DEPARTMENT OF PSYCHOLOGY

"PARENTING AND INTERNALIZING PROBLEMS: A MIXED-METHOD DESIGN"

DOCTOR OF PHILOSOPHY DISSERTATION

IRENE HERACLIDOU

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"PARENTING AND INTERNALIZING PROBLEMS: A MIXED-METHOD DESIGN"

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Irene Heraclidou

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ABSTRACT

The current study aimed to investigate the mediational effects of preadolescents' personality characteristics and coping strategies in the link between parenting and children's anxiety and depression. A secondary aim was to use additional qualitative analyses to identify factors of influence on extreme levels of negative parenting practices employed by mothers. The study used a cross-sectional design involving quantitative data from 369 public primary school children aged 10-12 years as well as qualitative data from narratives of mothers who were found to use extreme levels of negative parenting based on children's self-reports. Children responded to self-report scales demonstrating generally good psychometric properties. A semi-structured interview was designed for mothers with extreme levels of negative parenting, which included questions pertaining to factors that possibly influence their parenting behaviors. Both models (for Depression and Anxiety as outcomes) demonstrated a generally good fit. The model for Depression explained 42% of the variance in the outcome while the model for Anxiety explained 34% of the variance. Path model fit indices were overall satisfied in both models. Among the parenting variables, only maternal Rejection demonstrated a direct link with both outcomes and was also the most influential of all parenting variables, in terms total effects, in both models of Anxiety and Depression. Warmth only directly predicted Depression, while Psychological Control (PC) acted only as a distal predictor of the outcome in both models. Personality variables were generally stronger predictors than coping variables, which did not play an important role especially in the model for Depression. Neuroticism was the most influential of all the personality variables and Cognitive Processing, a newly formed coping strategy including 'positive restructuring' and 'cognitive consideration of solutions' scale items, was the most influential of all coping strategies used. Rejection indirectly predicted both outcomes through Neuroticism and also predicted Depression through Socially Prescribed Perfectionism (SPP) which also affected the outcome through Avoidance. Warmth predicted both outcomes through Extraversion and Cognitive Processing. Extraversion predicted Anxiety through Support-Seeking coping but predicted Depression through Cognitive Processing. Both Support-Seeking and Avoidance coping positively affected Cognitive Processing prior to its link with Depression. PC predicted both outcomes through Psychoticism, which was linked to Depression also through Cognitive Processing. Cognitive Processing demonstrated a negative link with Depression but had a positive effect on Anxiety. In the qualitative part of the study, the most influential factors for maternal negative parenting practices based on mothers' narratives in the interviews were

perfectionistic and controlling tendencies, rigidity, anxiety proneness, everyday stress and anxiety due to high job demands or multiple responsibilities, fatigue and self-neglect, an uninvolved partner, couple stress, lack of social support and cold or controlling parents (especially mothers) in childhood. Findings of the current study are generally consistent with previous research. Limitations of the current study lie in its cross-sectional nature and single-source, self-report data. In addition, some minor issues were documented regarding some derived scales, as well as administration modifications due to school-imposed COVID-19 restrictions and the general lack of involvement of fathers in data collection. The current study is one of the few to demonstrate comprehensive models of children's internalizing problems including the mediational effects of preadolescents' personality characteristics and coping strategies in the link between parenting and children's anxiety and depression, providing thus valuable data to inform practice. Future research should replicate current findings in longitudinal research using multiple informants and experimental, twin or intervention studies. In addition, the role of Cognitive Processing as a coping strategy should be further explored and clarified.

ΠΕΡΙΛΗΨΗ

Σκοποί: Η τρέχουσα έρευνα αποσκοπούσε στο να διερευνήσει τις διαμεσολαβητικές επιδράσεις των χαρακτηριστικών προσωπικότητας και των στρατηγικών αντιμετώπισης του στρες των προέφηβων ανάμεσα στη σχέση μεταξύ της γονεϊκότητας και των εσωτερικευμένων προβλημάτων των παιδιών. Ένας δευτερεύων στόχος ήταν να χρησιμοποιηθούν επιπρόσθετες ποιοτικές αναλύσεις οι οποίες θα ανέλυαν παράγοντες επιρροής στα ακραία επίπεδα αρνητικών γονεϊκών πρακτικών από τις μητέρες. Η έρευνα χρησιμοποίησε ένα σχέδιο διατομής το οποίο συμπεριλάμβανε ποσοτικά δεδομένα από 369 μαθητές δημόσιων δημοτικών σχολείων, ηλικιών 10-12 χρονών, καθώς και ποσοτικά δεδομένα από αφηγήματα των μητέρων, οι οποίες βρέθηκαν από την ποσοτική ανάλυση να χρησιμοποιούν αρνητικές γονεϊκές πρακτικές σε ακραία επίπεδα. Τα παιδιά απάντησαν σε κλίμακες αυτό-αναφοράς οι οποίες παρουσίαζαν γενικά καλές ψυχομετρικές ιδιότητες. Μια ημιδομημένη συνέντευξη σχεδιάστηκε για τις μητέρες με τις ακραίες γονεϊκές τιμές, η οποία περιλάμβανε ερωτήσεις που αφορούσαν παράγοντες που πιθανόν να επηρέαζαν τις γονεϊκές τους συμπεριφορές. Και τα δύο μοντέλα (ένα για την Κατάθλιψη και ένα για το Άγχος) παρουσίασαν γενικά καλή προσαρμογή. Το μοντέλο της Κατάθλιψης εξηγούσε το 42% της διακύμανσης στο αποτέλεσμα ενώ το μοντέλο του Άγχους εξηγούσε το 34% της διακύμανσης. Οι δείκτες προσαρμογής του μοντέλου διαδρομής ικανοποιήθηκαν σε γενικές γραμμές και στις δύο περιπτώσεις. Ανάμεσα στις γονεϊκές μεταβλητές, μόνο η μητρική Απόρριψη παρουσίασε μια άμεση συσχέτιση και με τα δύο αποτελέσματα και ήταν επίσης η μεταβλητή γονεϊκότητας με τις μεγαλύτερες συνολικές επιδράσεις και στα δύο μοντέλα. Η Ζεστασιά προέβλεπε την Κατάθλιψη μόνο έμμεσα, ενώ ο Ψυχολογικός Έλεγχος (ΨΕ) προέβλεπε μόνο έμμεσα και τα δύο αποτελέσματα. Οι μεταβλητές της προσωπικότητας ήταν γενικά πιο δυνατοί προβλεπτές από τις μεταβλητές αντιμετώπισης προβλημάτων, οι οποίες δε διαδραμάτισαν σημαντικό ρόλο, ειδικά στο μοντέλο της Κατάθλιψης. Ο Νευρωτισμός ήταν η μεταβλητή προσωπικότητας με τη μεγαλύτερη επίδραση και η Γνωστική Επεξεργασία, μια καινούργια μεταβλητή που προέκυψε η οποία περιλάμβανε ερωτήσεις σχετικές με τις κλίμακες ‘θετική αναδόμηση’ και ‘γνωστική μελέτη λύσεων’, ήταν η μεταβλητή αντιμετώπισης προβλημάτων με τη μεγαλύτερη επιρροή. Η Απόρριψη προέβλεπε και τα δύο αποτελέσματα μέσα από το Νευρωτισμό και επίσης προέβλεπε την Κατάθλιψη μέσω της Κοινωνικά Υπαγορευμένης Τελειομανίας (ΚΥΤ) η οποία επιδρούσε στο αποτέλεσμα μέσω και της Αποφυγής. Η Ζεστασιά προέβλεπε και τα δύο αποτελέσματα μέσω της Εξωστρέφειας και της Γνωστικής Επεξεργασίας. Η Εξωστρέφεια προέβλεπε το Άγχος μέσω της αντιμετώπισης Αποζήτησης Στήριξης αλλά προέβλεπε την Κατάθλιψη μέσω

της Γνωστικής Επεξεργασίας. Τόσο η Κοινωνική Αποζήτηση όσο και η Αποφυγή επιδρούσαν θετικά στη Γνωστική Επεξεργασία πριν η τελευταία επιδράσει στην Κατάθλιψη. Ο ΨΕ προέβλεψε και τα δύο αποτελέσματα μέσω του Ψυχωτισμού, ο οποίος συνδεόταν με την Κατάθλιψη επίσης μέσω της Γνωστικής Επεξεργασίας. Η Γνωστική Επεξεργασία τελικά προέβλεπε αρνητικά την Κατάθλιψη αλλά προέβλεπε θετικά το Άγχος. Στο ποιοτικό μέρος της έρευνας, οι παράγοντες με την περισσότερη επιρροή στη μητρική αρνητική γονεϊκότητα όπως προέκυψαν από τα αφηγήματα των μητέρων ήταν οι τάσεις τελειομανίας, ελέγχου και ακαμψίας, η τάση για άγχος, το καθημερινό στρες και το άγχος λόγω εργασιακών απαιτήσεων και πολλαπλών ρόλων, η κόπωση και η αυτό-παραμέληση, η ύπαρξη ενός μη εμπλεκόμενου πατέρα, οι διαμάχες του ζευγαριού, η έλλειψη κοινωνικής υποστήριξης και η ύπαρξη συναισθηματικά ψυχρών γονιών ή γονιών με τάσεις ελέγχου (ειδικά μητέρων) στην παιδική ηλικία. Τα ευρήματα της παρούσας έρευνας είναι γενικά σε συνάρτηση με τις προηγούμενες έρευνες. Οι περιορισμοί της παρούσας έρευνας κείτονται στην διατομική της φύση, στα δεδομένα από μία και μόνο πηγή για τη μέτρηση των ίδιων μεταβλητών και στα δεδομένα αυτό-αναφοράς. Επιπρόσθετα, μερικά μικρά θέματα παρουσιάστηκαν σχετικά με κάποιες κλίμακες που προέκυψαν, με κάποιες τροποποιήσεις στον τρόπο λήψης δεδομένων λόγω των επιβαλλόμενων από τα σχολεία και σχετικών με την πανδημία του COVID περιορισμών και με τη γενική ανάμειξη των πατέρων στην έρευνα. Η παρούσα έρευνα είναι μία από τις λίγες έρευνες που παρουσιάζουν περιεκτικά μοντέλα των εσωτερικευμένων προβλημάτων των παιδιών τα οποία συμπεριλαμβάνουν και τις διαμεσολαβητικές επιδράσεις της προσωπικότητας και του στυλ αντιμετώπισης προβλημάτων των παιδιών στην προεφηβεία, παρέχοντας έτσι χρήσιμα δεδομένα τα οποία μπορούν να ενημερώσουν τις πρακτικές. Η μελλοντική έρευνα θα μπορούσε να επαναλάβει τα τρέχοντα ευρήματα μέσα από μακροχρόνιες έρευνες που χρησιμοποιούν πολλαπλούς πληροφοριοδότες καθώς και μέσα από πειραματικές και παρεμβατικές έρευνες ή έρευνες διδύμων. Επιπρόσθετα, ο ρόλος της Γνωστικής Επεξεργασίας σαν στρατηγική αντιμετώπισης προβλημάτων, θα έπρεπε να ερευνηθεί και να διασαφηνιστεί περεταίρω.

INTRODUCTION

Children's mental health has captured a lot of research and societal attention the last few decades. It is considered that a lot of social problems in modern society stem from individuals' emotional difficulties, which are often rooted in childhood. Results of a recent meta-analysis drawing from studies conducted in 7 different European countries and involving school children aged 6–11, showed mental problems to emerge in 12.8 % of the pooled sample (Kovess-Masfety et al., 2016). Similar results were reported by Polanczyk et al. (2015) in their meta-analysis on the worldwide prevalence of mental health problems in children and adolescents. Additional analyses of the reported study, showed anxiety disorders to rank first of all mental disorders, with a prevalence of 6.5% and depressive disorder to rank second among the internalizing disorders, with a prevalence of 2.6% (Polanczyk et al., 2015).

Family system theorists assume that human behavior can best be understood within the family. Across the "generation" line, parents are required to nurture, control and make decisions for their children. Children, on the other hand, are considered to be subordinate and dependent on their parents (Lopez, 1986). Early life difficulties are thought to increase reactivity to stressful circumstances throughout life, as well as vulnerability to multiple stress-related disorders (Meaney, 2001; Bifulco, et al., 2000). Exposure to negative parenting and family dynamics have been found to place children at risk for displaying internalising (i.e. depression, anxiety) and externalising (i.e. aggression) problems (Kouros, Merrilees and Cummings, 2008). Vanaelst et al. (2012) found that factors, such as familial stress and social adversity, family economic hardship and negative family climate, were significantly related to psychosomatic and emotional difficulties in children. In addition, Ritchie and Buchanan (2011) found that negative parenting styles were significantly correlated with raised scores on the Strengths and Difficulties Questionnaire in a sample of adolescents.

