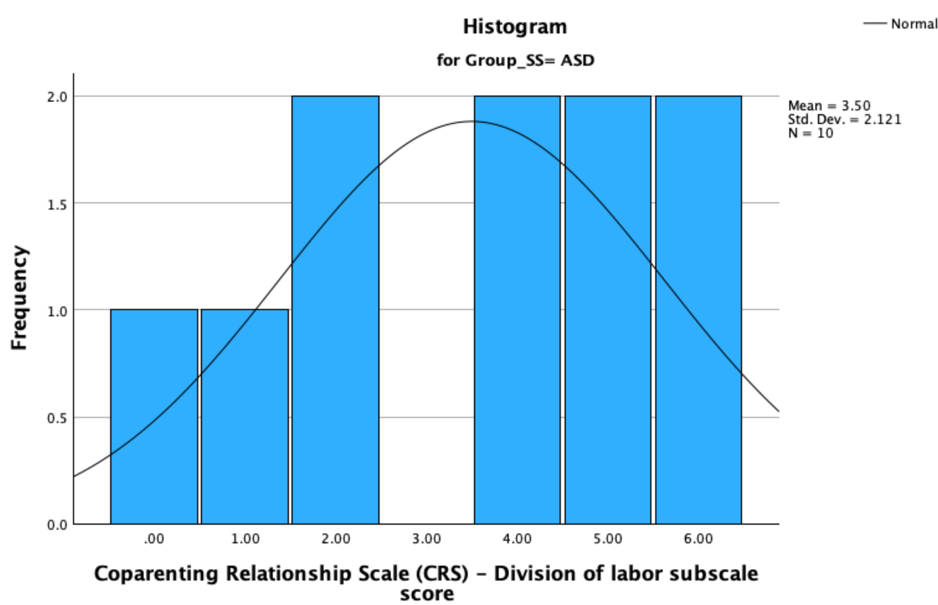


Figure F-13a.3

Exploratory Research Question 13a – Normality Histogram for ADHD Group

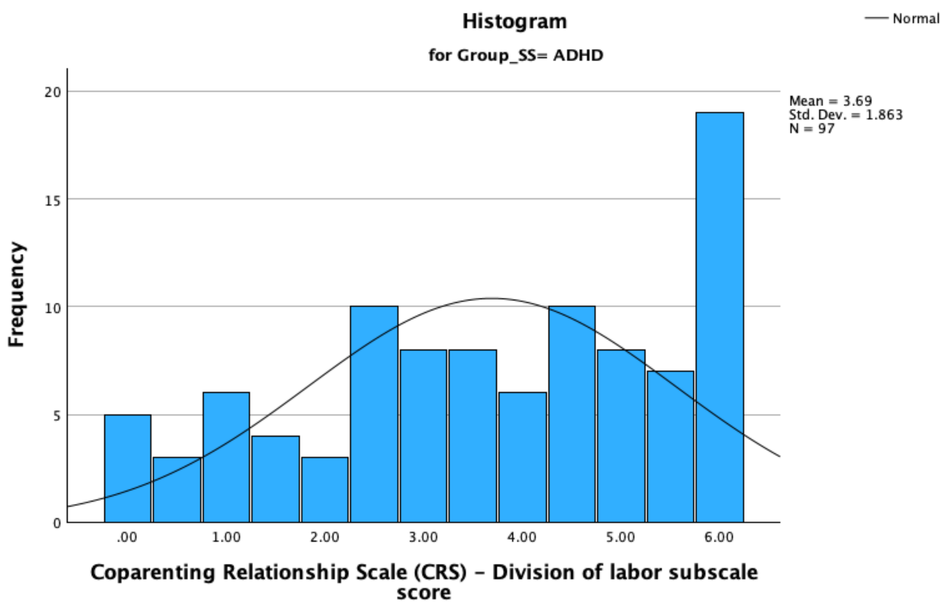


Figure F-13a.4

Exploratory Research Question 13a – Normality Histogram for ASD+ADHD Group

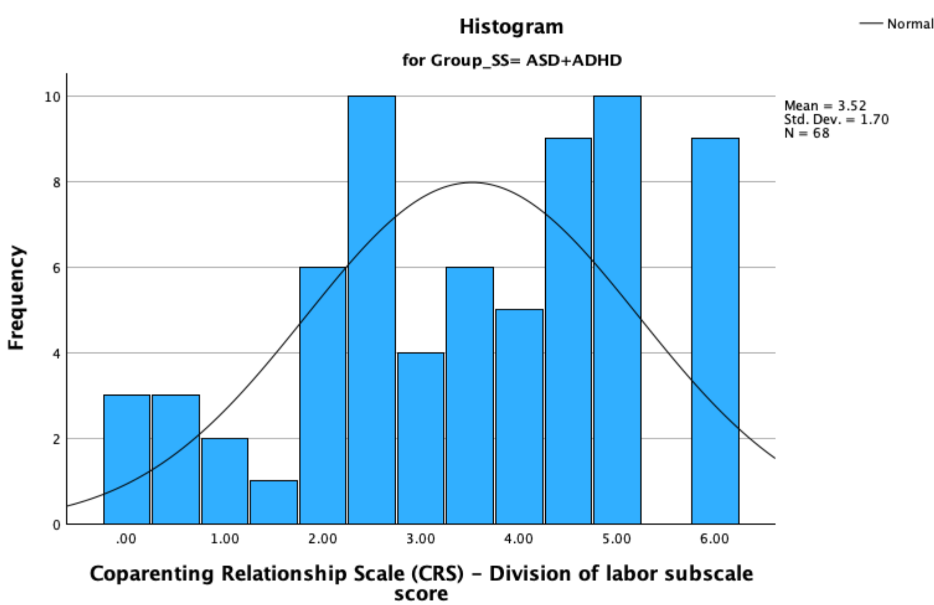


Figure F-13a.5

Exploratory Research Question 13a – Expected Normal Probability Plot for NT Group

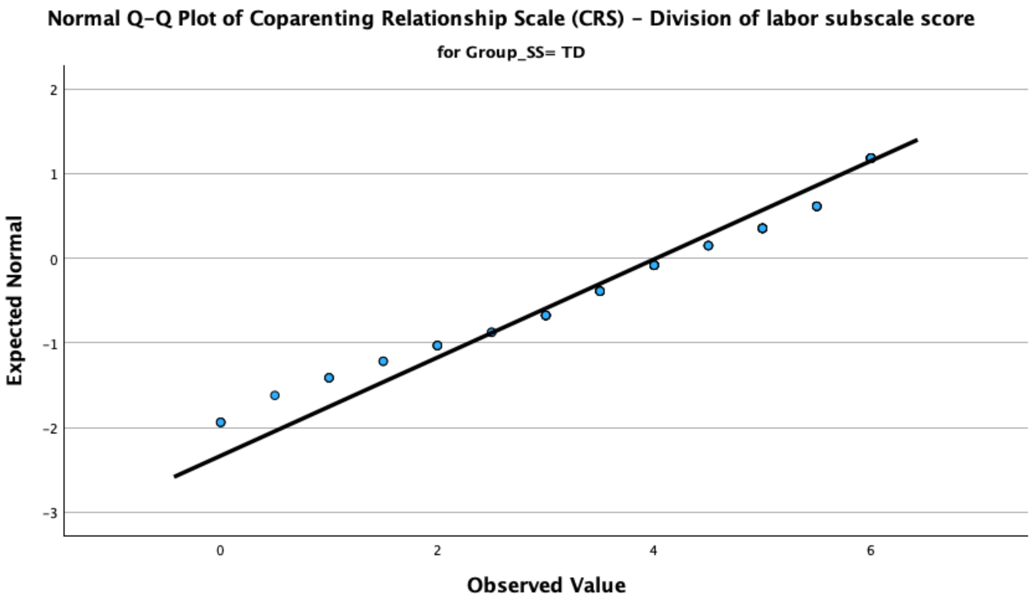


Figure F-13a.6

Exploratory Research Question 13a – Expected Normal Probability Plot for ASD Group

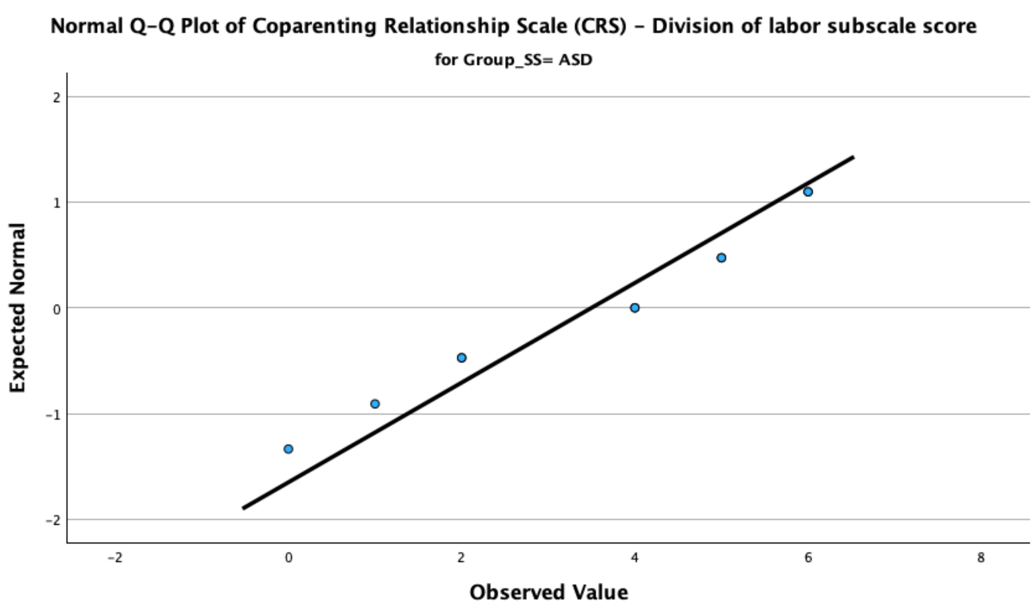


Figure F-13a.7

Exploratory Research Question 13a – Expected Normal Probability Plot for ADHD Group

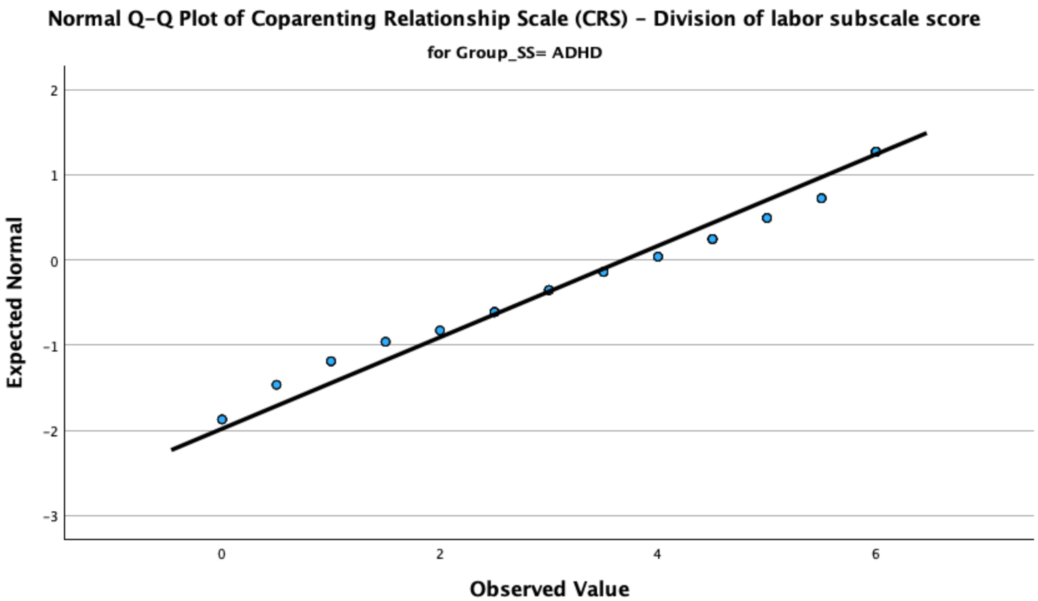
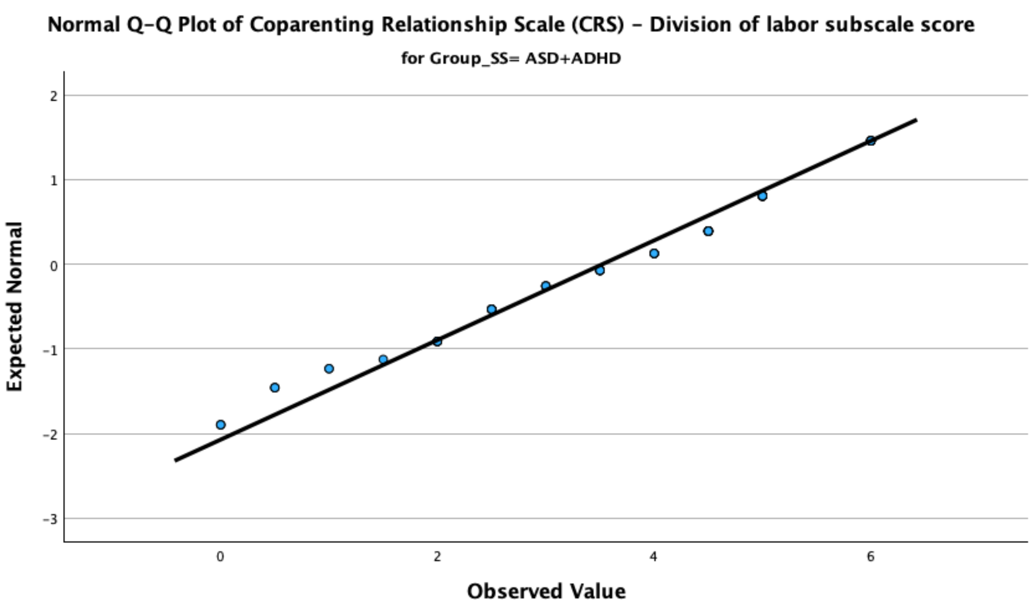


Figure F-13a.8

Exploratory Research Question 13a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 13b.

Figure F-13b.1

Exploratory Research Question 13b – Normality Histogram for NT Group

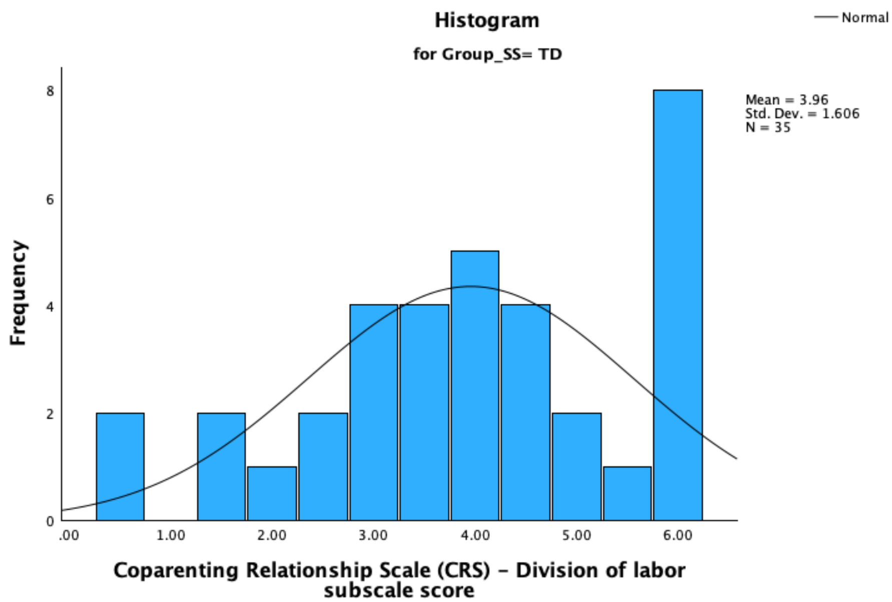


Figure F-13b.2

Exploratory Research Question 13b – Normality Histogram for ASD Group

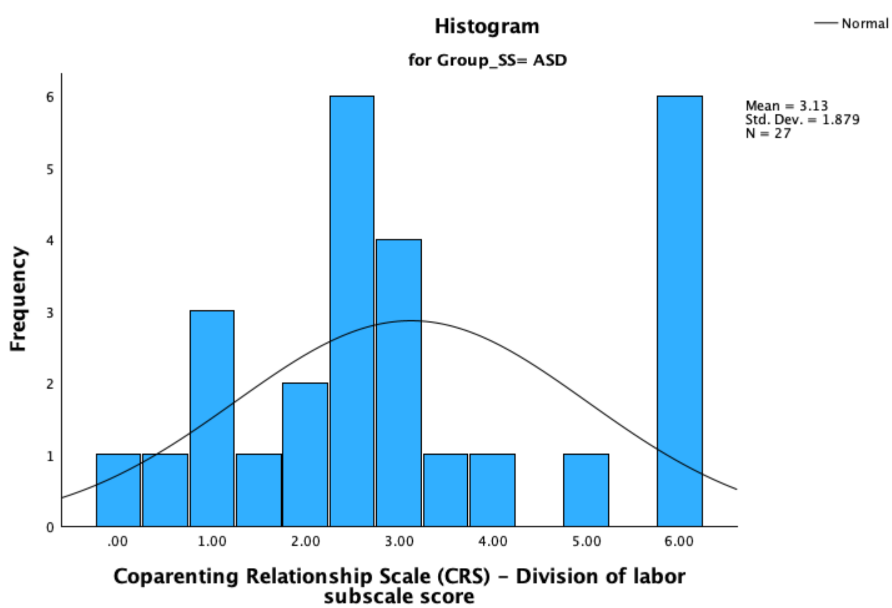


Figure F-13b.3

Exploratory Research Question 13b – Normality Histogram for ADHD Group

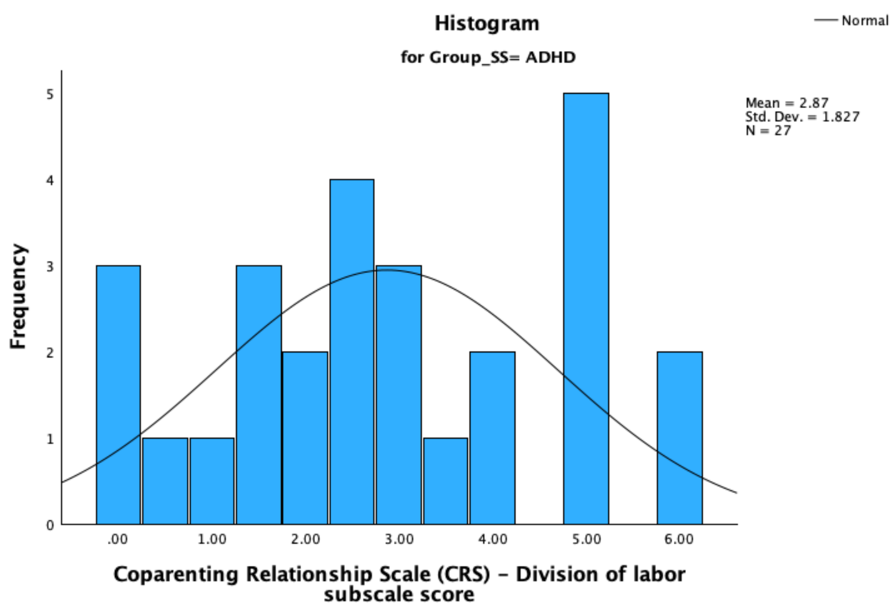


Figure F-13b.4

Exploratory Research Question 13b – Normality Histogram for ASD+ADHD Group

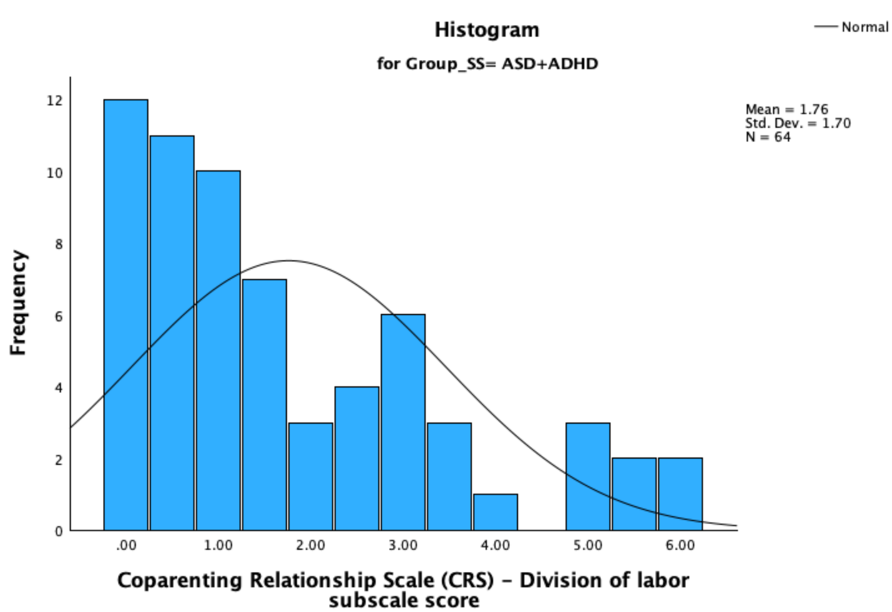


Figure F-13b.5

Exploratory Research Question 13b – Expected Normal Probability Plot for NT Group

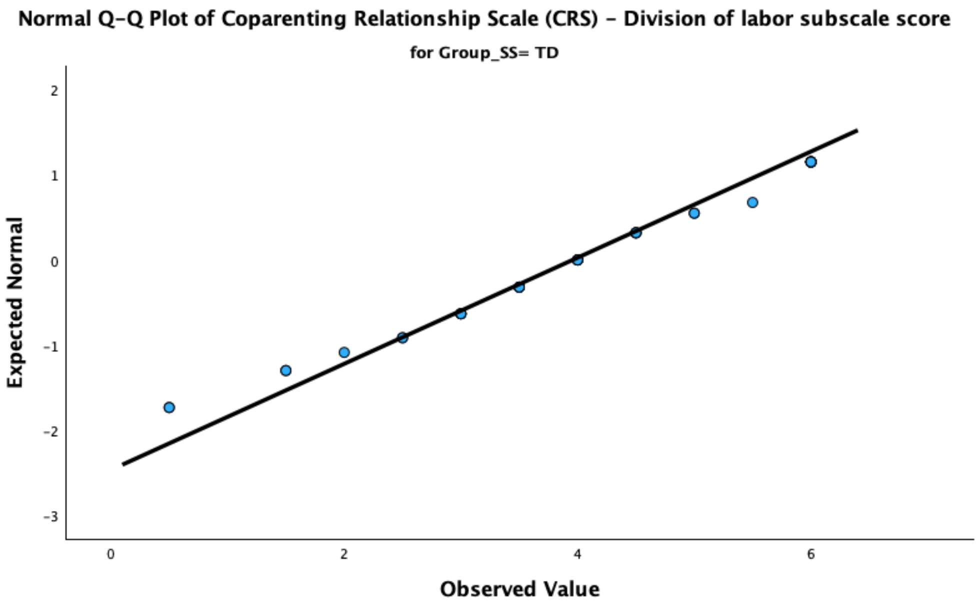


Figure F-13b.6

Exploratory Research Question 13b – Expected Normal Probability Plot for ASD Group

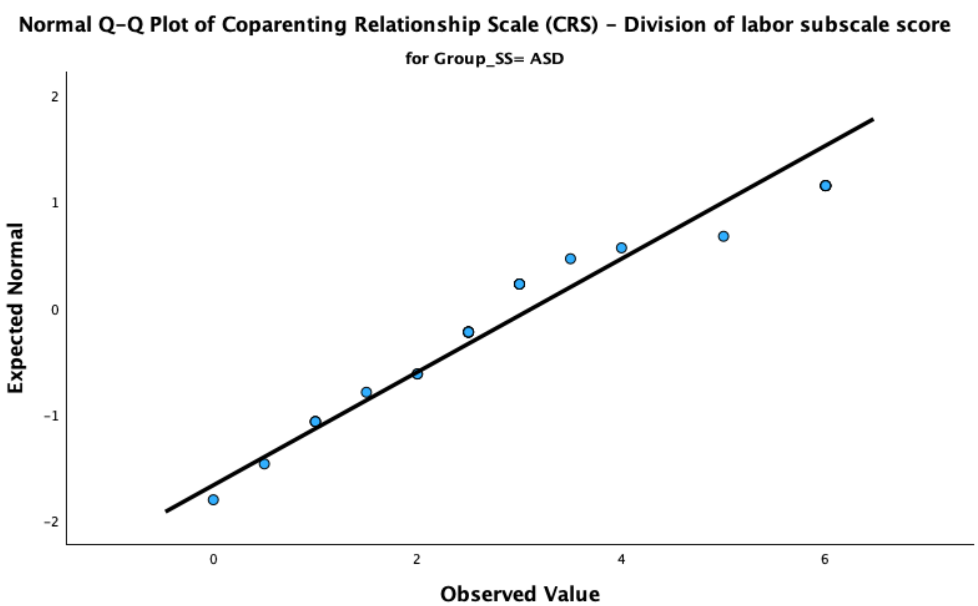


Figure F-13b.7

Exploratory Research Question 13b – Expected Normal Probability Plot for ADHD Group

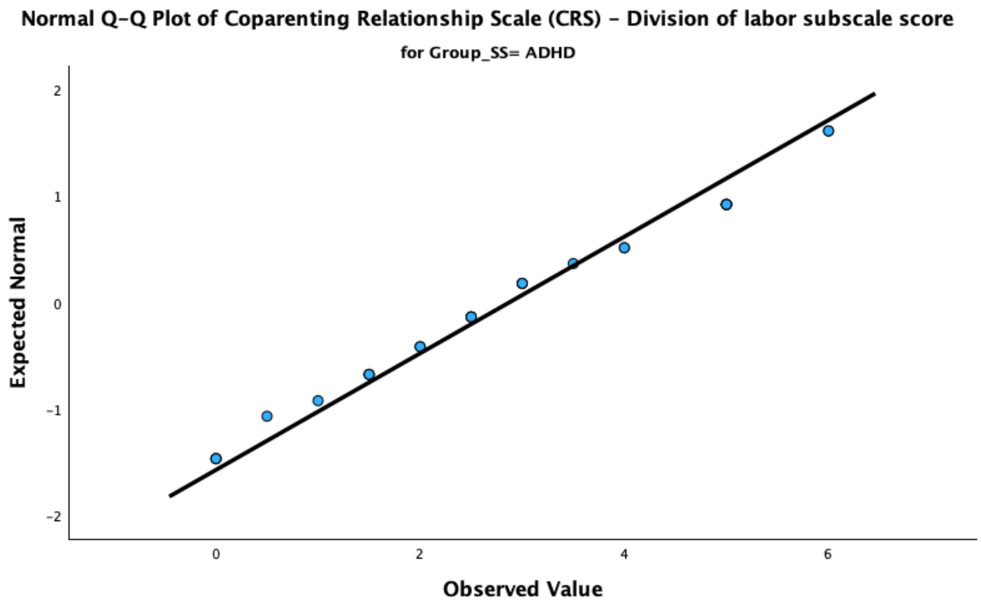
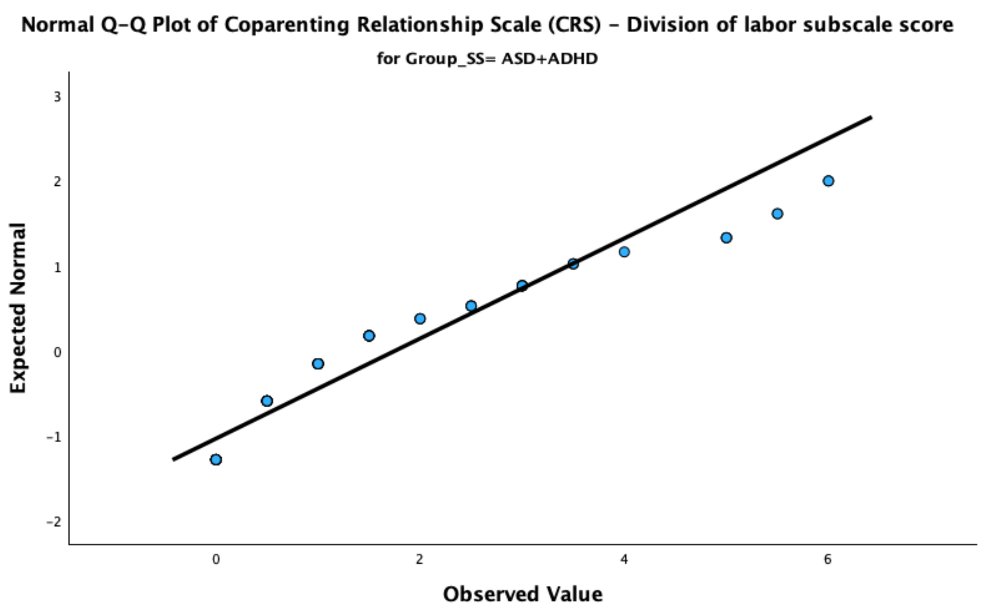


Figure F-13b.8

Exploratory Research Question 13b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 14

Table F-14

Assumption Testing – RQ 14: Family Interaction Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 14a: Mothers				$F(3,285) = 1.32$, $p = .267$
NT Group	-1.39 (0.25)	3.26 (0.50)	$W(92) = .89$, $p < .001$	
ASD Group	-1.23 (0.58)	1.11 (1.12)	$W(15) = .86$, $p = .023$	
ADHD Group	-0.94 (0.23)	2.05 (0.46)	$W(107) = .94$, $p < .001$	
ASD+ADHD Group	-0.47 (0.28)	0.14 (0.55)	$W(75) = .97$ $p = .094$	
RQ 14b: Fathers				$F(3,162) = .84$, $p = .475$
NT Group	-1.04 (0.40)	1.91 (0.78)	$W(35) = .92$, $p = .010$	
ASD Group	-0.48 (0.44)	0.04 (0.86)	$W(28) = .96$, $p = .349$	
ADHD Group	0.12 (0.43)	-0.33 (0.83)	$W(30) = .95$, $p = .171$	
ASD+ADHD Group	-1.45 (0.28)	2.66 (0.56)	$W(73) = .86$, $p < .001$	

Exploratory Research Question 14a.

Figure F-14a.1

Exploratory Research Question 14a – Normality Histogram for NT Group

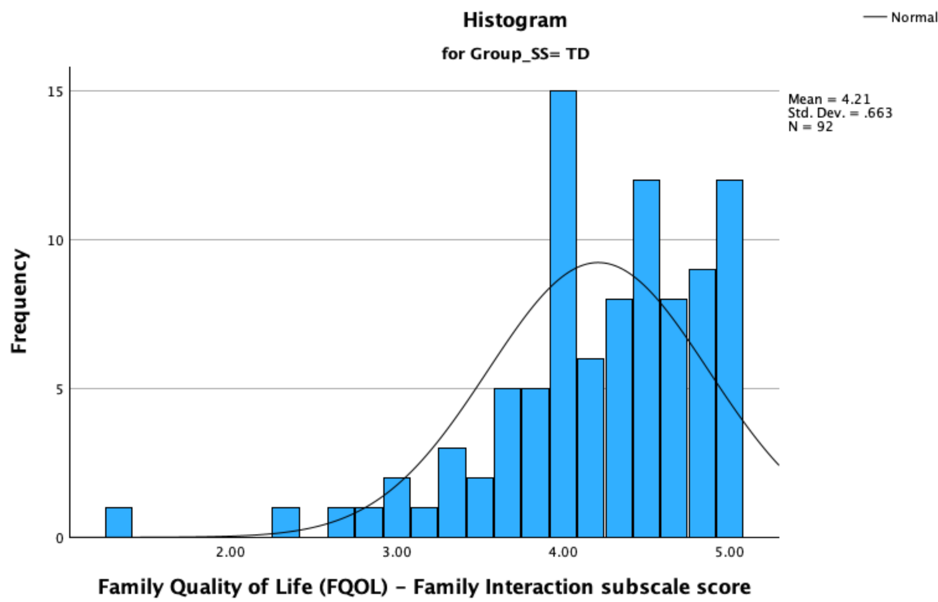


Figure F-14a.2

Exploratory Research Question 14a – Normality Histogram for ASD Group

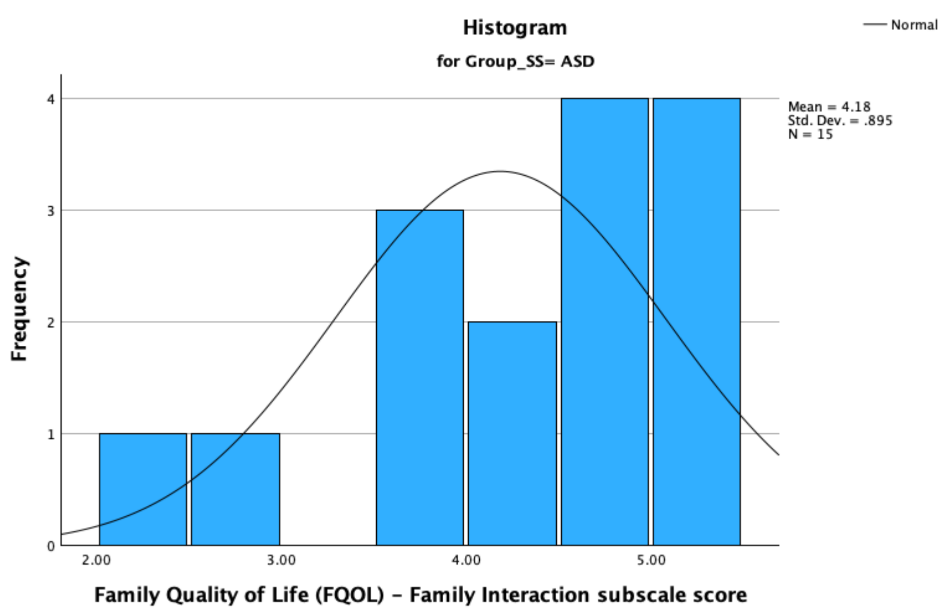


Figure F-14a.3

Exploratory Research Question 14a – Normality Histogram for ADHD Group

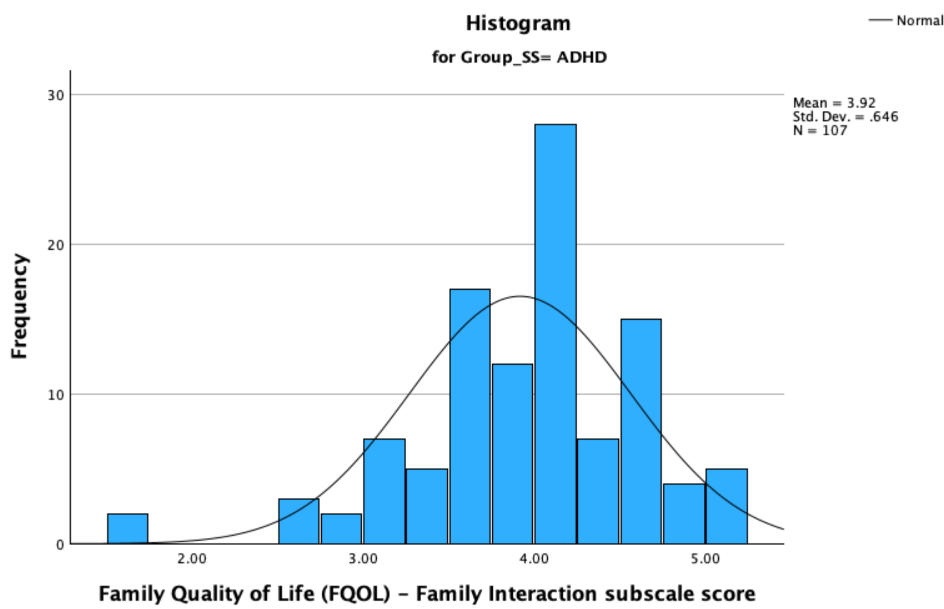


Figure F-14a.4

Exploratory Research Question 14a – Normality Histogram for ASD+ADHD Group

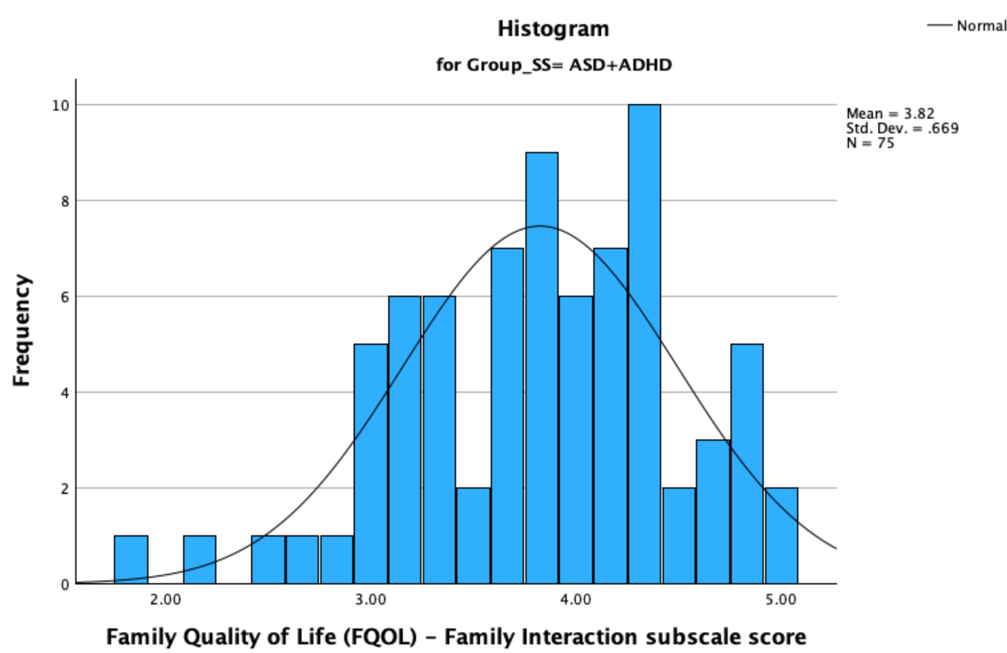


Figure F-14a.5

Exploratory Research Question 14a – Expected Normal Probability Plot for NT Group

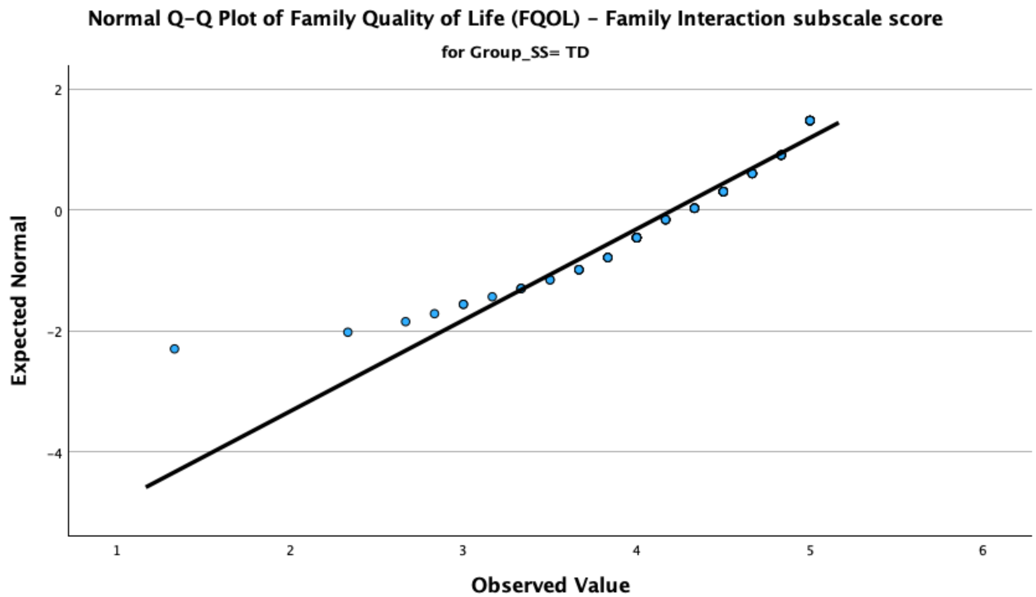


Figure F-14a.6

Exploratory Research Question 14a – Expected Normal Probability Plot for ASD Group

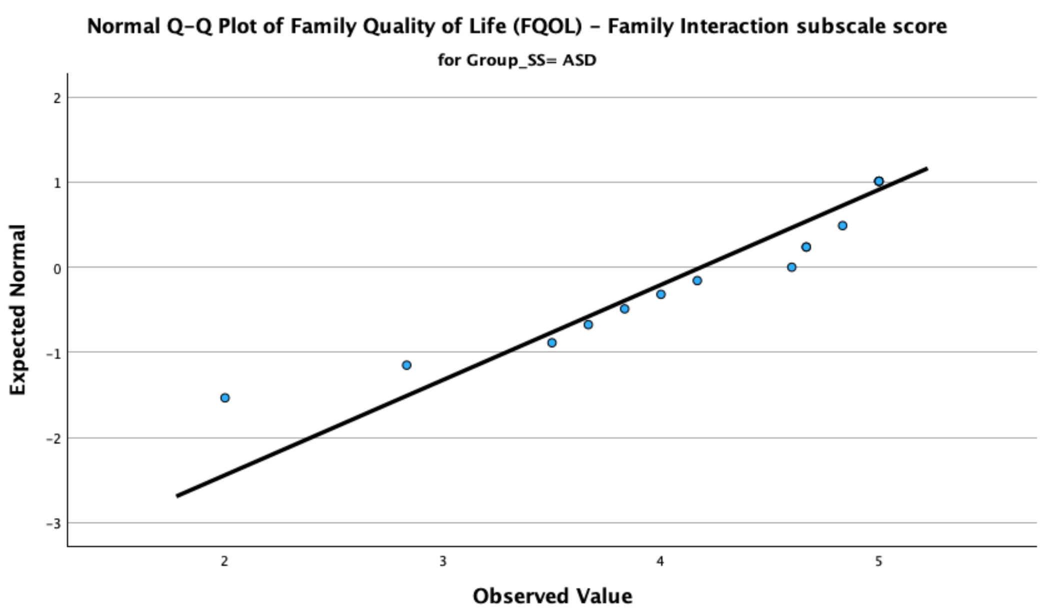


Figure F-14a.7

Exploratory Research Question 14a – Expected Normal Probability Plot for ADHD Group

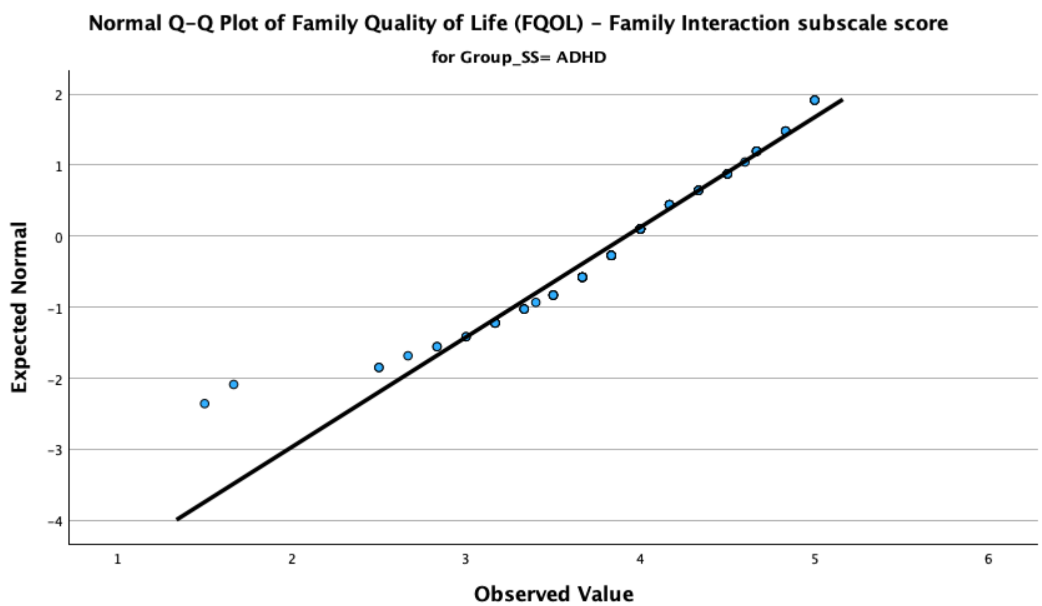
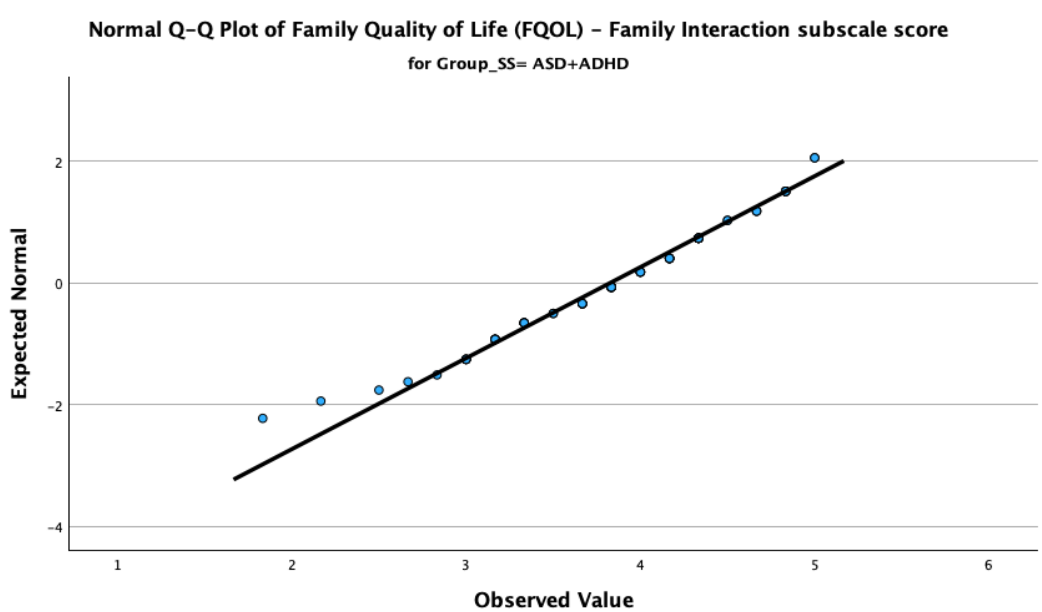


Figure F-14a.8

Exploratory Research Question 14a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 14b.