Parenting Dimensions

Parenting practices have often been studied as part of the so-called parenting styles, broad parenting typologies which characterize a general way of childrearing. The most well-known of such theories is the one proposed by Baumrind (1971), whose parenting styles are based on two parenting dimensions, namely demandingness or control (i.e. parental goals and expectations) and warmth or responsiveness. Based on this typology, control refers to parents' attempts to put healthy boundaries on children's behavior and is thus, considered beneficial for children's development and functioning. Nevertheless, in the last few years,

parental control has been viewed in negative terms in research. This is based on the observation that in extreme or unnecessarily high levels, control can have devastating effects in children's lives. The balanced demonstration of both parental support or warmth and respect for autonomy has well been documented in both Blatt's (1990) psychodynamic theory and Self-Determination Theory (Deci and Ryan, 2008), which propose that healthy personality development and emotional wellbeing, depend on the mutual interplay of interrelated developmental needs, namely interpersonal relatedness, self-definition and competence.

The importance of parenting in children's mental health is well portrayed in a study by Long et al. (2015) on monozygotic twins brought up in different parenting contexts. Results of this study showed that various parenting strategies (e.g. coldness, protectiveness, authoritarianism) were positively associated with psychological disorders and symptoms, particularly Major Depression, Generalized Anxiety, antisocial behaviour and Conduct Disorder. In terms of parental control, Krohne (1990) argued that children of controlling parents experience increased anxiety, as a result of having learned to expect negative consequences and to doubt their own competencies. There are various ways in which parents may excessively control children's lives but the most prominent of all as documented in the literature, are psychological control and overprotection.

Psychological control

Unlike behavioral control, which is similar to Baumrind's notion of control and is mainly negatively associated with externalizing problems, psychological control is considered a negative parenting practice (Nanda, Kotchick, & Grover, 2012) and is mostly positively associated with internalizing problems (e.g. Barber, Olsen, & Shagle, 1994; Barber, 1996; Nanda, Kotchick, & Grover, 2012). Psychological control has even been found to have a more consistent association with childhood anxiety than parental rejection, behavioral control or autonomy granting (McLeod et al., 2007; Nanda, Kotchick, & Grover, 2012). It involves attempts to control children's behavior through covert strategies of emotion manipulation, such as guilt induction, invalidation of feelings and conditional acceptance (Barber, 1996, Silk, et al., 2003). These emotionally inducing strategies seem to have devastating effects on both the parent-child relationship and children's personality development and psychological wellbeing (Shek, 2006). Specifically, parental psychological control has been linked to anxiety (Nanda, Kotchick, & Grover, 2012; Rousseau, Scharf & Smith, 2018; Xu et al., 2017; Xu, Cui, & Lawrence, 2020), depression (Barber, 1996; Van der Bruggen et al., 2010; Frazer, & Fite, 2016), eating disorders (Depestele et al., 2017), low self-esteem, life satisfaction (Shek,

2007) and general psychopathology (Young, Lennie, & Minnis, 2011) in childhood and adolescence.

Concerning anxiety in particular, Creveling-Benefield and Enrique (2019) found that parental psychological control was linked to childhood anxiety, through anxiety-related schemas (i.e. disconnection/rejection, impaired autonomy/performance), in a sample of 9–18-year-old children. Similarly, Lønfeldt et al. (2017), demonstrated that maternal psychological control is an environmental risk factor which contributes to a metacognitive vulnerability to anxiety in children. Xu, Cui, & Lawrence (2020), also found that maternal psychological control mediated the link between parental anxiety and anxiety in children.

In terms of depression, Frazer, & Fite (2016) found that in a sample of 9-12-year-old children, maternal psychological control, as perceived by the child, uniquely predicted children's depressive symptoms, irrespective of positive parenting practices present. In addition, in their longitudinal study, Kriston et al. (2012) found that parental psychological control was a risk factor for child depressive symptoms at several time points, ranging from when they were 8-9 to when they were 16-17 years of age. Similarly, Pettit et al. (2001), in their longitudinal and multi-informant study, found that high levels of parental psychological control were associated with higher levels of depression among 13-year old girls and teens who were high in preadolescent depression.

Overprotection

Just like psychological control, overprotection is another parenting practice which involves developmentally inappropriate autonomy restriction on the part of the parent. However, overprotection does not involve the covert strategies of emotional manipulation and conditional regard and is generally considered to be driven by more benign parental intentions, such as ensuring the safety and security of a child. Still, overprotection involves infantilization, extreme anxiety about parental functions and intrusiveness (Holmbeck et al., 2002) and is suggested to encourage perceptions of the world as a dangerous and unpredictable place (Hudson et al. 2011; Rapee et al. 2009). Not surprisingly then, overprotection is also linked to various negative child outcomes, especially internalizing problems. These include anxiety (Howard, et al., 2017), depression (Ivarsson, et al., 2016), disordered eating (Abebe, et al., 2014; Wertheim, et al., 1992), PTSD after natural disasters (Bokszczanin, 2008), low social competence (Doh & Falbo, 1999) and general adjustment difficulties (Hastings, Kahle, & Nuselovici, 2014).

Several studies have linked parental overprotection to childhood anxiety in particular. For example, a few studies have found links between parental overprotection and anxiety in the preschool years (Howard et al, 2017; Fliek et al., 2015) and early childhood (Laurin et. al, 2015). Morris and Oosterhoff (2016) also found that parental overprotection predicted social anxiety in children aged 9-12. Maternal overprotection was also found to predict lower quality of life and poorer life functioning in a sample of children suffering from food allergies (Chow, Pincus, & Comer, 2015). Further, Taborelli et al. (2013) found higher levels of overprotective parenting in mothers of daughters that later developed anorexia nervosa. Various studies have additionally linked current or past overprotective parenting behaviours to measures of anxiety-related maladjustment in emerging and later adulthood, such as separation anxiety (Brenning et al.,2017), low perceived self-control (Hong and Cui, 2020) and self-efficacy (Reed et al., 2016), low self-compassion through attachment anxiety (Pepping et al., 2015), heart-focused anxiety (Ong et al., 2011), worry (Spada et al., 2011), poor distress tolerance, psychological distress (Saleem et al., 2021), physical symptoms of anxiety, a fear of dying, negative self-beliefs, difficulty maintaining steadiness when anxious (Meites et al., 2012) and college adjustment (Darlow, Norvilitis, & Schuetze, 2017).

As concerns depression, overprotection was found to predict depressive symptoms in preadolescence and early adolescence but recent research is limited (Betts, Gullone, & Allen, 2009; Morris & Oosterhoff, 2016). Maternal overprotection was documented to affect depressive symptoms in a sample of 14-25-year-old patients of Type 1 diabetes (Prikken et al., 2019). Most research on overprotection and depression has been conducted with adult samples based on earlier recollections of parenting. In these studies, the link between overprotection and depression was mediated by low perceived self-control (Hong & Cui, 2020) and neediness, (Campos, Besser & Blatt, 2010). A couple of studies have found that maternal overprotection predicted depressive symptoms mainly in male adult subjects (Mancini et al.,2000; Masahiro et al., 2008). Paternal overprotection has also been linked to depressive symptoms in adulthood (e.g. Enns et al., 2000; Tokuyama et al., 2003) and was found to be higher among adult depressed outpatients with OCD traits and tendencies (Yoshida et al., 2005). Likewise, Often, Thomas, and Waller (2003) found that paternal overprotection was linked to depression in patients with auditory hallucinations through dissociation. Finally, some researchers have also found indirect links between so-called helicopter parenting, a form of overprotection mainly towards adult children, and depression, through pressure from perceived parental career expectations (Lee and Kang,

2018), self-alienation, lower levels of authentic living (Turner, Faulk, & Garner, 2020) and self-efficacy beliefs (Reed et al., 2016).

Generally, maternal overprotection predicted worse treatment outcomes to both CBT for depression (Motoshi et al., 2013) and antidepressant medication (Johnstone et al., 2009) in studies with clinically depressed adult patients.

Despite their importance, subdivisions of parental control such as psychological control and overprotection have rarely been given research attention and their relationship with internalizing problems has mostly been studied with late adolescent or adult samples, based on recollections of parenting in childhood (Nanda, Kotchick, & Grover, 2012).

Rejection

Perceived parental rejection refers to the child's understanding that their parents do not really love, care about or appreciate him/her. This understanding is key in creating a form of emotional maladjustment that involves viewing the self as not worthy of others' love and respect, and distrusting others in an emotional level (Rohner et al., 2020). Buchanan (2013) in her review of the book "Safeguarding Children from Emotional Maltreatment-What Works?" written by Jane Barlow and Anita Schrader McMillan, suggests that from all the categories of abuse, emotional maltreatment is the hardest to identify and manage and has the most profound and lasting effects on the child and his/her development.

Previous research has highlighted the importance of parental rejection in several mental health outcomes regardless of differences in culture, gender, language or ethnicity (Khaleque & Ali, 2017; Rohner & Lansford, 2017). Such outcomes include impairments in identity and self-direction (Davis & Anderson, 2020), aggression and non-suicidal self-injury (Cipriano et al., 2020), loneliness (Rohner et al., 2020), hostility, negative self-esteem, negative self-adequacy, emotional unresponsiveness, emotional instability, and negative worldview (Ramírez-Uclés et al, 2018; Putnick et al., 2020). Further links were found with low general psychological adjustment (Ki et al., 2018), low emotional resilience (Sart et al., 2016), emotional and behavioural difficulties (Havewala & Wang, 2021), dependence or defensive independence (Khaleque, 2017) and psychosocial adjustment in interpersonal relationships and emotional self-evaluations (Naumova et al., 2016). In addition, parental rejection was linked to borderline personality disorder (Ghaemi, 2016), low prosocial behaviour, social competence and school performance (Putnick, 2015) and emotion regulation and emotional eating (Vandewalle et al., 2016). Peer victimization was also found to be more frequent in youth who experienced parental rejection (Kaufman et al., 2020).

Parental rejection's link to anxiety in particular, has been portrayed quite often in the literature. For example, Miranda et al. (2016), in her study on adolescent emotional outcomes, found that parental rejection was associated with adolescent maladjustment measures, including anxiety symptoms and aggressive behaviour. Likewise, Mousavi, Low, and Hashim (2016) found that parental rejection, was linked to higher anxiety, independent of cultural group, with these associations being stronger for Caucasian American teenagers.

Nevertheless, most research on the links between rejection and anxiety focused on recalled parenting in young adult samples and college students. Findings from these studies have shown rejection to predict stress scores and general anxiety (Smout, Lazarus & Hudson, 2020), social anxiety (Giaouzi & Giovazolias, 2015) and distress intolerance and psychological distress (Sadia et al., 2021).

Concerning depression, Akse et al. (2004), in their cross-sectional study using data of a large number of adolescents drawn from the Conflict and Management of Relationships study (CONAMORE), found that perceived parental rejection was linked to depression in most of their personality type groups, irrespective of gender. In addition, Ehnvall et al. (2008), in their longitudinal study on adult patients referred to the Mood Disorders Unit for depression of a public hospital, found that female patients who recalled having been rejected by a parent in childhood, had a higher probability of making at least one suicide attempt in their lifetime. Campos and Holden (2015) also found links between parental rejection and suicide risk, both directly and indirectly through depression and interpersonal needs.

Emotional warmth

At the other end of parenting, lies parental warmth which has also been examined mainly in relation to its direct effects on child wellbeing (e.g. Doh & Falbo, 1999; Heider, et al., 2008). Ritchie and Buchanan (2011) have reported an alarmingly high percentage of adolescents reporting parents lacking in warmth and affection. Warmth is most often associated with positive child outcomes, such as compliance (van der Mark, et al., 2002) and smiling (Harker, et al., 2016) in infancy and toddlerhood and social competence in childhood and adolescence (Doh & Falbo, 1999). Because lack of warmth conveys to the child that the world is hostile and threatening, it is also negatively associated with internalizing problems (Hummel & Kiel, 2015) such as depression (Ivarsson, et al., 2016), disordered eating (Wertheim, et al., 1992) and PTSD (Bokszczanin, 2008). Flouri et al. (2015) found that positive parent-child relationships early in life, buffered the effects of multiple environmental risk adversities on internalizing and externalizing problems most consistently,

compared to other parenting measures, including increased parental involvement and authoritative parenting. In addition, Malmberg and Flouri (2011) found that quality of mother-child relationship buffered the effect of socioeconomic disadvantage, particularly on children's internalizing problems.

Warmth has also been linked to anxiety in adolescence. For example, Quach et al (2015) found that parental warmth moderated the link between parents' academic pressure and adolescents' symptoms of anxiety and depression. In addition, Butterfield et al. (2021) studied neural functioning in the brain regions that are involved in emotion regulation in adolescents with histories of anxiety, and found that maternal warmth predicted lower neural activation during criticism in the subgenual anterior cingulate (sgACC). This link was then associated with anxiety and depressive symptoms 2 years after treatment for these conditions.