Figure F-14b.1

Exploratory Research Question 14b – Normality Histogram for NT Group

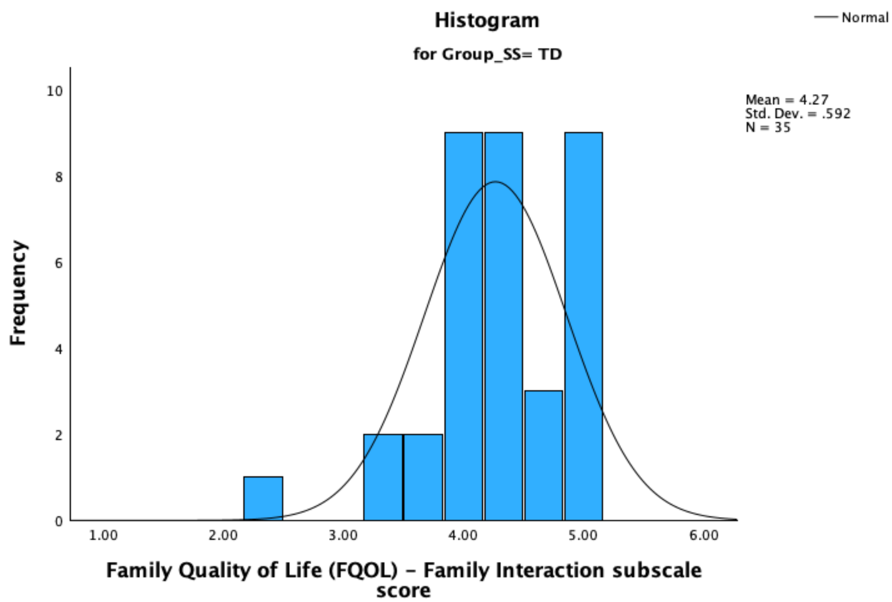


Figure F-14b.2

Exploratory Research Question 14b – Normality Histogram for ASD Group

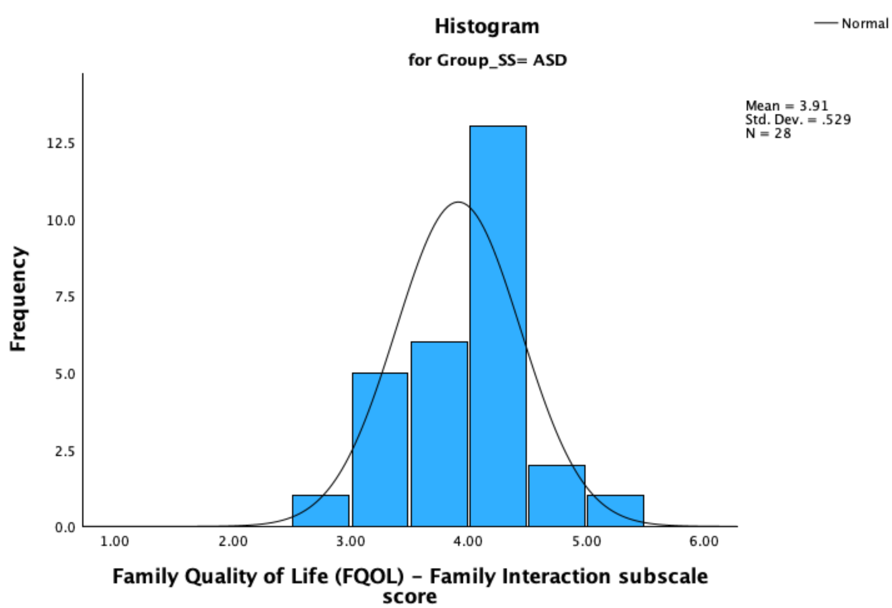


Figure F-14b.3

Exploratory Research Question 14b – Normality Histogram for ADHD Group

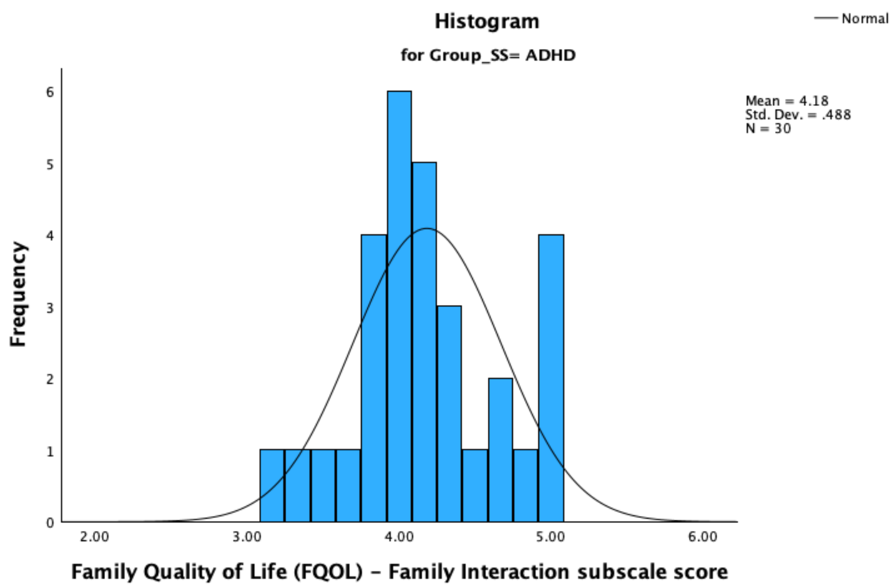


Figure F-14b.4

Exploratory Research Question 14b – Normality Histogram for ASD+ADHD Group

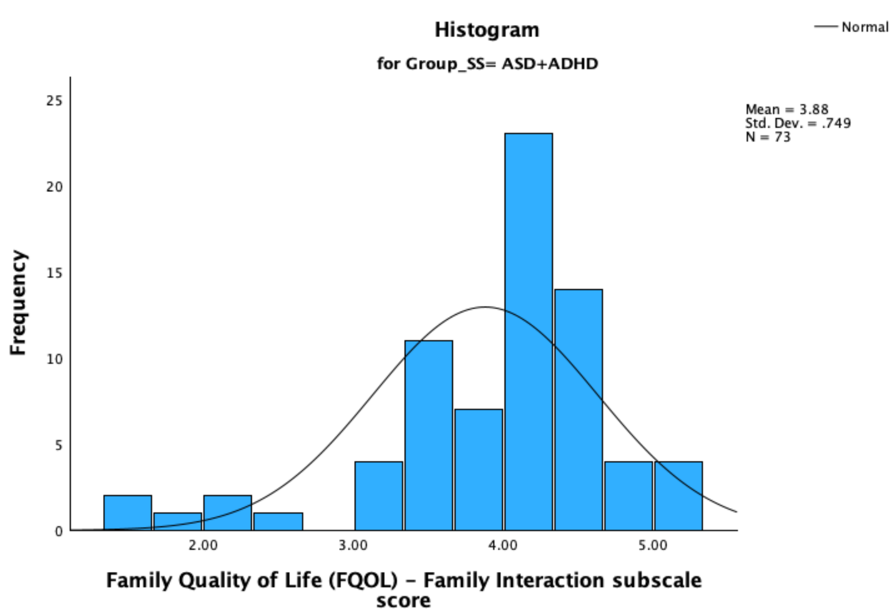


Figure F-14b.5

Exploratory Research Question 14b – Expected Normal Probability Plot for NT Group

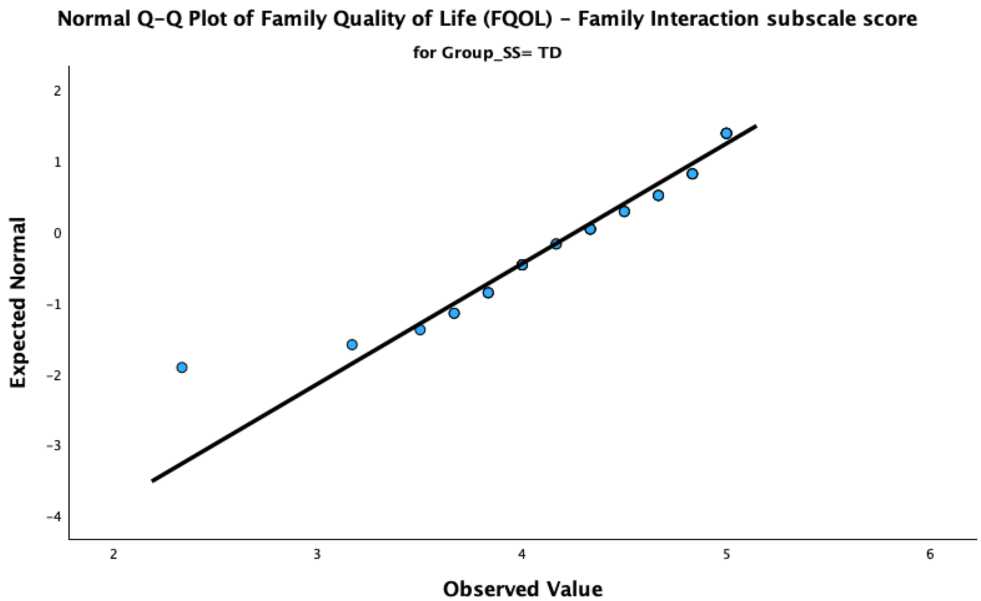


Figure F-14b.6

Exploratory Research Question 14b – Expected Normal Probability Plot for ASD Group

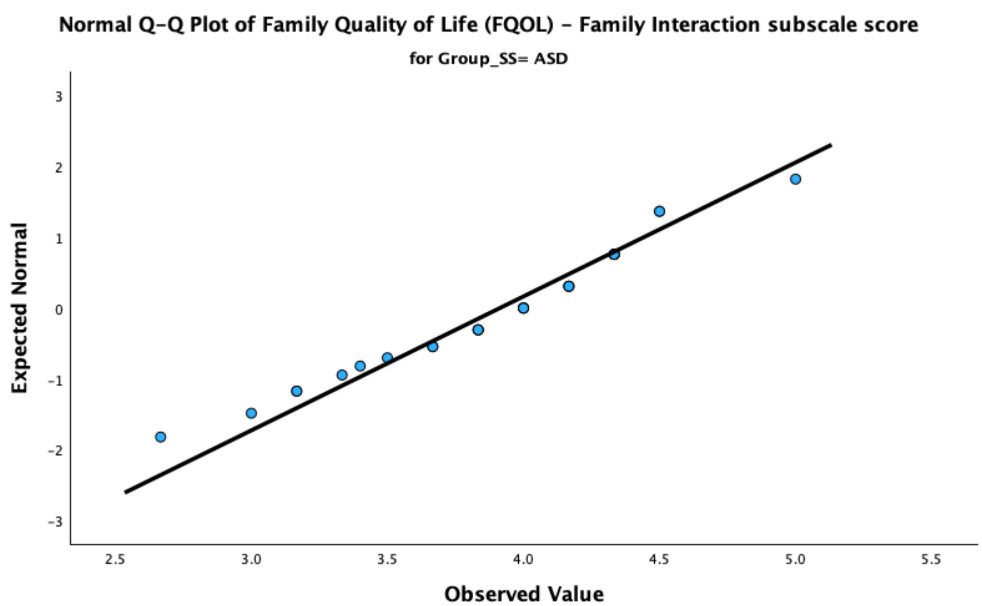


Figure F-14b.7

Exploratory Research Question 14b – Expected Normal Probability Plot for ADHD Group

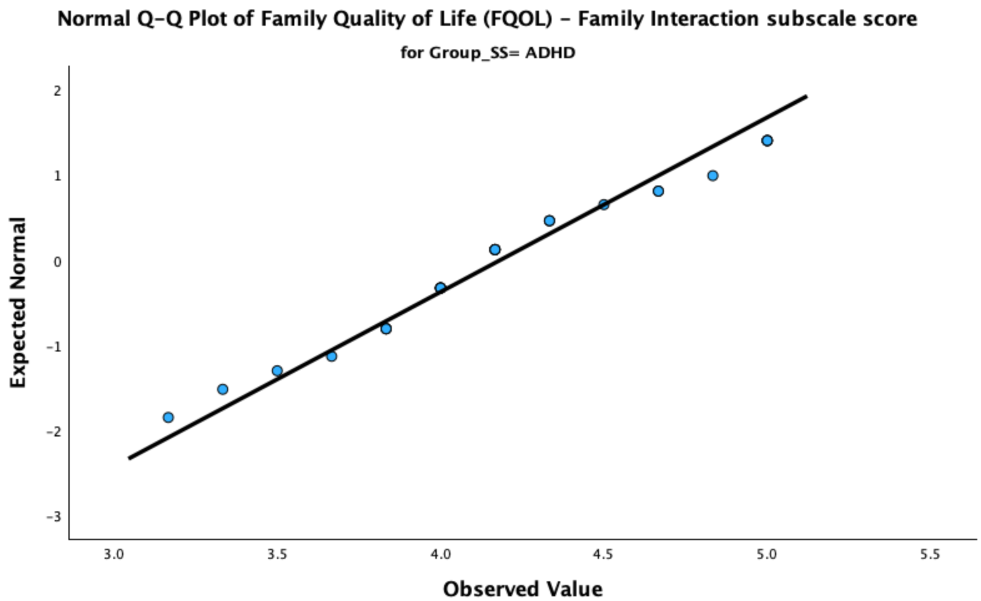
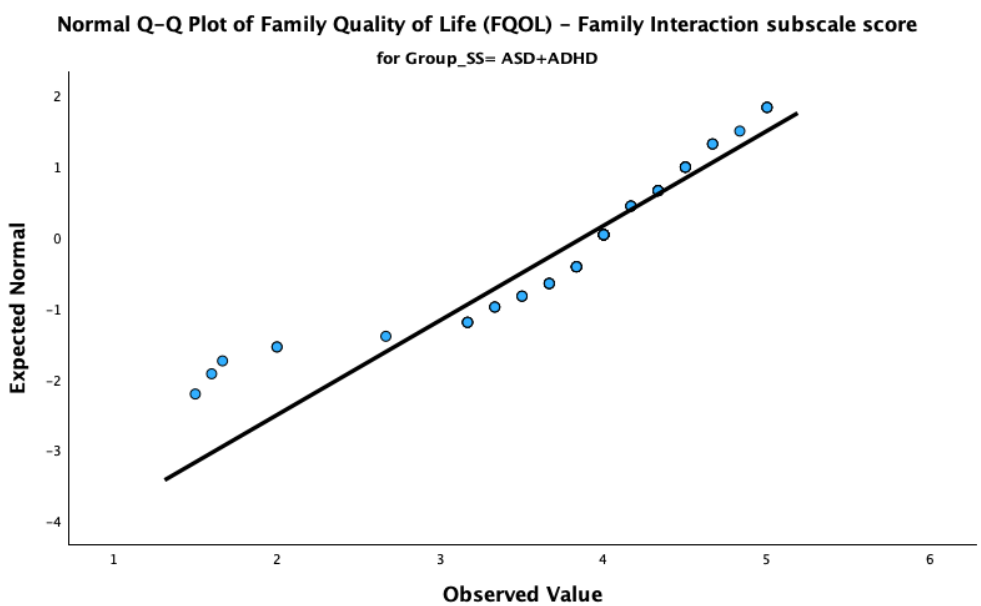


Figure F-14b.8

Exploratory Research Question 14b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 15

Table F-15

Assumption Testing – RQ 15: Parenting Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 15a: Mothers				$F(3,284) = .39$, $p = .764$
NT Group	-1.27 (0.25)	2.19 (0.50)	$W(92) = .89$, $p < .001$	
ASD Group	-0.86 (0.58)	0.85 (1.12)	$W(15) = .93$, $p = .268$	
ADHD Group	-0.51 (0.24)	0.28 (0.47)	$W(106) = .97$ $p = .018$	
ASD+ADHD Group	-0.37 (0.28)	0.16 (0.55)	$W(75) = .98$ $p = .232$	
RQ 15b: Fathers				$F(3,162) = 1.09$, $p = .353$
NT Group	-1.65 (0.40)	5.39 (0.78)	$W(35) = .85$, $p < .001$	
ASD Group	0.08 (0.44)	0.19 (0.86)	$W(28) = .93$, $p = .063$	
ADHD Group	-0.40 (0.43)	1.53 (0.83)	$W(30) = .94$ $p = .071$	
ASD+ADHD Group	-1.56 (0.28)	3.64 (0.56)	$W(73) = .86$, $p < .001$	

Exploratory Research Question 15a.

Figure F-15a.1

Exploratory Research Question 15a – Normality Histogram for NT Group

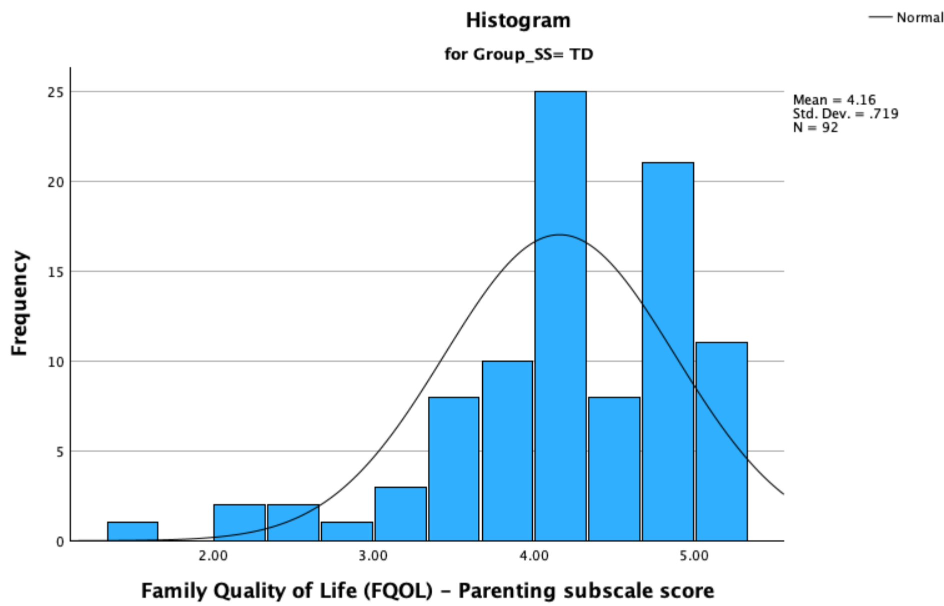


Figure F-15a.2

Exploratory Research Question 15a – Normality Histogram for ASD Group

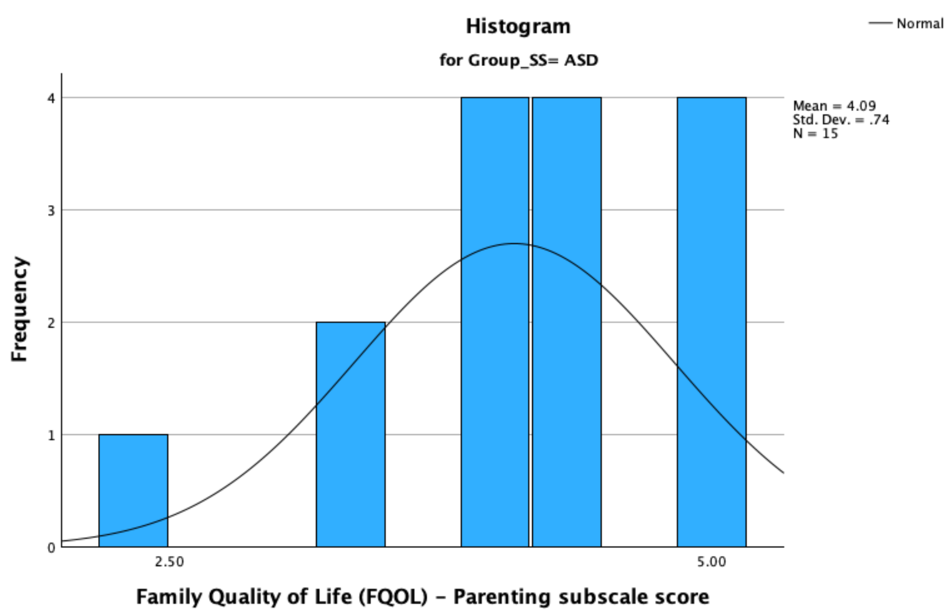


Figure F-15a.3

Exploratory Research Question 15a – Normality Histogram for ADHD Group

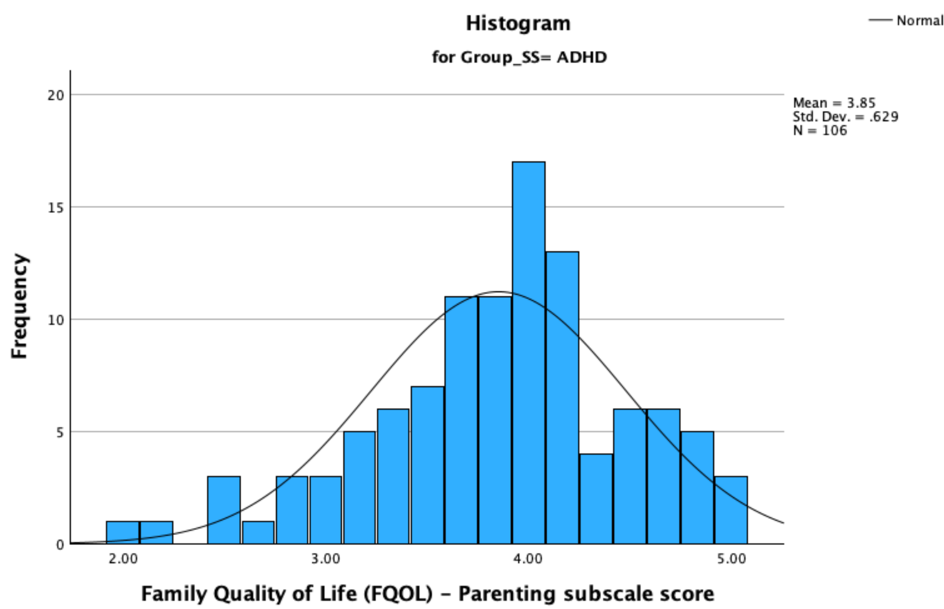


Figure F-15a.4

Exploratory Research Question 15a – Normality Histogram for ASD+ADHD Group

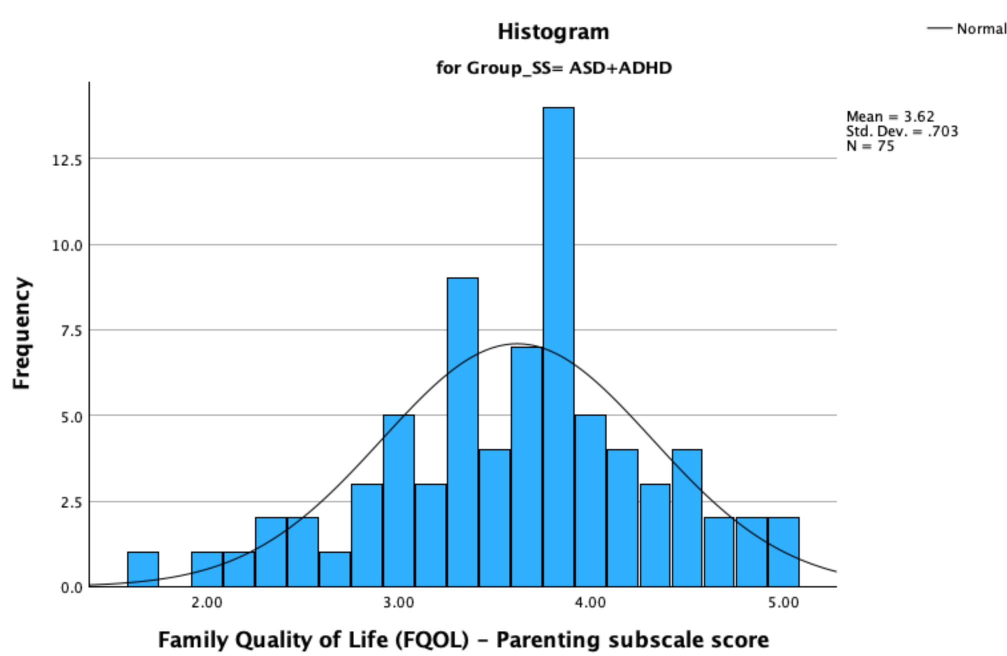


Figure F-15a.5

Exploratory Research Question 15a – Expected Normal Probability Plot for NT Group

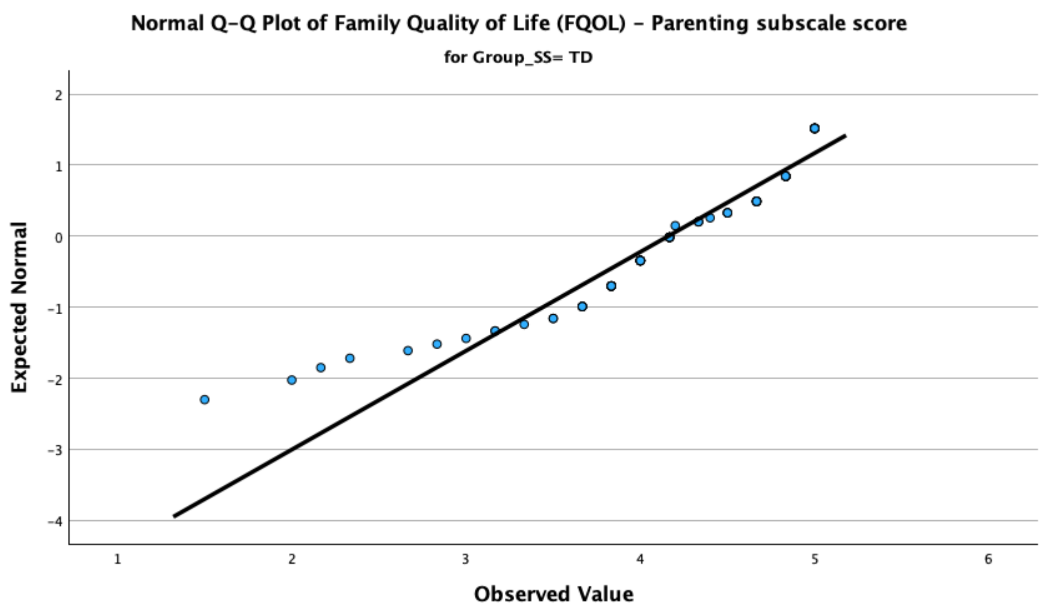


Figure F-15a.6

Exploratory Research Question 15a – Expected Normal Probability Plot for ASD Group

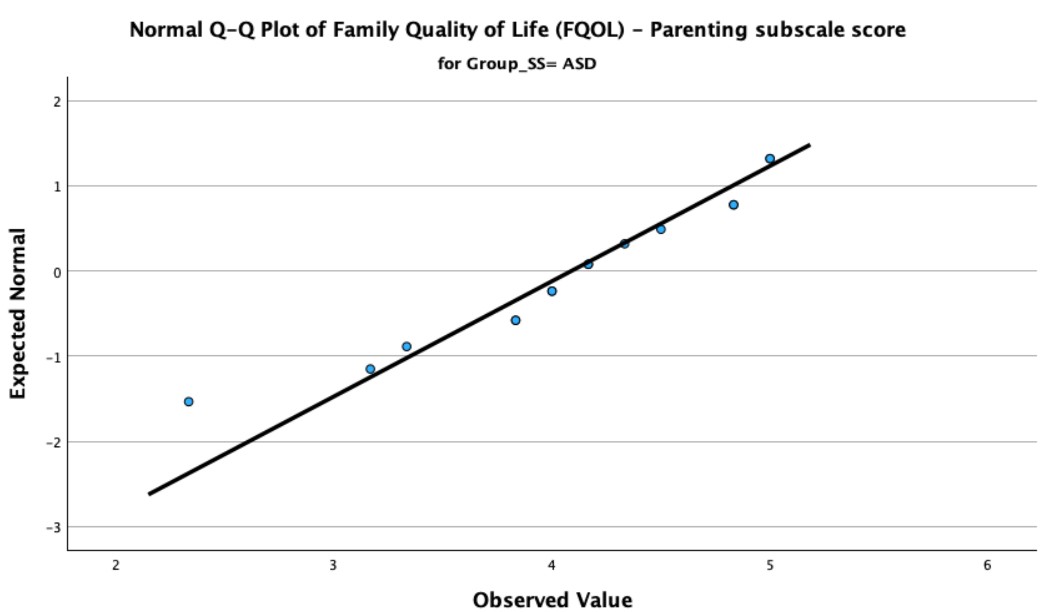


Figure F-15a.7

Exploratory Research Question 15a – Expected Normal Probability Plot for ADHD Group

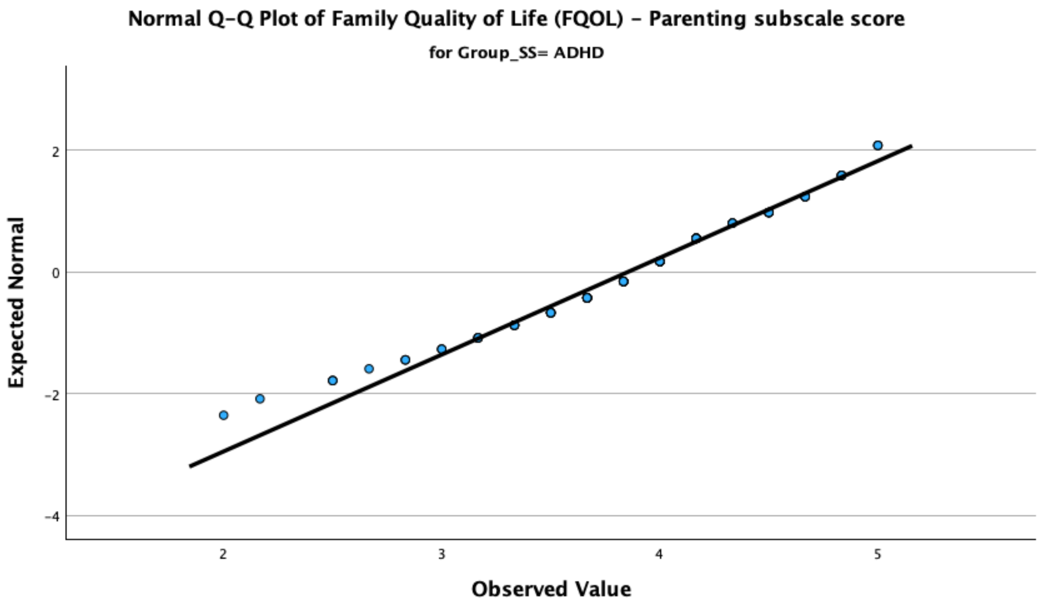
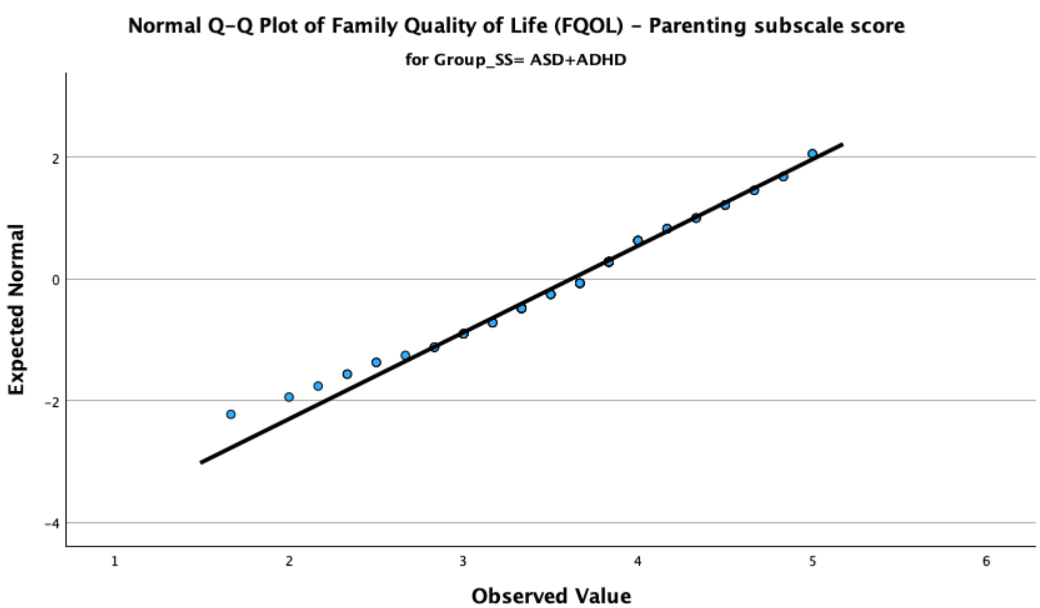


Figure F-15a.8

Exploratory Research Question 15a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 15b.