Hummel, Kiel and Zvirblyte (2016) found that maternal depression was negatively linked to toddlers' positive affect, and this relationship was mediated by decreases in maternal warmth. Parental warmth has also been linked to depression in childhood. For example, Rothenberg et al. (2020) found that earlier parental warmth predicted child-reported withdrawal and depressive symptoms at all ages (9-12 years) and in all 12 cultures and 9 countries examined. Further, in their longitudinal study on the relationship between parenting, temperament and internalizing and externalizing problems, Zubizarreta, Calvete and Hankin (2019) found parental warmth to consistently predict decreases in children's depression. In yet another study, perceived high parental warmth at age 7 predicted less child-reported depressive symptoms from ages 7 to 10, whereas perceived low parental warmth predicted increases in child-reported depressive symptoms, and these links were stronger for daughters than for sons (Trang & Yates, 2020). Parental warmth at age 13-14 was also negatively associated with later depressive symptoms for females, but not males, in a study on the links between early adolescent negative reactivity and parental warmth and their effects on adult depression (Lloyd et al., 2017). Likewise, Flouri (2004) found that closeness to mother at age 16 predicted life satisfaction at age 42 in both men and women and negatively predicted poor psychological functioning at age 42 in women. Findings also demonstrated that maternal involvement at age 7 predicted life satisfaction at age 42 in men.

Concerning adult samples, Elena Marie Piteo & MacKay (2021) found that parental warmth early in life, predicted symptoms of depression and anxiety in emerging adulthood and that this link was also mediated by defects in the differentiation of the self. A direct

association of parental warmth with distress tolerance and psychological distress was also found in college students, with warmth also moderating the negative effects of parental rejection and overprotection on psychological outcomes (Saleem et al., 2021). Finally, Matos, Duarte, and Pinto-Gouveia (2017) found that early memories of warmth and safeness, negatively predicted depressive, anxious and paranoid symptoms in adulthood, both directly and indirectly through fears of compassion for self and others as well as from others.

Child Characteristics and Wellbeing

Apart from environmental influences, such as parenting, research has shown that certain child personal characteristics and behaviours, such as personality traits and coping strategies, also affect children's emotional functioning.

Eysenck's Three-Factor Model of Personality

Eysenck's three-factor model of personality, is one of the most widely used models of personality in research and practice. According to this theory, personality is composed of three broad personality characteristics, namely extraversion, neuroticism, and psychoticism, which have been documented to be consistent worldwide across different cultures (Barrett & Eysenck, 1984) and to be relatively stable across time (Eysenck & Eysenck, 1985). Extraversion refers to sociability and stimulation-seeking; neuroticism refers to emotional reactivity and instability as well as to susceptibility to anxiety; psychoticism refers to aggressiveness and deviation (Eysenck, 1977).

A study by Muris, Meesters, and van Asseldonk (2018) showed that neuroticism and extraversion were correlated with shame in a positive and negative direction respectively, with shame subsequently being associated with a broad range of anxiety disorder symptoms. Similarly, in a study by Howard et al (2015), extraversion predicted better psychological functioning, in contrast with neuroticism, which predicted poorer functioning in a group of child/adolescent cancer patients and these effects were irrespective of cancer status. In addition, Lee, An, and Choe (2020) found that introversion predicted psychiatric symptoms, such as depression, psychopathy, hysteria and hypomania, among middle-school gifted children. The personality factors of introversion and neuroticism are also implicated in the development of social anxiety disorder, because of the role they play in cognitive biases that maintain the disorder (Kimbrel, 2009). What's more, in a study by Junker et al (2019) neuroticism and psychoticism were related to increased risk of later self-harm hospitalization, while extraversion demonstrated an inverse association with psychological maladjustment in an adolescent sample. A 30-year longitudinal study, has also shown

neuroticism at age 14, to be predictive of depression, anxiety, suicidality, poor self-esteem and general mental health difficulties at age 30, whereas extraversion at age 14, was linked to good social outcomes and self-esteem, albeit also being associated with substance dependence and overall mental health difficulties (Newton-Howes, Horwood, & Mulder, 2015). High neuroticism in young adulthood was also found to be a risk factor for first-onset anxiety and depressive disorders, while low extraversion was found to be a risk factor for agoraphobia (Prince et al., 2021). Likewise, Sanatkar et al. (2020) showed that low neuroticism was linked to less depression, anxiety, dysfunction and diabetes distress over the year, in a sample of mild-to-moderately depressed adults with type 2 diabetes, while high extraversion was linked to decreased anxiety and dysfunction.

Concerning psychoticism, this personality dimension is most often linked to externalizing problems. For example, Allsopp and Feldman (1974) found a positive link between psychoticism and antisocial behaviour in secondary school girls. Similarly, Hartsell (2021) found that psychoticism in adolescents involved in the criminal system, increased the variety of violent offending. In adult samples, psychoticism was once again found to predict mainly externalising outcomes, such as increased impulsivity, aggression, and suicidal behaviour (Tobore, 2019), smoking (Dimitriadis et al., 2016), synthetic cannabinoids use (Mensen et al., 2019), female sexual impulsivity (Carvalho et al., 2015) and sadomasochistic behaviours (Hopkins et al., 2016). Nevertheless, in a study by Christensen et al. (2021), psychoticism predicted mood and anxiety diagnoses. A few more studies have linked psychoticism to internalizing problems but these mainly involved adult samples. For example, psychoticism has been associated with major depression and mixed anxiety and depression diagnoses (Kennedy, 2001), obsessive compulsive subclinical problems and obsessive-compulsive diagnoses (Fullana et al., 2004), eating disorders (Fletcher et al., 2008) and depression in breast cancer patients (García-Torres & Alós, 2014). Research on the role of psychoticism in child and adolescent internalizing problems is lacking.

Perfectionism: A Narrow Personality Construct

Apart from broad personality constructs, personality theory and research has also included narrower personality constructs. Perfectionism is one such personality construct and is defined as setting disproportionably high standard while mainly valuing goal attainment and successes (Flett et al. 2011). One way that perfectionism has been defined in a more refined way, is through the distinction between self-oriented perfectionism (SOP) and socially prescribed perfectionism (SPP). SOP refers to self-impositions to be perfect, while SPP refers to perceived expectations and demands by others for the individual to be

perfect (Hewitt and Flett 1991a). These processes are often demonstrated in depression and anxiety disorders (e.g., Blatt et al. 1982; Cox et al. 2000).

Perfectionism is prevalent among children and adolescents (3 in every 10) and has a transdiagnostic nature (Flett, & Hewitt, 2014). It can be either adaptive or maladaptive, with maladaptive perfectionism being linked to the development and maintenance of various internalizing problems (Stoeber & Otto, 2006), adolescent suicidal behaviour (e.g. Bibeau & Dupuis, 2007) and poor treatment outcomes (Morris & Lomax, 2014). It is also related to anxiety, since it seemingly acts as a mechanism to avoid failure (Greblo & Bratko, 2014). Its effects can be either direct or indirect through coping (Flett, Mewitt, and Cheng, 2008; Flett, Druckman, Hewitt, and Wekerle, 2012; Shahar, et al., 2004).

Affrunti, Woodruff-Borden, and Affrunti (2016) found that perfectionism in children predicted increased worry, anxiety and depression. Perfectionism has also been linked to anxiety in adolescence (Karababa, 2020; Damian et al, 2017; Essau et al., 2008) and depression in adolescence (e.g. Levine et al.,2019; Jacobs et al, 2009 Rice et al., 2007) and adulthood (e.g. Abdollahi, Hosseinian, and Asmundson, 2018). Perfectionism in children and early adolescents has rarely been studied. Morris and Lomax (2014) also suggest that research on child perfectionism lacks quality.

Personality and Coping

Coping is a self-regulatory process which affects emotional adjustment as well as social, academic and relational functioning. It also seems to go hand in hand with anxiety in terms of etiology and mechanisms (Eisenberg, et al., 2010; Wenbin, et al., 2003; Klemanski, et al., 2017). In their study on early adolescent life satisfaction, Lyons, Huebner, & Hills (2016) found that extraversion predicted the use of more approach coping, whereas neuroticism predicted the use of more avoidance coping. In turn, approach coping predicted higher levels of life satisfaction, while avoidance coping predicted lower life satisfaction after a 6-month period. Similar results were reported by other researchers on the relationship between extraversion, approach coping and life satisfaction (Fernando 2008; Garbarino et al. 1991) and between neuroticism and avoidance coping and life satisfaction (Connor-Smith and Flachsbart 2007; McKnight et al. 2002; Suldo and Huebner 2006). In addition, Kalka & Karcz (2020), found that support-seeking moderated the links between neuroticism and psychological dissatisfaction on the one hand and extraversion and psychological satisfaction on the other hand, in an adolescent risk group for type 2 diabetes.

Nevertheless, most research on coping and personality focused on adult samples. For example, extraversion in adulthood predicted lower levels of depression directly and

indirectly through leisure coping (Nagata, McCormick, & Piatt, 2019). In addition, Morton, White, & Young (2015) found that the positive association between extraversion and post-traumatic growth in families of patients being diagnosed with schizophrenia, was mediated by social support and emotional or instrumental coping. The link between extraversion and approach coping was also highlighted in a study by Ferguson (2001), who found that extraversion loaded on the same factor as seeking social support and active coping. Erenoğlu & Sözbir (2020) also found that women low in extraversion tended to use ineffective coping skills and to experience more anxiety, depression and anger. Likewise, Corey et al. (2020) found that among former caregivers of people with dementia, those that were less extraverted and more neurotic, used dysfunctional coping strategies and reported more psychological distress and less sleep quality. Drapeau, Cerel, and Moore (2016) also found neuroticism to be the strongest negative predictor of help-seeking attitudes among suicide-bereaved adults. Concerning psychoticism, Ni, Qian and Wang (2017) found that greater psychoticism and use of avoidant coping were linked to higher pathological internet use.

Despite the links between approach and avoidant coping with positive and negative outcomes respectively, a few recent studies have yielded contradictory results. For example, Sebri et al. (2021), found that during the outbreak of COVID in Italy, extraversion was linked to less worry and neuroticism was linked to more worry through both emotion-focused and problem-focused coping, but emotion-focused coping in this instance, was found to be protective, whereas problem-focused coping was found to be hazardous for the development of worry. Likewise, Ribadier & Varescon (2019), in their study with alcohol use disorder individuals, found that the link between neuroticism and depression was mediated by an ineffective use of coping strategies, including avoidant coping. While extraversion was negatively linked to avoidant coping and positively linked to problem-focused coping, problem-focused coping was also predictive for depression in this study.

Perfectionism was also studied with regards to its relationship with internalizing problems, even though studies involved mainly adult samples. Results have shown that the interplay between maladaptive perfectionism and avoidance coping, results in more distress, anxiety and depression and less life satisfaction (O' Connor & O' Connnor, 2003; Gnilka, et al., 2012; Weiner & Carton, 2012). Noble, Ashby, and Gnilka (2014) documented that adaptive perfectionists demonstrated low levels of depression, whereas maladaptive perfectionists had high levels of depression and these relationships were mediated by avoidant coping. Similarly, Richard et al. (2021) found that the relationship between self-critical perfectionism and daily negative affect was mediated by behavioural disengagement

tendencies. Trudel-Fitzgerald et al. (2017) also found that perfectionism was linked to anxiety and depression among cancer patients through emotional preoccupation coping and distraction coping but also through palliative coping. Abdollahi, Hosseinian, and Asmundson (2018) showed that emotion-focused and avoidant coping strategies partially mediated the relationship between perfectionism and depression. Apart from avoidant coping, maladaptive perfectionism was also associated with less use of collective coping, which mediated the link between perfectionism and negative psychological outcomes (i.e. anxiety, depression, loneliness) in a study among African American women (Liao, Wei, & Yin, 2020).

Biopsychosocial Models of Childhood Internalizing Problems

Complex biopsychosocial models, such as the diathesis-stress model, suggest that emotional difficulties are the product of an interplay between both environmental influences (e.g. parenting, contextual factors) and child dispositional or other cognitive and behavioral characteristics (Hastings, Kahle, & Nuselovici, 2014). Further, socio-ecological models of development, developed in the late 1970s, propose that individuals affect and are affected by a complex range of social influences and environmental interactions. The inherently bidirectional nature of the relationship between a child and its environment, is emphasized by transactional models of development, which propose that child development is the result of a continuous and dynamic interplay between the child and its experiences as derived from social settings (Bronfenbrenner, 1977; Sameroff, 2009). This notion is supported by longitudinal research (e.g. Barber, 1996) and may explain the fact that children and parents often seem to get caught in vicious cycles of negative interactions and psychological symptoms (Depestele et al., 2017). Transactional models are also important in that, apart from just confirming the long-known links between parenting and children functioning, they also uncover the mechanisms behind these relationships (Hummel & Kiel, 2015). Nevertheless, only few studies have looked into such processes by developing and testing mediational and interactive models. As a result, the mechanisms behind the intergenerational transmission of internalizing problems remain unclear.