Figure F-15b.1

Exploratory Research Question 15b – Normality Histogram for NT Group

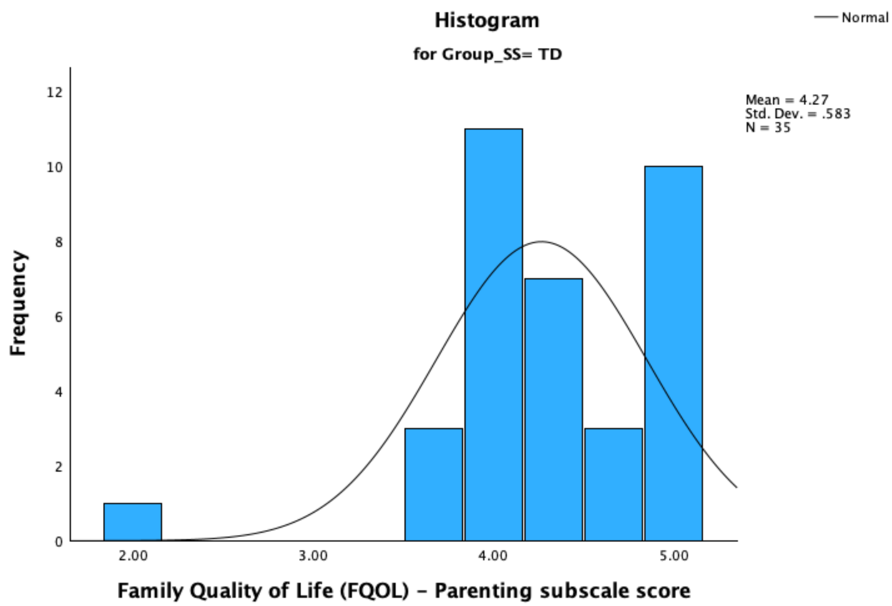


Figure F-15b.2

Exploratory Research Question 15b – Normality Histogram for ASD Group

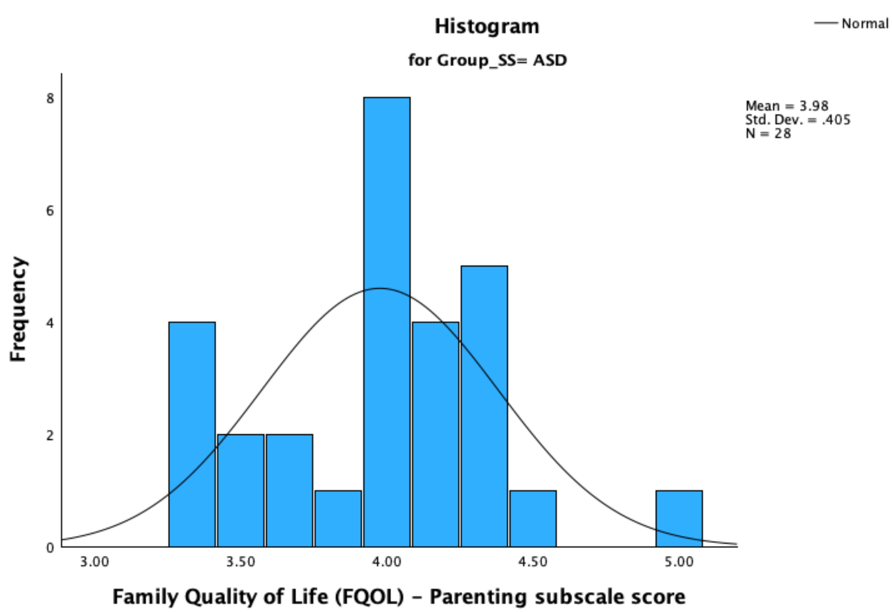


Figure F-15b.3

Exploratory Research Question 15b – Normality Histogram for ADHD Group

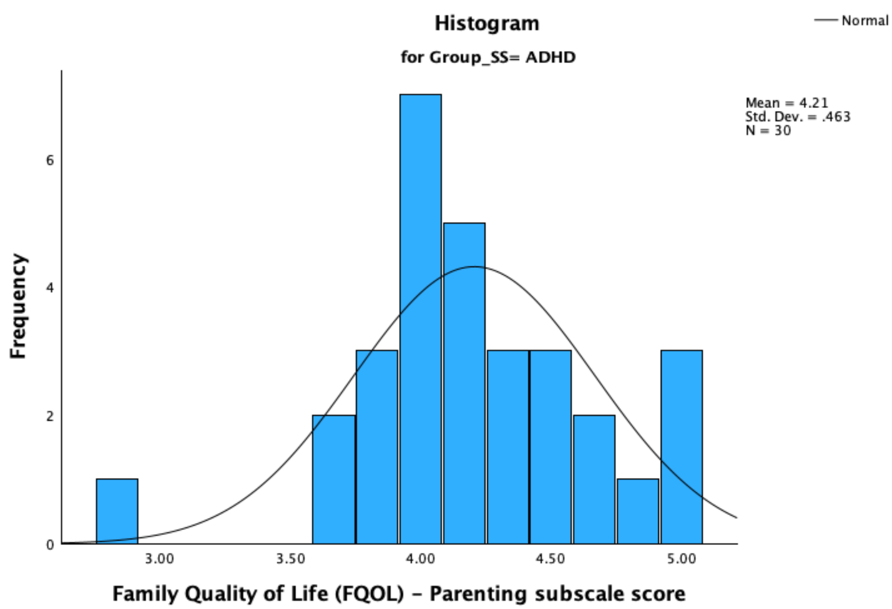


Figure F-15b.4

Exploratory Research Question 15b – Normality Histogram for ASD+ADHD Group

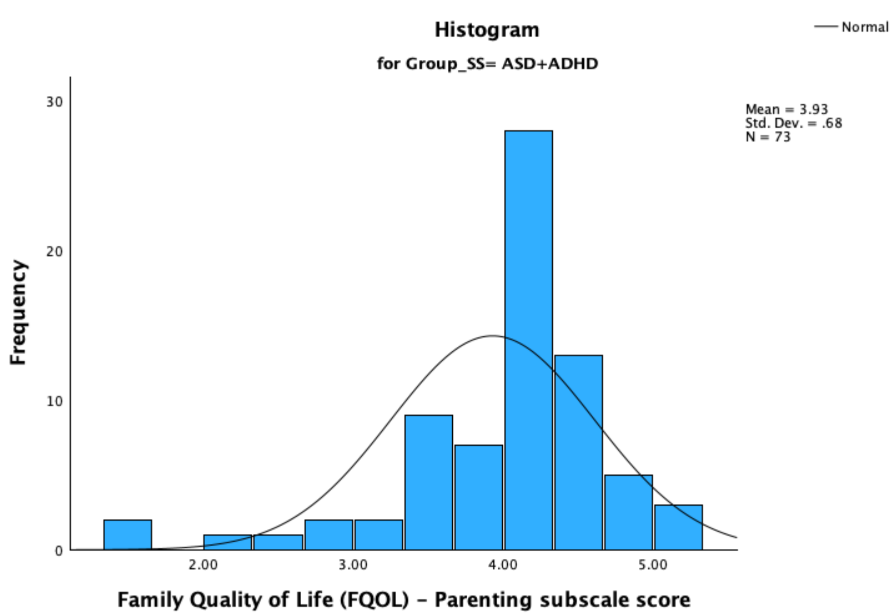


Figure F-15b.5

Exploratory Research Question 15b – Expected Normal Probability Plot for NT Group

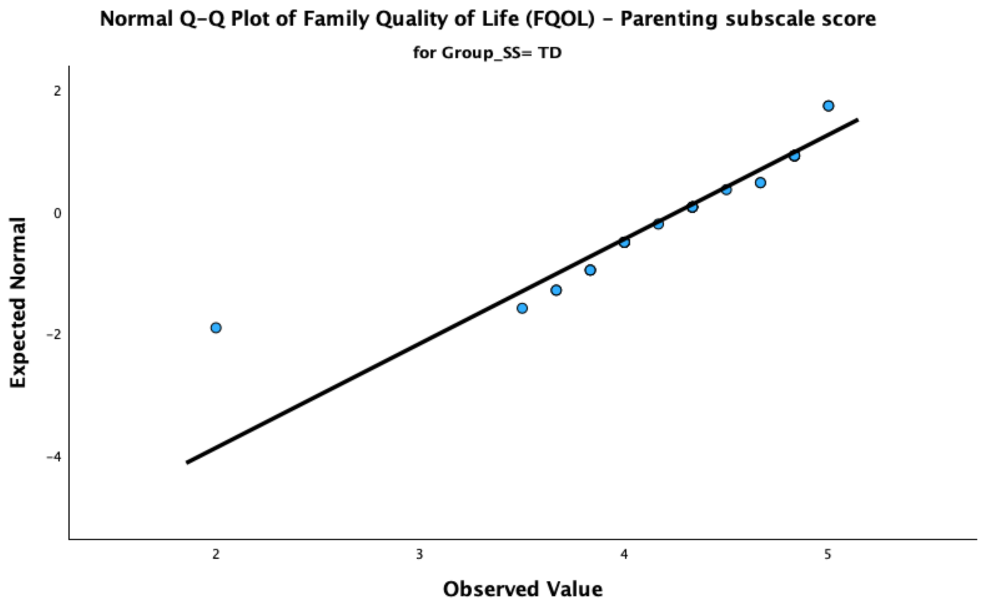


Figure F-15b.6

Exploratory Research Question 15b – Expected Normal Probability Plot for ASD Group

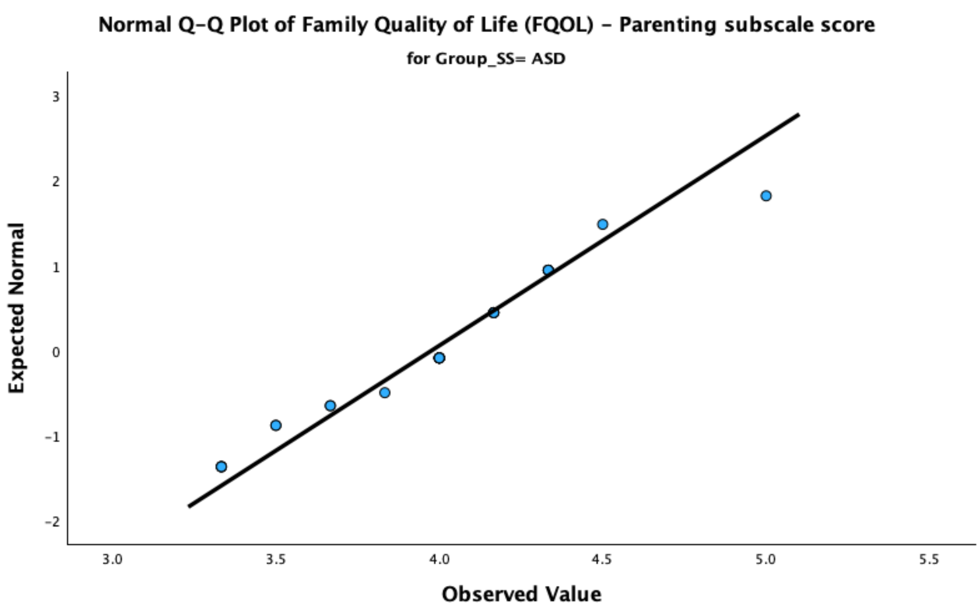


Figure F-15b.7

Exploratory Research Question 15b – Expected Normal Probability Plot for ADHD Group

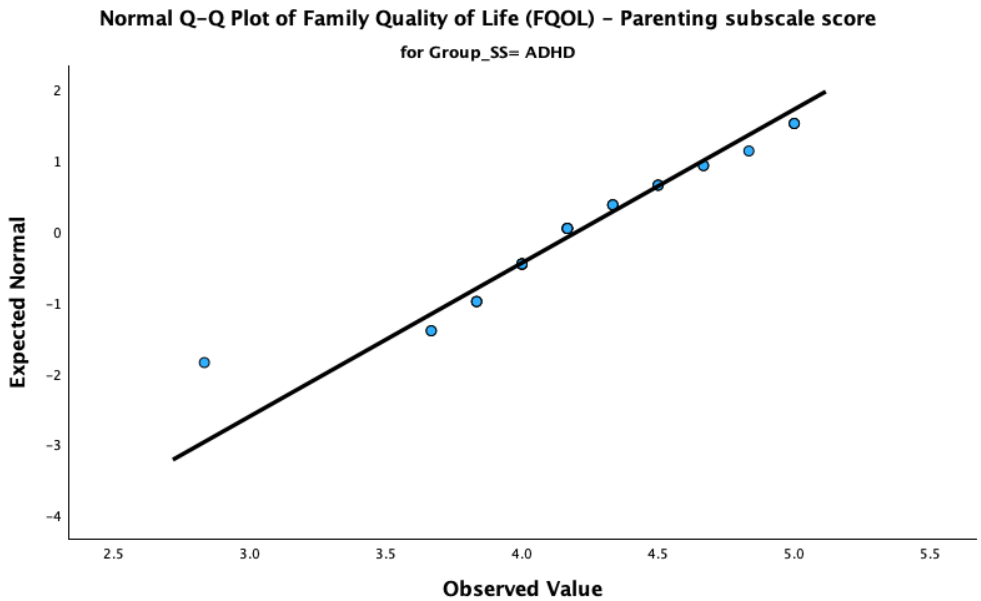
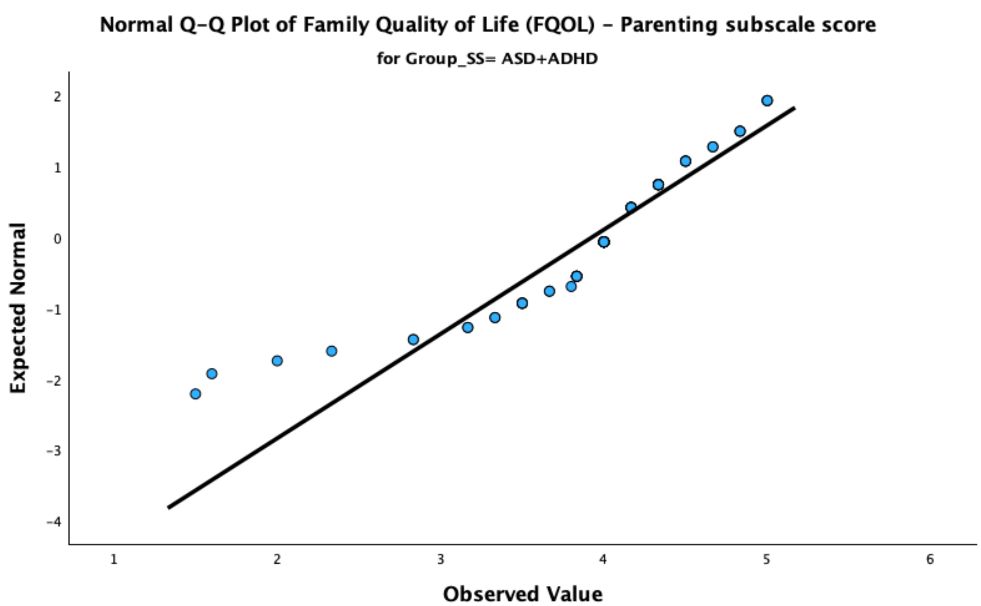


Figure F-15b.8

Exploratory Research Question 15b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 16

Table F-16

Assumption Testing – RQ 16: Emotional Well-Being Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 16a: Mothers				$F(3,285) = .80$, $p = .494$
NT Group	-.97 (0.25)	-0.04 (.50)	$W(92) = .87$, $p < .001$	
ASD Group	-1.12 (0.58)	1.87 (1.12)	$W(15) = .89$, $p = .064$	
ADHD Group	-0.19 (0.23)	-0.70 (0.46)	$W(107) = .97$ $p = .021$	
ASD+ADHD Group	-0.01 (.28)	-0.87 (0.55)	$W(75) = .97$ $p = .100$	
RQ 16b: Fathers				$F(3,162) = .12$, $p = .950$
NT Group	-0.97 (0.40)	1.91 (0.78)	$W(35) = .93$, $p = .028$	
ASD Group	0.23 (0.44)	-0.85 (0.86)	$W(28) = .95$, $p = .186$	
ADHD Group	0.23 (0.43)	-0.26 (0.83)	$W(30) = .97$ $p = .523$	
ASD+ADHD Group	-0.63 (0.28)	0.56 (0.56)	$W(73) = .94$, $p = .003$	

Exploratory Research Question 16a.

Figure F-16a.1

Exploratory Research Question 16a – Normality Histogram for NT Group

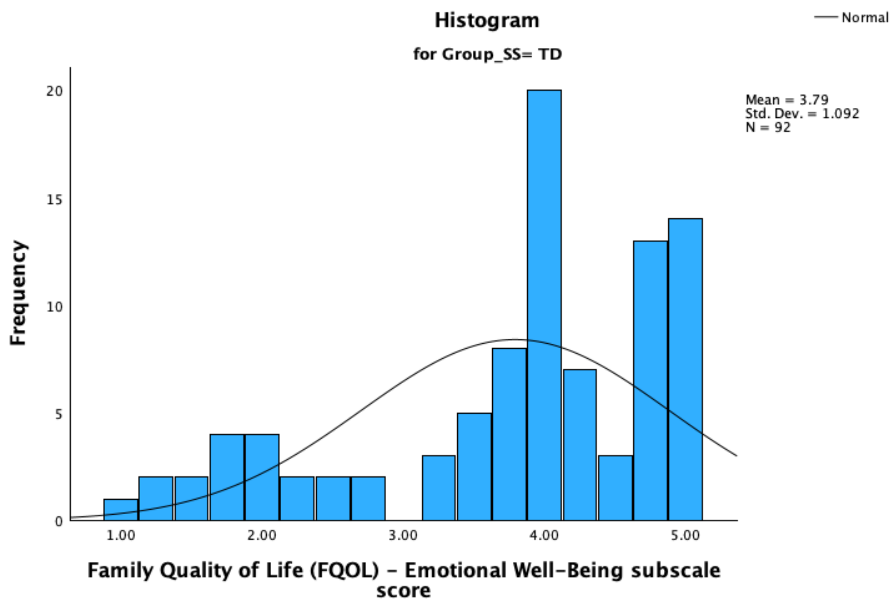


Figure F-16a.2

Exploratory Research Question 16a – Normality Histogram for ASD Group

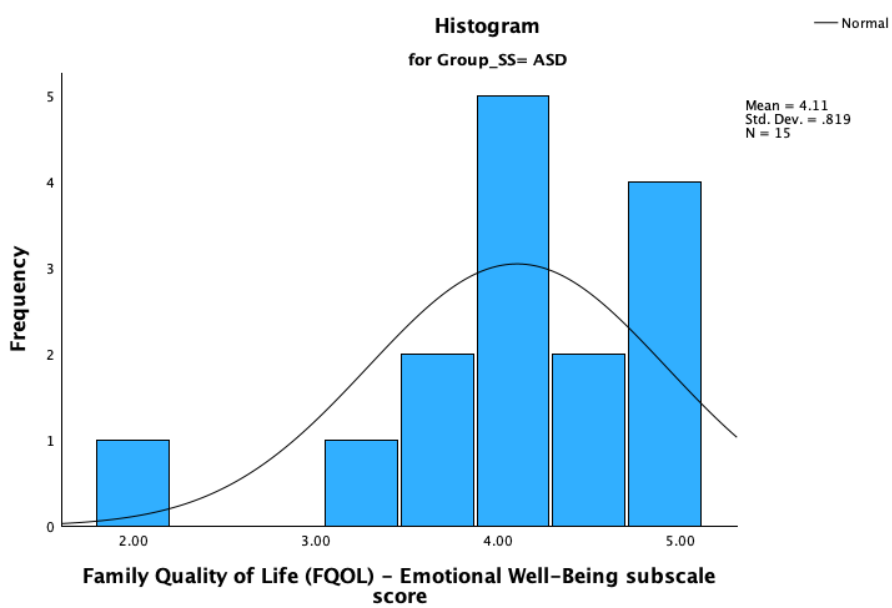


Figure F-16a.3

Exploratory Research Question 16a – Normality Histogram for ADHD Group

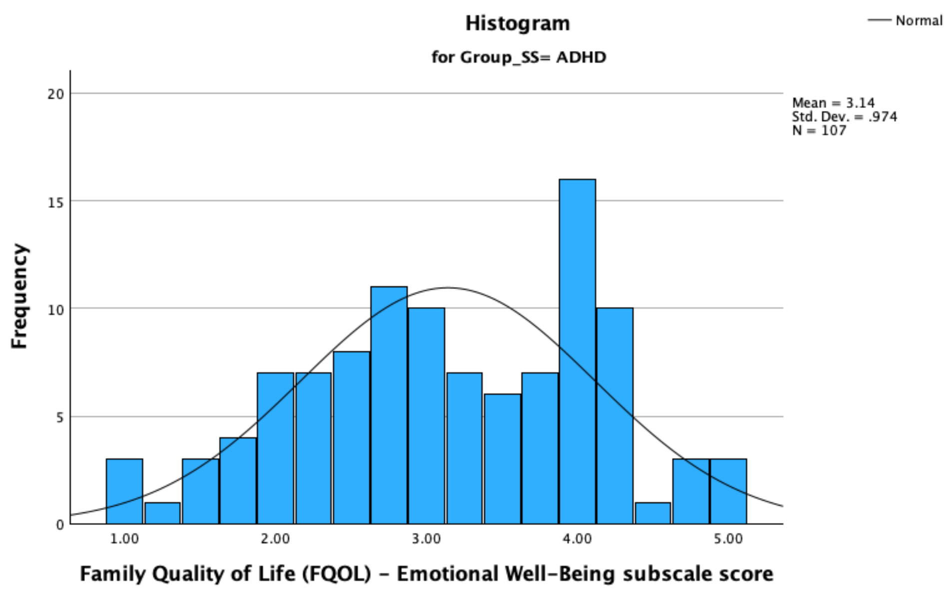


Figure F-16a.4

Exploratory Research Question 16a – Normality Histogram for ASD+ADHD Group

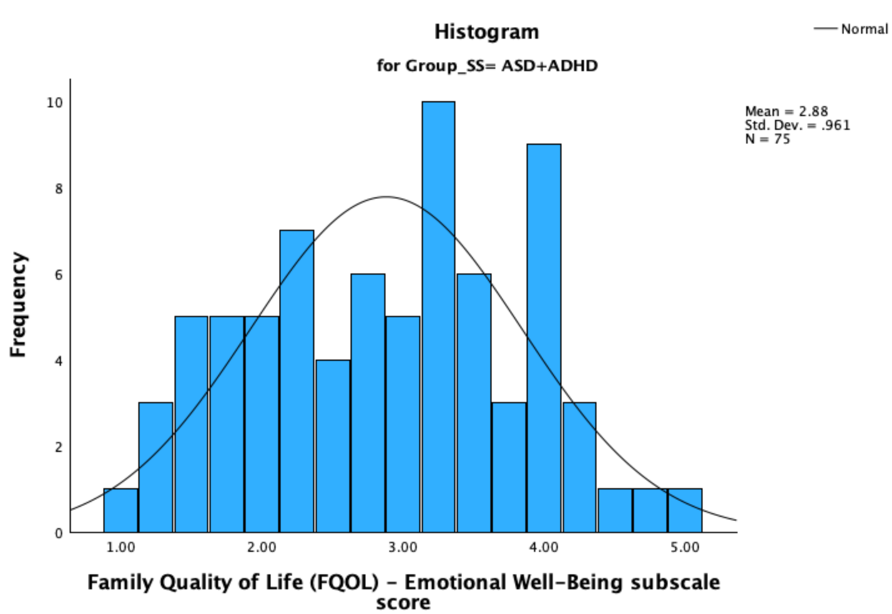


Figure F-16a.5

Exploratory Research Question 16a – Expected Normal Probability Plot for NT Group

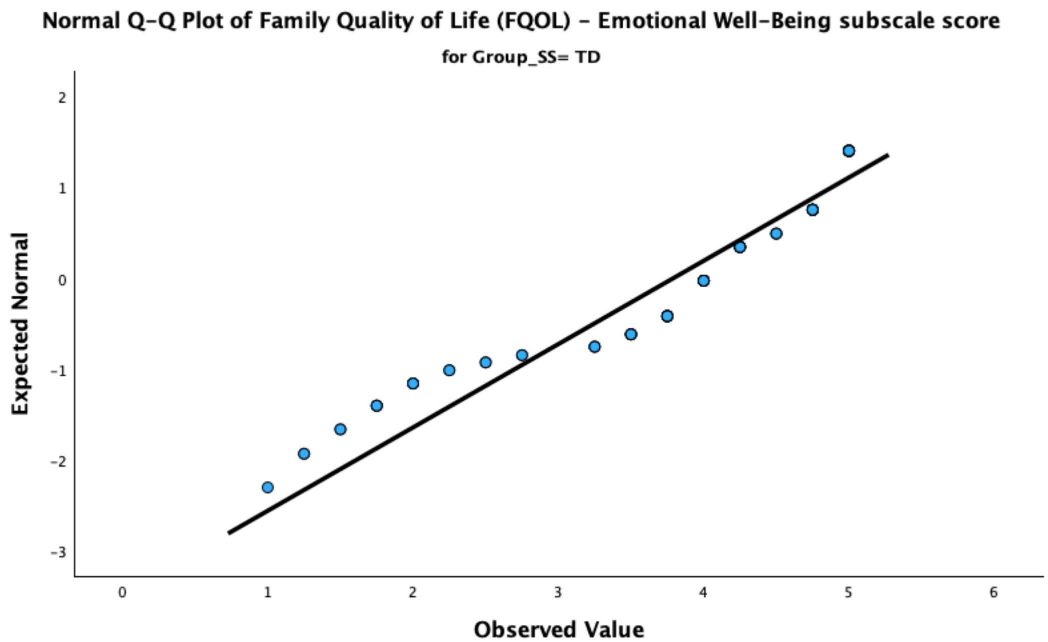


Figure F-16a.6

Exploratory Research Question 16a – Expected Normal Probability Plot for ASD Group

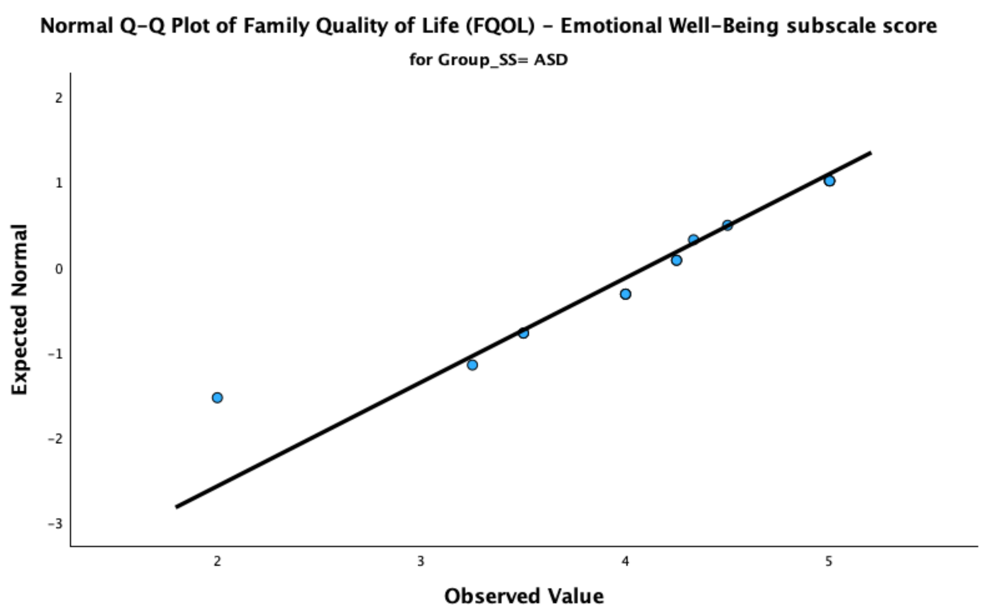


Figure F-16a.7

Exploratory Research Question 16a – Expected Normal Probability Plot for ADHD Group

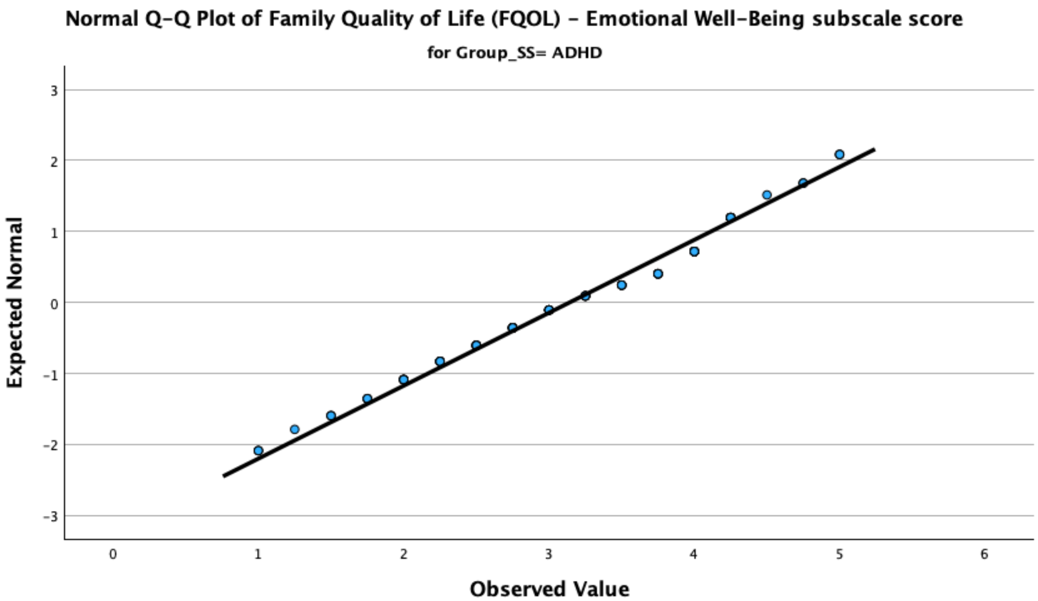
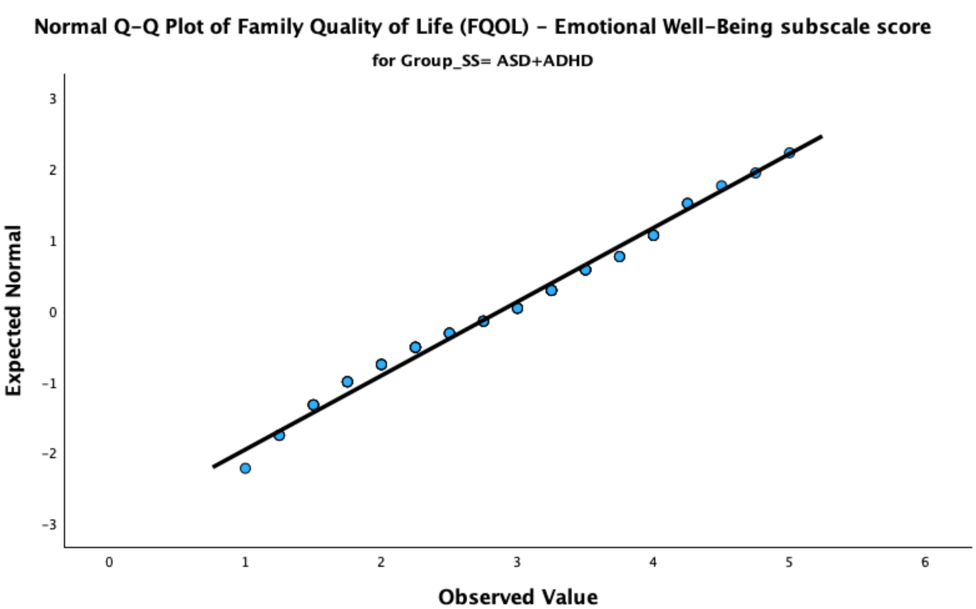


Figure F-16a.8

Exploratory Research Question 16a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 16b.

Figure F-16b.1

Exploratory Research Question 16b – Normality Histogram for NT Group

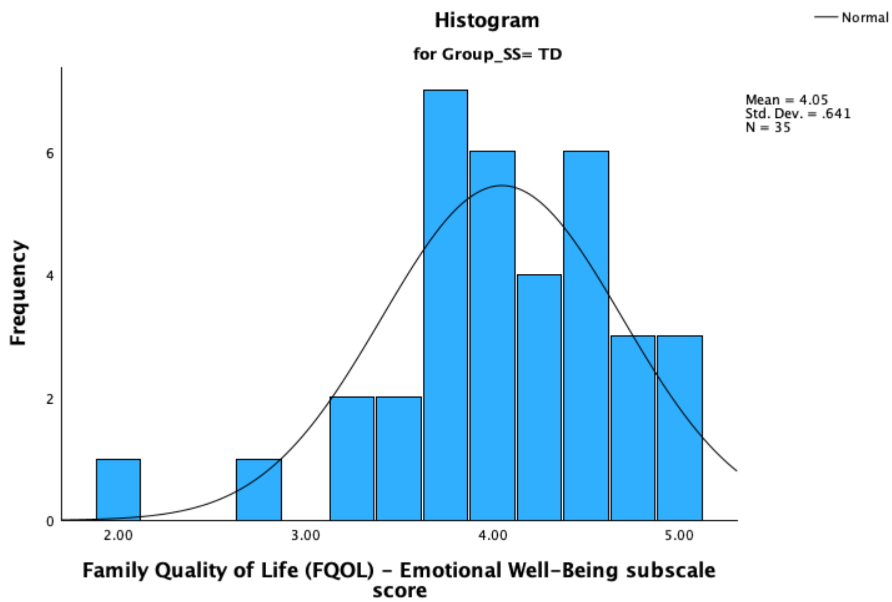


Figure F-16b.2

Exploratory Research Question 16b – Normality Histogram for ASD Group

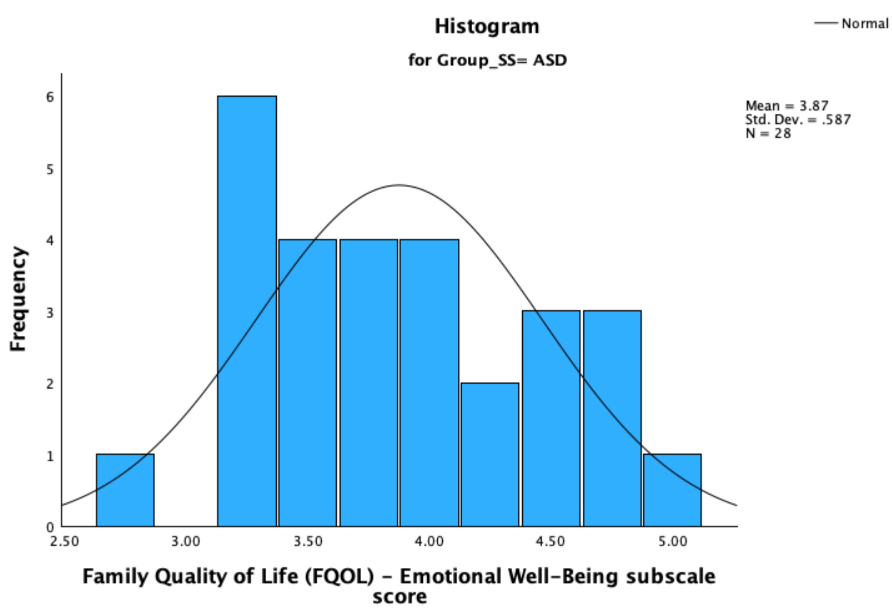


Figure F-16b.3

Exploratory Research Question 16b – Normality Histogram for ADHD Group

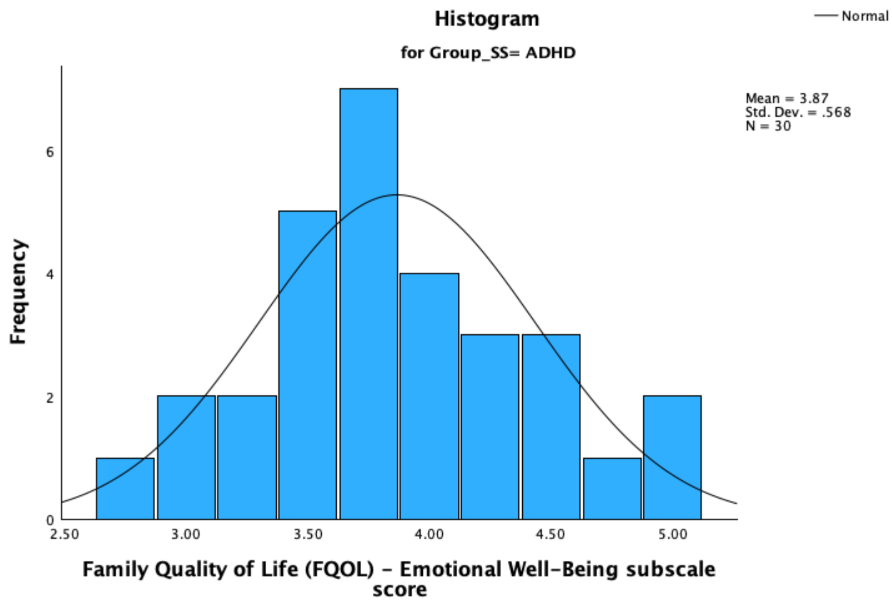


Figure F-16b.4

Exploratory Research Question 16b – Normality Histogram for ASD+ADHD Group

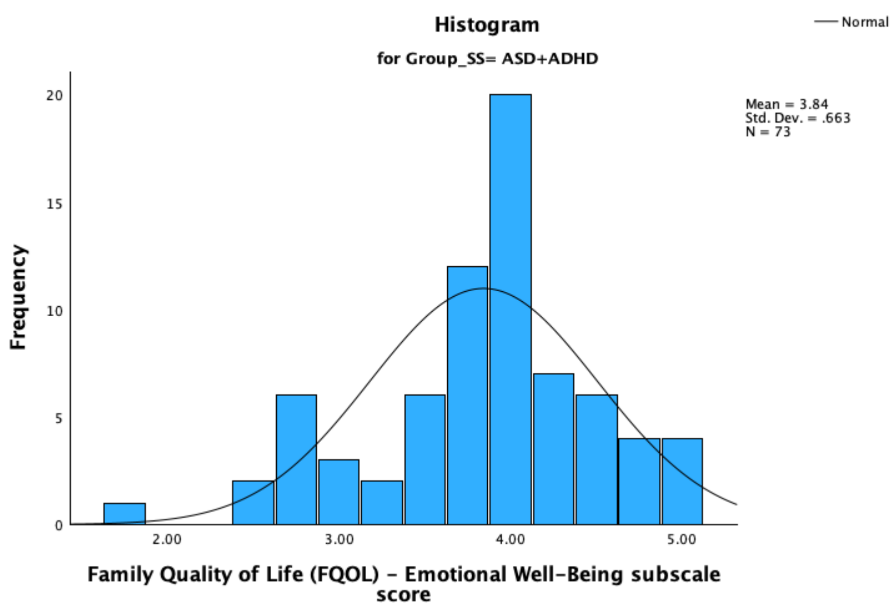


Figure F-16b.5

Exploratory Research Question 16b – Expected Normal Probability Plot for NT Group

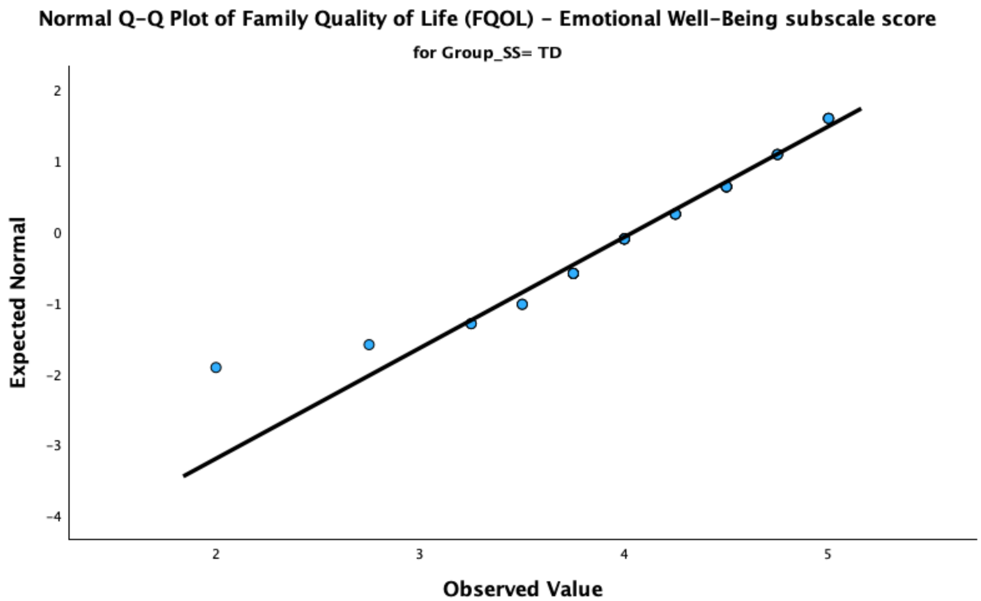


Figure F-16b.6

Exploratory Research Question 16b – Expected Normal Probability Plot for ASD Group

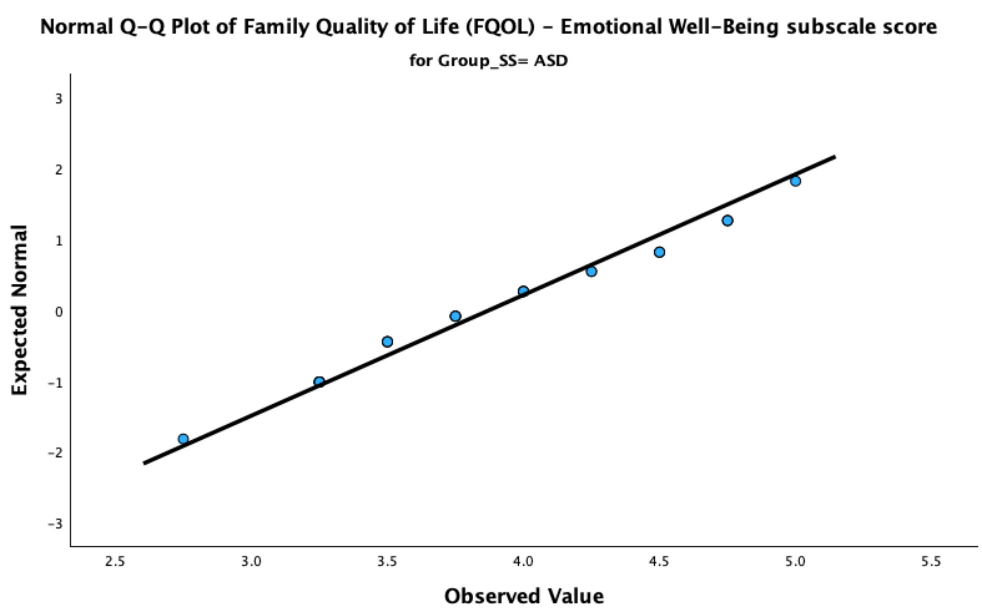


Figure F-16b.7

Exploratory Research Question 16b – Expected Normal Probability Plot for ADHD Group

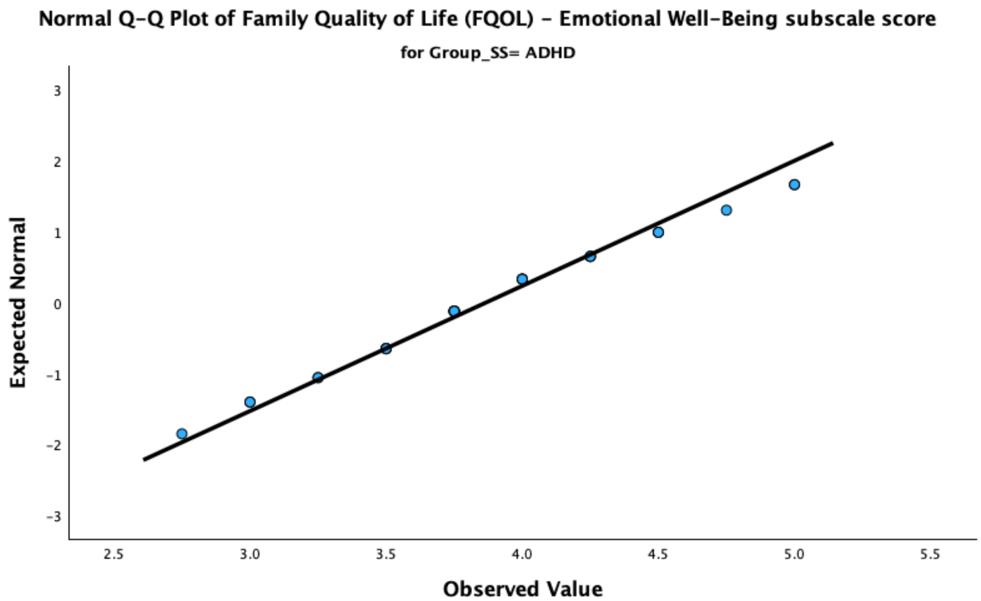
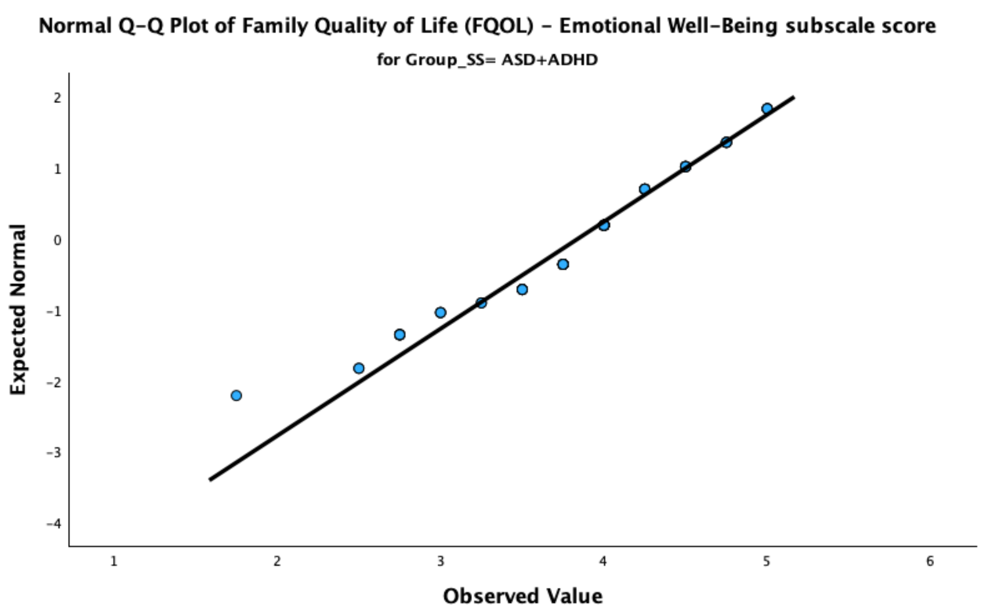


Figure F-16b.8

Exploratory Research Question 16b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 17

Table F-17

Assumption Testing – RQ 17: Physical/Material Well-Being Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 17a: Mothers				$F(3,283) = 4.32$, $p = .005$
NT Group	-1.05 (0.25)	1.08 (0.50)	$W(91) = .88$, $p < .001$	
ASD Group	-1.27 (0.58)	2.67 (1.12)	$W(15) = .84$, $p = .011$	
ADHD Group	-0.67 (0.15)	0.15 (0.47)	$W(106) = .94$, $p < .001$	
ASD+ADHD Group	-0.69 (0.28)	-0.08 (0.55)	$W(75) = .94$, $p < .001$	
RQ 17b: Fathers				$F(3,162) = .95$, $p = .420$
NT Group	-0.65 (0.40)	-0.05 (0.78)	$W(35) = .91$, $p = .007$	
ASD Group	0.11 (0.44)	0.34 (0.86)	$W(28) = .96$, $p = .358$	
ADHD Group	-0.18 (0.43)	-0.16 (0.83)	$W(30) = .95$ $p = .214$	
ASD+ADHD Group	-0.96 (0.28)	1.82 (0.56)	$W(73) = .92$, $p < .001$	

Exploratory Research Question 17a.

Figure F-17a.1

Exploratory Research Question 17a – Normality Histogram for NT Group

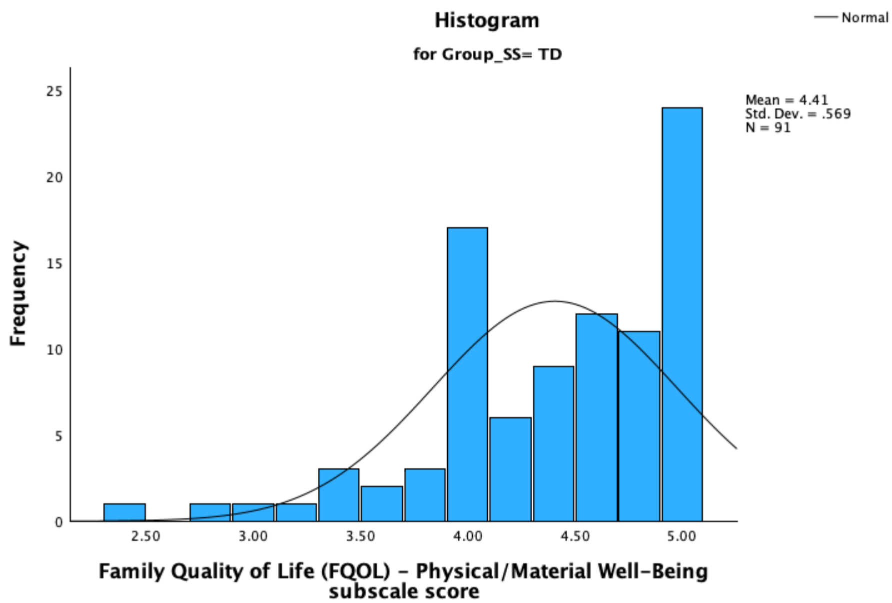


Figure F-17a.2

Exploratory Research Question 17a – Normality Histogram for ASD Group

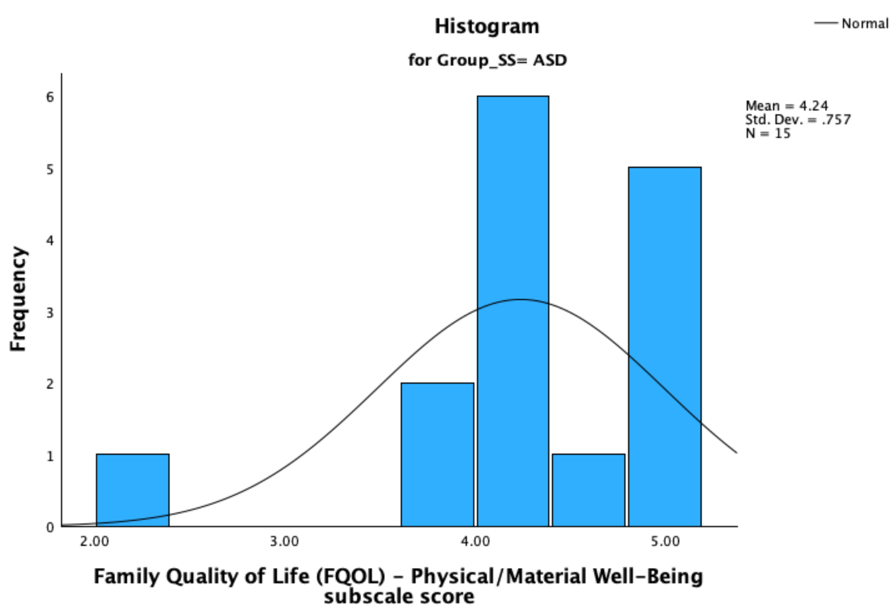


Figure F-17a.3

Exploratory Research Question 17a – Normality Histogram for ADHD Group

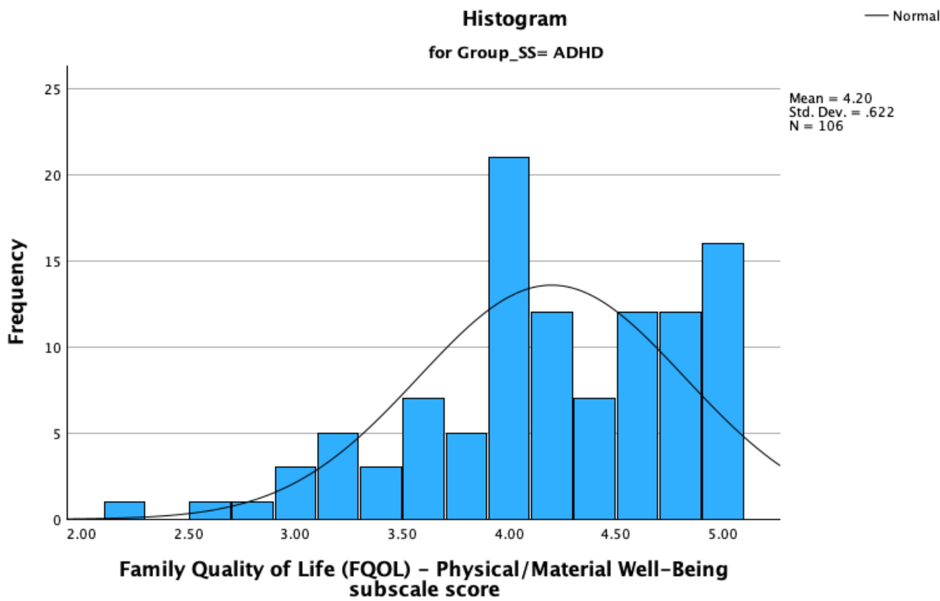


Figure F-17a.4

Exploratory Research Question 17a – Normality Histogram for ASD+ADHD Group

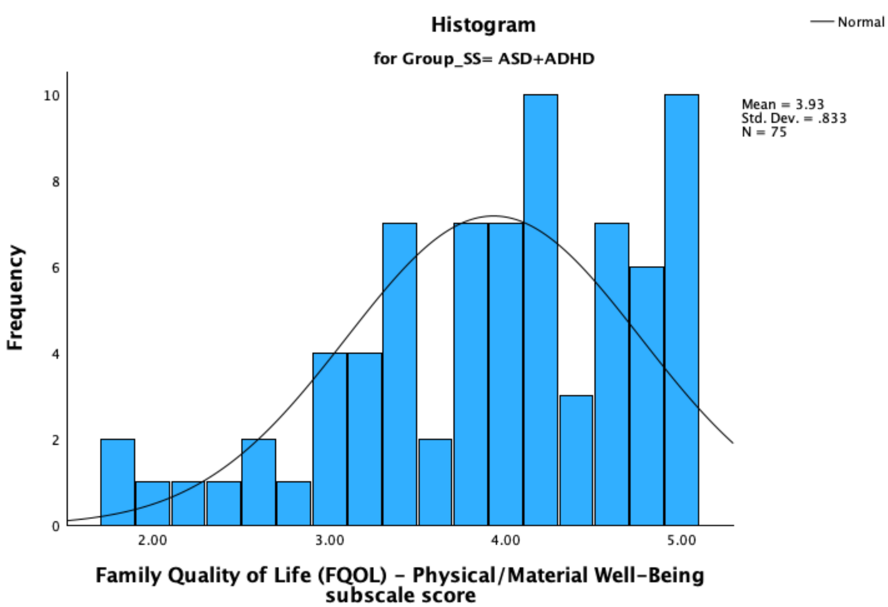


Figure F-17a.5

Exploratory Research Question 17a – Expected Normal Probability Plot for NT Group

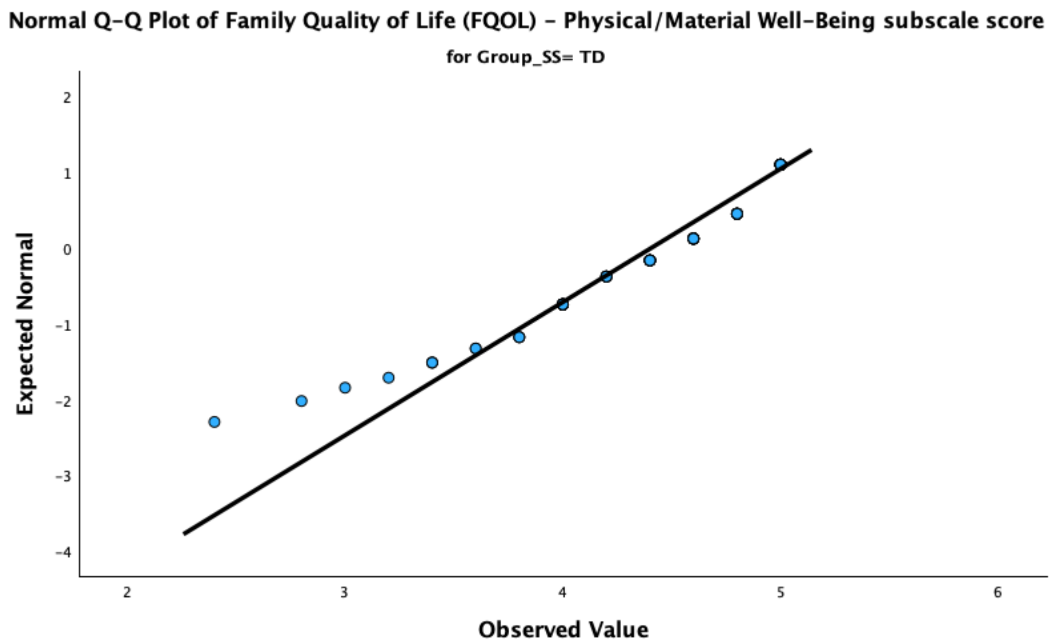


Figure F-17a.6

Exploratory Research Question 17a – Expected Normal Probability Plot for ASD Group

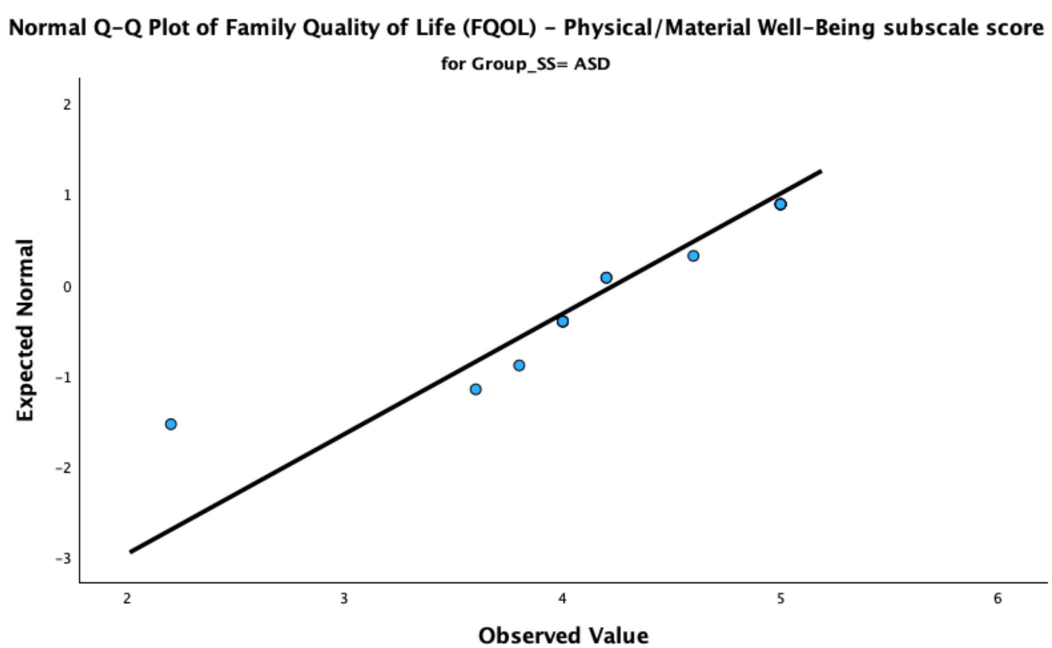


Figure F-17a.7

Exploratory Research Question 17a – Expected Normal Probability Plot for ADHD Group

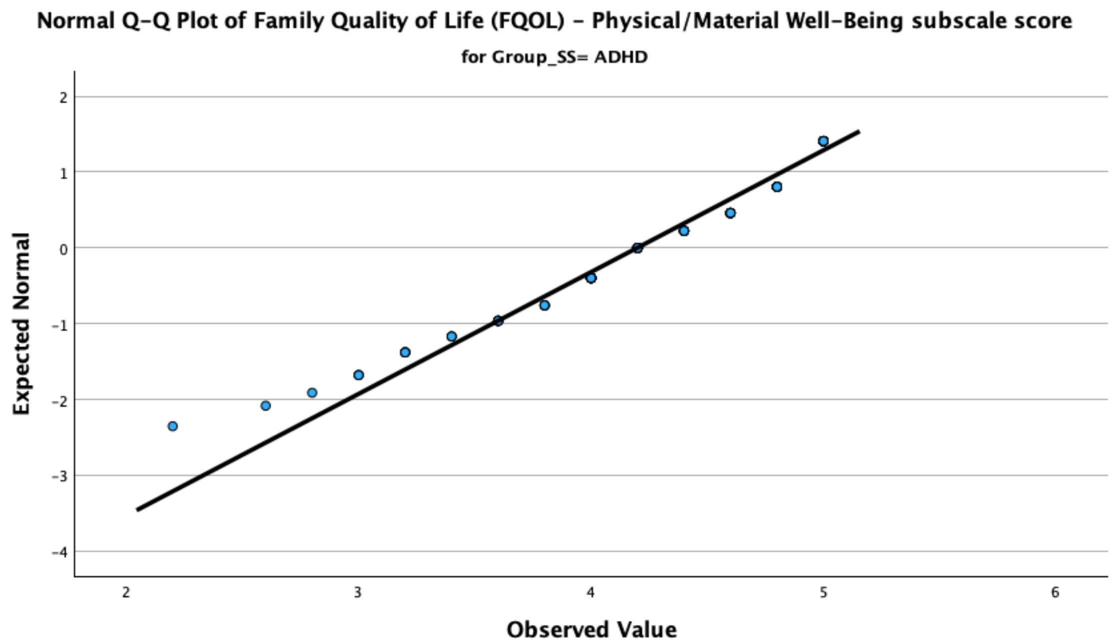
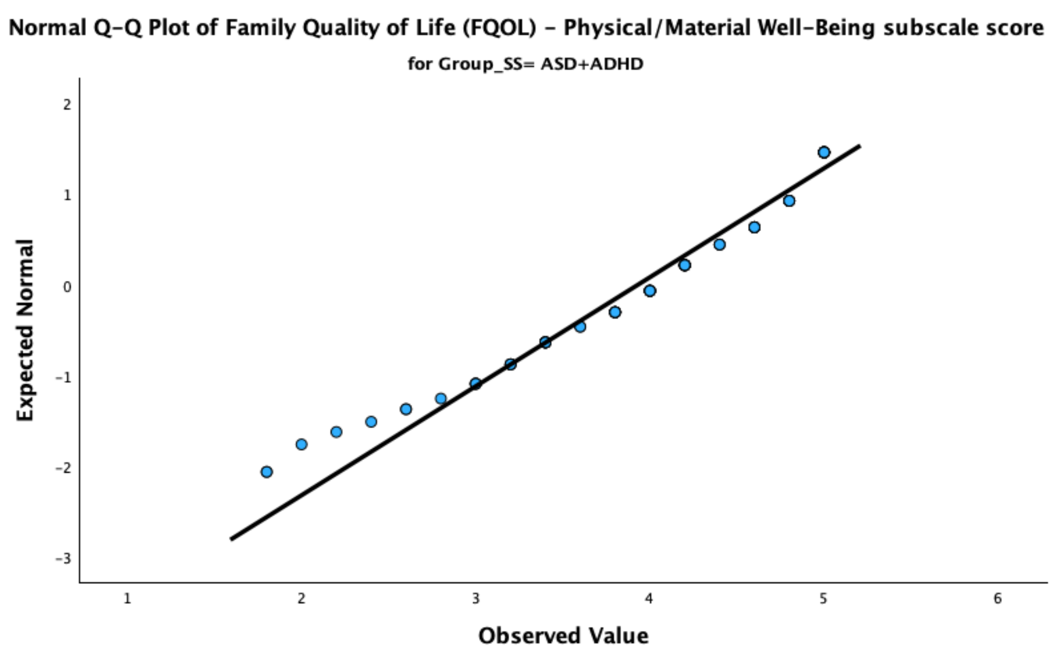


Figure F-17a.8

Exploratory Research Question 17a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 17b.

Figure F-17b.1

Exploratory Research Question 17b – Normality Histogram for NT Group

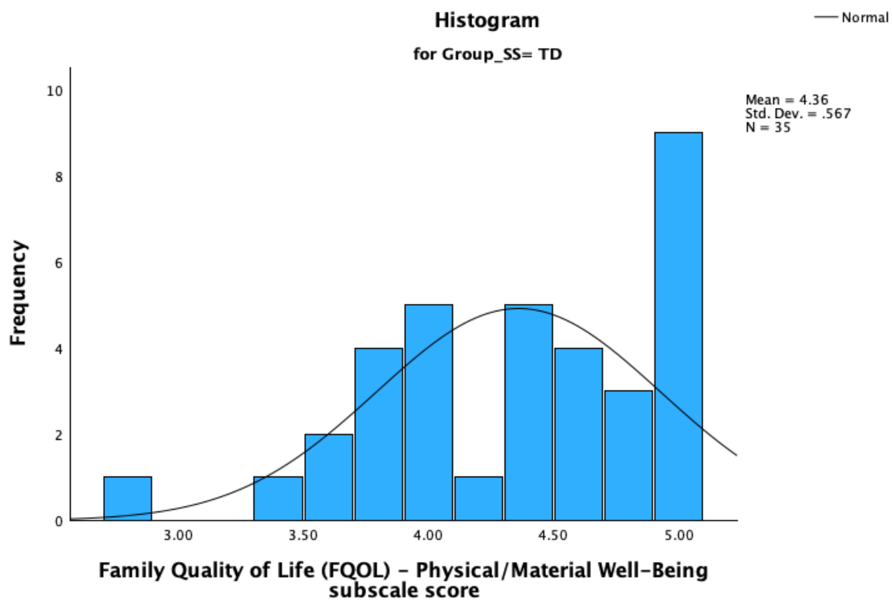


Figure F-17b.2

Exploratory Research Question 17b – Normality Histogram for ASD Group

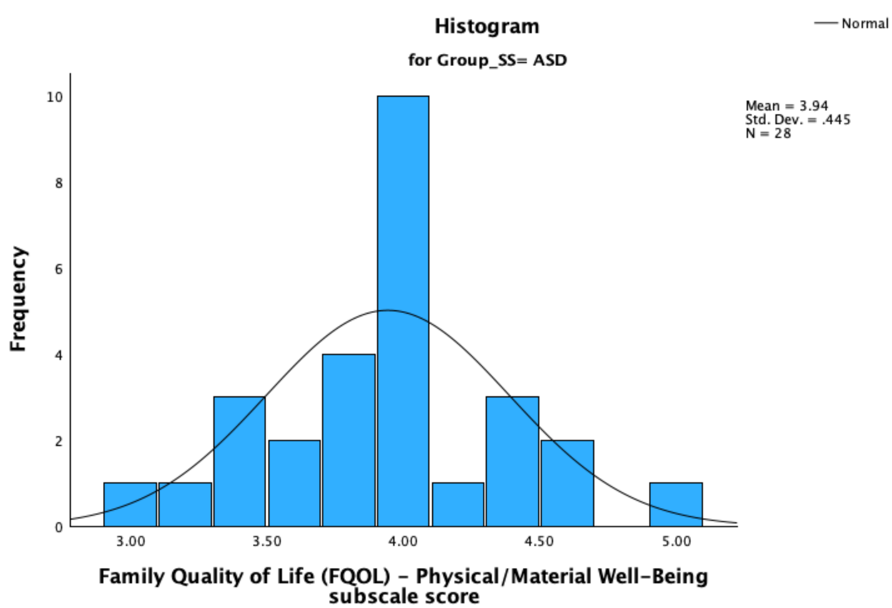


Figure F-17b.3

Exploratory Research Question 17b – Normality Histogram for ADHD Group

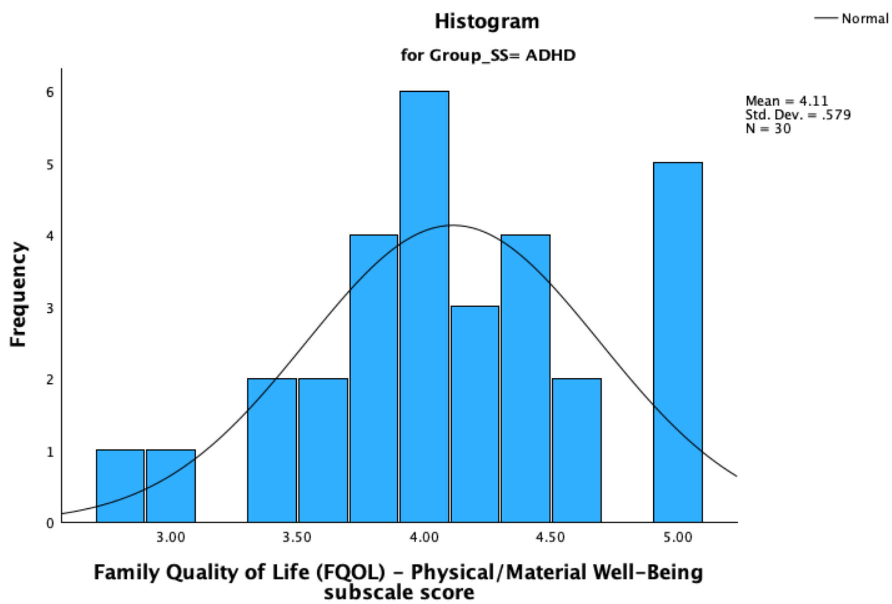


Figure F-17b.4

Exploratory Research Question 17b – Normality Histogram for ASD+ADHD Group

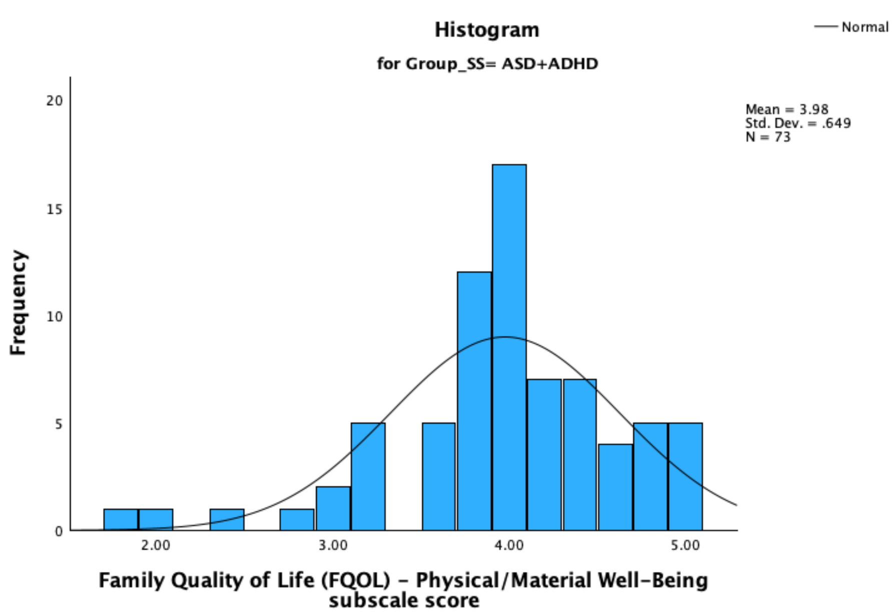


Figure F-17b.5

Exploratory Research Question 17b – Expected Normal Probability Plot for NT Group

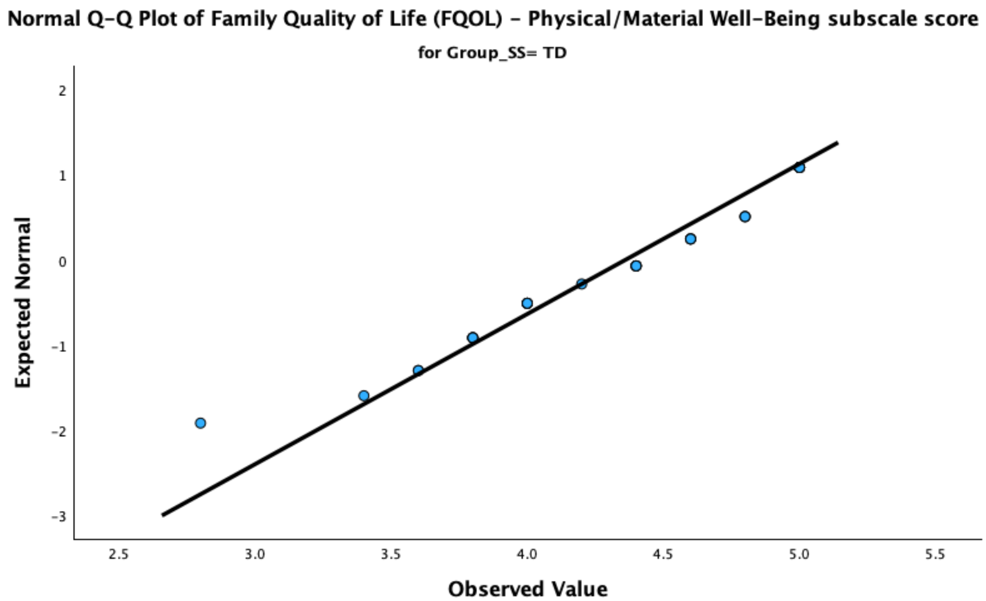


Figure F-17b.6

Exploratory Research Question 17b – Expected Normal Probability Plot for ASD Group

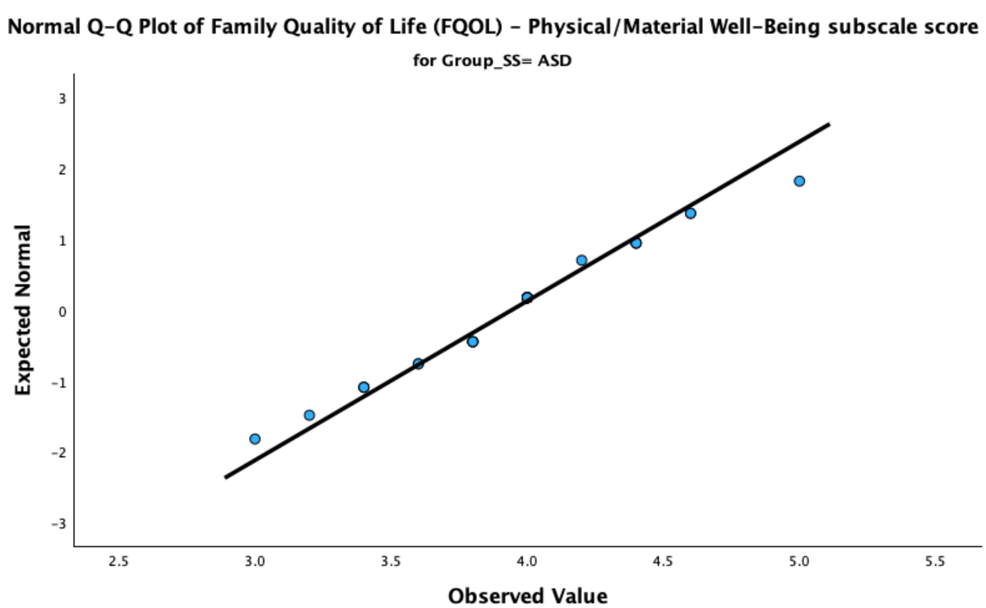


Figure F-17b.7

Exploratory Research Question 17b – Expected Normal Probability Plot for ADHD Group

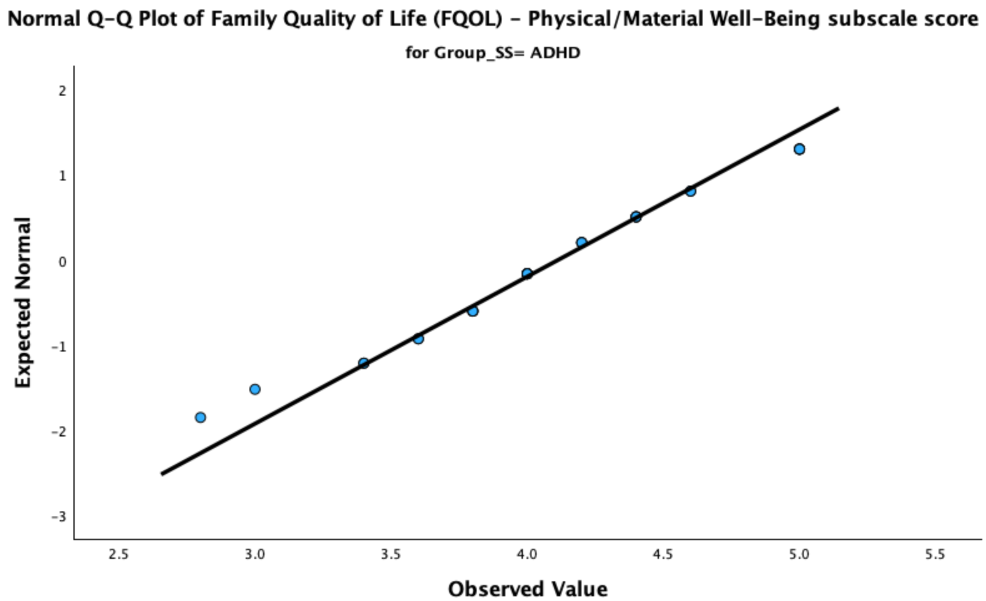
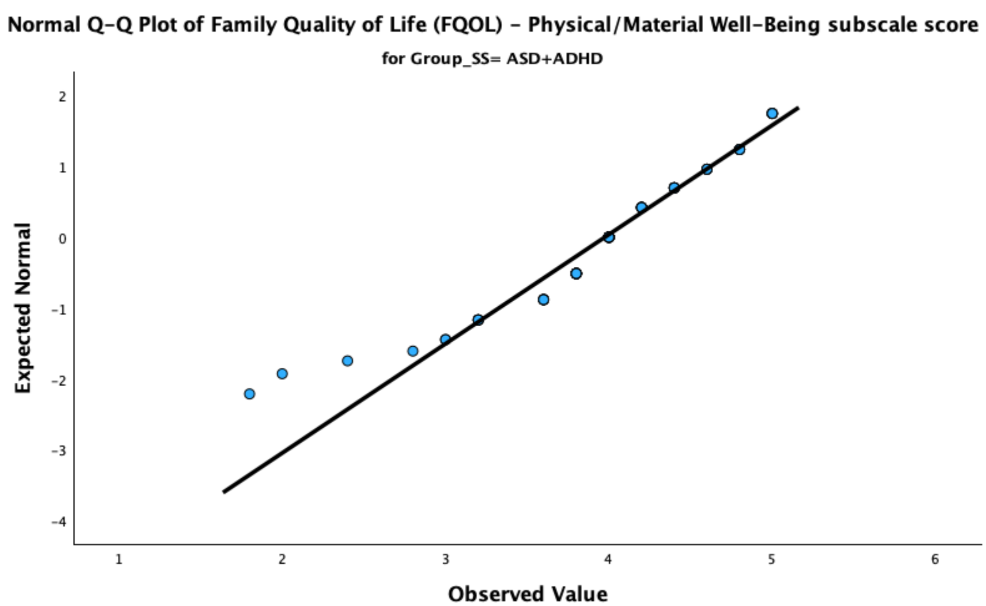


Figure F-17b.8

Exploratory Research Question 17b – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 18

Table F-18

Assumption Testing – RQ 18: Disability-Related Support Across Neurodevelopmental Groups

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test	Levene's Test
RQ 18a: Mothers				$F(3,284) = 5.12$, $p = .002$
NT Group	-0.69 (0.25)	1.26 (0.50)	$W(91) = .86$, $p < .001$	
ASD Group	-1.03 (0.58)	1.77 (1.12)	$W(15) = .88$, $p = .049$	
ADHD Group	-0.26 (0.23)	0.19 (0.46)	$W(107) = .96$, $p = .002$	
ASD+ADHD Group	-0.57 (0.28)	0.13 (0.55)	$W(75) = .96$, $p = .012$	
RQ 18b: Fathers				$F(3,162) = 1.39$, $p = .249$
NT Group	-1.08 (0.40)	1.93 (0.78)	$W(35) = .89$, $p = .002$	
ASD Group	-0.97 (0.44)	2.83 (0.86)	$W(28) = .92$, $p = .035$	
ADHD Group	-0.79 (0.43)	0.59 (0.83)	$W(30) = .91$, $p = .014$	
ASD+ADHD Group	-0.52 (0.28)	0.47 (0.56)	$W(73) = .96$, $p = .012$	

Exploratory Research Question 18a.

Figure F-18a.1

Exploratory Research Question 18a – Normality Histogram for NT Group

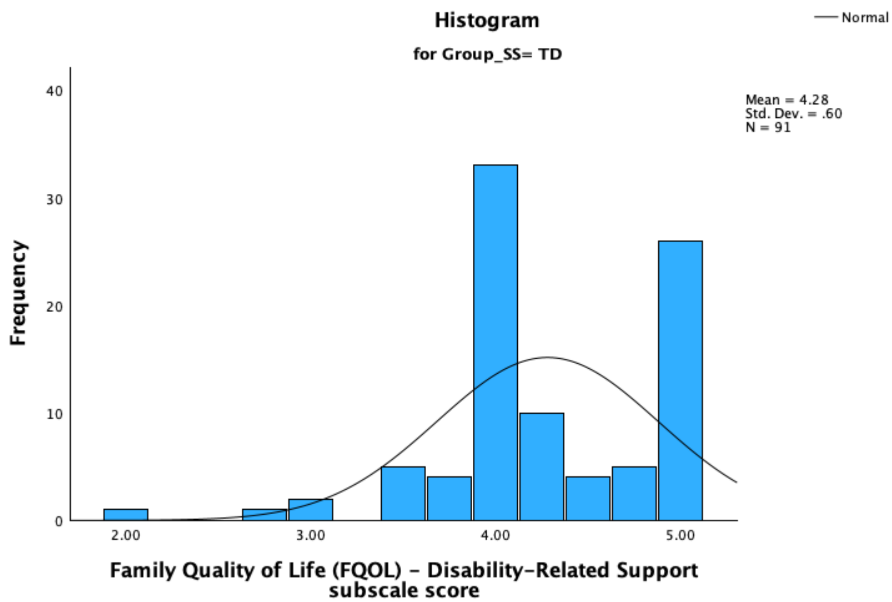


Figure F-18a.2

Exploratory Research Question 18a – Normality Histogram for ASD Group

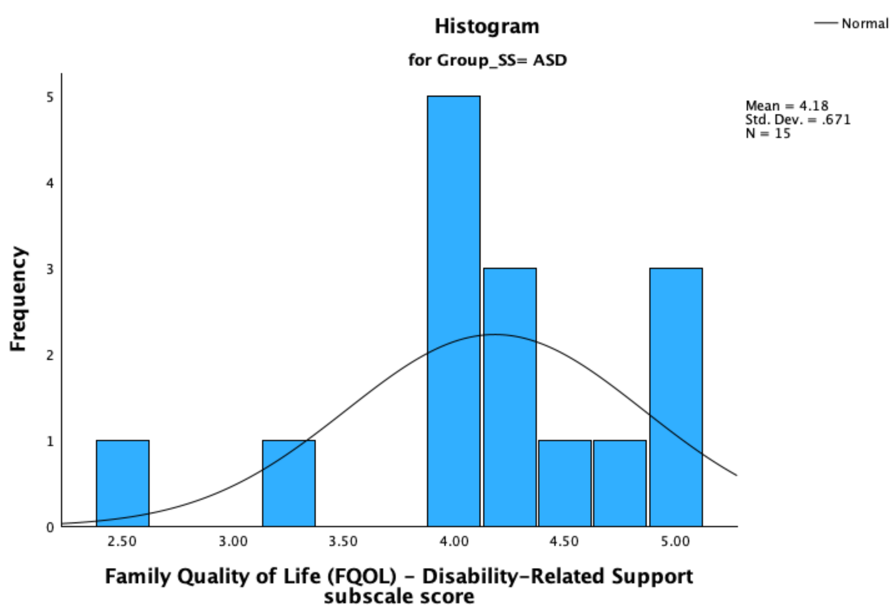


Figure F-18a.3

Exploratory Research Question 18a – Normality Histogram for ADHD Group

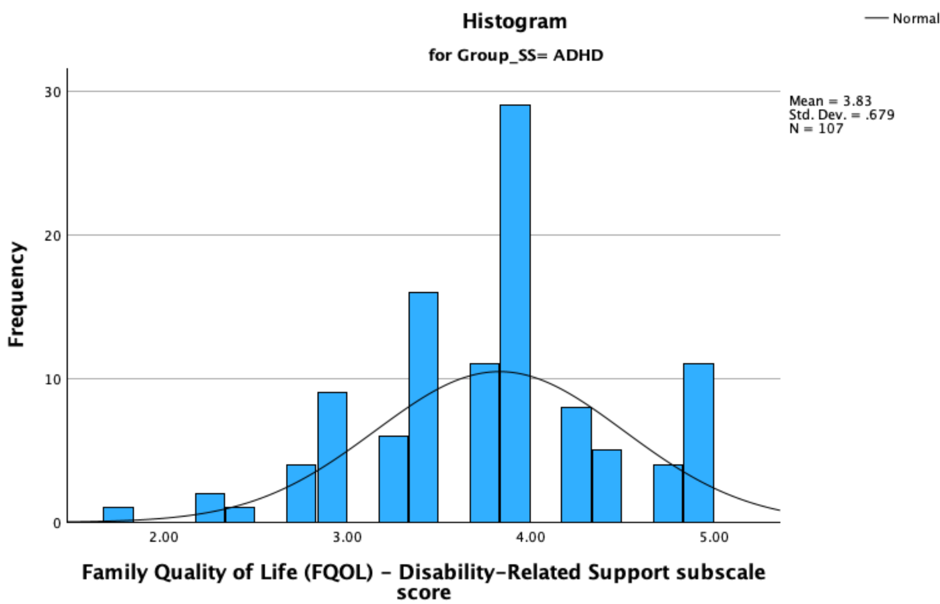


Figure F-18a.4

Exploratory Research Question 18a – Normality Histogram for ASD+ADHD Group

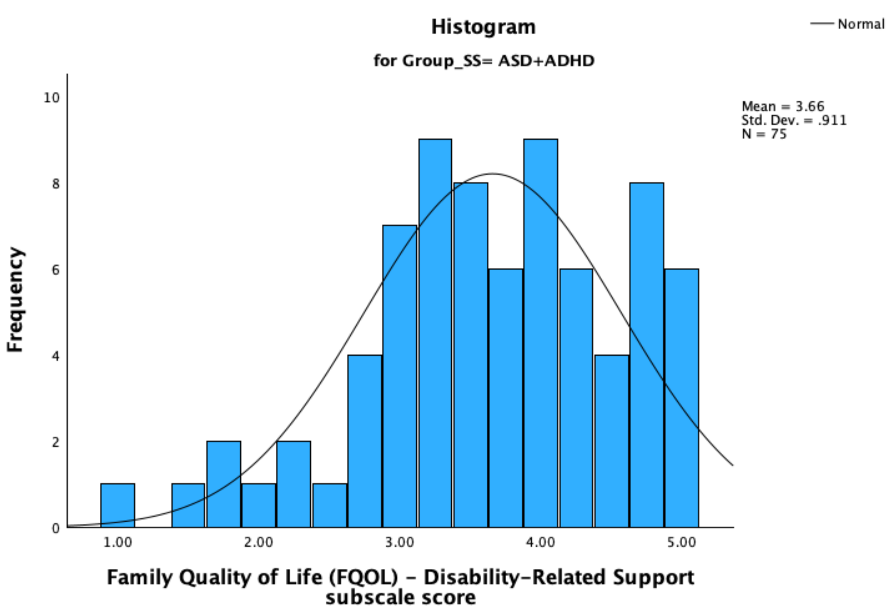


Figure F-18a.5

Exploratory Research Question 18a – Expected Normal Probability Plot for NT Group

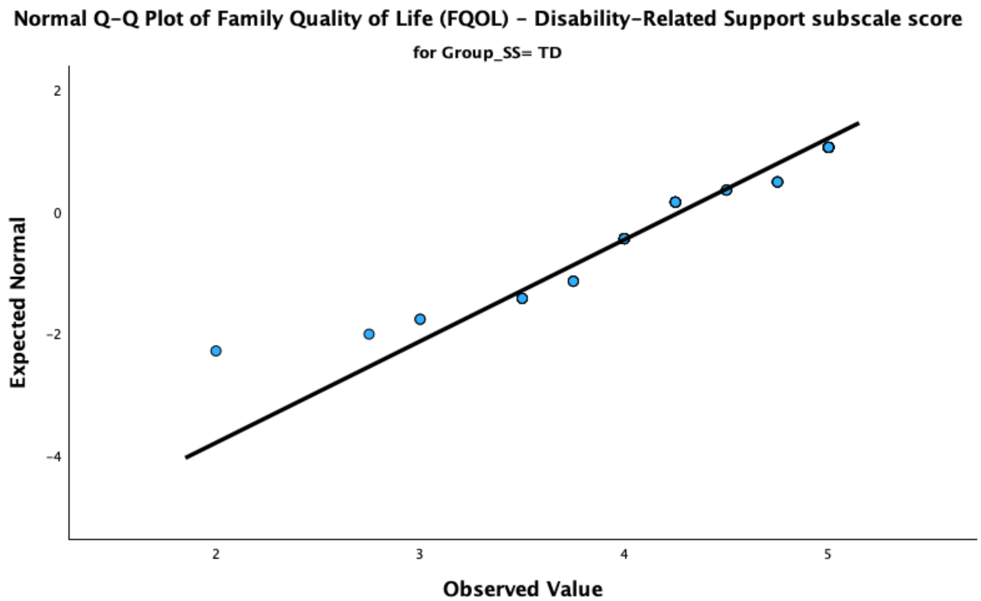


Figure F-18a.6

Exploratory Research Question 18a – Expected Normal Probability Plot for ASD Group

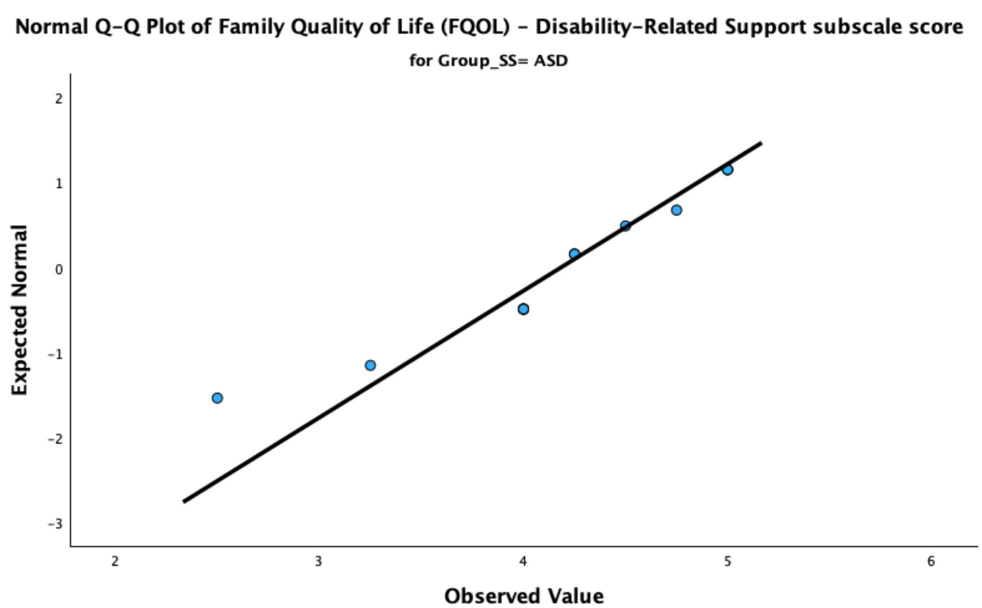


Figure F-18a.7

Exploratory Research Question 18a – Expected Normal Probability Plot for ADHD Group

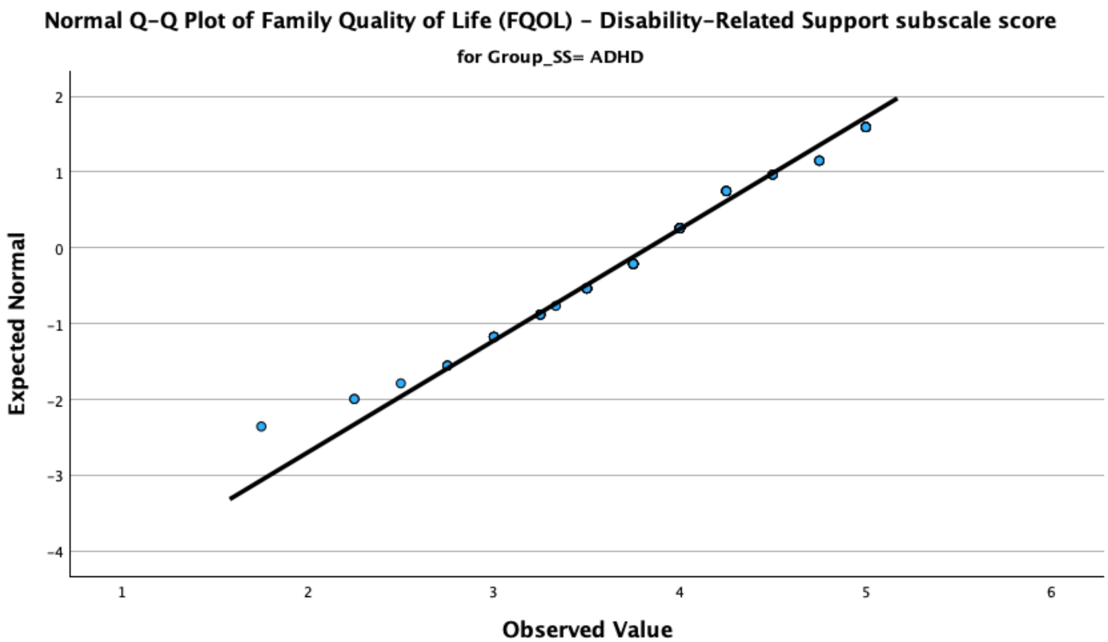
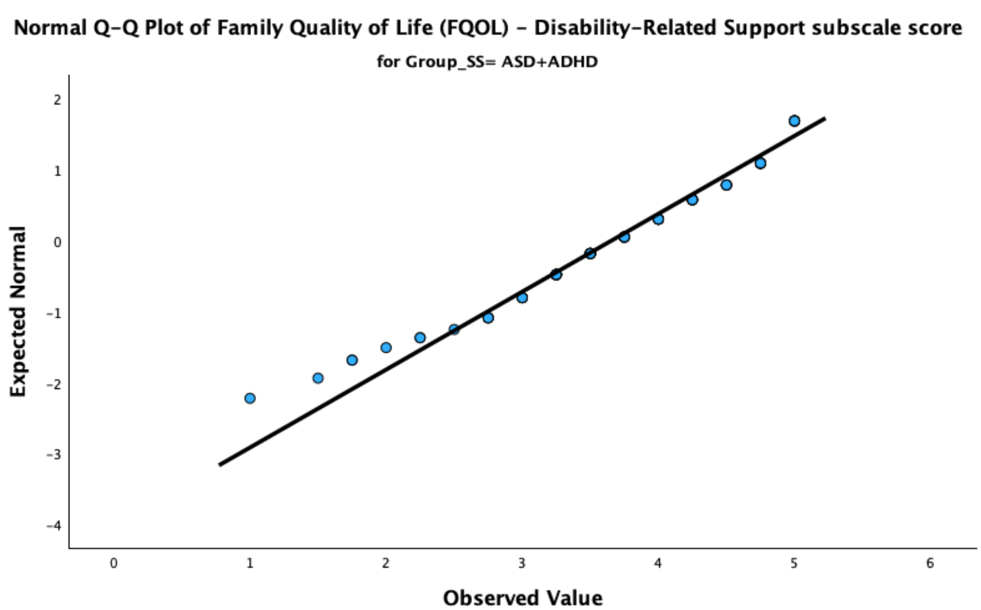


Figure F-18a.8

Exploratory Research Question 18a – Expected Normal Probability Plot for ASD+ADHD Group



Exploratory Research Question 18b.