One way that child and parental characteristics interact with each other and is employed mostly in studies with adult children, considers children's personality to moderate or mediate the link between parenting and child outcomes. This is based on two theoretical models, namely the differential susceptibility model and social-cognitive theory respectively. Based on the differential susceptibility model, a child's personality may predispose them to be more vulnerable to environmental influences, such as parenting (Belsky, 1997). In fact, temperamental characteristics such as emotional reactivity and behavioral inhibition are

directly and even conceptually linked to internalizing problems (Wood et al., 2007). In addition, Hummel and Kiel (2015) found maternal intrusiveness to predict less, and not more, internalizing problems in girls high in negative affectivity.

On the other hand, social learning and social-cognitive perspectives propose that children are not so much genetically predisposed to the negative effects of parenting, but instead internalize parental demands and lack of warmth as their own cognitive schemas and expectancies in a way that leads to increased anxiety or depression. A good example of this theory is the Social Reaction Model (Flett, et al., 2002) of perfectionism which proposes that perfectionism develops as a coping mechanism to controlling environments so as to overcompensate for feelings of humiliation, helplessness and perceived incompetence or contingent self-esteem internalized (McArdle, 2009). Indeed, modern society nowadays calls for individual achievement and competitiveness, values which can be passed on to children by their parents through parenting. What's more, correlations between parent and child perfectionism are rather weak and research has found that, unlike broad temperamental characteristics which are thought to be the result between a child's disposition and its environment, perfectionism is a cognitive behavioral construct that albeit describing a person's personality, is mostly passed on to children through parenting (e.g. Barber, 1996; Flett, et al., 2002; Gong, Fletcher, & Bolin, 2015; Soysa & Weiss, 2014).

Based on the social-cognitive paradigm, other adult child characteristics such as neuroticism, self-esteem, self-criticism and coping were found to mediate the link between parenting (e.g. bonding, lack of care, overprotection), and either depression or academic motivation (Schiffrin & Miriam-Liss, 2017; Enns, Cox, & Larsen, 2000; Campos, Beser, & Blatt, 2010). In addition, McArdle (2009) found that both personality (neurotic perfectionists) and parental psychological control moderated the link between two other parental practices (overprotection and acceptance) on self-esteem. This finding is particularly important in that it acknowledges the simultaneous effects of more than one parenting behaviors on children's personality and internalizing problems.

Parenting may have effects on internalizing problems also through coping. In fact, coping can be disrupted through parenting, as early as infancy, when mothers are overly intrusive, leading to increased internalizing problems (Egeland, Piata, & O' Brien, 1993). Indeed, a few studies have linked parental psychological control (Jackson et al., 1998; Langrock et al., 2002; Steele et al., 1997) and low support (Herman and McHale, 1993; Blomgren, Astrom, & Ronnlund, 2016) to more avoidant coping strategies and fewer problem-focused and support-seeking strategies. Likewise, Gaylord-Hardn, Campbell, and

Kesselring (2010), found that maternal support was linked to more functional coping strategies, such as active coping and support-seeking. Despite the evidence, findings on the relationship between parenting and children's coping are inconsistent, with some finding significant associations and others failing to do so (Almas, Grusec, & Tackett, 2011; Gaylord-Harden, 2008).

Intra-persponal and Extra-personal Influences on Parenting

The varied and significant effects that parenting has on child wellbeing, whether by interacting with child characteristics or being their main source, calls for a more thorough investigation of factors that may influence parental choice of parenting strategies per se. Only few studies have directly and simultaneously considered child, parental and contextual characteristics of influence on parenting and these have mainly used either infants and toddlers or young adults as research samples (e.g. McFadden, & Tamis-Lemonda, 2013).

Child characteristics that were found to influence parenting include gender (Hummel & Kiel, 2015), prematurity (Poehlmann, et al., 2012), mild medical conditions early in a child's life (e.g. jaundice, problems with feeding, crying), being first-born (Thomasgard, 1998), and developmental delays (Caplan & Baker, 2017). In addition, Flouri (2004) found that child characteristics pertaining to emotional and behavioural difficulties, were significantly related to child-reported parental involvement and that stepfathers in particular that viewed their stepchildren as emotionally well-adjusted reported higher parental involvement than when they viewed them as having emotional and behavioural difficulties.

Parental characteristics of influence include personality characteristics such as perfectionism (Cook & Kearney, 2009; Greblo, & Bratko, 2014; Soenens, et al., 2006), neuroticism, agreeableness (e.g. Tang, et al, 2016; Verhoeven, et. al, 2007), extraversion, conscientiousness (Clark, et al., 200; Smith, et al., 2007) and dependency and self-criticism (Tang, et al., 2016). They also include emotional states such as depressive symptoms (Malmberg & Flouri, 2011; Mcfadden & Tamis-Lemonda, 2013; Tomlinson, Cooper, & Murray, 2005), stress (Mcfadden & Tamis-Lemonda, 2013), anxiety disorders (Thomasgard, 1998) and parental anxiety and regret (Segrin, et al., 2013). The link between these characteristics and parenting (most often psychological control) may explain their transgenerational nature (e.g. McClure et al., 2001). For example, parents may project their own desires and fears on to children and vicariously experience their children's successes and failures as if they are their own. Perfectionist parents may also communicate to their children that their love for them depends on their flawless performance, conditioning them to strive for perfection in order to avoid self and others' criticism (Soenens, et al., 2006;

Greblo, & Bratko, 2014; Randolph, & Dykman, 1998). Despite the evidence, systematic studies investigating traits and qualities of parents who behave in negative, especially controlling, ways, are lacking (e.g. Greblo, & Bratko, 2014 ; Randolph, & Dykman, 1998; Soenens, et al., 2006) and those that do exist, have sometimes yielded inconsistent and contradictory results (Clark, et al., 200; Smith, et al., 2007).

Apart from child and parental characteristics, some demographic and contextual factors have been found to also influence parenting. These include young age, married status (Mcfadden & Tamis-Lemonda, 2013), partner support (Tomlinson, Cooper, & Murray, 2005), couple stress (Tang, et al., 2016), culture (Caplan & Baker, 2016) and intensive parenting ideologies (Schiffrin, et al., 2014; Warner, 2012). In association with overprotection in particular, Thomasgard (1998) further reports such risk factors of negative parenting as difficulties in parents' separation-individuation as children, an illness that was perceived as life-threatening (e.g. croup, pregnancy complications) and high health-care utilization.

Taken all together, even though there generally is an amount of literature on the social cognitive theories of internalizing problems on the one hand and on the effects of either parental, child or contextual characteristics on parenting per se on the other hand, a more thorough and comprehensive account of these influences in child psychological outcomes and parenting, has rarely been documented. In addition, previous research has focused more on adult recollections rather than current child experiences of parenting on emotional outcomes (e.g. Nagata, McCormick, & Piatt, 2019; Sanatkar et al., 2020; Piteo & MacKay, 2021).

Research Questions

Quantitative Study

Based on ecological and social-cognitive models of mental health, the current study will test a comprehensive mediational model of childhood internalizing problems.

In particular, it is hypothesized that parenting will be linked to internalizing problems (anxiety, depressive symptoms) directly and indirectly through two groups of serial mediations, namely child personality characteristics and child coping strategies. Specifically, negative parenting practices (i.e. psychological control, overprotection, rejection) are expected to be linked to children's internalizing problems both directly and indirectly, through a positive link, on the one hand, with child neuroticism, psychoticism and perfectionism, and through a negative link, on the other hand, with child extraversion. Neuroticism, psychoticism and perfectionism are in turn expected to both directly and

indirectly predict internalizing problems, through positive associations with avoidance and distraction coping and through negative associations with support-seeking and active coping. Extraversion, on the other hand, is expected to predict internalizing problems both directly and indirectly through a positive link with active and support-seeking coping and through a negative link with avoidant and distraction coping. Ultimately, active and support-seeking coping strategies are expected to negatively predict the internalizing outcomes, in contrast with avoidant and distraction coping strategies which are expected to positively predict the outcomes.

Correspondingly, positive parenting (i.e. warmth) is expected to predict child anxiety and depression both directly and indirectly, through two serial mediational paths. In particular, warmth will positively predict child extraversion, which will predict the outcomes both directly and indirectly through positive associations with active and support-seeking coping strategies and through negative associations with avoidant and distraction coping. At the same time, warmth will negatively predict child neuroticism, psychoticism and perfectionism and all these personality variables will, in turn, predict child depression and anxiety directly and indirectly, through positive links with child avoidant and distraction coping strategies and through negative links with active and support-seeking coping strategies. Avoidant and distraction coping will ultimately positively predict depression and anxiety whereas active and support-seeking coping will negatively predict the outcomes.

Qualitative Study

Mothers using either extremely high levels of negative or extremely low levels of positive parenting strategies are expected to demonstrate personal tendencies related to high perfectionism, neuroticism, dependency and self-criticism and to low extraversion. They also expected to report being highly depressed, stressed or anxious or experience parental regret. Their narratives are also expected to include reports of their (participating) child's premature birth, history of health problems or developmental delays. In terms of context, maternal narratives are expected to include becoming mothers at a young age, being a single mother or having minimal partner support, experiencing couple stress or conflict and operating under particular cultural expectations about parenting or intensive parenting ideologies. In the case of overprotection in particular, mothers are expected to mention difficulties in separation-individuation as children, past experiences of illnesses perceived as life-threatening, high health-care utilization and mild medical conditions, early in their child's life. Newly emerged influential factors coming from mothers' own experiences, will also be identified and explored.

Rationale and Importance

Anxiety was chosen as an outcome variable among other internalizing problems due to its high prevalence in childhood and adolescence, its chronic nature (Costello et al., 2011) and its importance on children's social and emotional functioning (e.g. Hummel & Kiel, 2015; Pine, 1997). The importance of examining parental factors as determinants of anxiety in children is demonstrated in the evidence of the advantages of either family-focused CBT or of child-focused CBT intervention for anxiety, which includes a family component (Cobham, Dadds, & Spence, 1998; Wood et al., 2009). Only few studies have looked at the association between anxiety and parenting and those who did, focused mainly on panic disorder (Heider et al., 2008).

At the same time, depression is also prevalent in children and adolescents and usually leads to substantial suffering and impaired functioning and to an increased risk of suicidal behavior. It also demonstrates high comorbidity with other psychiatric disorders. About half of affected cases do not meet remission criteria after 12 months of being untreated while the risk of relapse is considerably high (Thomsen, 2011).

The two controlling parenting practices, namely psychological control and overprotection, were chosen along with rejection and warmth, because of their central role in parenting (Schaefer, 1959; Maccoby, & Martin, 1983). Despite its importance, research on parental psychological control and internalizing problems is scarce and reported results on the associations between parental warmth or rejection and child anxiety are inconsistent and weak (DiBartolo & Helt, 2007; McLeod et al., 2007). Regarding overprotection, the vast majority of studies are based on retrospective accounts of adults and no study has, to our knowledge, compared overprotection with psychological control in terms of their effects on child outcomes. Considering that these two practices may be motivated by different parental intentions (Hastings, Kahle, & Nuselovici, 2014), it is interesting to see whether they have different effects on anxiety and depression. Finally, even though it is apparent in the literature that positive and negative parenting practices are not mutually exclusive (Hummel & Kiel, 2015), only few studies have considered their combined effects (Harker et al., 2016).

The current study will also be one of the very few studies to include a range of parental and child characteristics and behaviors in its comprehensive models of child internalizing problems, based on the ecological and social cognitive models of mental health (Soenens, Vansteenkiste, & Luyten, 2010; Thomasgard & Metz, 1993 Bronfenbrenner, 1977; Sameroff, 2009). Identifying essential, superordinate processes that operate together to affect the development or maintenance of internalizing symptoms, could aid in explaining

the mechanisms behind these links, as well as uncovering comorbidities and directing therapeutic interventions more effectively (Hummel & Kiel, 2015). Further, because these processes could be resistant to change in adulthood, studying them in children, may have even more valuable preventative and therapeutic implications (Shafran & Mansell, 2001).

Apart from just examining the effects of parent behaviors and child characteristics on childhood anxiety, the current study also explores other parental, family, situational and contextual characteristics that potentially contribute to parenting itself. This can give a more detailed and thorough account of parenting and can help explain the intergenerational transition of dysfunctional characteristics and states such as anxiety and maladaptive perfectionism (McClure, et al., 2001). What's more, the few studies that have simultaneously explored various determinants of parenting, mostly did so with very young aged samples (e.g. McFadden, & Tamis-Lemonda, 2013). The current study aims to fill this gap and provide a richer and more thorough account of parenting as demonstrated in individuals that are of high risk for contributing to their own and their children's mental health problems.

METHOD

Design

The current PhD project involved an analytical, population-based, cross-sectional study among 11-12-year-old children in the Republic of Cyprus. To test the study hypotheses, a mixed method design was employed involving both quantitative and qualitative data, procedures and analyses (further details in the subsequent sub-sections).