Figure F-18b.1

Exploratory Research Question 18b – Normality Histogram for NT Group

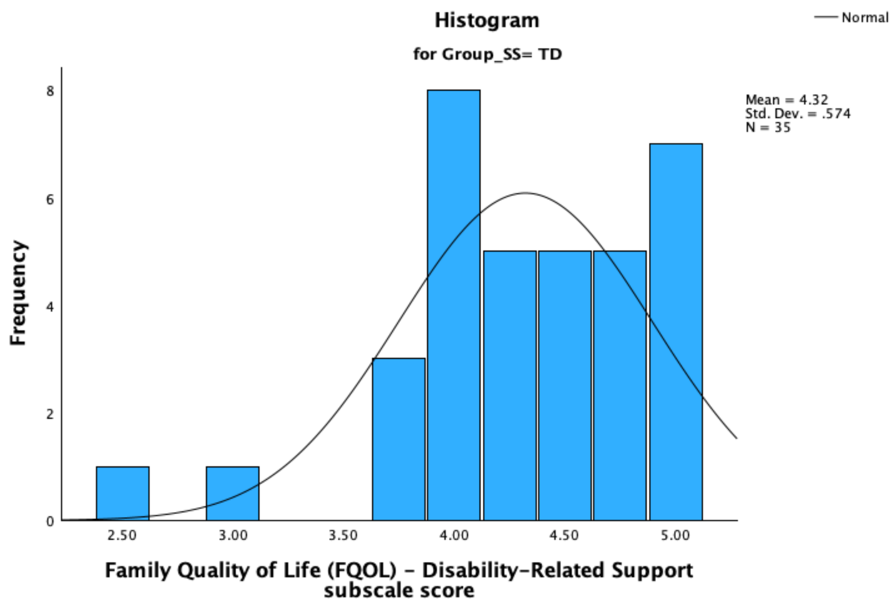


Figure F-18b.2

Exploratory Research Question 18b – Normality Histogram for ASD Group

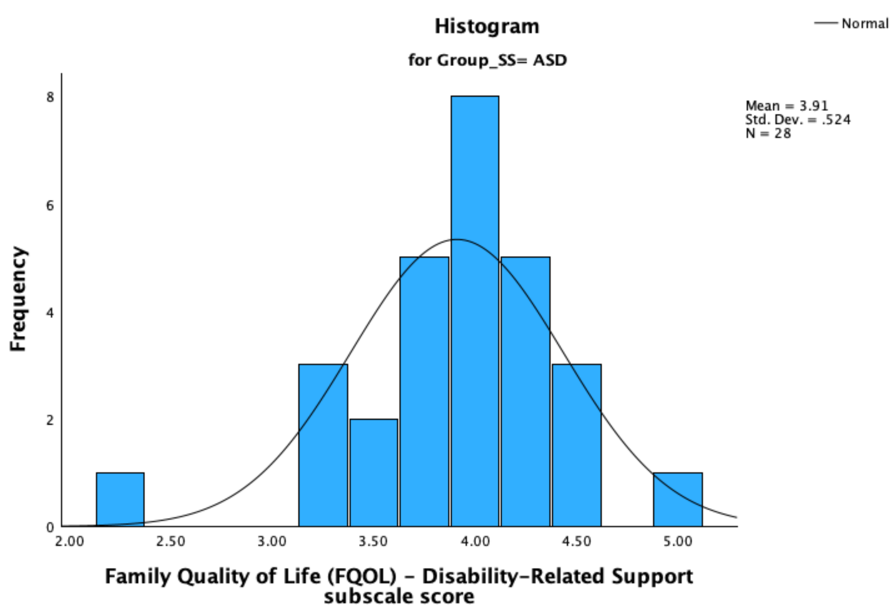


Figure F-18b.3

Exploratory Research Question 18b – Normality Histogram for ADHD Group

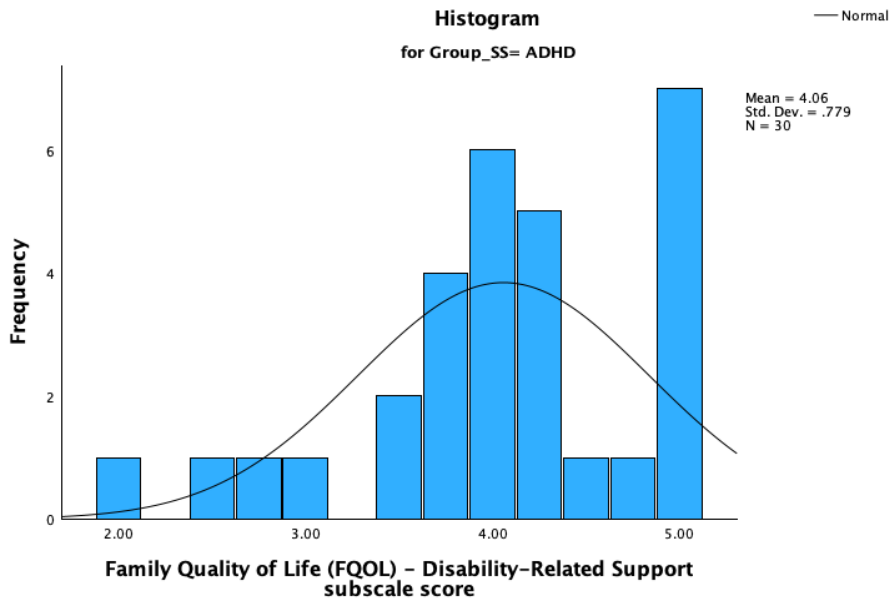


Figure F-18b.4

Exploratory Research Question 18b – Normality Histogram for ASD+ADHD Group

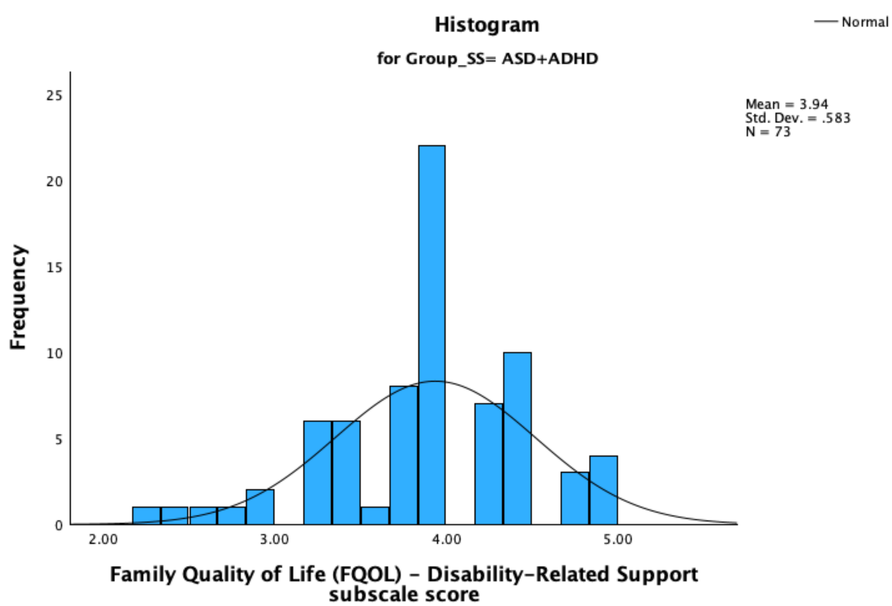


Figure F-18b.5

Exploratory Research Question 18b – Expected Normal Probability Plot for NT Group

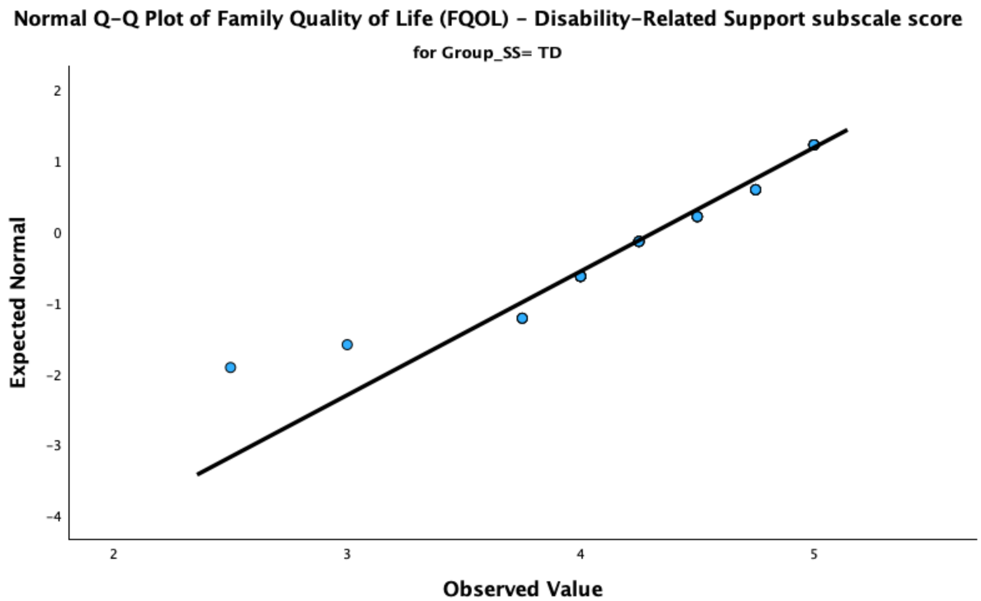


Figure F-18b.6

Exploratory Research Question 18b – Expected Normal Probability Plot for ASD Group

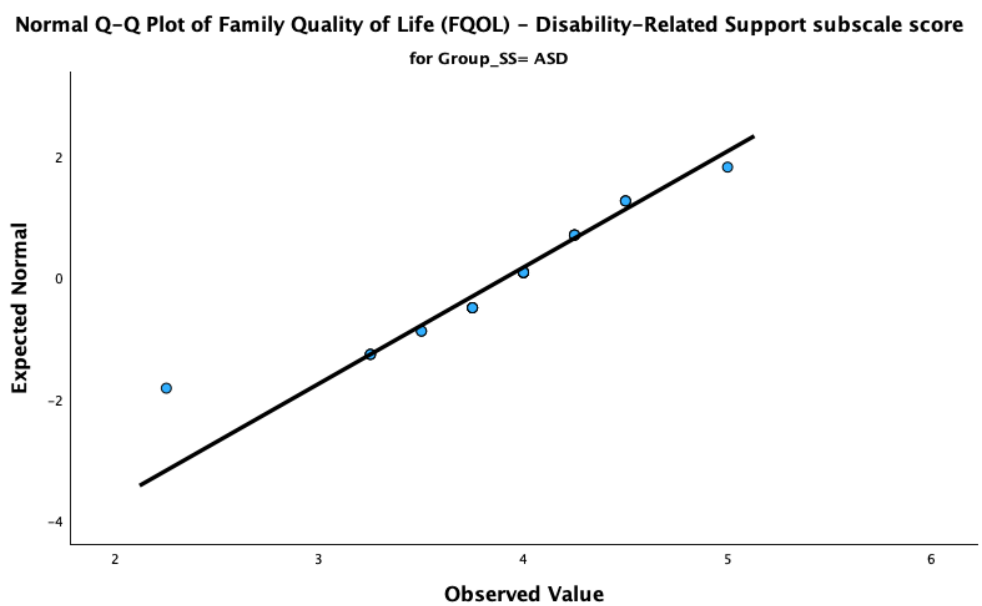


Figure F-18a.7

Exploratory Research Question 18b – Expected Normal Probability Plot for ADHD Group

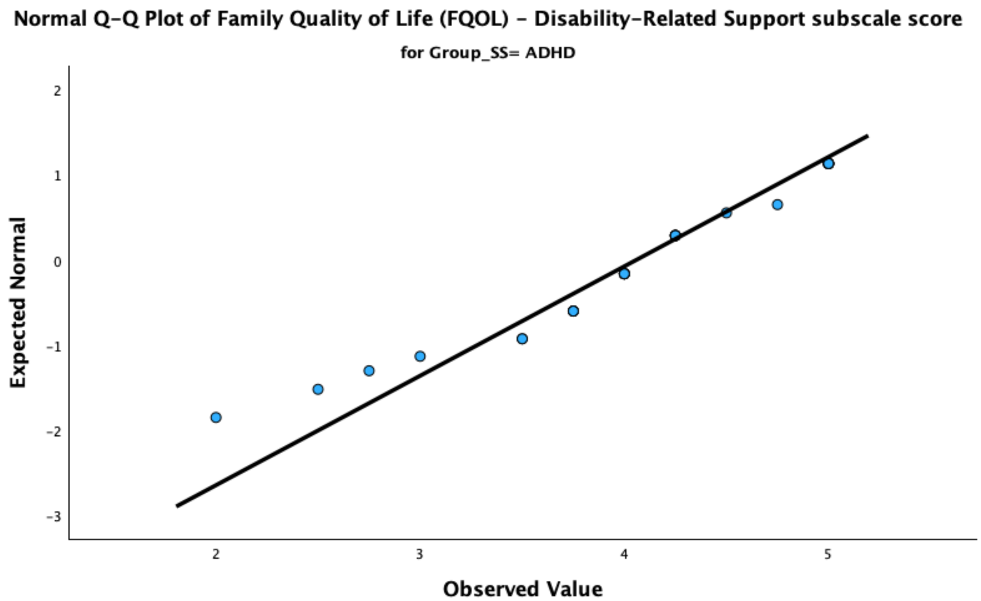


Figure F-18a.8

Exploratory Research Question 18b – Expected Normal Probability Plot for ASD+ADHD Group

Exploratory Research Question 19

Table F-19

Assumption Testing – RQ 19: Coparenting Agreement Between Mothers & Fathers			
	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
19a: NT Group	1.35 (0.58)	2.41 (1.12)	$W(15) = .87, p = .037$
19b: ASD and/or ADHD Group	0.93 (0.32)	3.96 (0.62)	$W(57) = .93, p = .003$

Research Question 19a.

Figure F-19a.1

Research Question 19a – Normality Histogram

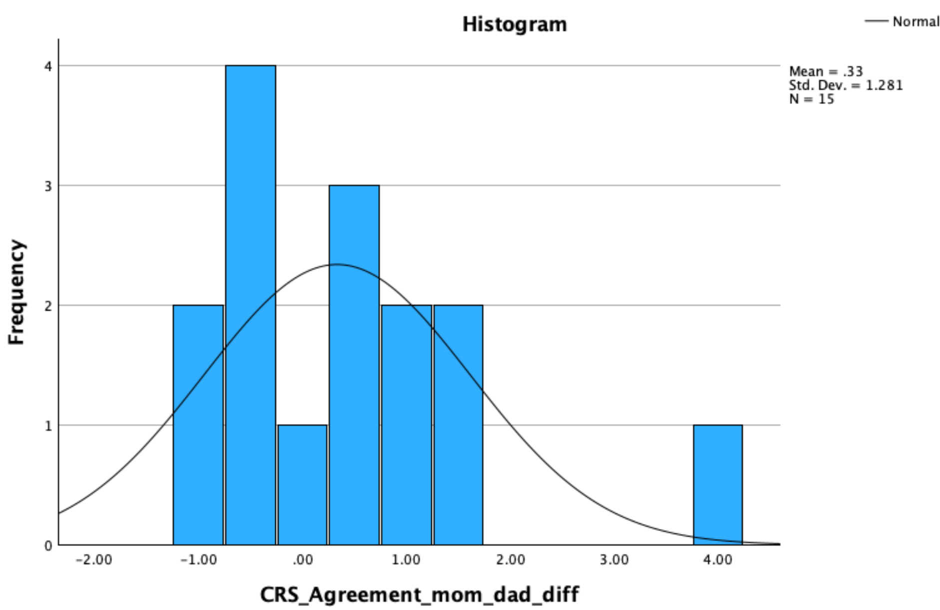
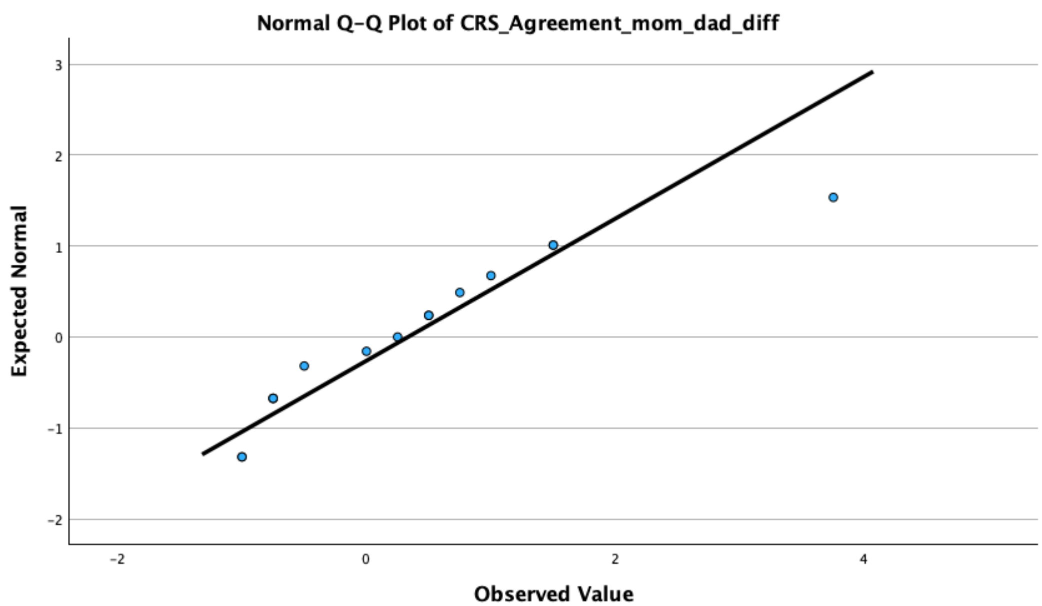


Figure F-19a.2

Research Question 19a – Expected Normal Probability Plot



Research Question 19b.

Figure F-19b.1

Research Question 19b – Normality Histogram

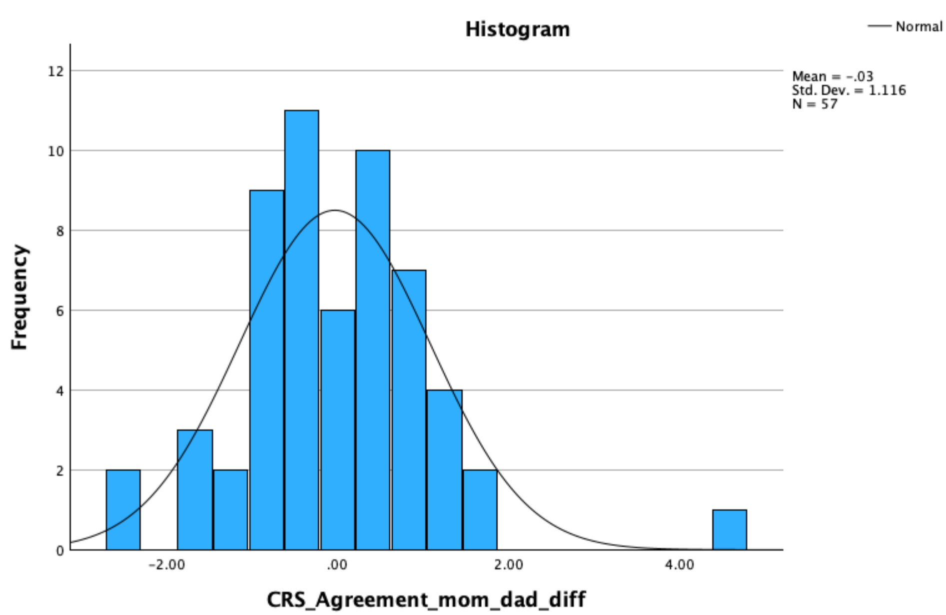
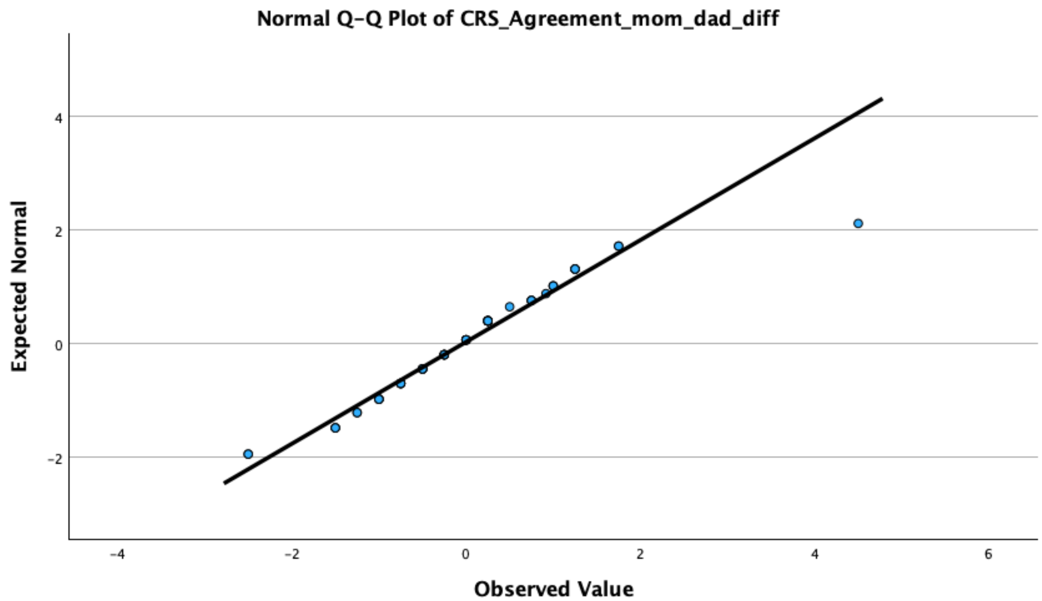


Figure F-19b.2

Research Question 19b – Expected Normal Probability Plot



Exploratory Research Question 20

Table F-20

Assumption Testing – RQ 20: Coparenting Closeness Between Mothers & Fathers			
	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
20a: NT Group	1.25 (0.58)	0.80 (1.12)	$W(15) = .82, p = .007$
20b: ASD and/or ADHD Group	-0.63 (0.32)	1.08 (0.62)	$W(57) = .97, p = .093$

Research Question 20a.

Figure F-20a.1

Research Question 20a – Normality Histogram

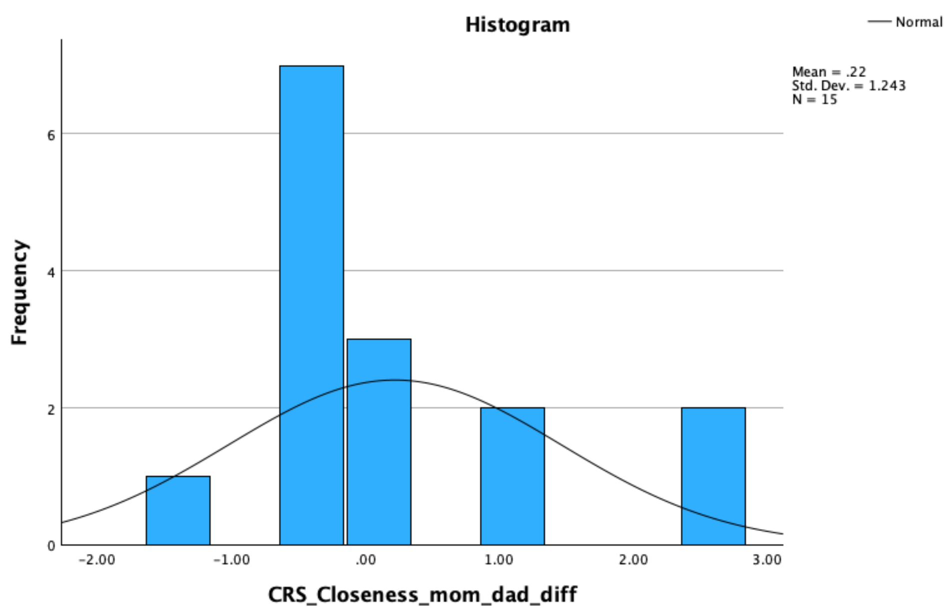
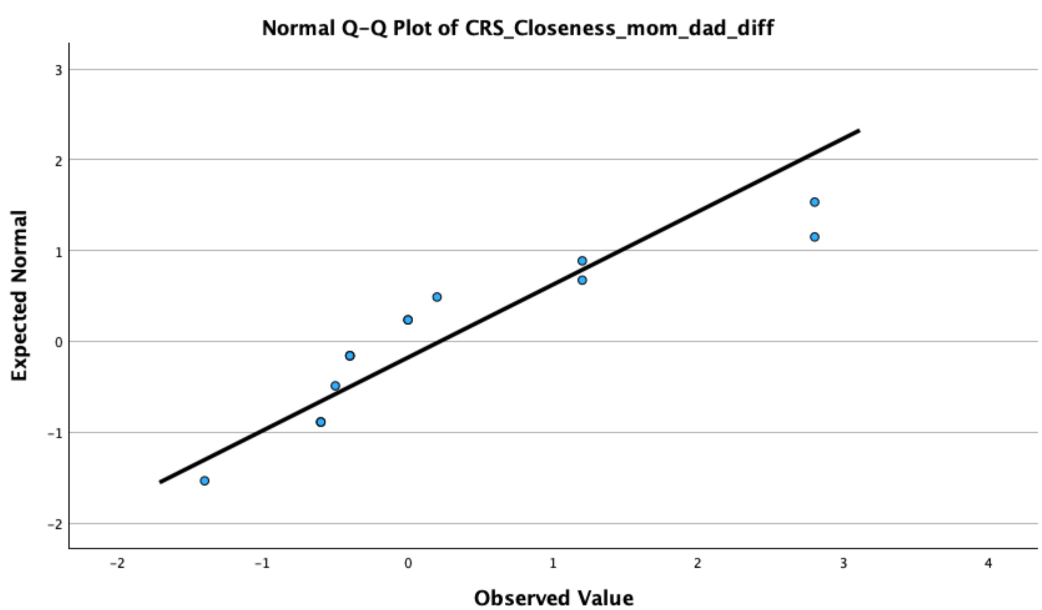


Figure F-20a.2

Research Question 20a – Expected Normal Probability Plot



Research Question 20b.

Figure F-20b.1

Research Question 20b – Normality Histogram

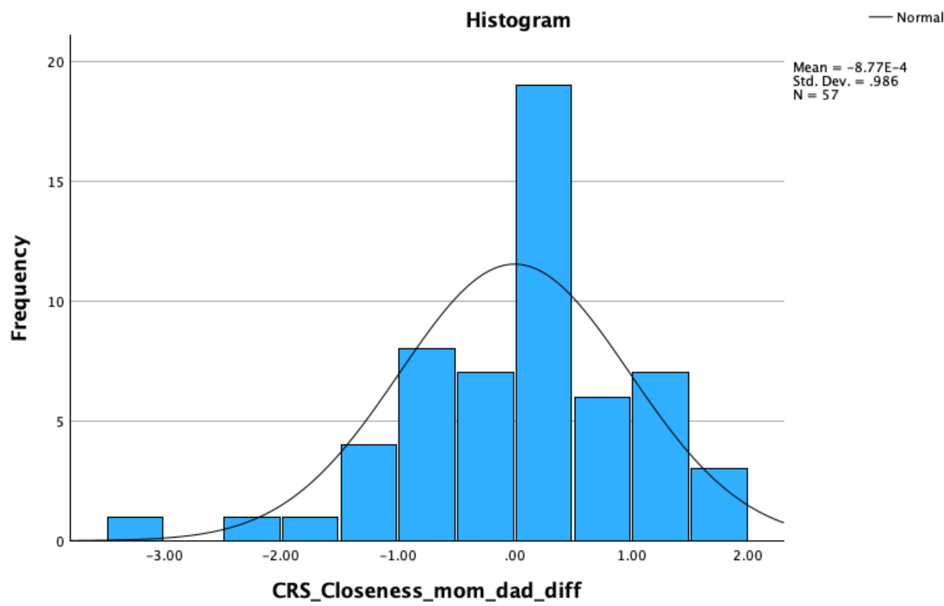
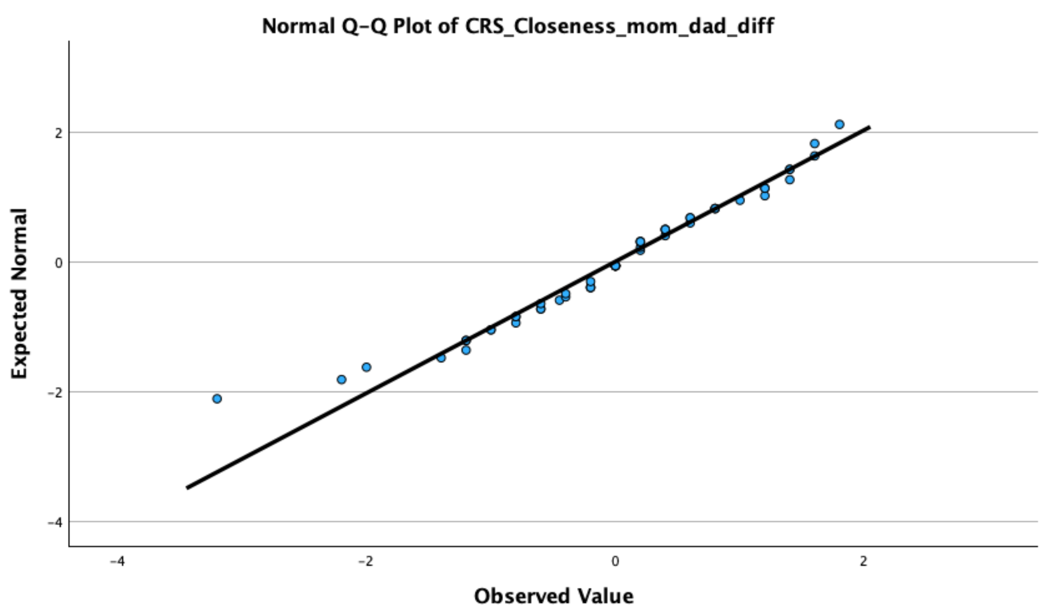


Figure F-20b.2

Research Question 20b – Expected Normal Probability Plot



Exploratory Research Question 21

Table F-21

Assumption Testing – RQ 21: Exposure to Conflict Between Mothers & Fathers			
	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
21a: NT Group	0.20 (0.58)	-1.24 (1.12)	$W(15) = .88, p = .052$
21b: ASD and/or ADHD Group	-1.88 (0.32)	4.12 (0.63)	$W(56) = .80, p < .001$

Research Question 21a.

Figure F-21a.1

Research Question 21a – Normality Histogram

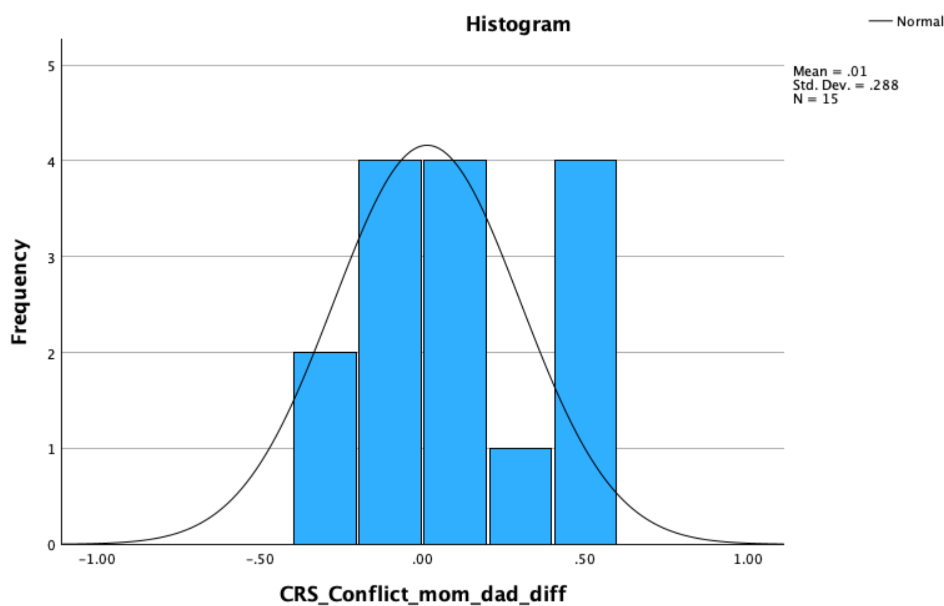
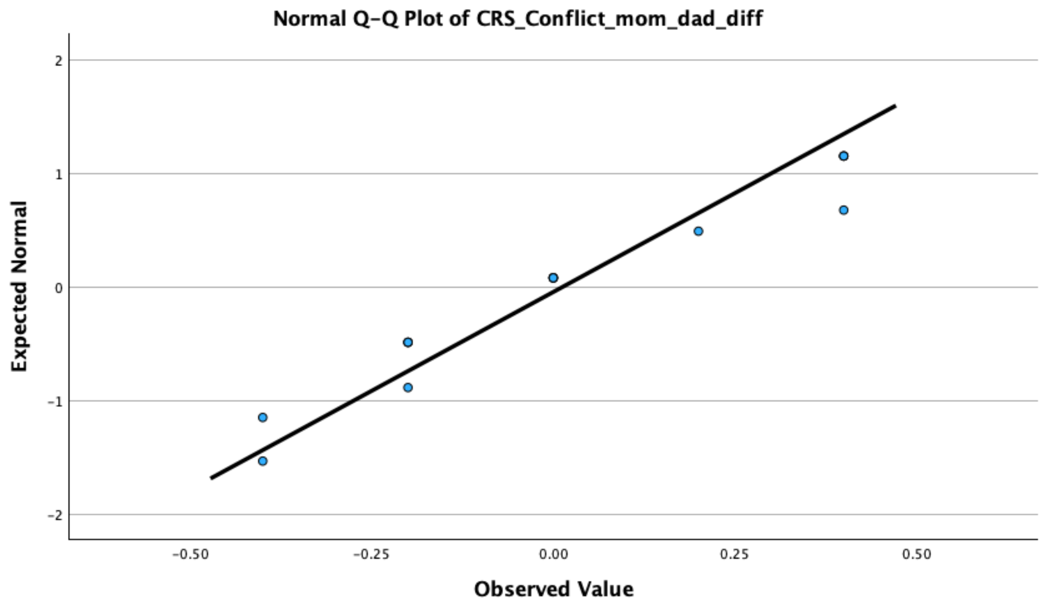


Figure F-21a.2

Research Question 21a – Expected Normal Probability Plot



Research Question 21b.

Figure F-21b.1

Research Question 21b – Normality Histogram

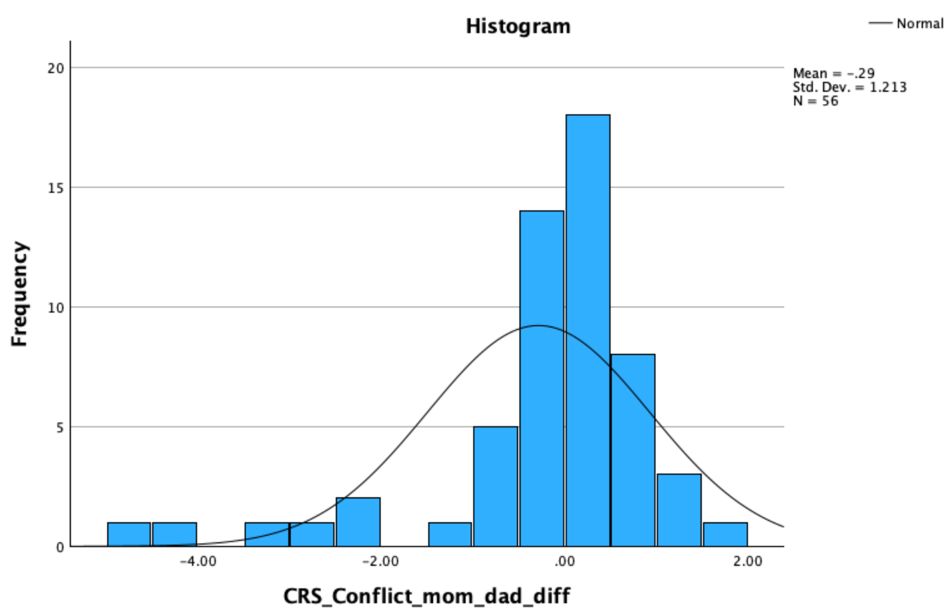
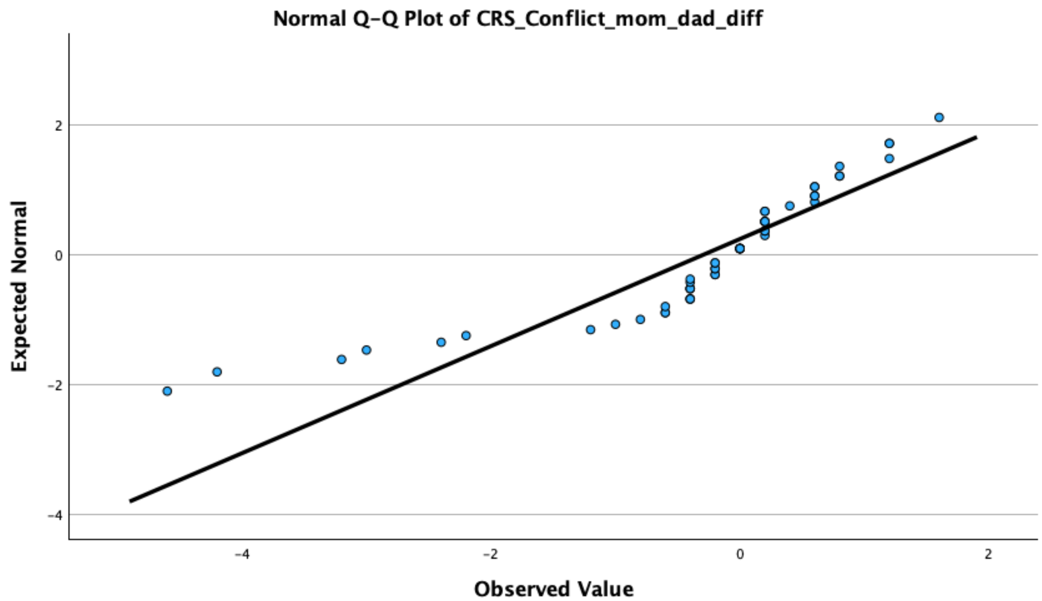


Figure F-21b.2

Research Question 21b – Expected Normal Probability Plot



Exploratory Research Question 22

Table F-22

Assumption Testing – RQ 22: Coparenting Support Between Mothers & Fathers			
	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
22a: NT Group	0.36 (0.58)	-0.40 (1.12)	$W(15) = .96, p = .641$
22b: ASD and/or ADHD Group	0.23 (0.32)	1.06 (0.63)	$W(56) = .97, p = .219$

Research Question 22a.

Figure F-22a.1

Research Question 22a – Normality Histogram

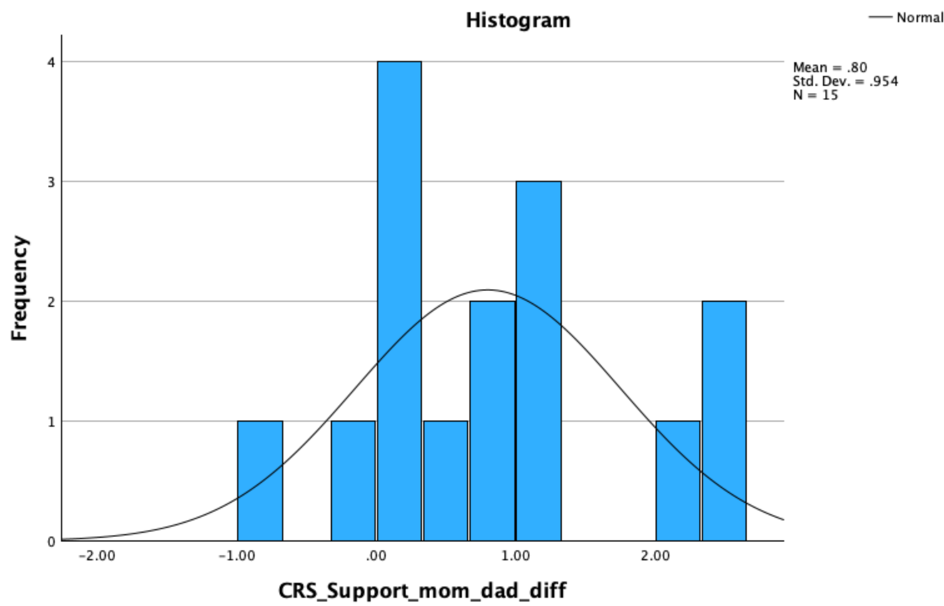
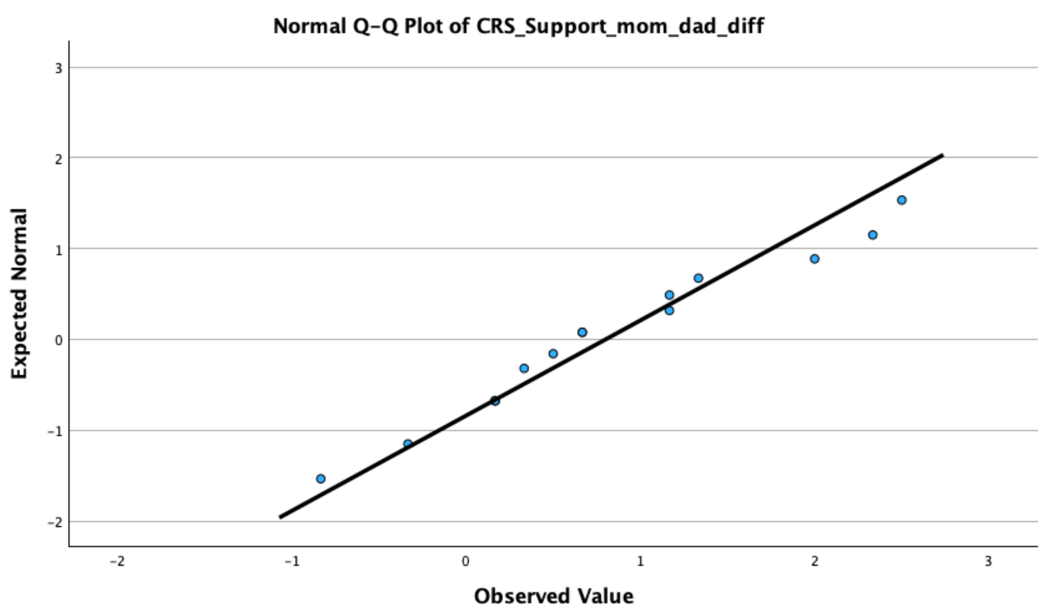


Figure F-22a.2

Research Question 22a – Expected Normal Probability Plot



Research Question 22b.

Figure F-22b.1

Research Question 22b – Normality Histogram

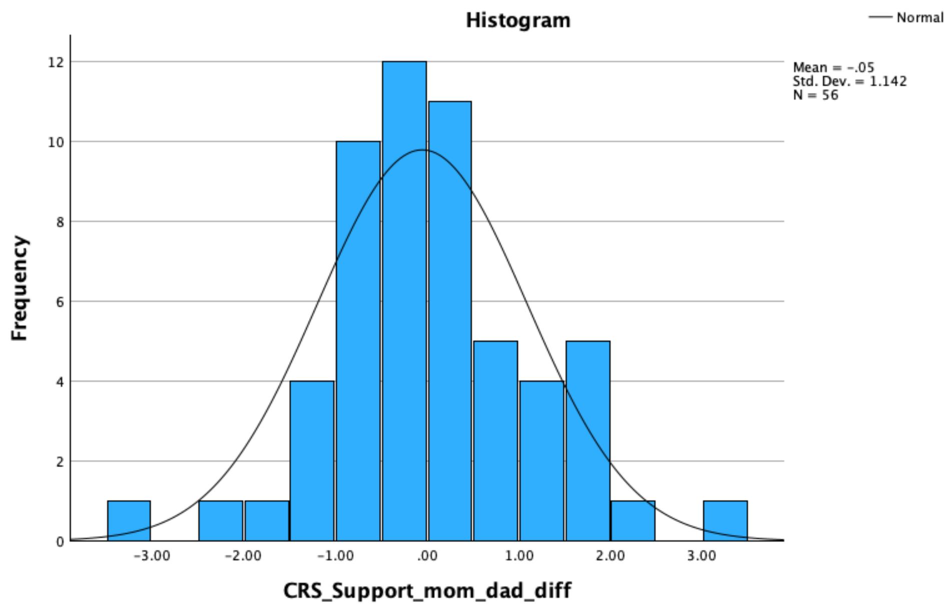
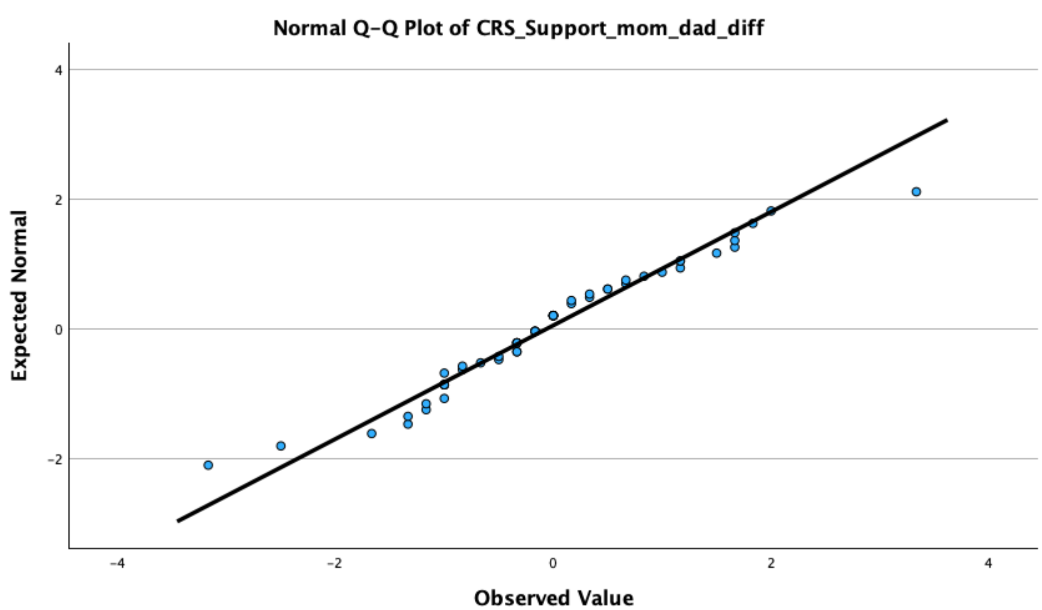


Figure F-22b.2

Research Question 22b – Expected Normal Probability Plot



Exploratory Research Question 23

Table F-23

Assumption Testing – RQ 23: Coparenting Undermining Between Mothers & Fathers			
	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
23a: NT Group	0.02 (0.58)	-0.06 (1.12)	$W(15) = .96, p = .612$
23b: ASD and/or ADHD Group	-0.95 (0.32)	1.17 (0.63)	$W(56) = .93, p = .004$

Research Question 23a.

Figure F-23a.1

Research Question 23a – Normality Histogram

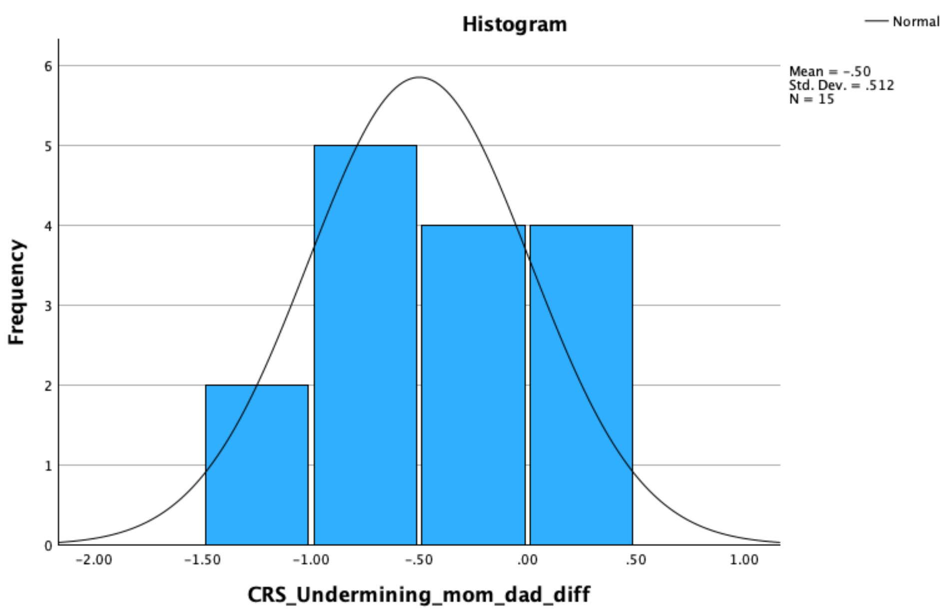
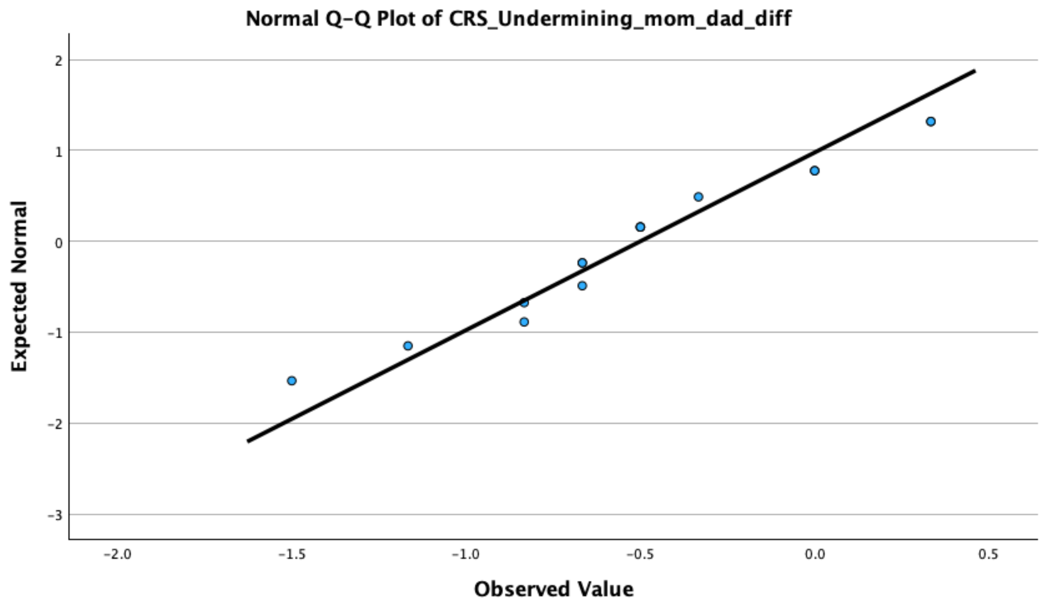


Figure F-23a.2

Research Question 23a – Expected Normal Probability Plot



Research Question 23b.

Figure F-23b.1

Research Question 23b – Normality Histogram

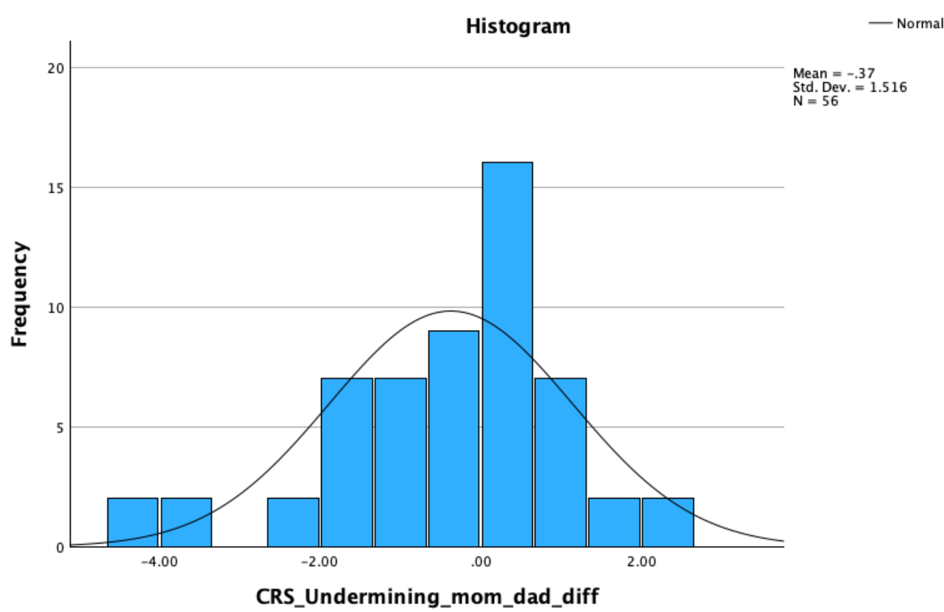
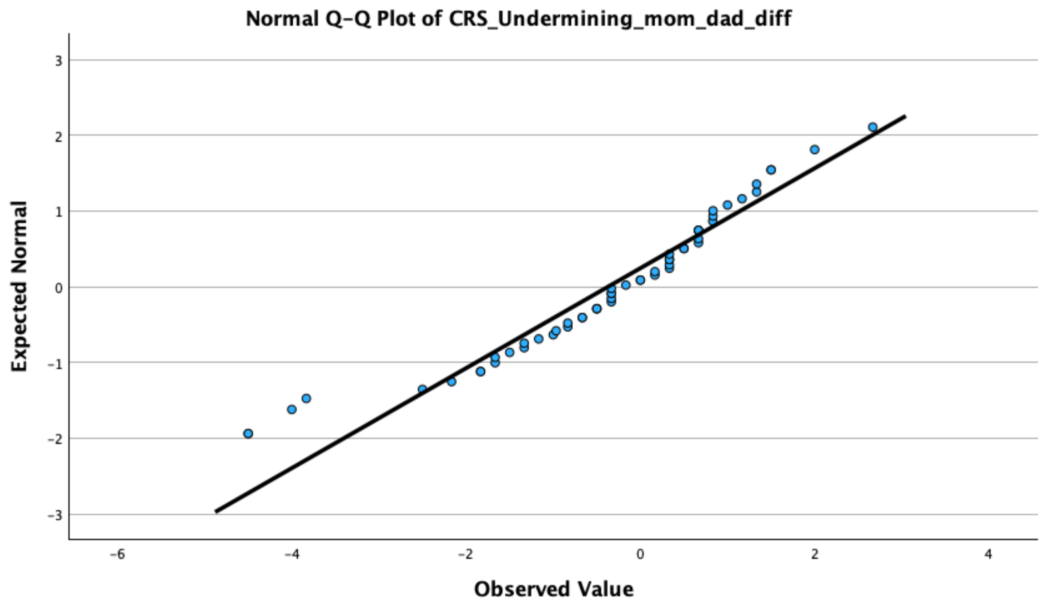


Figure F-23b.2

Research Question 23b – Expected Normal Probability Plot



Exploratory Research Question 24

Table F-24

Assumption Testing – RQ 24: Endorsement of Partner Parenting Between Mothers & Fathers			
	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
24a: NT Group	-0.45 (0.58)	-0.32 (1.12)	$W(15) = .95, p = .514$
24b: ASD and/or ADHD Group	-0.64 (0.32)	1.68 (0.62)	$W(57) = .97, p = .149$

Research Question 24a.

Figure F-24a.1

Research Question 24a – Normality Histogram

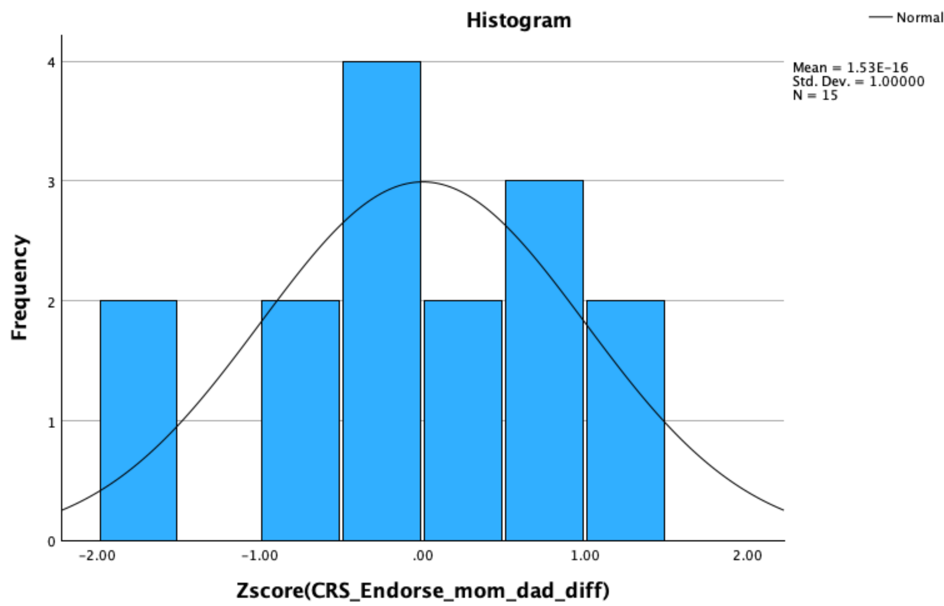
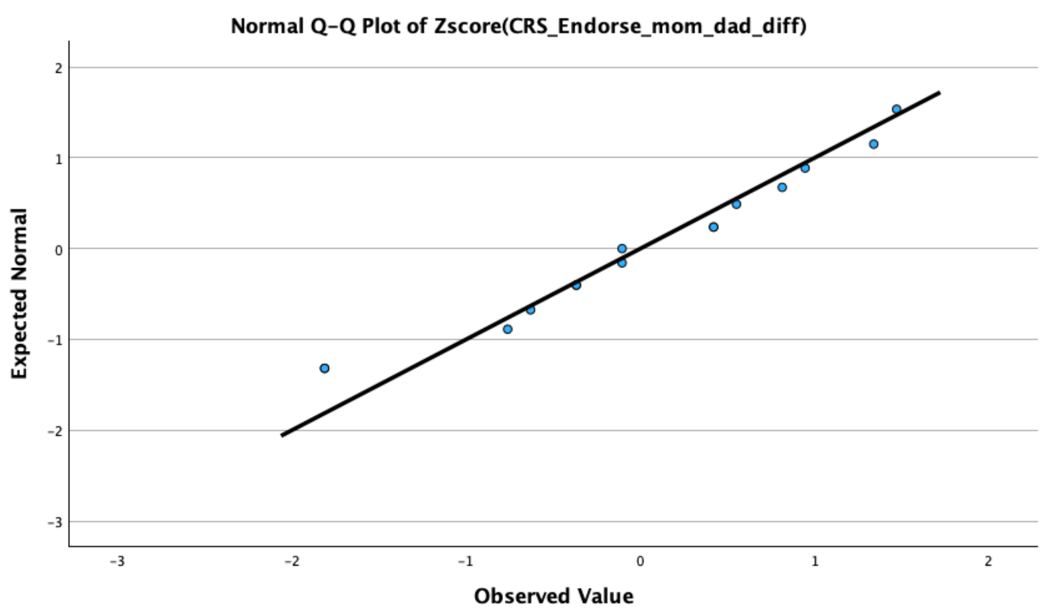


Figure F-24a.2

Research Question 24a – Expected Normal Probability Plot



Research Question 24b.

Figure F-24b.1

Research Question 24b – Normality Histogram

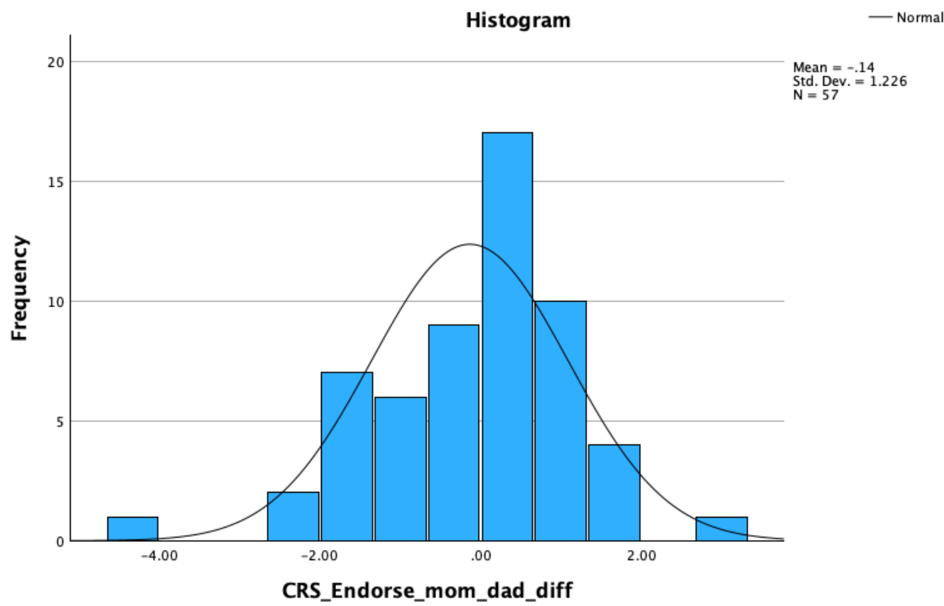
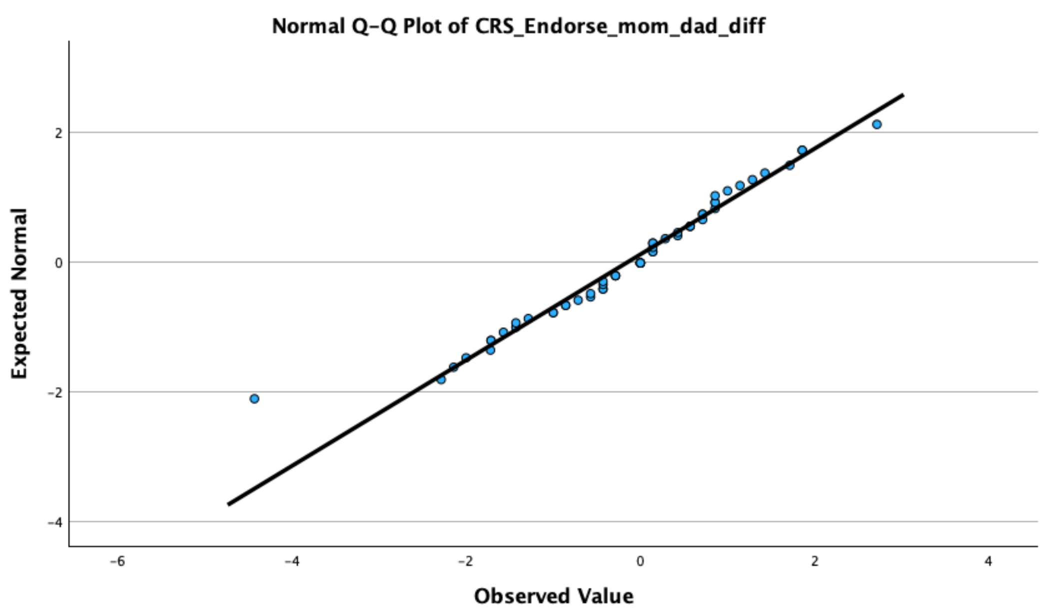


Figure F-24b.2

Research Question 24b – Expected Normal Probability Plot



Exploratory Research Question 25

Table F-25

Assumption Testing – RQ 25: Division of Labor Between Mothers & Fathers

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
25a: NT Group	-0.04 (0.58)	-0.45 (1.12)	$W(15) = .95, p = .582$
25b: ASD and/or ADHD Group	0.01 (0.33)	0.21 (0.64)	$W(54) = .97, p = .191$

Research Question 25a.

Figure F-25a.1

Research Question 25a – Normality Histogram

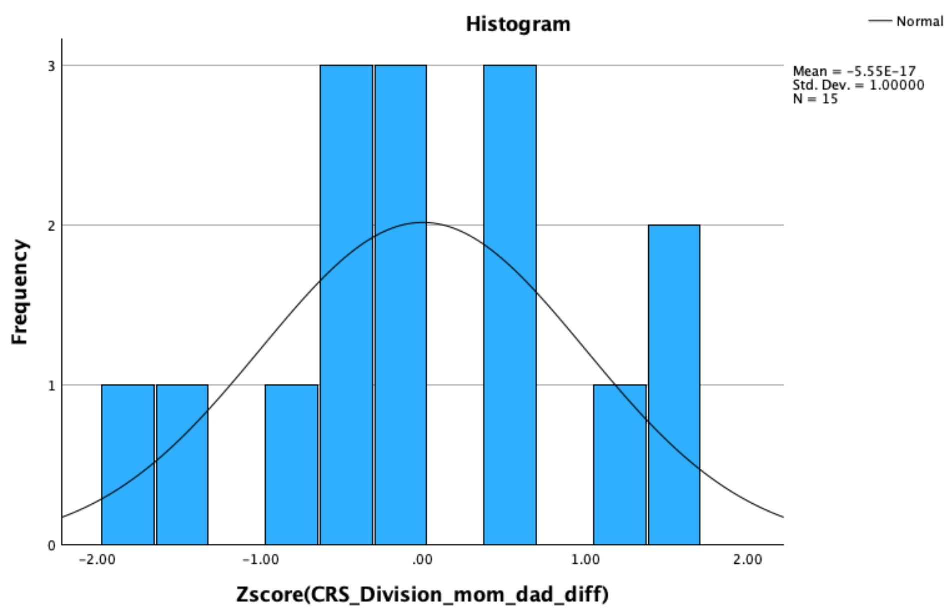
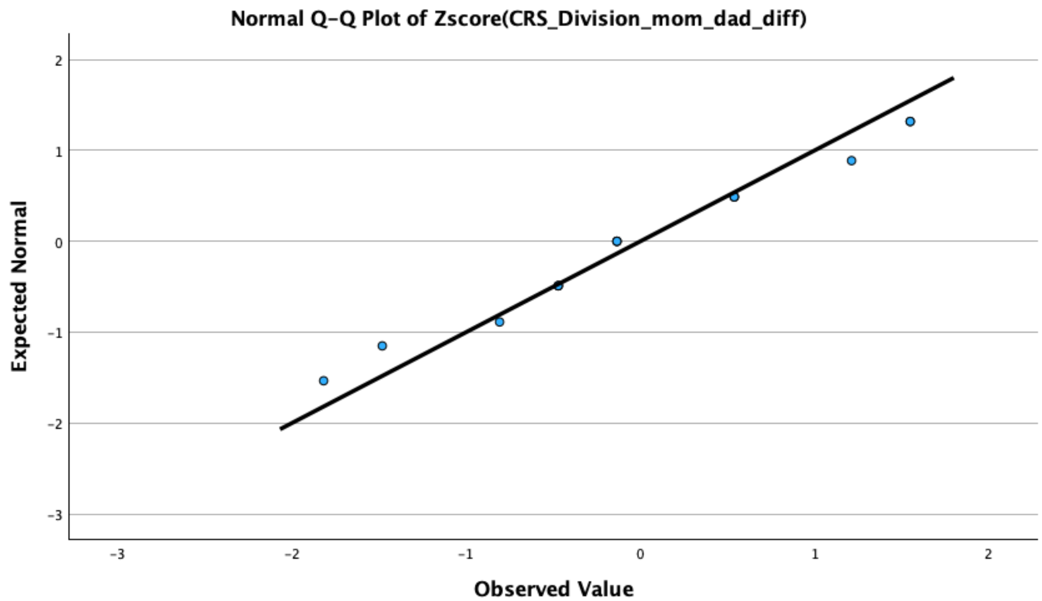


Figure F-25a.2

Research Question 25a – Expected Normal Probability Plot



Research Question 25b.

Figure F-25b.1

Research Question 25b – Normality Histogram

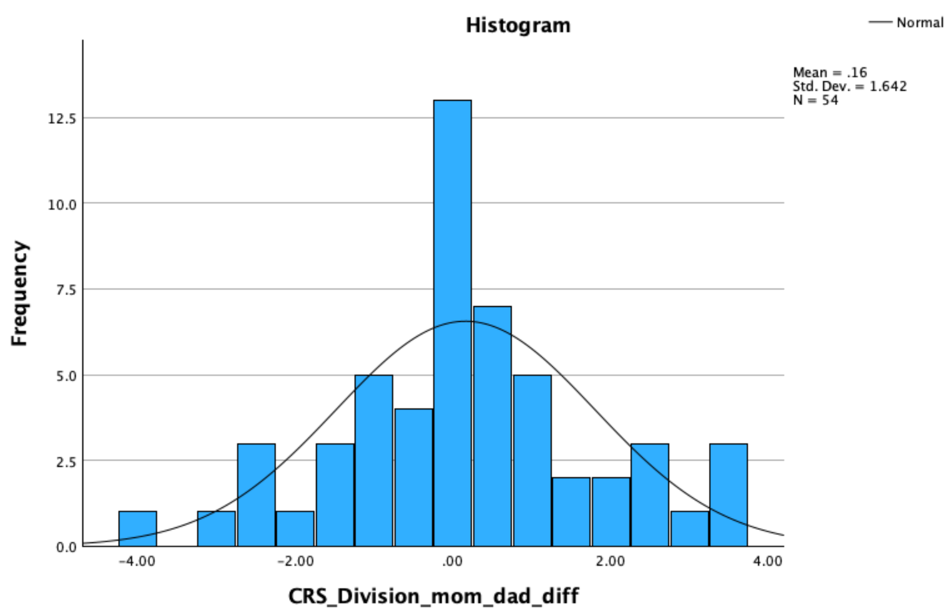
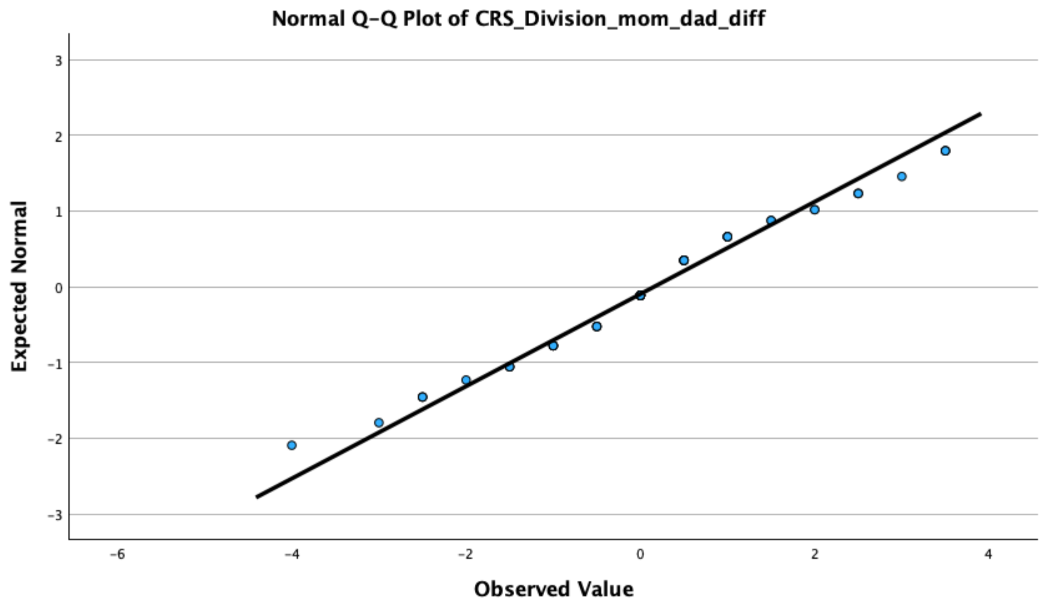


Figure F-25b.2

Research Question 25b – Expected Normal Probability Plot



Exploratory Research Question 26

Table F-26

Assumption Testing – RQ 26: Family Interaction Between Mothers & Fathers			
	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
26a: NT Group	0.99 (0.52)	0.02 (1.01)	$W(19) = .86$, p = .009
26b: ASD and/or ADHD Group	-0.01 (0.29)	0.61 (0.58)	$W(67) = .96$, $p = .016$

Research Question 26a.

Figure F-26a.1

Research Question 26a – Normality Histogram

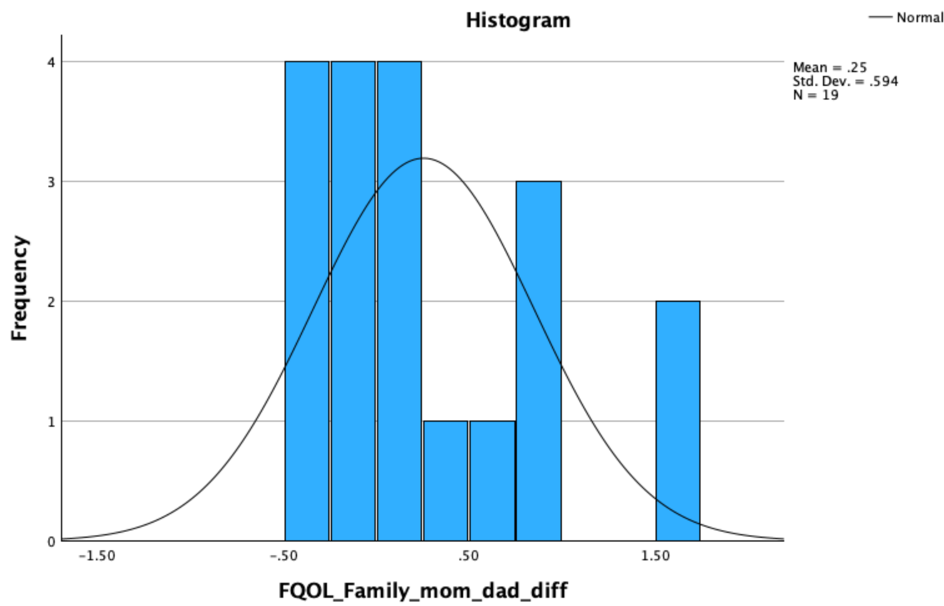
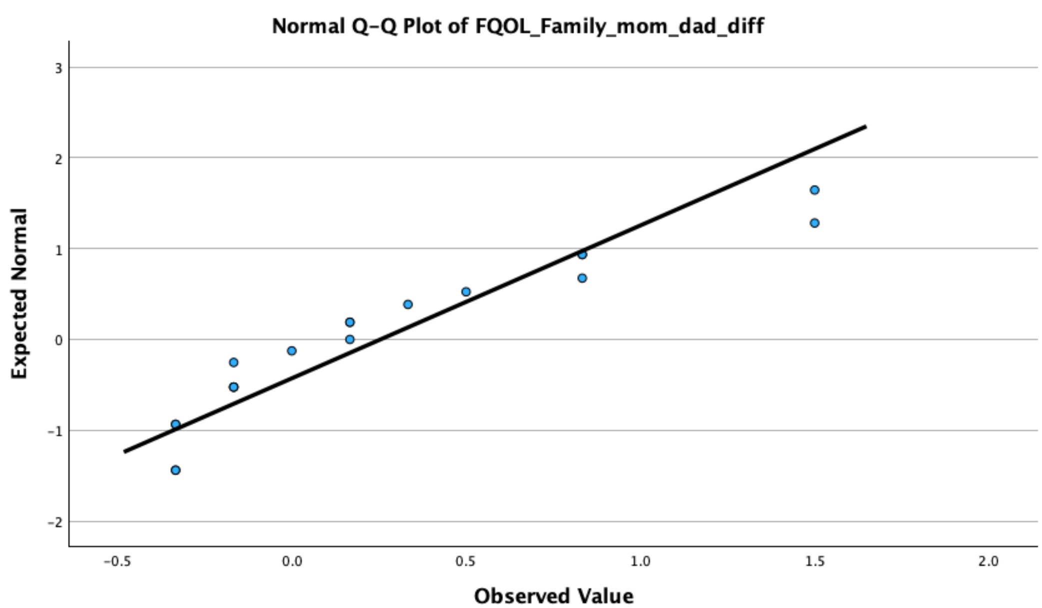


Figure F-26a.2

Research Question 26a – Expected Normal Probability Plot



Research Question 26b.

Figure F-26b.1

Research Question 26b – Normality Histogram

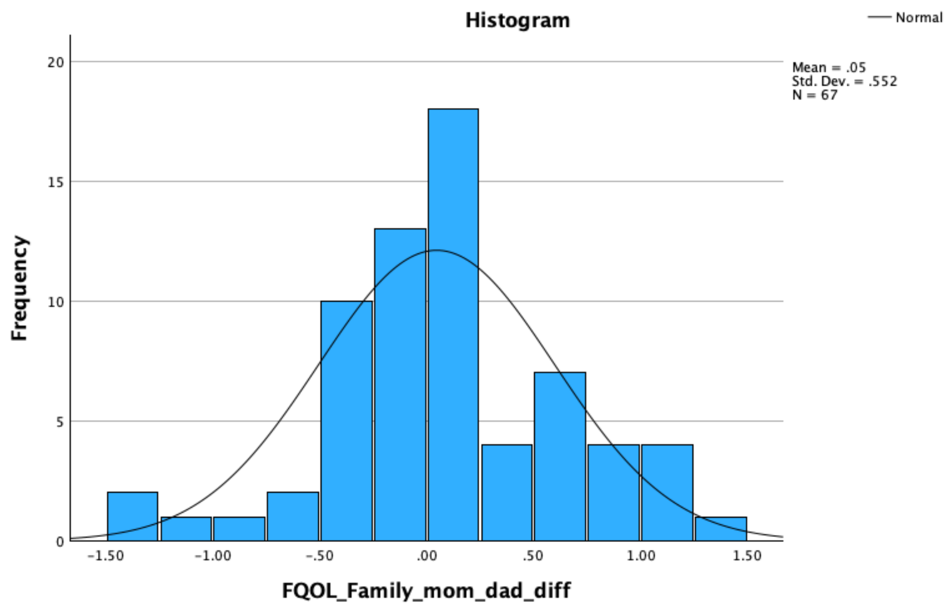
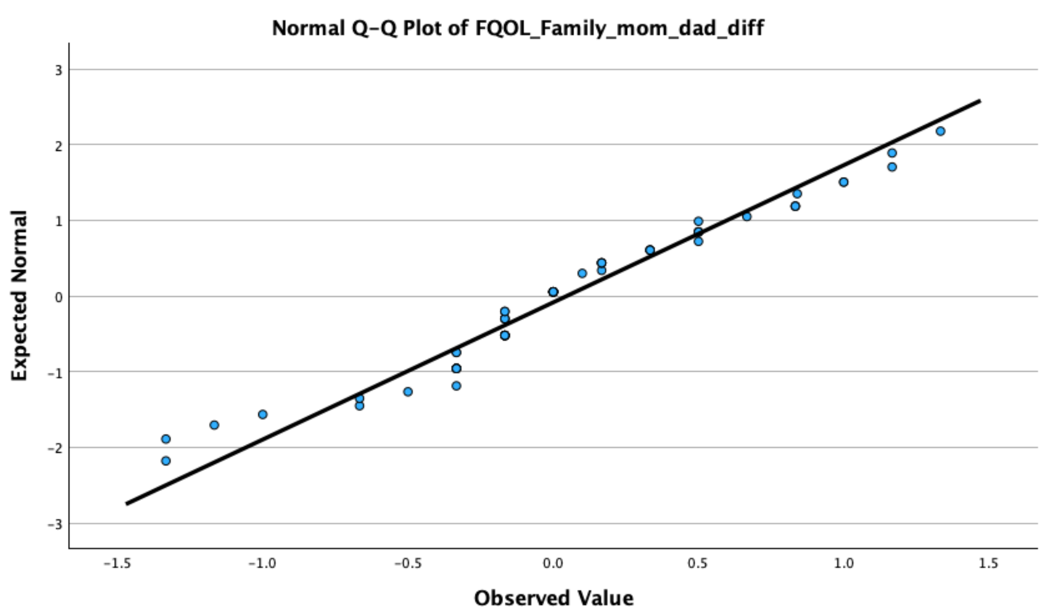


Figure F-26b.2

Research Question 26b – Expected Normal Probability Plot



Exploratory Research Question 27

Table F-27

Assumption Testing – RQ 27: Parenting Between Mothers & Fathers			
	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
27a: NT Group	0.09 (0.52)	-0.84 (1.01)	$W(19) = .97$, p = .691
27b: ASD and/or ADHD Group	-0.36 (0.29)	0.03 (0.58)	$W(67) = .98$, $p = .352$

Research Question 27a.