Participants

The source population of the current study were preadolescents and early adolescents attending public primary schools in urban areas of Nicosia, Cyprus. A final sample of 369 10-12-year-old children (355 mothers) from 14 primary schools, whose parents gave informed consent, were eventually recruited into the study (see following sub-section for procedures) The sample of children included 47.1% boys (n=172) and 52.9% girls (n=163). 38.9% were 10-year-olds (n=143), 54.1% were 11-year-olds (n=199) and 7.1% were 12-year-olds (n=26). 46.6% of the children were 5th graders (n=172) and 53.3% were 6th graders (n=197); 85.4% were Greek Cypriots (n=315), 7.9% were of mixed nationality (n=29) and 6.8% were of other nationalities (n=25). 12.7% were only children in their family (n=46), 58.6% had just 1 sibling (n=214), 19.8% had 2 siblings (n=72); 6.8% had 3 siblings (n=25) and 2.2% had 4-5 siblings (n=8). 42.9% of the children were first-born (n=135), 51.1% were last in order of birth (n=161) and 6% were born in between their siblings (n=19). Based solely again on the children's responses, 96.4% of mothers (n=322) and 99.1% of fathers (n=332) were working; 3.6% of mothers (n=12) and 0.9% of fathers (n=3) were reported as unemployed. For the qualitative part of the study, 27 mothers whose children participated in the study (3.2% of all mothers in the quantitative component mentioned above) were selected based on their children's extreme scores in the questionnaires about their mothers' parenting. In particular, the invited mothers for the qualitative part of the study were: (i) 9 mothers who were identified as having very high psychological control parenting style (based on their children's responses); (ii) 15 mothers identified as having very high rejection parenting style (based on their children's responses); and (iii) 3 mothers identified as having low emotional warmth parenting style (based on their children's responses). Subsequently, from the 27 invited mothers, 14 agreed to participate (following informed consent) but only 9 of them actually proceeded with the interview. These mothers demonstrated the following characteristics (as initially identified based on their children's responses in the quantitative part's questionnaire): 3 with high psychological control parenting, 3 with high rejection

parenting, 3 with low emotional warmth parenting and 1 with both high psychological control and rejection, and 1 with high psychological control, high rejection and low emotional warmth.

For procedures regarding participant recruitment, for both the quantitative and qualitative part, see following sub-section.

Sampling Procedures

Participant Recruitment for Quantitative Part

Prior to initiating the participant recruitment procedure, the study protocol was sent to all relevant governmental bodies for approval. Consequently, the study was reviewed and approved by the Centre of Educational Research and Evaluation (accountable to the Ministry of Education and Culture) and the Cyprus National Bioethics Committee (ΕΕΚΒ/ΕΠ/2019/106). All parents/caregivers of participating children completed informed consent and all children provided informed assent prior to taking part in the study.
The sampling approach was initiated by approaching all primary schools in the city of Nicosia, from an official list provided by the Cyprus Ministry of Education. From the 49 schools approached via phone, 14 schools accepted to participate, following consent from the school's principal. Informed consent forms were initially given to 1400 5th and 6th grade children from the 14 participating primary schools, to be signed by both parents. From those, 375 children returned the informed consent signed by both parents (27% response rate) and from those 6 children were absent due to sickness during the day of data collection, resulting in a final number of 369 children who completed the study's questionnaire and were thus eligible to participate.

Arrangements were made in agreement with each school's principal so as to mix classes of participating children when possible in order for the PhD candidate to administer a series of self-report questionnaires. In this case, each child completed questionnaires on a single day during a double academic period. Participating children were either in their classroom in the presence of the PhD candidate and their main teacher while non-participating children were silently completing other school work, or in a separate classroom with the PhD candidate alone. Instructions were given to the children about questionnaire completion while ensuring confidentiality and independent responding. The PhD candidate was responsible for providing any assistance relevant to the questionnaires when needed.

Some rearrangements had to be made for some schools due to either restrictions imposed by the Ministry of Education, as part of the government's containment measures to limit spreading of COVID-19 in schools, or school staff's concerns regarding safety issues

relevant to the spread of the specific infectious disease. In particular, the majority of the schools which allowed the PhD candidate to enter the school to administer the questionnaires, asked for each class to complete the questionnaires separately. Participating children were then subdivided further into groups of 5-10 so as to ensure physical distance. In this case, the PhD candidate was the only one in charge of administering the questionnaires and monitoring the procedure.

Further rearrangements had to be made in terms of administration, for schools that were interested in participating in the study, but were hesitant as to allow the PhD candidate to enter the school for data gathering. Specifically, 2 schools asked for the teacher of each class or the principal to administer the questionnaires themselves. In this case, written instructions were given to the teachers concerning matters of confidentiality, independent responding and silence in the classroom during the administration. At the same time, written instruction about questionnaire completion were given to each teacher to read out loud to the participating children. Each questionnaire was given in an envelope which needed to be sealed before being returned to the teacher. Teachers were also instructed not to open any of the sealed envelopes but to hand it to the PhD candidate after administration.

Finally, 3 schools asked to allow participating children to complete the questionnaires at home. For this to be made possible, the PhD candidate made phone calls to all parents who had given informed consent to give a renewed informed assent with the data collection rearrangements prior to handing the questionnaires to the teachers. Parents were also given instructions not to interfere with their child's responding on the questionnaires and to strictly respect their privacy. Principals and teachers were also given written instructions with all relevant information for their use as well as precise instructions about questionnaire completion to read to participating children. Questionnaires for each child were given in an envelope for the child to complete at home and return it in 2 weeks' time sealed and containing the completed questionnaires. Again, teachers were instructed not to open any sealed envelope but gather each of them and hand them to the PhD candidate as soon as all are returned by the children.

In either case, participating parents/guardians and children were given the right to ask any question about the research program at any given time. Conduct details had be given to parents/guardians from the start along with the consent form. In addition, mothers and other guardians had the right to make a complaint about the research program at any given time to the Head of the Research Support Services of the University of Cyprus.

From the 369 participating children, a small number (n=15) only returned partially completed questionnaires, but these were followed-up with the help of the corresponding school's principal and eventually these questionnaires were completed by the participating children to an acceptable extent.

Participant Recruitment for Qualitative Part

For the qualitative part of the study, mothers whose children's scores on the parenting questionnaires lied at extreme ends of responding (statistical outliers), were called via phone by the PhD candidate in order to gain informed assent about their participation in the second part of the study. Arrangements were made with each mother about the way, place and time of the interview. Mothers were given the choice between having the interview via phone, via an online video call, or in person at the PhD candidate's private office. The PhD candidate is a Registered School Psychologist working in private practice for several years and is experienced in interviewing parents about children's emotional and behavioral difficulties and their parenting practices. Participating mothers were offered free counseling about their parenting and challenges in their family at the end of each interview.

Measures

Quantitative Study Measures

Basic demographic information were included in a battery of questionnaires completed by children. This included the child's school grade, age, gender, ethnicity, number of siblings, birth order and parents' employment status.

Maternal Psychological Control. The Psychological Control Scale—Youth Self-Report (PCS-YSR; Barber 1996; Barber, Olsen, & Shagle, 1994) was used to measure psychological control in the current sample. The PCS-YSR is an 8-item scale for children and adolescents containing questions such as: "My mother/father is always trying to change how I feel or think about things"). It is a 3-point Likert-type scale ranging from 1 "not like her/him" to 3 "a lot like her/him" with higher scores reflecting increased perception of parental psychological control. In our study, children rated psychological control only for their mothers.

Barber (1996) provided evidence for the one-dimensional factor structure and the validity of this scale. Its psychometric properties have been verified in subsequent cross-cultural studies. For example, Barber et al. (2005) showed adequate validity and reliability and theoretically meaningful relation to developmental outcomes across 10 different countries. Adequate internal consistency has also been shown in other studies (Haan et al, 2013; Gugliandolo et al., 2015; Romm, Metzger & Alvis, 2019).

Since the questionnaire was used in Greek for the purposes of the current PhD study, it was translated and back translated by two fluent speakers of Greek and English. The resulting Greek version of the questionnaire was given to a small sample of preadolescent children (n=14) from the PhD candidate's private practice (following consent from the parents), for pilot testing. The participating children in the pilot phase did not report any issues as regards comprehension of questions and completed the questionnaire with relative ease. The performance of the questionnaire in the Greek language was checked in the whole study sample (n=369) and was comparable to that observed in the literature. In particular, statistical analyses in the current study's sample showed a two-factor structure, one factor containing 5 items pertaining to interruption and criticism (e.g. "My mother is a person who changes the subject whenever I have s.th to say") and the other containing 3 items pertaining to intervening and imposition of thoughts and emotions (e.g. "My mother is a person who would like to be able to tell me how to feel or think about things all the time".) Internal consistency for these two factors was acceptable (Cronbach's $\alpha = 0.71$) and poor (Cronbach's $\alpha = 0.55$) respectively. Because of the second factors' poor internal consistency, it was not used in further analyses and was dropped altogether.

Maternal Overprotection, Rejection and Warmth. For assessing overprotection, rejection and warmth, a 23-item short version of the Egna Minnen Betraffande Uppfostran-child version questionnaire (EMBU-C; (Castro et al. 1993; Gruner et al. 1999; Arrindell et al.,1999) was used. The EMBU-C was modified from the original EMBU (Perris et al., 1980), to assess children's perception of mothers and fathers separately. Arrindell et al. (1999) suggested a 3-factor solution for their short version, including Overprotection, Rejection and Emotional Warmth. The Overprotection subscale refers to perceptions of the mother as feeling fearful and anxious for the child's safety, engendering guilt, and being intrusive. The Emotional Warmth subscale refers to perceptions of the mother as giving special attention, praising, having unconditional love, and being supportive and affectionate. The Rejection subscale involves perceptions of the mother as criticizing and inducing guilt through nonverbal communication. Items are scored on a 4-point Likert scale (1 = no, never, 2 = yes, sometimes, 3 = yes, often, and 4 = yes, always). Various studies conducted in different countries have mostly shown the three subscales to demonstrate at least adequate internal consistency (e.g. Arrindell & Engebretsen, 2000; Muris et al. 2003; Aluja, Del Barrio, & Garcia, 2006; Young et al., 2013).

For the current study, since the questionnaire was used in Greek for the first time, it was translated and back translated by two fluent speakers of Greek and English. The

resulting Greek version of the questionnaire was given to a small sample (n=14) of preadolescent children (for details regarding translation and pilot testing, please refer to previous sub-section). The performance of the questionnaire in the Greek language was checked in the whole study sample (n=369) and was comparable to that observed in the literature, apart from the fact that the Overprotection subscale failed to load on a distinct factor and hence was omitted for further analyses. As concerns the other subscales, 11 items loaded on the Rejection subscale (e.g. "My mother criticizes me and tells me how lazy and useless I am in front of others") and 7 items loaded on the Emotional Warmth subscale (e.g. "Between me and my mother, there is warmth and tenderness"). We found good internal consistency for Rejection (Cronbach's α = 0.80) and acceptable internal consistency for Emotional Warmth (Cronbach's α = 0.76).

Broad Child Personality Traits. To assess children's personality, a short-form of the Junior Eysenck Personality Questionnaire (JEPQ-S; Francis & Pearson, 1988; Eysenck & Eysenck, 1975). was used. Items translated in Greek and corresponding to the original short form, were obtained from a Greek version (Kokkinos et al., 2010) of the full JEPQ (Eysenck and Eysenck 1975). This Greek version was based on the initial Greek translation provided by Dimitriou (1986) following minor vocabulary adaptations. JEPQ-S contains 24 items that are allocated into 4 distinct subscales, each corresponding to a different personality dimension. The subscales are Neuroticism, Extraversion, Psychoticism and the Lie scale. Each subscale contains 6 items that are answered in a "yes or no" fashion. In the original study, Cronbach's alphas were found to be acceptable for Neuroticism (α=0.71), questionable for Extraversion (α=0.69) and the Lie scale (α=0.65) and poor for Psychoticism (α=0.58). According to the authors, internal consistency values are considered adequate for such a short version (Francis & Pearson, 1988; Francis, Lankshear, & Pearson, 1989; Francis, 1997). These findings were replicated in a study by Smith (1996). Williams, Francis, & Robbins (2007) subsequently found adequate internal consistency for all subscales.

Cronbach's alphas of the initial Greek version (Dimitriou, 1986) ranged from .56 to .89. Correspondingly, Kokkinos, Charalambous & Davazoglou (2010) found Cronbach's alphas ranging from .64 to .81. In our sample, a Principal Component Analysis confirmed the 3-factor structure, with 4 items loading on Neuroticism (α=.60), 5 items loading on Extraversion (α=.63), and 6 items loading on Psychoticism (α=.60).