Figure F-27a.1

Research Question 27a – Normality Histogram

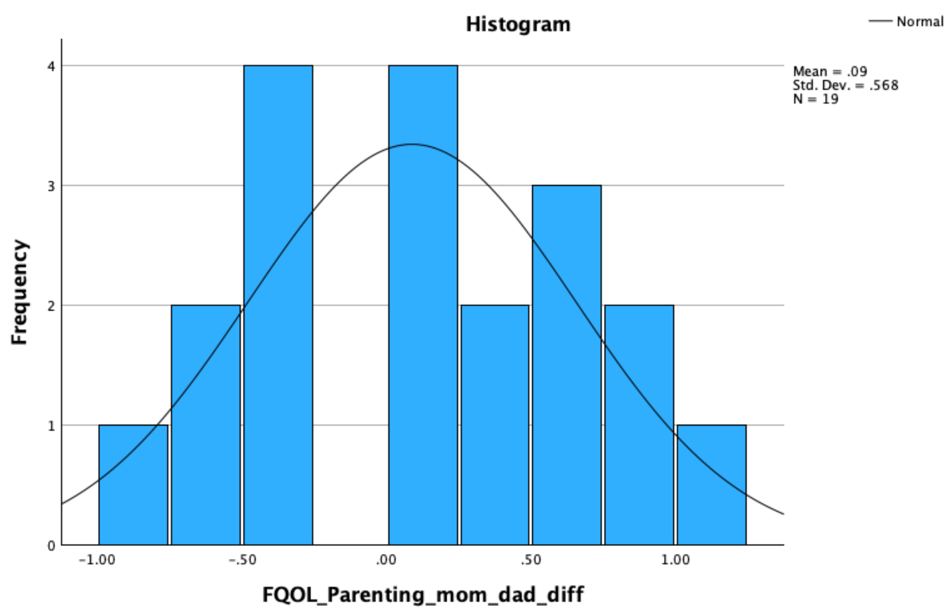
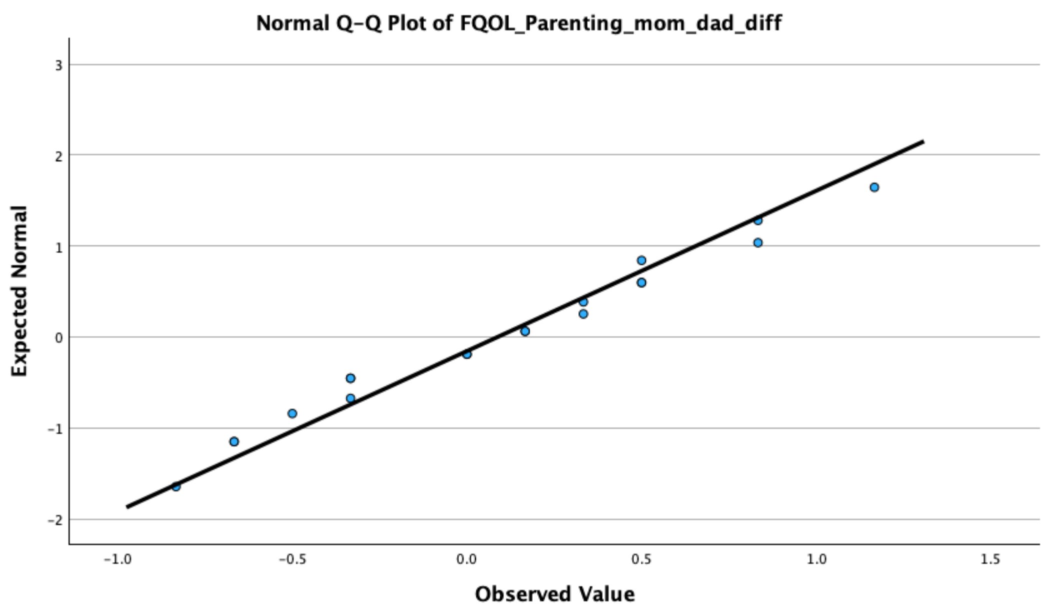


Figure F-27a.2

Research Question 27a – Expected Normal Probability Plot



Research Question 27b.

Figure F-27b.1

Research Question 27b – Normality Histogram

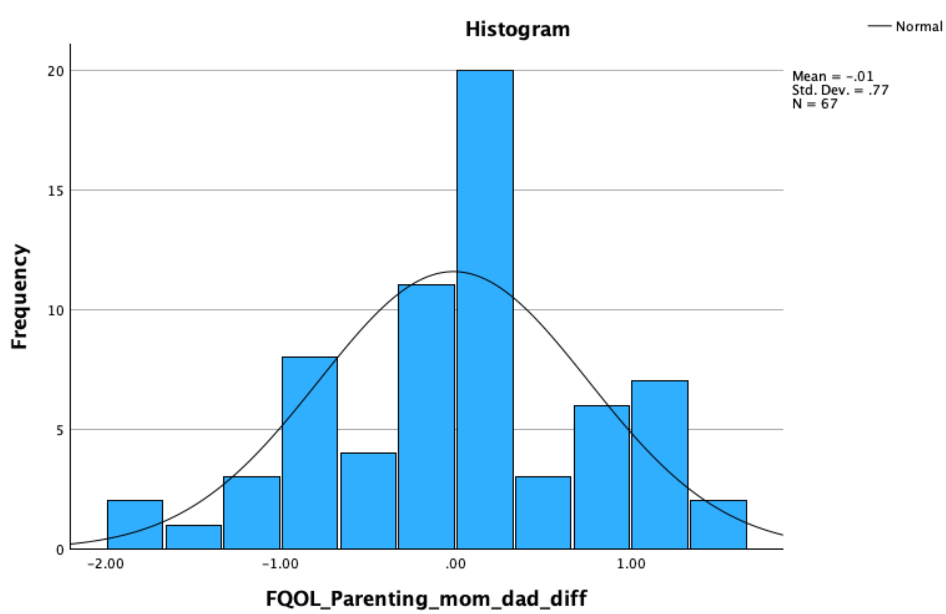
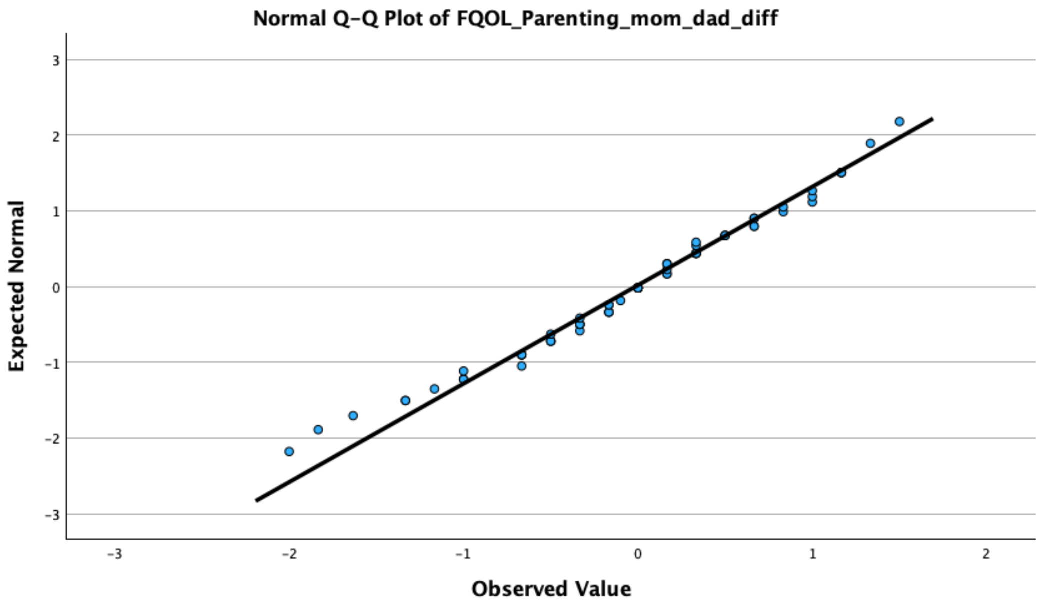


Figure F-27b.2

Research Question 27b – Expected Normal Probability Plot



Exploratory Research Question 28

Table F-28

Assumption Testing – RQ 28: Emotional Well-Being Between Mothers & Fathers

	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
28a: NT Group	0.69 (0.52)	0.40 (1.01)	$W(19) = .96$, $p = .489$
28b: ASD and/or ADHD Group	-0.09 (0.29)	-0.10 (0.58)	$W(67) = .99$, $p = .727$

Research Question 28a.

Figure F-28a.1

Research Question 28a – Normality Histogram

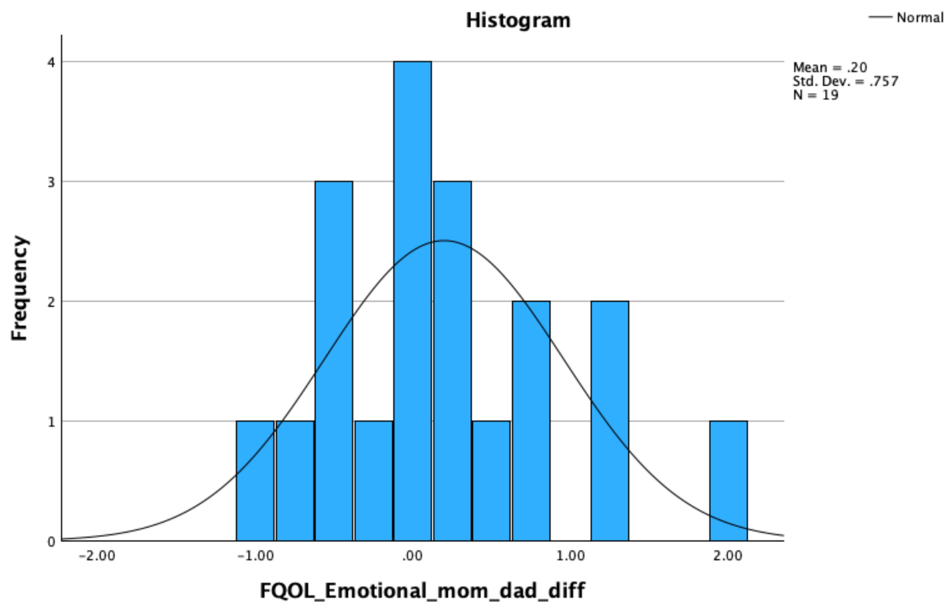
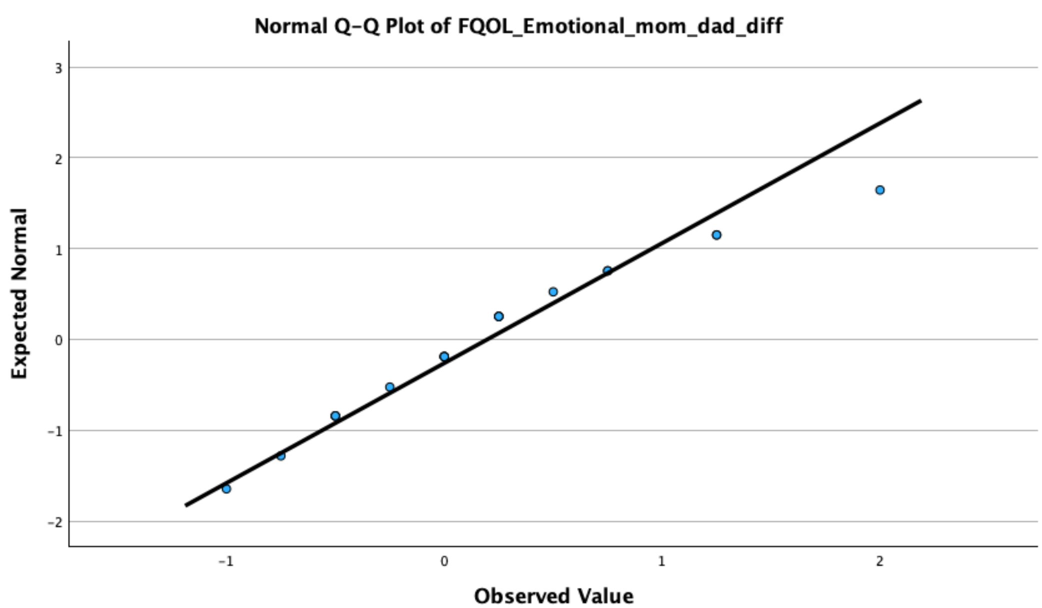


Figure F-28a.2

Research Question 28a – Expected Normal Probability Plot



Research Question 28b.

Figure F-28b.1

Research Question 28b – Normality Histogram

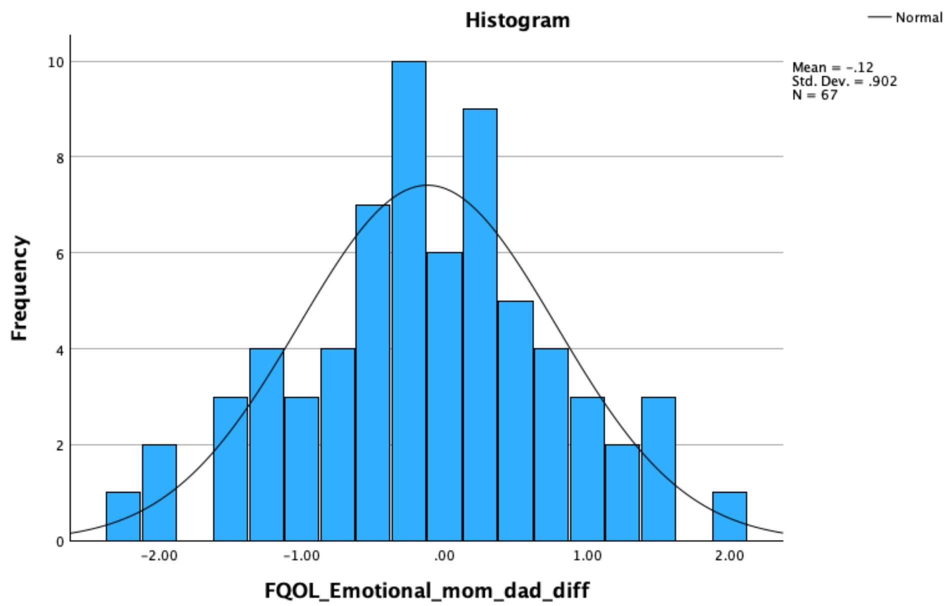
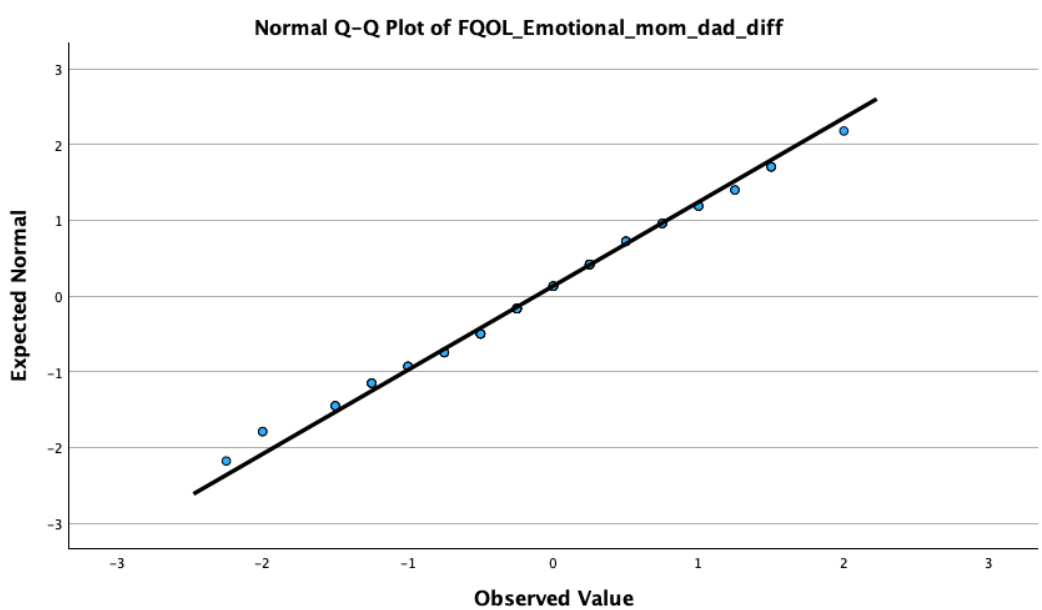


Figure F-28b.2

Research Question 28b – Expected Normal Probability Plot



Exploratory Research Question 29

Table F-29

Assumption Testing – RQ 29: Physical/Material Well-Being Between Mothers & Fathers			
	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
29a: NT Group	0.74 (0.52)	0.42 (1.01)	$W(19) = .91$, p = .076
29b: ASD and/or ADHD Group	1.26 (0.29)	5.47 (0.58)	$W(67) = .90$, $p < .001$

Research Question 29a.

Figure F-29a.1

Research Question 29a – Normality Histogram

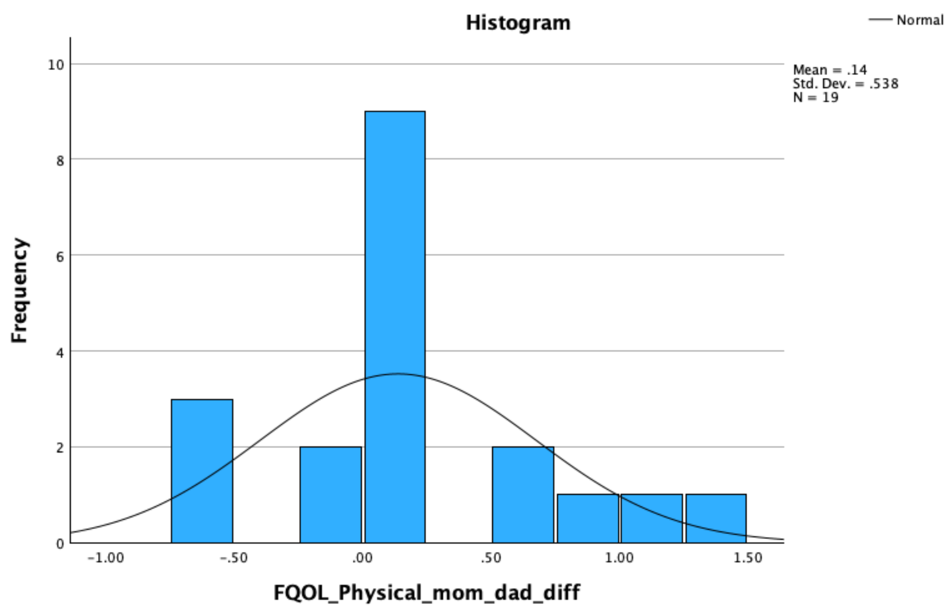
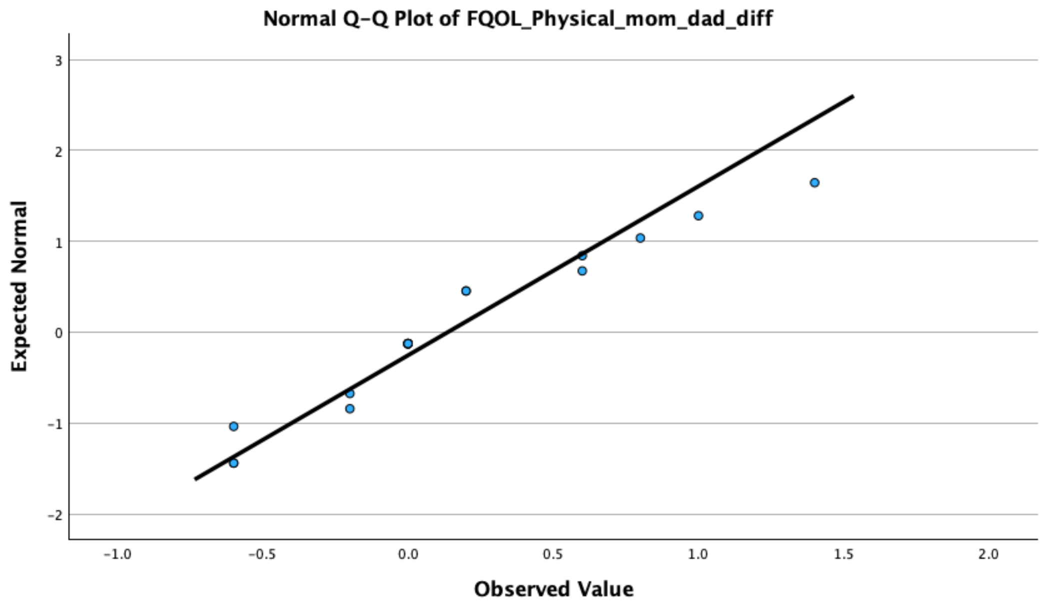


Figure F-29a.2

Research Question 29a – Expected Normal Probability Plot



Research Question 29b.

Figure F-29b.1

Research Question 29b – Normality Histogram

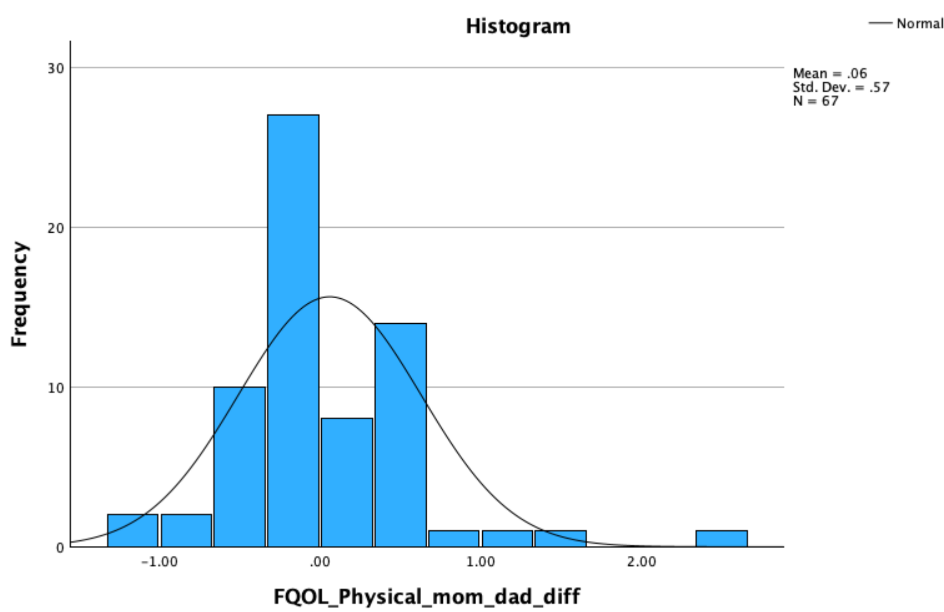
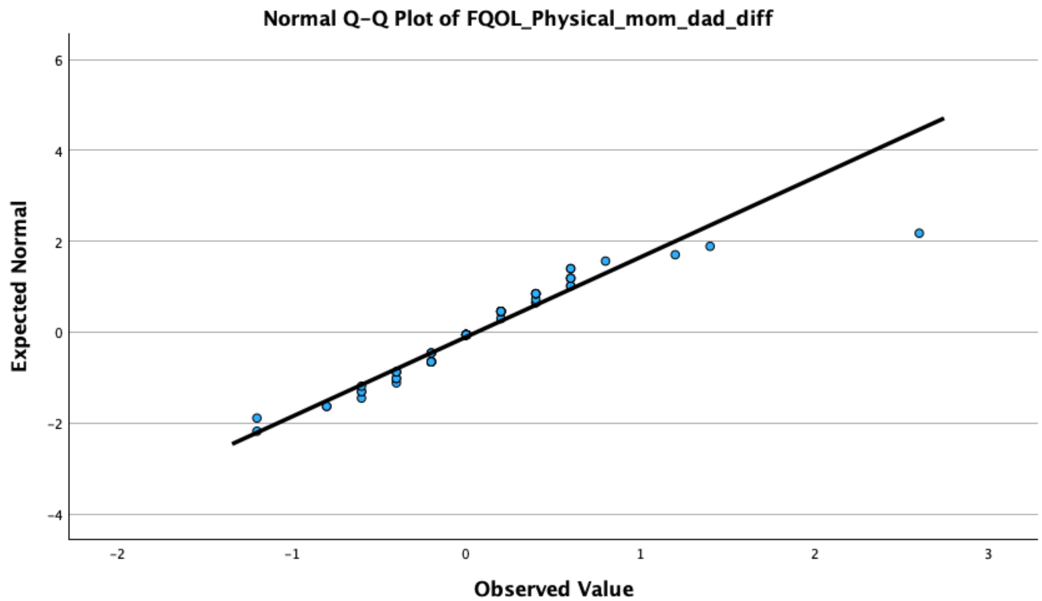


Figure F-29b.2

Research Question 29b – Expected Normal Probability Plot



Exploratory Research Question 30

Table F-30

Assumption Testing – RQ 30: Disability-Related Support Between Mothers & Fathers			
	Skewness Statistic (SE)	Kurtosis Statistic (SE)	Shapiro-Wilk Test
30a: NT Group	0.15 (0.52)	0.08 (1.01)	$W(19) = .94$, p = .308
30b: ASD and/or ADHD Group	-0.13 (0.29)	1.69 (0.58)	$W(67) = .95$, $p = .005$

Research Question 30a.

Figure F-30a.1

Research Question 30a – Normality Histogram

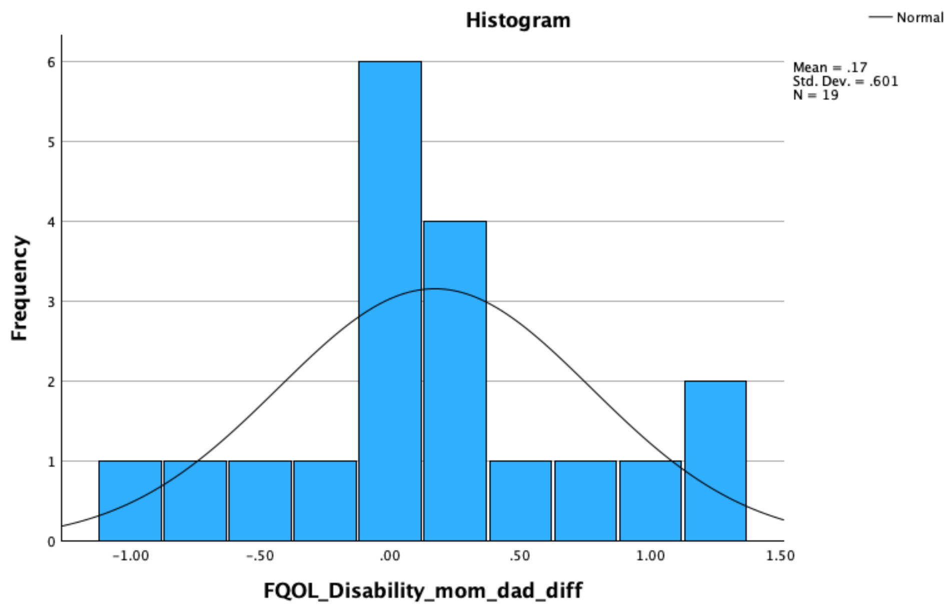
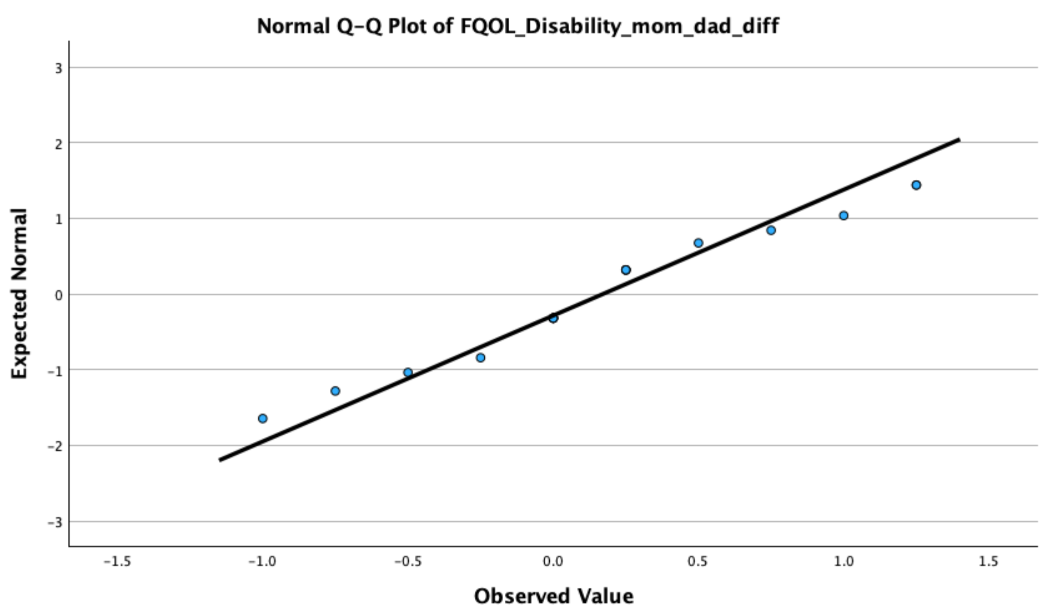


Figure F-30a.2

Research Question 30a – Expected Normal Probability Plot



Research Question 30b.

Figure F-30b.1

Research Question 30b – Normality Histogram

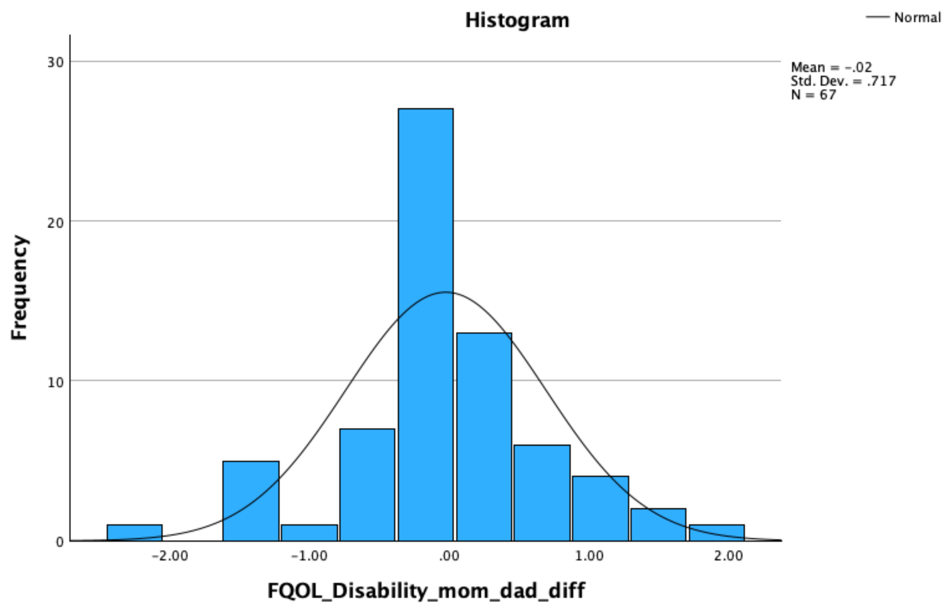
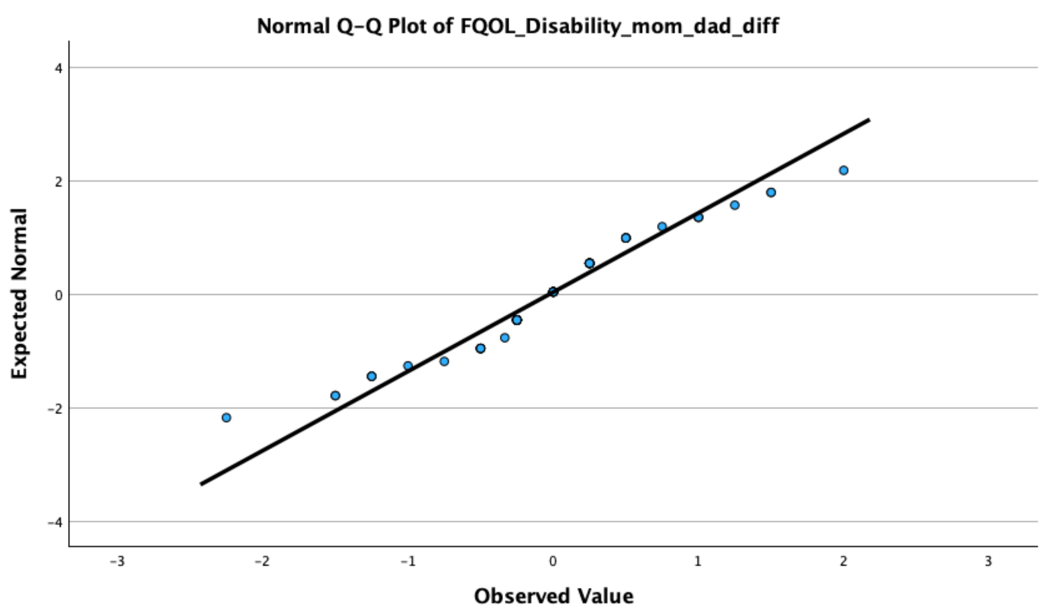


Figure F-30b.2

Research Question 30b – Expected Normal Probability Plot



Appendix G

Cronbach's Alphas

Table G-1

Cronbach Alphas – Mothers

Instrument	Items	*N*	Cronbach's α	Interpretation
Social Communication Questionnaire (SCQ)	39	250	.73	Acceptable
ADHD Rating Scale-5 (ADHD-RS-5)	18	283	.95	Excellent
Developmental Profile 4 (DP-4) - Cognitive Scale	42	262	.94	Excellent
Strengths and Difficulties Questionnaire (SDQ) - Conduct Difficulties Scale	10	276	.71	Acceptable
Coparenting Relationship Scale (CRS)	35	251	.95	Excellent
Family Quality of Life Scale (FQOL)	25	280	.94	Excellent

Table G-2

Cronbach Alphas – Fathers

Instrument	Items	*N*	Cronbach's α	Interpretation
Social Communication Questionnaire (SCQ)	39	128	.89	Good
ADHD Rating Scale-5 (ADHD-RS-5)	18	155	.96	Excellent
Developmental Profile 4 (DP-4) - Cognitive Scale	42	151	.93	Excellent
Strengths and Difficulties Questionnaire (SDQ) - Conduct Difficulties Scale	10	157	.83	Good
Coparenting Relationship Scale (CRS)	35	154	.92	Excellent
Family Quality of Life Scale (FQOL)	25	161	.93	Excellent

Appendix H

Tables Displaying Results of Nonsignificant Exploratory Analyses

Research Question 7a.

Table H-7a

RQ 7a – Mothers' Coparenting Agreement Across Groups

Measure	NT Group (n = 76)		ASD Group (n = 11)		ADHD Group (n = 96)		ASD+ADHD Group (n = 68)		$F(3, 247)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Coparenting Agreement	4.27	1.38	4.14	1.64	3.79	1.41	3.68	1.53	2.41	.03

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Research Question 8b.

Table H-8b

RQ 8b – Fathers' Coparenting Closeness Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 27)		ADHD Group (n = 27)		ASD+ADHD Group (n = 66)		$F(3, 151)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Coparenting Closeness	4.49	1.31	4.26	0.90	4.29	0.83	4.24	0.87	0.53	.01

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Research Question 10a.

Table H-10a

RQ 10a – Mothers' Coparenting Support Across Groups

Measure	NT Group (n = 76)		ASD Group (n = 11)		ADHD Group (n = 96)		ASD+ADHD Group (n = 68)		$F(3, 247)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Coparenting Support	4.55	1.48	4.48	1.77	3.98	1.46	4.01	1.58	2.54	.03

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Research Question 10b.

Table H-10b

RQ 10b – Fathers' Coparenting Support Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 26)		ADHD Group (n = 27)		ASD+ADHD Group (n = 65)		$F(3, 149)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Coparenting Support	4.53	1.36	4.90	1.06	4.13	1.20	4.73	1.03	2.40	.05

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Research Question 13a.

Table H-13a

RQ 13a – Mothers' Division of Labor Across Groups

Measure	NT Group (n = 75)		ASD Group (n = 10)		ADHD Group (n = 97)		ASD+ADHD Group (n = 68)		$F(3, 246)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Division of Labor	4.02	1.72	3.50	2.12	3.69	1.86	3.52	1.70	1.03	.01

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Research Question 16b.

Table H-16b

RQ 16b – Fathers' Emotional Well-Being Across Groups

Measure	NT Group (n = 35)		ASD Group (n = 28)		ADHD Group (n = 30)		ASD+ADHD Group (n = 73)		$F(3, 162)$	η^2
	M	SD	M	SD	M	SD	M	SD		
Emotional Well-Being	4.01	0.64	3.88	0.59	3.87	0.57	3.84	0.66	0.91	.02

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Research Question 19a.

Table H-19a

RQ 19a – Coparenting Agreement of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(14)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Coparenting Agreement	4.71	0.74	4.38	0.90	1.01	.330	0.260

Research Question 19b.

Table H-19b

RQ 19b – Coparenting Agreement of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		*t*(56)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Coparenting Agreement	3.01	1.27	3.05	1.36	-0.22	.829	-0.029

Research Question 20a.

Table H-20a

RQ 20a – Coparenting Closeness of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(14)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Coparenting Closeness	4.85	0.72	4.63	1.13	0.69	.504	0.177

Research Question 20b.

Table H-20b

RQ 20b – Coparenting Closeness of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		*t*(56)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Coparenting Closeness	4.21	1.16	4.21	1.00	-0.01	.995	-0.001

Research Question 21a.

Table H-21a

RQ 21a – Exposure to Conflict of Paired Parents in the NT Group

Measure	Mothers		Fathers		$t(14)$	p	Cohen's d
	M	SD	M	SD			
Exposure to Conflict	0.61	0.29	0.60	0.36	0.18	.860	0.046

Research Question 21b.

Table H-21b

RQ 21b – Exposure to Conflict of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		$t(55)$	p	Cohen's d
	M	SD	M	SD			
Exposure to Conflict	2.10	1.87	2.39	1.92	-1.76	.083	-0.236

Research Question 22b.

Table H-22b

RQ 22b – Coparenting Support of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		$t(55)$	p	Cohen's d
	M	SD	M	SD			
Coparenting Support	4.57	1.11	4.63	1.11	-0.35	.727	-0.047

Research Question 23b.

Table H-23b

RQ 23b – Coparenting Undermining of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		$t(55)$	p	Cohen's d
	M	SD	M	SD			
Coparenting Undermining	2.52	1.99	2.89	1.90	-1.83	.072	-0.245

Research Question 24a.

Table H-24a

RQ 24a – Endorsement of Partner Parenting of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(14)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Endorsement of Partner Parenting	4.97	0.92	5.29	0.48	-1.12	.282	-0.289

Research Question 24b.

Table H-24b

RQ 24b – Endorsement of Partner Parenting of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		*t*(56)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Endorsement of Partner Parenting	4.16	1.09	4.29	0.96	-0.83	.408	-0.110

Research Question 25a.

Table H-25a

RQ 25a – Division of Labor of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(14)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Division of Labor	4.87	1.22	4.67	0.99	0.52	.610	0.135

Research Question 25b.

Table H-25b

RQ 25b – Division of Labor of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		*t*(53)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Division of Labor	3.13	2.15	2.97	2.06	0.70	.484	0.096

Research Question 26a.

Table H-26a

RQ 26a – Family Interaction of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(19)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Family Interaction	4.37	0.47	4.11	0.61	1.87	.078	0.428

Research Question 26b.

Table H-26b

RQ 26b – Family Interaction of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		*t*(66)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Family Interaction	4.07	0.60	4.02	0.52	0.69	.494	0.084

Research Question 27a.

Table H-27a

RQ 27a – Parenting of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(18)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Parenting	4.25	0.71	4.16	0.61	0.67	.509	0.155

Research Question 27b.

Table H-27b

RQ 27b – Parenting of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		*t*(66)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Parenting	4.02	0.69	4.03	0.58	-0.14	.887	-0.017

Research Question 28a.

Table H-28a

RQ 28a – Emotional Well-Being of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(18)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Emotional Well-Being	4.18	0.89	3.99	0.69	1.14	.271	0.261

Research Question 28b.

Table H-28b

RQ 28b – Emotional Well-Being of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		*t*(66)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Emotional Well-Being	3.57	1.02	3.69	0.93	-1.08	.282	-0.132

Research Question 29a.

Table H-29a

RQ 29a – Physical/Material Well-Being of Paired Parents in the NT Group

Measure	Mothers		Fathers		*t*(18)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Physical/Material Well-Being	4.43	0.46	4.29	0.49	1.11	.282	0.254

Research Question 29b.

Table H-29b

RQ 29b – Physical/Material Well-Being of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		*t*(66)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Physical/Material Well-Being	4.19	0.59	4.13	0.64	0.86	.394	0.105

Research Question 30a.

Table H-30a

RQ 30a – Disability-Related Support of Paired Parents in the NT Group

Measure	Mothers		Fathers		$t(18)$	p	Cohen's d
	M	SD	M	SD			
Disability-Related Support	4.33	0.43	4.16	0.49	1.24	.231	0.285

Research Question 30b.

Table H-30b

RQ 30b – Disability-Related Support of Paired Parents in the Clinical Group

Measure	Mothers		Fathers		$t(66)$	p	Cohen's d
	M	SD	M	SD			
Disability-Related Support	3.92	0.76	3.95	0.68	-0.27	.788	-0.033

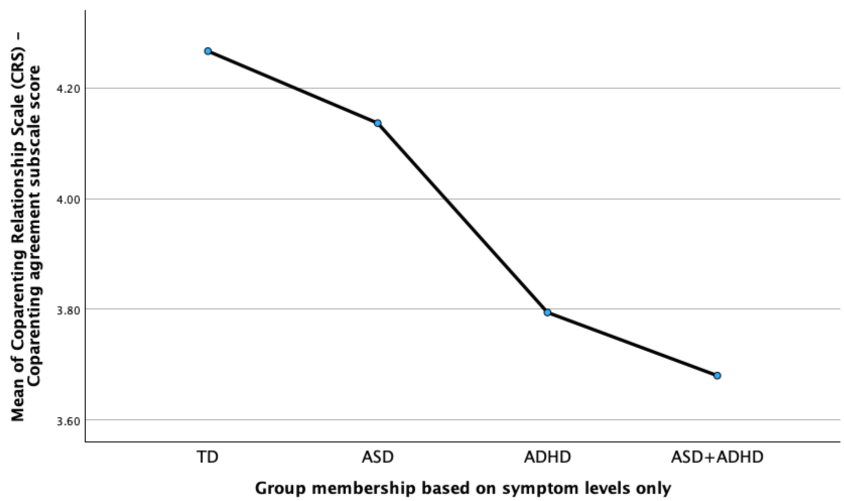
Appendix I

Graphs Displaying Results of Exploratory Analyses

Research Question 7a.