Child Perfectionism. A 9-item short version of the Child and Adolescent Perfectionism Scale (CAPS-SF; Bento et al., 2020) was used to assess perfectionism in children. The original CAPS is the most widely used multidimensional measure of child and adolescent

perfectionism. It is a Likert-type scale ranging from 1 (Lie-not true at all) to 5 (Very true) for assessing Self-Oriented and Socially Prescribed Perfectionism (Flett et al., 2016). The scale was validated for use with children (O'Connor, Dixon, & Rasmussen, 2009) and has shown good psychometric properties (O'Connor, Rasmussen, & Hawton, 2010). Development of the CAPS-SF was initially constructed with a Portuguese-speaking sample. Self-oriented perfectionism (SOP) is captured in 4 items (e.g. "wanting to be the best at everything") and refers to personal demands of self-perfection and self-criticism. Socially-prescribed perfectionism (SPP) includes 5 items ("There are people in my life that expect me to be perfect") and refers to perceptions of expectations and demands others place on the person to be perfect. It should be noted that the CAPS-SF items was reverse-coded in an effort to assist children with reading difficulties. Bento et al. (2020) demonstrated good internal consistency for the SPP-SF subscale (α=.87) and acceptable internal consistency for the SOP-SF subscale (α=.77).

For the current study, since the questionnaire was used in Greek for the first time, translation and back translation was applied, followed by pilot testing (please refer to previous sections for details of the above procedure). The performance of the questionnaire in the Greek language was checked in the whole study sample (n=369) and was comparable to that observed in the literature. In particular, in the current study's sample, the 2-factor structure was confirmed. The SOP subscale consisted of 4 items (e.g. "My family expects me to be perfect") and showed good internal consistency (α=.86) and the SPP subscale consisted of 3 items (e.g. "I try to be perfect in everything that I do") and showed adequate internal consistency (α=.78).

Child Coping. The Children's Coping Strategies Checklist- Revision 1 (CCSC-R1; Ayers & Sandler, 1999) was used to assess coping strategies employed by children. It is a 54-item self-report questionnaire in a Likert scale format, ranging from 1 ('never') to 4 ('usually') which assesses preferred methods of coping with stress. Children are asked to respond to questions as to how often they have used each strategy to solve problems in the past month. It contains broad and specific subscales, namely Active Coping Strategies (incl. problem-focused coping, positive cognitive restructuring), Distraction Strategies (incl. distracting actions, physical release of emotions), Avoidance Strategies (incl. avoidant actions, repression, wishful thinking), and Support-Seeking Strategies (incl. support for actions and support for emotions). The scale has been widely used in the literature (e.g. Hanks et al., 2016; Simpson, et al., 2018; Delvecchio et al., 2019; Rabinowitz et al., 2020).

Research has shown good psychometric properties for the scale (e.g. Ayers & Sandler, 1999; Gaylord-Harden, 2008; Morris, 2009; Scott, 2012; Thorne, Andrews, & Nordstokke, 2013).

For the current study, since the questionnaire was used in Greek for the first time, translation and back translation was applied, followed by pilot testing (please refer to previous sections for details of the above procedure). Additionally, for the current study, instructions were slightly modified to allow for habitual ways of coping or coping styles (i.e. "When I had a problem…"). Children were also given examples of social, academic and other problems that children their age may periodically be facing. The performance of the questionnaire in the Greek language was checked in the whole study sample (n=369) and was comparable to that observed in the literature. In particular, in the current study's sample, factor analysis confirmed the 4 broad coping factors but, wishful thinking as a specific strategy failed to enter any of the broad ones. 21 items loaded on Active Coping (e.g. "You thought about which things are best to do to handle the problem") with excellent internal consistency (α=.92), 8 items loaded on Support-Seeking (e.g. "You told people how you felt about the problem") with excellent internal consistency (α=.91), 9 items loaded on Distraction coping (e.g. "You did some exercise") with good internal consistency (α=.83), and 7 items loaded on Avoidance coping (e.g. "You just forgot about it") with acceptable internal consistency (α=.71). Nevertheless, items corresponding to either Direct Problem Solving or Seeking Understanding, two dimension which had originally been included in the Active Coping subscale, did not load on any factor in the current data and thus were omitted from further analyses. However, the remaining subdimensions of Active Coping, namely Cognitive Decision Making and Positive Reframing, both refer to cognitive processing of the problem, either by considering alternative solutions or by reframing the situation and the broader context in more favourable terms. Since none of these two dimensions refers to actual decisions or actions, it was decided to use the term "Cognitive Processing" instead of "Active Coping" to refer to the factor which items of these dimensions loaded on.

Internalizing Problems. To assess anxiety and depression, a short version of the Revised Child Anxiety and Depression Scale (RCADS; Chorpita et al, 2000; Ebesutani et al., 2012) was used. The RCADS is a revision of the Spence Children's Anxiety Scale (SCAS; Spence, 1998), specifically adjusted to correspond to certain DSM-IV anxiety disorders. The short version used in the current study yields a total anxiety and a total depression score. Studies with community and clinical samples examining the psychometric properties of various versions of the RCADS, support its reliability and validity for assessing anxiety and depression in youth (Chorpita et al., 2000; de Ross, Gullone, & Chorpita, 2002; Kosters et al.,

2015; Esbjorn et al, 2012). The 25-item short form was found to have only small differences from the larger forms of the scale maintaining good reliability coefficients (Ebesutani et al., 2012; Piqueras et al., 2017).

For the current study, since the questionnaire had been used in Greek for the first time until the time of authority evaluation and data collection, translation and back translation was applied, followed by pilot testing (please refer to previous sections for details of the above procedure). In particular, after factor analyzing the data in the current sample, the 2-factor structure of the scale pertaining to depression and anxiety, was achieved. More specifically, 10 items loaded on the Depression scale (e.g. "I feel I don't have energy to do things") which showed good internal consistency (α=.83) and 8 items loaded on the Anxiety scale (e.g. "I worry that something bad will happen") which showed acceptable internal consistency (α=.78). Two questions had to be reconsidered after recommendations by the evaluative committee of the Ministry of Education. Specifically, item "I think about death" was requested to be omitted all together and item "I feel I am not worthy" had to be altered as "I feel I am worthy". For the latter item, reverse coding was conducted after entering the data for statistical analysis.

It should be noted that a Greek version of the full RCADS was standardized in the Greek population by Giannopoulou et al. (2021) but was not published until after the PhD candidate had collected the data. Nevertheless, the translated version of the scale used in the current study closely resembles the one proposed by the authors of the aforementioned published study. This standardized translated Greek version demonstrated good psychometric properties in the original study.

Qualitative Study Measures

Semi-Structured Interview. A semi-structured interview was constructed to be used with mothers who were scored by their children as extreme in their use of negative parenting. Interviews lasted from 40 to 70 minutes depending on content and flow of the conversation. Questions included in the interview referred to parental, child, family and contextual factors that have been found in the literature to influence choice of parenting behaviors in parents. For example, selected subjects were asked of their intentions at the time they applied the negative parenting practices, as well as their cultural values, parenting ideologies and personal childhood experiences.

Questions also pertain to specific family events or family characteristics, including being pregnant at a relatively young or old age, pregnancy or delivery complications, frightening choking experiences or other medical events concerning the child, divorce or

parental conflict, lack of partner support, cultural minority issues or lack of social support, and economical stressors. Parental characteristics and emotional states were also considered when developing the interview questions, including parental anxiety and regret, general anxiety or depression, parental efficacy, coping and perfectionism or antagonism. Further, questions pertaining to child characteristics that might influence the mother's parental behavior, were included in the interview, such as developmental delays or other neurodevelopmental problems, difficult temperament and behavioral or emotional problems.

The semi-structured format was chosen for the interview so as to allow parents to mention more freely their own accounts of parenting, as well as other uniquely perceived influential factors, not considered beforehand by the interviewer. In addition, this format was to allow for newly formed questions to be formed as the interviews unfolded to help participants expand and elaborate on their ideas and personal opinions. Interviews were recorded and transferred to written transcripts.

All interviews were conducted by the PhD Candidate, an experienced registered School Psychologist, while ensuring confidentiality and providing a context where subjects were treated with respect, empathy and unconditional acceptance.

Data Analysis

Quantitative Data Analysis

Factor Analysis. An Exploratory Factor Analysis (EFA) was conducted for each instrument of the quantitative study to determine factor structure using IBM SPSS 27. Originally all items were entered for analysis for each scale separately. Descriptive statistics were obtained in terms of correlations including coefficients, significance levels, determinant and KMO & Barlett's Test of Sphericity. A Principal Components method was chosen to freely determine factor structures in the current sample. Initially, an unrotated solution was determined and a scree test was chosen to determine the number of statistically significant factors that can be retained in the analysis so as to get a reasonable proportion of variance explained. Factor extraction was also established based on eigenvalues that were greater than 1, as one indication of how many factors to retain.

Assumptions of a factor analysis were met based on sample size, since the current sample was >300 subjects, a criterion proposed by Tabachnick & Fidell (2001). A criterion for sample size adequacy was for the KMO and Barlett's test of Sphericity, specifically the Kaiser-Meyer-Olkin Measure of Sampling Adequacy, to be greater than .5. As an EFA assumption, there should also be reliable correlations among the variables and this was

tested based on the KMO & Barlett's Test of Sphericity which if significant, meant that there was at least one significant correlation between items in the dataset. Multicollinearity/singularity as an assumption was determined by a correlation matrix between the variables of interest.

Scale items that were less than .3 under the Extraction table Communalities were taken into consideration as insufficient in subsequent interpretations. Factors with an eigenvalue greater than 1 were noted and compared to ones determined by a parallel analysis application, which calculates eigenvalues from randomly generated correlation matrices based on a SAS-based code written by O' Connor (2000). Number of variables/items and sample size were entered in the parallel analysis for each scale separately. Factors with eigenvalues that were larger than the corresponding random eigenvalues were retained (Horn 1965). Based on the parallel analysis engine, the recommended values for number of random correlation matrices and percentile of eigenvalues are 100 and 95 respectively, while lower percentile values tend to lead to factor over extraction (Cota et al. 1993; Glorfeld 1995; Turner 1998; Velicer et al. 2000).

A Confirmatory Factor Analysis (CFA) was then conducted using fixed number extraction depending on the new number of factors that were retained in the parallel analysis. Maximum Iterations were turned into 50 so that the analysis was possible with the data. An Oblimin rotation was initially selected as a means to determine whether factors were orthogonal or oblique. Coefficients were sorted by size and those that were less than .4 were suppressed. The Component Correlated Matrix determined whether factor correlations were orthogonal or oblique. If correlation coefficients were less than .5, the correlation matrix was considered orthogonal. In all cases, correlation matrixes were orthogonal, so a CFA was reconducted one final time using a Varimax rotation. The Rotated Component Matrix determined which scale item loaded under which factor.
Scale items were then checked to determine if they are theoretically consistent. Items that were theoretically inconsistent with the majority of items that loaded on a factor were dropped. Factors which contained only a small number of variables which themselves were theoretically inconsistent with each other were dropped altogether.

Items that loaded on a component were then checked for internal consistency reliability with IBM SPSS 27 so as to determine how well each item in each scale were capturing the overall variability of the derived factors. This method is based on how closely related (correlated) the items within a single derived factor are. Internal consistency was measured with Cronbach's alpha (Cronbach, 1951) since it is the most common test score

reliability coefficient. Factors with Cronbach's alpha coefficients greater than 0.7 were retained for the main analysis. Factors with Cronbach alphas less than 0.6 were omitted. The most commonly used rule of thumb for interpreting Cronbach's alpha coefficients provides the following criteria for internal consistency: $\alpha \geq 0.9$, Excellent; $\alpha = 0.8 - 0.9$, Good; $\alpha = 0.7-0.8$ Acceptable; $\alpha = 0.6 - 0.7$, Questionable; $\alpha = 0.5 - 0.6$, Poor; $\alpha < 0.5$, Unacceptable (Lavrakas, 2008; Salkind, 2015).

Items of retained factors were then added to compose total scores for each factor in the form of cumulative scale variables, to be used for further analyses.

All derived scales (components) and relevant loadings (as well as report of internal consistency) from the Factor Analysis described above, can be found in Table 1.

Table 1

Principal Components (Scales) for the Main Variables of Interest, Derived Through Principal Component Analysis

Psychological control	
Items	*Loadings*
PsychContr3	0.80
PsychContr1	0.72
PsychContr7	0.71
PsychContr8	0.65
PsychContr2	0.49
Cronbach's Alpha	*0.712*

Warmth		**Rejection/Authoritarianism**	
Items	*Loadings*		*Loadings*
s_EMBU_C12	0.70	s_EMBU_C7	0.68
s_EMBU_C9	0.66	s_EMBU_C16	0.64
s_EMBU_C23	0.65	s_EMBU_C13	0.63
s_EMBU_C19	0.63	s_EMBU_C21	0.60
s_EMBU_C6	0.59	s_EMBU_C20	0.59
s_EMBU_C2	0.56	s_EMBU_C22	0.55
s_EMBU_C14	0.51	s_EMBU_C18	0.53
Cronbach's Alpha	*0.757*	s_EMBU_C15	*0.52*
		s_EMBU_C4	0.48
		s_EMBU_C1	0.48
		s_EMBU_C10	0.41
		Cronbach's Alpha	*0.803*

Neuroticism		**Extraversion**		**Psychoticism**	
	Loadings		*Loadings*		*Loadings*
JEPQ_S14	0.78	JEPQ_S9	0.65	JEPQ_S21	0.61
JEPQ_S10	0.75	JEPQ24	0.62	JEPQ_S1	0.55
JEPQ_S17	0.56	JEPQ_S3	0.61	REV_JEPQ11	0.54
JEPQ_S6	0.52	JEPQ_S22	0.60	JEPQ_S5	0.52
Cronbach's Alpha	*0.601*	JEPQ_S19	0.50	JEPQ_S15	0.47
		Cronbach's Alpha	*0.633*	JEPQ_S13	0.44
				Cronbach's Alpha	*0.603*

Perfectionism (self)		**Perfectionism (others)**	
	Loadings		*Loadings*
CAPS_s1	0.85	CAPS_s5	0.84
CAPS2_s2	0.77	CAPS_s3	0.82
CAPS_s8	0.63	CAPS_s6	0.82
Cronbach's Alpha	*0.782*	CAPS_s7	0.79
		Cronbach's Alpha	*0.885*

Active Coping		**Support Seeking Coping**		**Distraction Coping**		**Avoidance Coping**	
	Loadings		*Loadings*		*Loadings*		*Loadings*
CCSC_R1_35	0.64	CCSC_R1_4	0.80	CCSC_R1_53	0.75	CCSC_R1_36	0.71
CCSC_R1_44	0.63	CCSC_R1_28	0.78	CCSC_R1_39	0.72	CCSC_R1_3	0.61
CCSC_R1_6	0.66	CCSC_R1_38	0.78	CCSC_R1_25	0.72	CCSC_R1_15	0.57
CCSC_R1_43	0.62	CCSC_R1_7	0.77	CCSC_R1_20	0.70	CCSC_R1_27	0.57
CCSC_R1_29	0.61	CCSC_R1_13	0.71	CCSC_R1_12	0.66	CCSC_R1_5	0.46

CCSC_R1_34	0.61	CCSC_R1_18	0.69	CCSC_R1_9	0.59	CCSC_R1_37	0.46
CCSC_R1_45	0.61	CCSC_R1_22	0.69	CCSC_R1_52	0.46	CCSC_R1_21	0.42
CCSC_R1_41	0.59	CCSC_R1_30	0.59	CCSC_R1_32	0.44	*Cronbach's Alpha*	*0.710*
CCSC_R1_17	0.57	*Cronbach's Alpha*	*0.908*	CCSC_R1_42	0.43		
CCSC_R1_1	0.56			*Cronbach's Alpha*	*0.826*		
CCSC_R1_19	0.56						
CCSC_R1_31	0.54						
CCSC_R1_2	0.54						
CCSC_R1_24	0.53						
CCSC_R1_23	0.53						
CCSC_R1_47	0.50						
CCSC_R1_8	0.50						
CCSC_R1_50	0.50						
CCSC_R1_11	0.42						
CCSC_R1_49	0.41						
CCSC_R1_16	0.41						
Cronbach's Alpha	*0.915*						

Depression		**Anxiety**	
	Loadings		*Loadings*
RCAD_s13	0.72	RCAD_s24	0.69
RCAD_s18	0.70	RCAD_s22	0.65
RCAD_s4	0.64	RCAD_s17	0.61
RCAD_s20	0.62	RCAD_s21	0.61
RCAD_s15	0.59	RCAD_s5	0.60
RCAD_s1	0.58	RCAD_s2	0.58

RCAD_s10	0.58	RCAD_s7	0.55
RCAD_s8	*0.57*	*RCAD_s12*	0.46
REV_RCAD16	0.49	*Cronbach's Alpha*	*0.775*
RCAD_s23	0.45		
Cronbach's Alpha	*0.828*		

Summary Statistics and Variable Distributions. Summary statistics and variable distributions were calculated using IBM SPSS 27. These descriptive statistics were calculated for all numeric scales constructed following the procedure described in the previous sub-section (factor analysis). Initially, the distribution of variables was tested using histograms and Q-Q plots, while box-plots were used for visualizing extreme values (outliers and high leverage points). Additionally, departure from normality was assessed via skewness and kurtosis statistics and was tested statistically using the Shapiro–Wilk test. Variables showing evidence of departure from normality and/or contained extreme values, were noted for consideration in subsequent analyses.

Summary statistics calculated included the mean, the median, the standard deviation (SD), and the interquartile range (IQR). For variables showing evidence of departure from normality, the median and IQR, were considered additional to the mean and SD, as the former set of statistics are more robust to departures from normality and represent the central tendency and dispersion of the variable better.

Correlation and Linear Regression. Since several of the variables showed evidence of departure from normality, correlations between variables were estimated using Spearman's rank correlation analysis, rather than Pearson correlation analysis, since the former is more robust to departures from normality and gives more valid estimates for the correlation between two numeric variables. Correlations were estimated between the predictor variables of interest (Psychological Control, Warmth, Rejection, Neuroticism, Extraversion, Psychoticism, Self-Oriented Perfectionism, Socially-Prescribed Perfectionism, Cognitive Processing coping, Support-Seeking coping, Distraction coping, Avoidance coping), as well as between each independent variable of interest and the two outcome variables of interest (Depression and Anxiety). These pairwise correlations, with the corresponding p-values, were estimated in the form of a correlation matrix.

Simple linear regression was ran treating each predictor variable (as described above), in turn, as independent variable and each of the outcome variables (Depression and Anxiety), separately as dependent variables. From these analyses, unstandardized regression coefficients (B), with their 95% Confidence Intervals (95% CI) and the corresponding p-values, were derived. Additionally, multiple linear regression was performed, using the following three models:

Model 1 included all three parenting variables (Psychological Control, Warmth, Rejection) as independent variables and Depression or Anxiety as dependent variable.

Model 2 included all three parenting variables as independent variables, plus all five child personality variables (Neuroticism, Extraversion, Psychoticism, Self-Oriented Perfectionism, Socially-Prescribed Perfectionism) and Depression or Anxiety as dependent variables.

Model 3 included all three parenting variables as independent variables, plus all five child personality variables, plus all four child coping variables (Cognitive Processing, Support-Seeking coping, Distraction coping, Avoidance coping) and Depression or Anxiety as dependent variable.

For all analyses, a p-value of <.05 was taken as evidence of a statistically significant association between each of the independent variables of interest and each of the dependent variables of interest.

Multiple Imputation. Due to the relatively high number of missing values in key variables (e.g. 61 for Cognitive Processing Coping, 34 for Rejection, etc.), multiple imputation was applied to the dataset before proceeding to the next analysis step, namely path analysis. The rationale for this approach is that the path model runs only for cases with complete data on all variables of interest (i.e. complete-case analysis), substantially decreasing the sample size in this case (from n=369 to n=198).

Multiple imputation was conducted in IBM SPSS 27 (Analyze > Multiple Imputation > Impute Missing Data Values). All key variables of interest as well as demographic factors were included in the imputation model. The procedure imputes multiple values for missing data for these variables. The number of imputations to compute. was set to the default (5). The output (imputed) dataset consists of the original dataset (including missing data) plus 5 sub-datasets with imputed values for each variable including missing data in the original dataset. When an analysis is conducted on the imputed dataset, SPSS provides the results for each imputed sub-dataset, as well as the original dataset, simultaneously giving a pooled estimate for the 5 imputed sub-datasets.

In case of path analysis, this feature is not available in IBM SPSS AMOS 27, the software used for path analysis (see sub-section below), therefore path analyses where conducted, in turn, in the original dataset and all imputed sub-datasets.

Path Analysis. Path Analysis using structural equation modelling (IBM SPSS AMOS 27) was used to test mediation paths between the three categories of variables (parenting practices, child personality characteristics, and child coping strategies). In this mediation model, the constructed scales of perceived maternal practices (PC, Warmth, Rejection) served as exogenous variables, influencing childhood internalizing problems (Depression and

Anxiety) directly and indirectly through two consecutive sets of mediators (endogenous variables): (i) children's personality characteristics (Neuroticism, Extraversion, Psychoticism, Self-Oriented Perfectionism, Socially-Prescribed Perfectionism); and (ii) children's coping strategies (Cognitive Processing, Support-Seeking, Distraction, Avoidance).

In order to build this model, the following approach was followed. Firstly, a hypothesis-driven path model was constructed based on current knowledge from theoretical models and frameworks in the literature. In this model, all exogenous variables (perceived maternal practices) lead to all children's personality characteristics (first set of mediators), in turn leading to all children's personality characteristics (second set of mediators), which in turn lead to each of two internalizing outcomes of interest (Depression and Anxiety). Apart from the aforementioned indirect effects, this model also allowed for direct effects of all the independent variables (both exogenous and endogenous) on Anxiety and Depression (dependent variables). In addition, this model allowed for associations between the endogenous variables from within the same category (e.g. SPP and SOP, Avoidance coping and Cognitive Processing, etc.) It should be noted, that separate theoretical models were constructed for each of the two outcomes of interest (Depression and Anxiety).

Following this, a data-driven approach was followed for building the final path model for each outcome. This approach involved running first the hypothesis-driven model and excluding, in turn, any path which was not backed up by the data (i.e. the path that revealed no bivariate association between the two variables involved). In particular, only statistically significant paths (regression coefficient p-value < .05) were kept in the final model. As in the case of the initial hypothetical models, these data-driven models differed between the two outcomes (Depression and Anxiety), as revealed by the data (more information in the Results section).

The above path analysis provides estimates of the magnitude and significance of the hypothesized links between variables in the path diagram. Path coefficients were estimated using the Maximum Likelihood estimator (MLE). Standardised estimates, squared multiple correlations, indirect, direct, and total effects, were all reported in the output. Test of normality for all variables included in the paths and regression assumptions, including the presence of outliers and high leverage values were previously investigated, as described in the previous sub-section. Bootstrapping was also used to generate bootstrap standard errors, used for calculating confidence intervals and testing the statistical significance of indirect and total effects.

The coefficient of determination (R-squared) was used as an indication for "explanation" of the variance of the outcome variables, by the independent variables (exogenous and endogenous) included in the path model. The R-squared (R^2) denotes the proportion of explained variance accounted for by the independent (predictor) variables out of the total variables. The higher the proportion, the better is the predictive power of the model.

Model fit was tested through particular fit indices including the Goodness of Fit (GFI), Comparative Fit Index (CFI), the Tucker–Lewis index (TLI), the Normed Fit Index (NFI) and the root mean square error of approximation (RMSEA) (Akaike, 1998). RMSEA values that are less than .05 signify a good model fit while RMSEA values that are less than .08 signify a marginal model fit (MacCallum et al., 1996). GFI, NFI, TLI, and CFI values greater than or equal to.95 represent a good model fit, while values between.90 and .94 represent a marginal model fit (Hu & Bentler, 1999). The chi-square test goodness of fit, as a commonly used measure of absolute fit in research, was also reported. The relative chi-square (CMIN/DF), which is generally highly dependent on sample size, was also used as a measure of model fit. An acceptable fit emerges with value of less than 3 (Kline, 1998). Alternative mediation path models (derived following the above procedure), were compared in terms of model fit and overall determination (R^2). In cases where two alternative models showed very similar fit and R^2, the most parsimonious model, (which did not compromise model fit and determination) was chosen as the main model. The path diagram and corresponding output of the final model for each outcome of interest (depression and anxiety) is presented in the main Results section. Fit indices and specific path coefficients in tabular form are shown is the Appendices section.

Qualitative Data Analysis

Qualitative analysis was used to further enrich the findings emerging from the quantifying part of the study, by exploring possible determinants of the parenting practices of interest in detail. Mothers whose children had extreme scores on the parenting scales used in the quantifying part of the study, were selected so as to give their own account of which factors actually influence their own parenting behaviour. This was done in an effort to elicit information and gain a deeper understanding of maternal intentions, attitudes and actions that lie behind negative parenting on a more personal level and directly from their source, that is mothers. Being in a more open manner, qualitative analysis, particularly based on semi-structured interviews, would encourage discussion, flexibility and provide some context surrounding maternal behaviours.

Content analysis was chosen as a type of qualitative analysis based on its potential to also partially quantify data while uncovering meaningful categories and their frequency of occurrence in the content of the data. It is also considered a reliable method since it follows systematic procedures that be replicated. At the same time, content analysis allows for assumptions about the subjects and can simultaneously allow the exploration of relevant behaviours, attitudes, viewpoints, values and emotions (Lindgren, 2020). Among different types of content analysis, conceptual content analysis fitted the purpose of the qualitative part of the current study best since it allows for the identification of meaningful concepts in a text and their frequency. In general, conceptual content analysis is used to quantify the number of times a word, concept or theme appears in the content of qualitative data so as to draw inferences based on the patterns that emerge (Christie, 2007; Wilson, 2011).