Figure I-7a

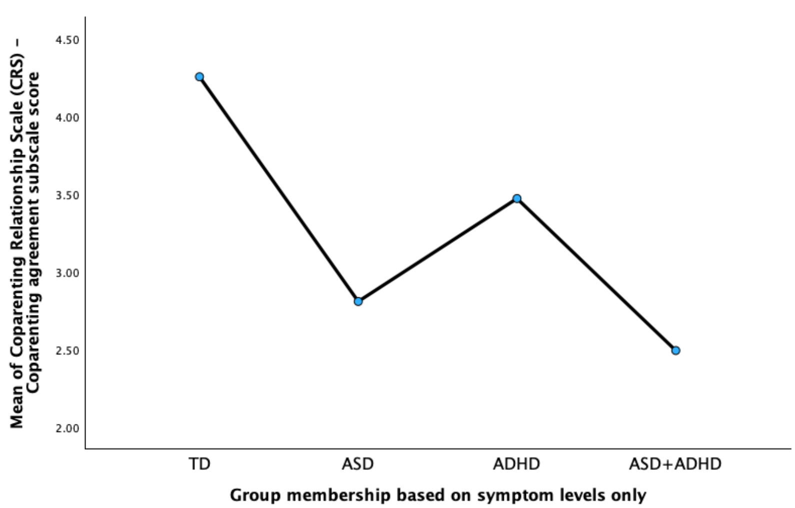
Research Question 7a – Graph Representing Mothers' Coparenting Agreement Across Groups



Research Question 7b.

Figure I-7b

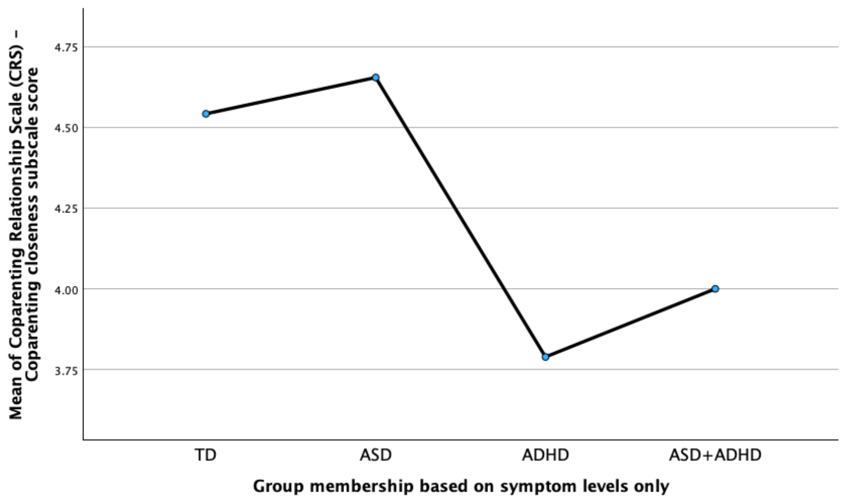
Research Question 7b – Graph Representing Fathers' Coparenting Agreement Across Groups



Research Question 8a.

Figure I-8a

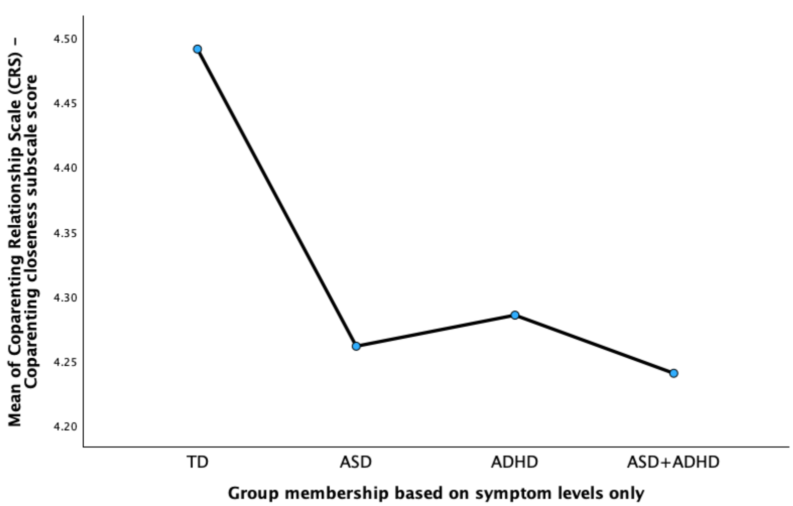
Research Question 8a – Graph Representing Mothers' Coparenting Closeness Across Groups



Research Question 8b.

Figure I-8b

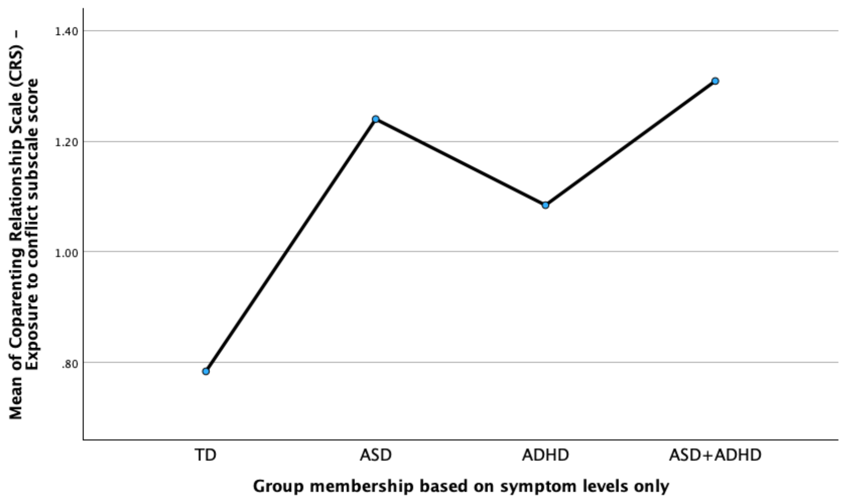
Research Question 8b – Graph Representing Fathers' Coparenting Closeness Across Groups



Research Question 9a.

Figure I-9a

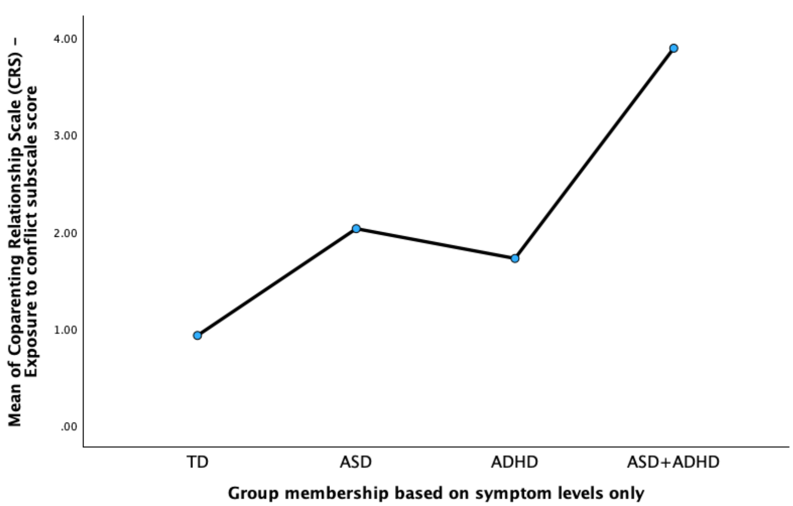
Research Question 9a – Graph Representing Mothers' Exposure to Conflict Across Groups



Research Question 9b.

Figure I-9b

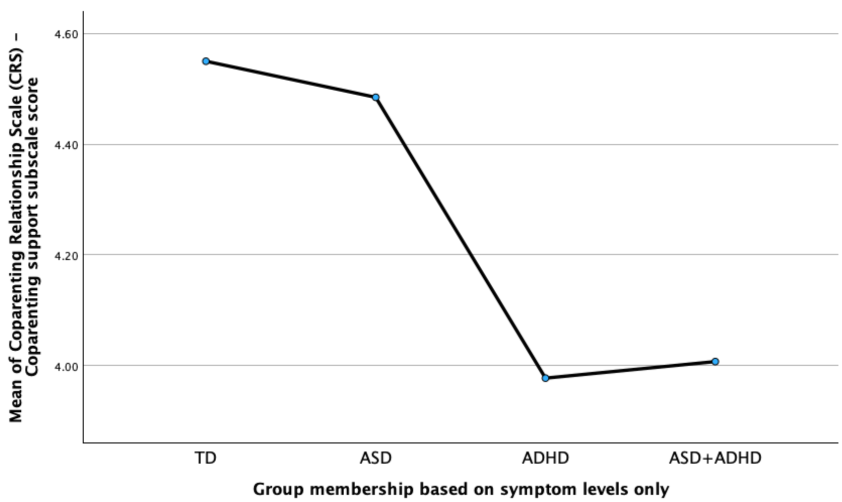
Research Question 9b – Graph Representing Fathers' Exposure to Conflict Across Groups



Research Question 10a.

Figure I-10a

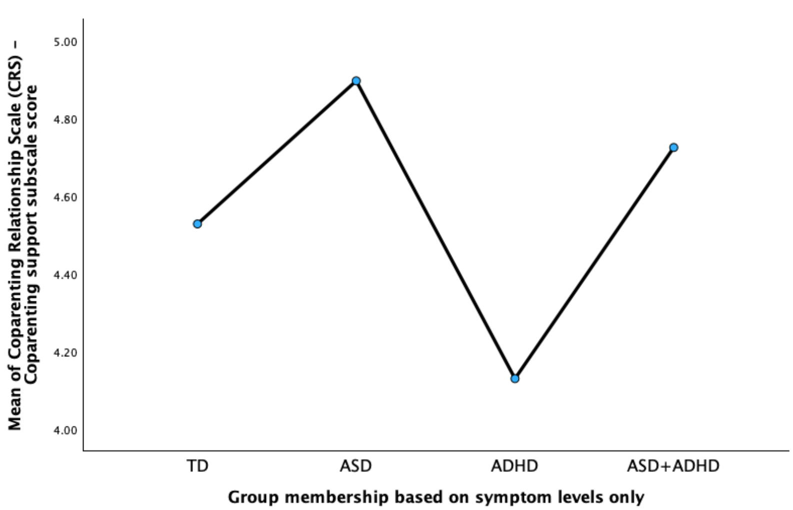
Research Question 10a – Graph Representing Mothers' Coparenting Support Across Groups



Research Question 10b.

Figure I-10b

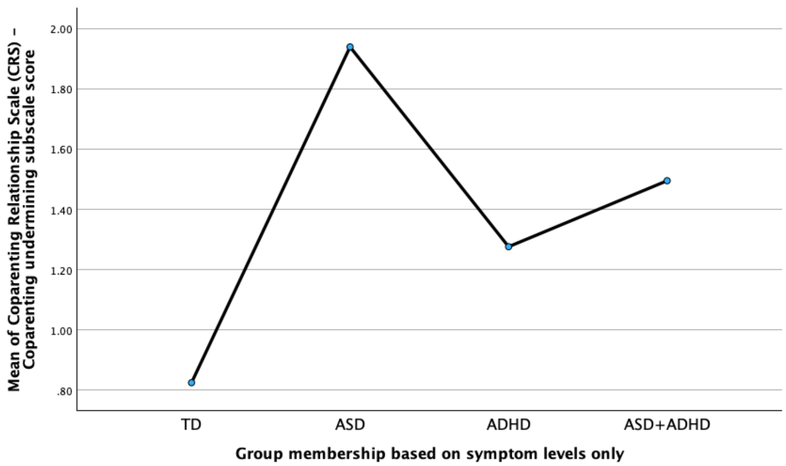
Research Question 10b – Graph Representing Fathers' Coparenting Support Across Groups



Research Question 11a.

Figure I-11a

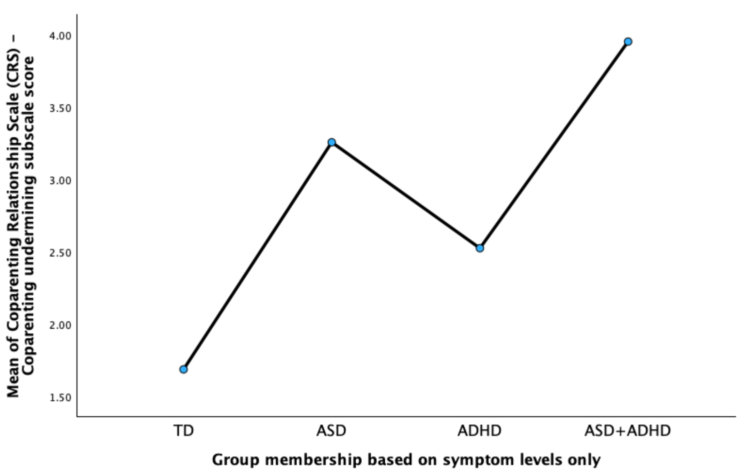
Research Question 11a – Graph Representing Mothers' Coparenting Undermining Across Groups



Research Question 11b.

Figure I-11b

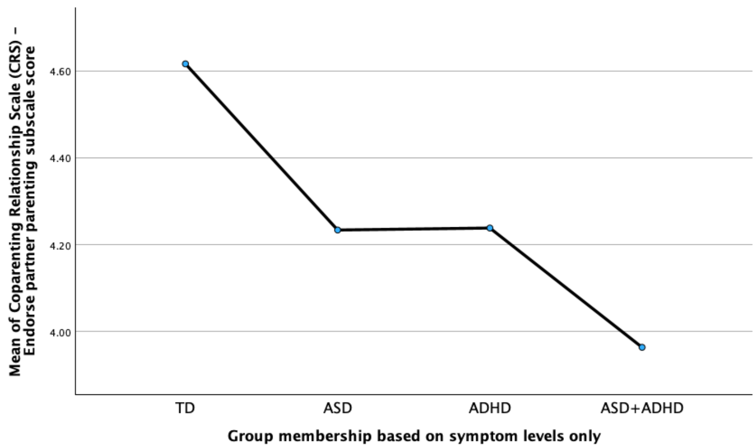
Research Question 11b – Graph Representing Fathers' Coparenting Undermining Across Groups



Research Question 12a.

Figure I-12a

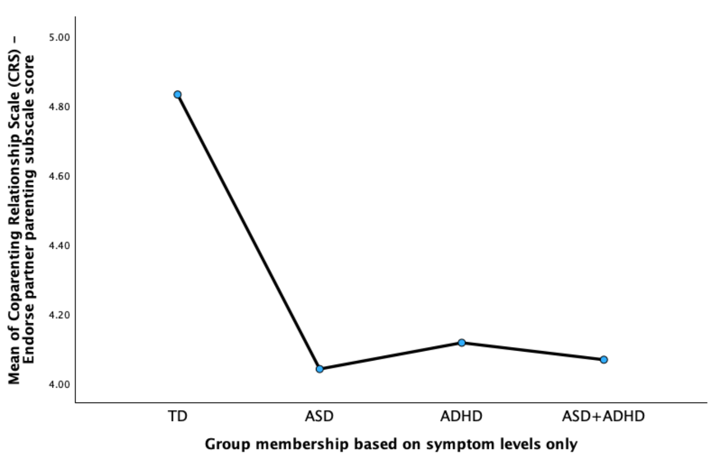
Research Question 12a – Graph Representing Mothers' Endorsement of Partner Parenting Across Groups



Research Question 12b.

Figure I-12b

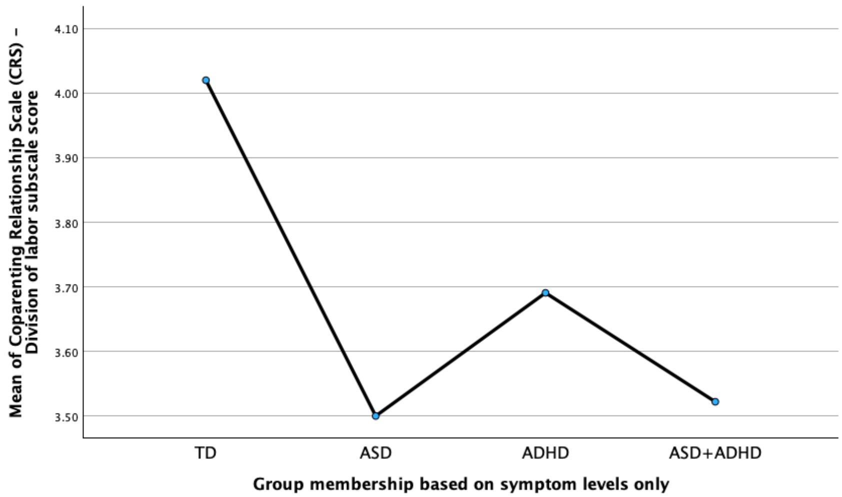
Research Question 12b – Graph Representing Fathers' Endorsement of Partner Parenting Across Groups



Research Question 13a.

Figure I-13a

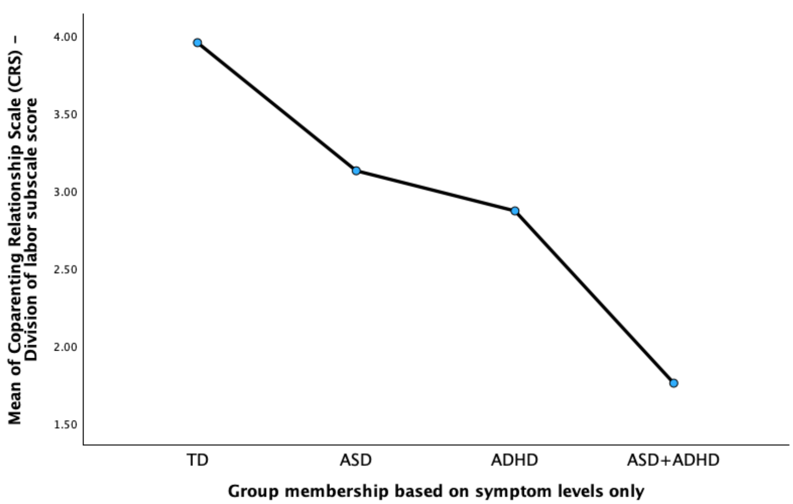
Research Question 13a – Graph Representing Mothers' Division of Labor Across Groups



Research Question 13b.

Figure I-13b

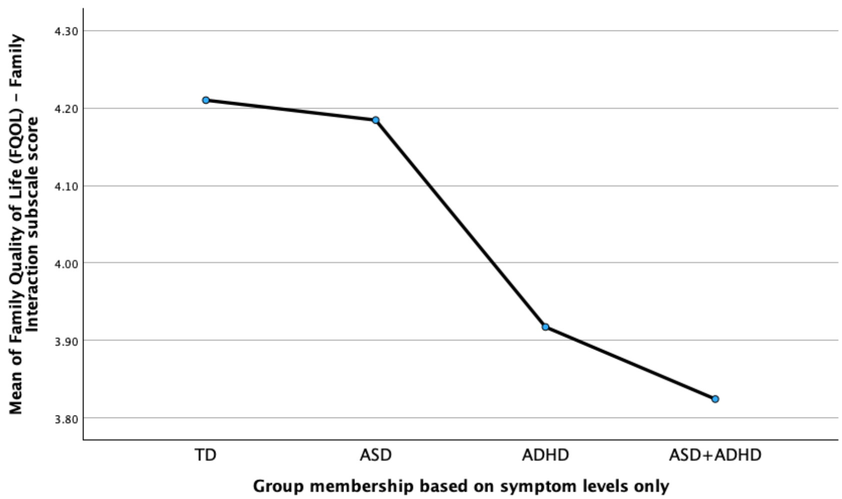
Research Question 13b – Graph Representing Fathers' Division of Labor Across Groups



Research Question 14a.

Figure I-14a

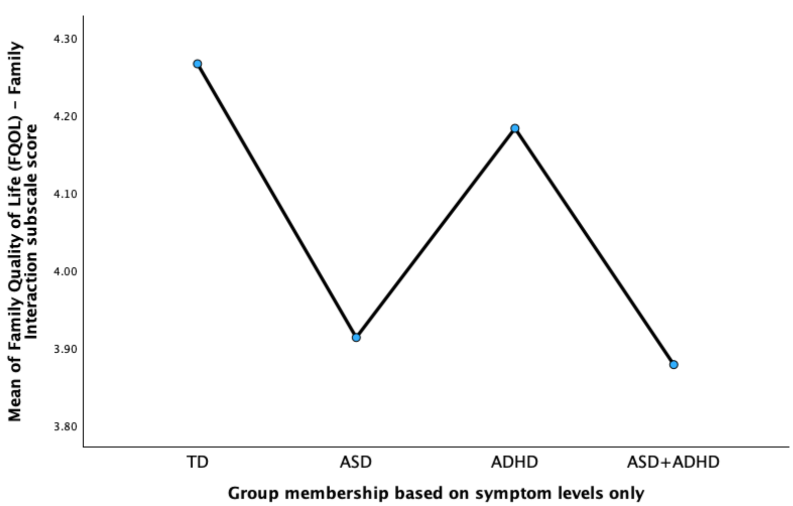
Research Question 14a – Graph Representing Mothers' Family Interaction Across Groups



Research Question 14b.

Figure I-14b

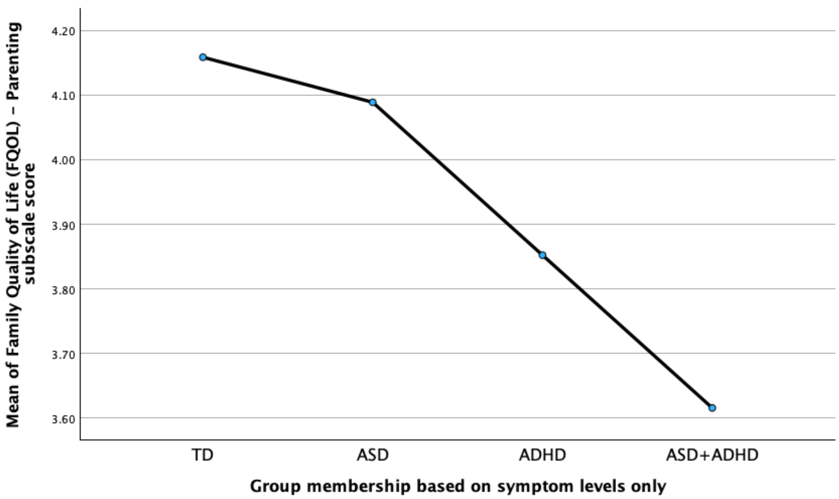
Research Question 14b – Graph Representing Fathers' Family Interaction Across Groups



Research Question 15a.

Figure I-15a

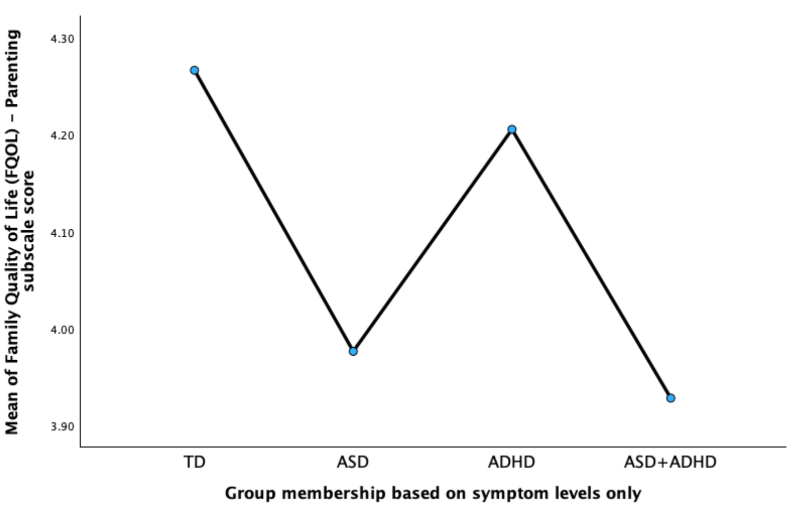
Research Question 15a – Graph Representing Mothers' Parenting Across Groups



Research Question 15b.

Figure I-15b

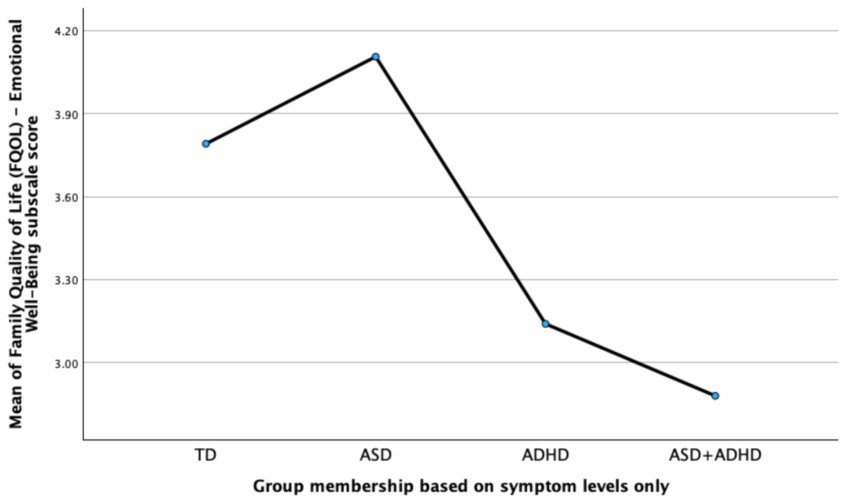
Research Question 15b – Graph Representing Fathers' Parenting Across Groups



Research Question 16a.

Figure I-16a

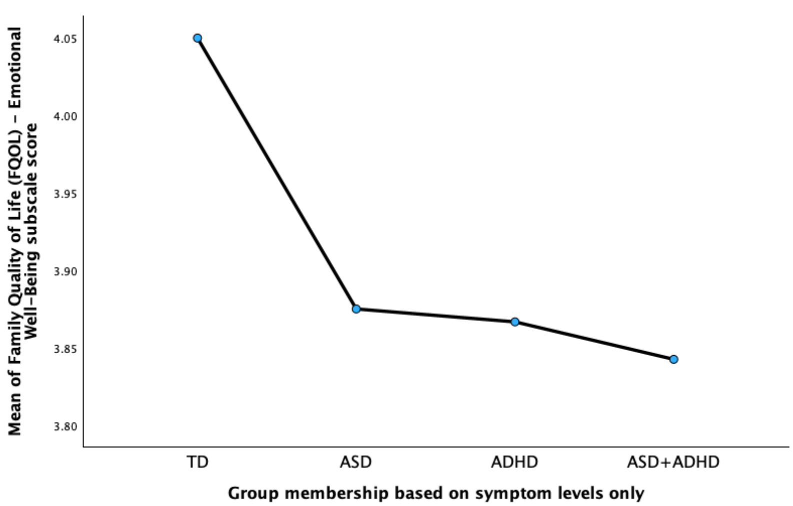
Research Question 16a – Graph Representing Mothers' Emotional Well-Being Across Groups



Research Question 16b.

Figure I-16b

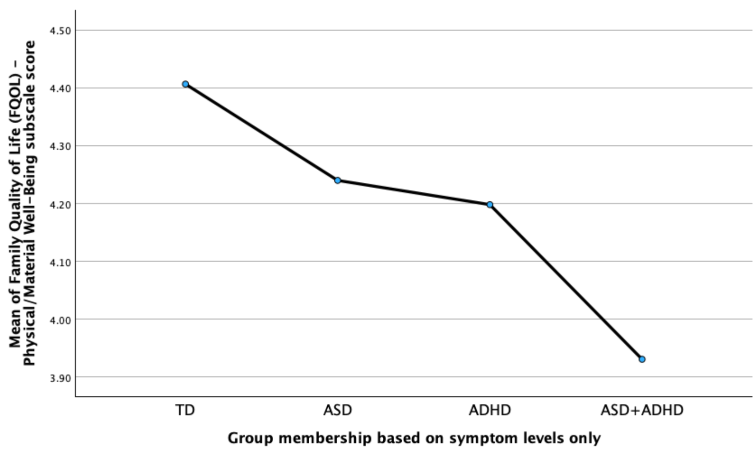
Research Question 16b – Graph Representing Fathers' Emotional Well-Being Across Groups



Research Question 17a.

Figure I-17a

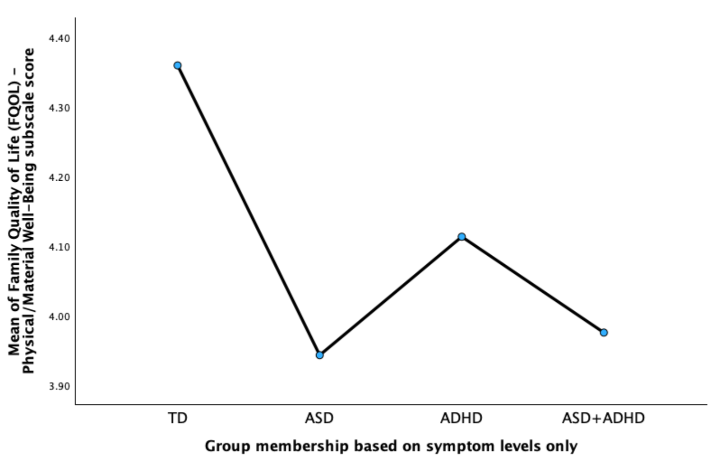
Research Question 17a – Graph Representing Mothers' Physical/Material Well-Being Across Groups



Research Question 17b.

Figure I-17b

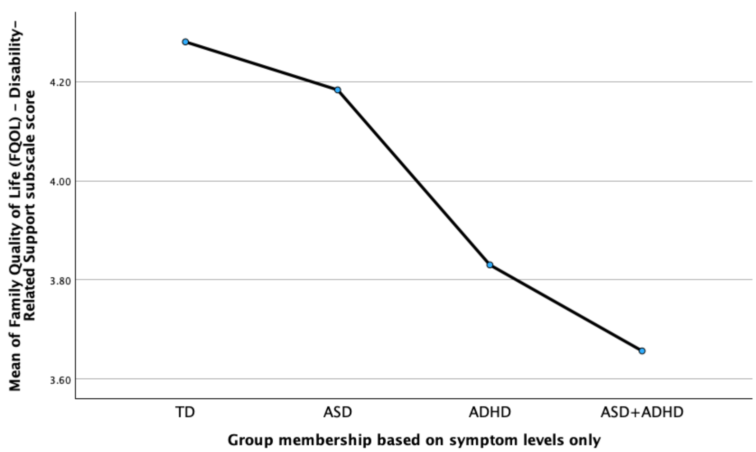
Research Question 17b – Graph Representing Fathers' Physical/Material Well-Being Across Groups



Research Question 18a.

Figure I-18a

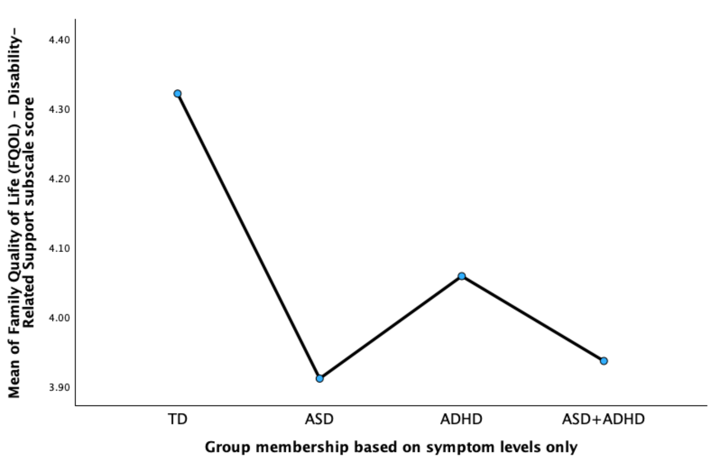
Research Question 18a – Graph Representing Mothers' Disability-Related Support Across Groups



Research Question 18b.

Figure I-18b

Research Question 18b – Graph Representing Fathers' Disability-Related Support Across Groups



Appendix J

Summary of Key Findings

- *Differences in coparenting across parents of children with symptoms of ADHD, ASD, ASD+ADHD, and parents of NT children.*
    - **Mothers:** mothers of NT children had higher *coparenting quality* (M = 4.70, SD = .95) than mothers of children with clinically significant symptoms of ADHD (M = 4.23, SD = 1.00; $p = .016$) or ASD+ADHD (M = 4.12, SD = 1.17; $p = .006$).
    - **Fathers:** fathers of NT children had higher levels of *coparenting quality* (M = 4.56, SD = .97) than fathers of children with ASD (M = 3.78, SD = .82; p = .003), ADHD (M = 3.91, SD = .79; p = .020), and ASD+ADHD (M = 3.28, SD = .98; p < .001). Fathers of children with ADHD had higher *coparenting quality* than fathers of children with ASD+ADHD (p = .009).
- *Differences in FQOL across parents of children with symptoms of ADHD, ASD, ASD+ADHD, and parents of NT children.*
    - **Mothers:** mothers of NT children had higher *FQOL* (M = 4.19, SD = .61) than mothers of children with clinically significant symptoms of ADHD (M = 3.82, SD = .55; $p < .001$) or ASD+ADHD (M = 3.62, SD = .62; $p < .001$). Mothers of children with ASD alone also had higher FQOL (M = 4.16, SD = .74) than those with ASD+ADHD ($p = .009$).
    - **Fathers:** fathers of NT children had higher FQOL (M = 4.26, SD = .52) than fathers of children with ASD+ADHD (M = 3.91, SD = .59; p = .010).
- *Differences between paired mothers and fathers.*
    - **Dyads:** No significant differences in *coparenting quality* or *FQOL* between mothers and fathers of TD children or children with ASD and/or ADHD.
- *Coparenting quality predicting higher FQOL in parents after controlling for child cognitive functioning and child age.*
    - **Mothers:** higher coparenting quality predicted higher FQOL in mothers of NT children (p <.001; $\Delta R^2 = .34$), children with ADHD (p < .001, $\Delta R^2 = .32$) and ASD+ADHD (p < .001, $\Delta R^2 = .19$).
    - **Fathers:** higher coparenting quality predicted higher FQOL in fathers of NT children (p < .001, $\Delta R^2 = .35$), and fathers of children with ASD (p = .006, $\Delta R^2 = .23$) and ASD+ADHD (p = .028, $\Delta R^2 = .06$).
    - **Dyads:** higher composite coparenting quality predicted higher composite FQOL in paired parents of NT children (p = .017, $\Delta R^2 = .26$)
- *Clinical levels of child ASD, ADHD, and ASD+ADHD symptomology did not moderate the relation between **mothers’**, **fathers’**, nor **dyads’** coparenting quality and FQOL.*

Appendix K

Discussion of Results of Nonsignificant Exploratory Analyses

Exploratory Analyses of Aspects of Coparenting Across Neurodevelopmental Groups of Mothers

Results indicated no significant differences between the coparenting agreement, coparenting support, and division of labor scores of mothers across groups. Nonsignificant results for these subscales and for some neurodevelopmental groups across other subscales may have been influenced by issues pertaining to the subsamples, which may have had an impact on the power of this analysis to detect true effects. First, many of the distributions of scores deviated from normality. Second, the subsample of mothers of children with ASD was quite small (n = 11) and sometimes appeared bimodal (e.g., coparenting support). Third, there may have been a degree of sampling bias affecting some scores, in that the mothers of children with NDs who choose to participate in research studies may be less stressed, more intentional about coparenting, or active in learning and advocating for their children.

Alternatively, these results may indicate that many mothers of children with and without NDs experience relatively similar level of coparenting agreement, support, and division of labor. It may take time and resources for parents to discuss and come to agreement on childrearing issues and parents who experience greater parenting stress may find it more difficult to coordinate in such a way; however, it may be the case that parents of children with more complex behavioural challenges, such as children with neurodevelopmental disorders, may intentionally spend more time discussing their parenting approaches due to a perceived need to present a united front and create consistency for their children (e.g., Downes & Cappe, 2021; Hock et al., 2012). Furthermore, qualitative research suggests that some parents of children with ASD perceive their child's ND as bringing the family closer together as they work to help their child (Myers et al., 2009). Thus, mothers of children with NDs may be intentionally engaging in processes that buffer against possible negative impacts of additional stress on the coparenting relationship.

Exploratory Analyses of Aspects of Coparenting Across Neurodevelopmental Groups of Fathers

Results demonstrated no significant difference in coparenting closeness or coparenting support scores of fathers across groups. Therefore, the presence of symptoms of NDs did not appear to impact the perceived coparenting closeness or support of fathers in this sample. The lack of significant differences in coparenting support scores may have been affected by deviations from normality in the distributions of some subgroups. Similar to the groups of mothers, many fathers reported high levels of coparenting support. This may have been influenced by sampling bias, as fathers who choose to participate in online research may also be fathers who experience less stress and who have more supportive coparenting relationships. Alternatively, these results may indicate that many fathers experience relatively high levels of coparenting support and coparenting closeness, regardless of child ND symptomology. As referred to above, some parents of children with ASD perceive their child's ND as bringing the family closer together (Myers et al., 2009).

Exploratory Analyses of Aspects of FQOL Across Neurodevelopmental Groups of Fathers

Results demonstrated no significant difference in emotional well-being scores of fathers across groups. While the pattern of scores was relatively consistent with overall FQOL in terms of the rank order of scores, the means were so close that there was no meaningful difference between fathers in this sample on emotional well-being. Based on these results, fathers of children with and without symptoms of ASD and/or ADHD experience relatively similar, and relatively high, levels of satisfaction with their emotional support/help from others outside the family and time to pursue interests.

Exploratory Analyses of Aspects of Coparenting Quality Between Paired Mothers and Fathers

Consistent with overall coparenting quality, there was no statistically significant difference in the coparenting agreement, coparenting closeness, exposure to conflict, endorsement of partner parenting, or satisfaction with the division of labor reported by mothers and fathers of NT children, nor between mothers and fathers of children with symptoms of NDs. As described above, given the engagement and organization required to coordinate participation of both parents, it is unsurprising that these coparents would be quite congruent in their views of their agreement on childrearing issues and experiences of shared joys of parenting. They may also be more likely to endorse positive views of their coparent's parenting skills than parents in the wider population. The lack of difference in exposure to conflict reported by mothers and fathers is conceptually unsurprising, as occurrences of conflictual interactions may be considered more objective than subjective experiences, such as degree of shared enjoyment or support. Given that previous research suggests mothers often take on more childrearing responsibility than fathers (Farr & Patterson, 2013; Raley et al., 2012; Van Egeren, 2004), it is possible that mothers in this sample were satisfied with this division of responsibility in their families. Alternatively, as suggested previously, parents within this sample may tend to have more egalitarian beliefs about family roles, as both parents took the time to share their parenting experiences.

Interestingly, despite the finding of significant differences between mothers and fathers of NT children, there was no significant difference in the coparenting support or coparenting undermining scores reported by mothers and fathers of children with symptoms of NDs. This was consistent with the nonsignificant difference in the overall coparenting quality. This result suggests that mothers and fathers of children with clinically significant levels of ND symptomology feel similarly supported by their coparent and experience similar levels of coparenting behaviours that compromise their parenting effectiveness or confidence from their coparent. It may be the case that having a child with a ND, and facing particular caregiving challenges, may prompt mothers and fathers in some families to intentionally support their coparent more. This interpretation is consistent with qualitative research indicating that some parents report that having a child with an ND has led to increased support within the family (Myers et al., 2009). Perhaps increased childrearing demands led both mothers and fathers in this sample to feel open to supporting their coparent in parenting. Given that, on average, both mothers and fathers of children with ND symptomology reported higher coparenting undermining than mothers and fathers of NT children, these results seem to suggest undermining occurring from both parents, rather than more prominent maternal gatekeeping. This may be associated with higher level of parenting demands and parenting stress in families of children with NDs (e.g., Brobst et al., 2009; Hayes & Watson, 2013; Kaiser et al., 2011; Theule et al., 2013).

Exploratory Analyses of Aspects of FQOL Between Paired Mothers and Fathers

Consistent with overall FQOL, there was no statistically significant difference in reported satisfaction with family interactions, parenting, emotional well-being, physical/material well-being, or disability-related support between mothers and fathers of either NT children nor between mothers and fathers of children with clinically significant symptoms of ASD and/or ADHD. These results suggest that mothers and fathers within the same families tend to be similarly satisfied with the quality time, communication, teamwork, and support between family members, as well as the support, teaching, and understanding provided to the children by family members. This is consistent with the lack of significant difference for other variables that may be connected to family interactions, such as coparenting closeness and division of labor. These results also indicate that mothers and fathers within the same families tend to be similarly satisfied with the emotional support and help from others outside the family, as well as having time to pursue interests. In addition, mothers and fathers seem to be similarly satisfied with their family's access to resources such as medical/dental care, transportation, financial security, and safety. Furthermore, they appear to be similarly satisfied with the supports that allow their children to be successful at home, at school, and in friendships.

Exploratory Analyses of Associations Between Aspects of Coparenting Quality and FQOL

Coparenting Agreement

Coparenting agreement was not associated with any aspects of FQOL for mothers of children with ASD or fathers of children with ADHD. It is possible that sample size or deviations from normality contributed to this; however, it is also possible that coparenting agreement is less saliently connected to FQOL for these parents.

Exposure to Conflict

Exposure to conflict was not significantly associated with any components of FQOL for parents of children with ASD, or for fathers of children with ADHD or ASD+ADHD. In some cases, this may have been influenced by small subsample sizes or non-normal distributions of scores; however, it is also possible that exposure to conflict is less saliently connected to FQOL for some parents.

Coparenting Undermining

Coparenting undermining was not significantly associated with any components of FQOL for parents of children with ASD, or for fathers of children with ADHD. This may have been influenced by subsample issues, or it could indicate that coparenting undermining is less saliently connected to FQOL for some parents.

Division of Labor

Division of labor was not significantly associated with any components of FQOL for fathers of NT children or fathers of children with ASD or ADHD. This is consistent with previous research suggesting that dissatisfaction with division of labor is more impactful for mothers than fathers (Block, 2016; Farr & Patterson, 2013; Khazan et al., 2008).