In the current study, qualitative data were drawn from the semi-structured interviews conducted with mothers who had been identified as having extreme score on the parenting scales completed by their children in the quantitative part of the study. The full content of the interviews was then transferred into written transcripts which were subsequently broken down into manageable code categories (i.e. “codes”) based on theoretically important maternal, child and contextual characteristics that potentially influence the maternal use of the parenting practices under study. Once the text in the transcripts was coded into manageable code categories, the codes were further categorized into subcategories to summarize data even further through a process of selective reduction. Codes and subcategories were pre-defined based on the research questions but flexibility to add categories through the coding process was also allowed. This rude was decided so as to allow for the inclusion and analysis of new and significant concepts that could have important implications to the research questions under study. Coding was performed for the existence of a concept in each transcript so that a concept was counted only once when it appeared in one particular transcript. However, coding was also performed for the frequency of a concept by counting the number of times it appeared in all transcripts as a whole, coming from all participants. Concepts in the transcripts were coded as the same when they appeared in different forms. In some instances, words that implied a concept and not explicitly stated it were also included. Transcripts were coded by hand so as to be able to recognize error and to also allow for inclusion of implicit information. Irrelevant, unwanted or unused text in the transcripts was re-examine and either subsequently included in the code categorization or ignored altogether.

The codes initially selected from the transcripts were all possible determinants of maternal use of parenting practices. These included words, phrases and sentences with explicit or implicit meaning. Implicit meaning was further clarified while still conducting the interview to ensure the objectivity of meaning to a bigger extent. As mentioned above, codes were broken down into subcategories. These included: 1. Maternal factors, 2. Child factors, and 3. Contextual factors. All of these subcategories were predetermined from the research questions that had been based on theoretical knowledge and were set before conducting the interviews.

These subcategories were further divided into more distinct categories as follows: "1. Maternal factors" was subdivided into: A. Personality and behavior; B. Emotional difficulties; C. Mother's childhood. "Personality and behavior" was further subdivided into: I. Controlling (authoritarian, overprotective); II. Perfectionism; III. Rigidity, IV. Prone to anxiety or anxiety disorder; V. Does not express feelings; VI. Values adherence of rules, schedules and organization; VII. Does not value active listening, communication. "2. Emotional difficulties" was further subcategorized into: I. Anger issues (low patience, takes thinks personally as disrespect); II. Venting; III. Depressive symptoms; IV. Self-esteem issues; V. Stress and anxiety; VI. Worries of child's safety; VII. Worries about child's social adjustment; VIII. Exhaustion, self-neglected; IX. Feels uncomfortable with unconditional expressions of love/affection; X. Does not express feelings. "3. Mother's childhood" was subcategorized as: I. Controlling mother (high PC, rejecting, authoritarian); II. Emotionally cold or distant parents; III. Mother prone to anxiety and a perfectionist; IV. Mother worked long hours or had multiple responsibilities; V. Father was away (abroad or working long hours); VI. Parents were refugees; VII. Guilt feelings and repressed emotions as a child; VIII. Behavioral problems as a child/teenager.

"3. Child factors" were subdivided into: A. Developmental history (premature birth, delays, current difficulties); B. Health history problems; C. Personality and behavior; D. Reactions to maternal negative behavior; E. Social problems (no friends, lack of assertiveness, bullying history); F. Emotional problems (withdrawal, anxiety, low self-esteem). "C. Personality and behavior" was further subdivided into: I. Low motivation and self-initiation; II. Behavioral Problems (stubbornness, demandingness, impulsiveness); III. Anxiety prone; IV. Perfectionism; V. Overly mature; VI. Does not express feelings. "D. Reactions to maternal negative behavior" was further subcategorized as: I. Aggressive/emotional reactions; II. Passive reactions; III. Talks about fairness; IV. Tries to gain mother's affection/attention.

"3. Contextual factors" was subdivided into: A. Family issues; B. Social support network; C. Other stressors; D. Past life events. "A. Family issues" was further subdivided into: I. More than 2 children; II. Big age gap with other children; III. Sibling rivalry and fights; IV. Challenging characteristics/behaviors of other children; V. Father uninvolved (works long hours, is abroad or does not help); VI. Couple conflicts/arguments; VII. Mother from another country. "B. Social support network" was further subdivided into: I. No support from grandparents; II. No other social support. "C. Other stressors" was further subcategorized into: I. Demanding job/workload; II. Time constraints (multiple responsibilities); III. Financial difficulties. "D. Past life events" was further subdivided into: I. Difficult or unwanted pregnancy or difficult after birth period; II. Traumatic past events in family (domestic violence, other child's accident, death child's uncle).

RESULTS

Descriptive statistics

Demographic characteristics of study participants, can be found in Table 2. Regarding the main predictor (parenting, personality, coping) and outcome (Depression and Anxiety) variables of interest, Table 3 displays descriptive statistics for all derived predictor and outcome variables.

Concentrating in Table 3, as regards parenting, the mean perceived maternal Psychological Control (PC) score was *6.47 (range = 5-13, SD = 1.81)*, the mean perceived maternal Rejection score was *15.4 (range = 9-28, SD = 4.21)* and the mean perceived maternal Warmth score was *23.4 (range = 11-32 SD = 3.84)*. Participants' scores on childhood personality characteristics were: Neuroticism (*range = 4-8, M = 5.82, SD = 1.29),* Extraversion (*range = 5-10, M = 8.89, SD = 1.31),* Psychoticism (*range = 9-14, M = 10.5, SD = 1.40*), Self-Oriented Perfectionism (SOP) (*range = 3-15, M = 10.6, SD = 3.13)* Socially Prescribed Perfectionism (SPP) (*range = 4-20, M = 12.1, SD = 4.78)*. In terms of childhood coping scores, the following were observed: Cognitive Processing coping (*range = 23-84, M = 55.1, SD = 12.1),* Support-Seeking coping (*range = 8-32, M = 19.9, SD = 6.37),* Distraction coping (*range = 9-36, M = 22.7, SD = 6.43)* Avoidance coping (*range = 7-28, M = 15.9, SD = 4.02)*. Participants' average scores on the two outcomes of interest were: Depression scale (*range = 10-35, M = 17.8, SD = 5.07)* and Anxiety scale (*range = 9-32, M = 19.0, SD = 4.80)*.

Histograms and Q-Q plots were used to assess the distribution of each variable graphically. Since the mean and standard deviation for some variables were affected by non-normal distributions (primarily skewness) and/or extreme values, it is recommended that the median and IQR are also considered as measures of central tendency and dispersion for those variables, since these are more robust to non-normality. For the current study, PC, Rejection and Psychoticism were positively skewed with high leverage values lying to the right of the distribution. The three variables displayed a Mdn of 6.00 (IQR = 2.00), 14.0 (IQR = 4.00), and 10.0 (IQR = 2.00) respectively. Depression was slightly positively skewed with outliers lying to the right of the distribution and a Mdn of 17.0 (IQR = 6.00). The following variables were negatively skewed with high leverage values lying to the left of the distribution: Warmth, Extraversion, SOP. Warmth displayed a Mdn of 24.0 (IQR = 6.00), Extraversion a Mdn of 9.00 (IQR = 2.00) and SOP a Mdn of 11.0 (IQR = 4.00). Neuroticism, SPP and Cognitive Processing, Support-Seeking, Distraction and Avoidance coping were all normally distributed. Anxiety was also generally normally distributed.

Boxplots showing variation in the sample for each variable provide an indication of how the values in the data were spread out. Boxplots for the parenting variables demonstrated the highest number of outliers, compared to other scales, in the upper end of the Rejection scale's boxplot and quite a few outliers in the upper end of the PC scale's boxplot. The Rejection and PC scales demonstrated 15 and 9 outliers respectively. A boxplot for the Warmth scale showed only 3 outliers in its lower end. None of the personality and coping variables showed any outliers in their boxplots. Boxplots for the dependent variables however demonstrated 7 and only 2 outliers for the Depression and the Anxiety scale respectively. Outliers for both the dependent variables were plotted in the lower end of their boxplots.

Table 2

Demographic Characteristics of Study Participants

	Frequency	**%**
Gender		
Male	172	47.1
Female	193	52.9
Total	365	100.0
Missing	4	
Age		
10	143	38.9
11	199	54.1
12	26	7.1
Total	368	100.0
Missing	1	
Grade		
5^{th}	172	46.6
6^{th}	197	53.4
Total	369	100.0
Ethnicity		
Cypriot	315	85.4
Mixed	29	7.9
Other	25	6.8
Total	369	100.0

No. of siblings		
0	46	12.7
1	214	58.6
2	72	19.8
3	25	6.8
4	5	1.4
5	3	0.8
Total	365	100.0
Missing	4	

Order of birth		
First	135	42.9
in between	19	6.0
Last	161	51.1
Total	315	100.0
Missing	54	

Mother's employment		
Working	322	96.4
not working	12	3.6
Total	334	100.0
Missing	35	

Father's employment		
Working	332	99.1
not working	3	0.9
Total	335	100.0
Missing	34	

Table 3

Summary Statistics and Normality Tests for the Main Variables of Interest

	Valid obs.	Miss.	Mean	Median	SD	IQR	Min	Max	Skewness (s.e.)	Kurtosis (s.e.)	Shapiro-Wilk. test
Psychological Control (PC)	360	9	6.47	6.00	1.81	2.00	5	13	1.41 (0.13)	1.57 (0.26)	p <.001
Warmth	358	11	23.4	24.0	3.84	6.00	9	28	-1.02 (0.13)	0.81 (0.26)	p <.001
Rejection	335	34	15.4	14.0	4.21	4.00	11	32	1.73 (0.13)	3.28 (0.27)	p <.001
Neuroticism	365	4	5.82	6.00	1.29	2.00	4	8	0.11 (0.13)	-1.04 (0.26)	p <.001
Extraversion	347	22	8.89	9.00	1.31	2.00	5	10	-1.22 (0.13)	0.79 (0.26)	p <.001
Psychoticism	356	13	10.5	10.0	1.40	2.00	9	14	0.87 (0.13)	-0.04 (0.26)	p <.001
Self-Oriented Perfectionism (SOP)	364	5	10.6	11.0	3.13	4.00	3	15	-0.60 (0.13)	-0.22 (0.26)	p <.001
Socially-Prescribed Perfectionism (SPP)	355	14	12.1	12.0	4.78	8.00	4	20	-0.12 (0.13)	-1.01 (0.26)	p <.001
Cognitive Processing Coping	308	61	55.1	54.0	12.1	16.0	23	84	0.00 (0.14)	-0.10 (0.28)	p = .28
Support Seeking Coping	346	23	19.9	20.0	6.37	9.25	8	32	-0.04 (0.13)	-0.81 (0.26)	p <.001
Distraction Coping	350	19	22.7	23.0	6.43	9.00	9	36	-0.01 (0.13)	-0.70 (0.26)	p = .001
Avoidance Coping	339	30	15.9	16.0	4.02	6.00	7	28	0.32 (0.13)	-0.05 (0.26)	p = .002
Depression	347	22	17.8	17.0	5.07	6.00	10	35	0.96 (0.13)	0.80 (0.26)	p <.001
Anxiety	358	11	19.0	18.0	4.80	6.00	9	32	0.47 (0.13)	-0.16 (0.26)	p <.001

Bivariate Regression Analysis

Table 4 displays a correlation matrix of all correlations between the predictor variables of the model. Spearman's rank correlation coefficients (ρ) were estimated and the criteria of Cohen (1988), were used for evaluating the strength of the pairwise correlations. Only statistically significant correlations will be reported here. Among the parenting variables, a relatively strong positive correlation was found between maternal Psychological Control (PC) and Rejection ($\rho = .56$, $p < .01$). PC was negatively and moderately correlated with Warmth ($\rho = -.29$, $p < .001$). Rejection was also moderately negatively related to Warmth ($\rho = -.32$, $p < .01$). These associations are in the expected direction since both PC and Rejection are considered to be negative parenting practices, while Warmth is considered to be a positive parenting practice. PC was positively and weakly related to the more dysfunctional personality traits of Neuroticism ($\rho = .21$, $p < .01$), Psychoticism ($\rho = .17$, $p < .01$) and Socially Prescribed Perfectionism (SPP) ($\rho = .24$, $p < .01$) and was weakly and negatively related to Cognitive Processing ($\rho = -.14$, $p < .05$), a coping strategy most often considered functional in terms of emotional outcomes. Rejection followed a similar pattern since it was also weakly and positively related to Neuroticism ($\rho = .22$, $p < .01$), Psychoticism ($\rho = .21$, $p < .01$) and SPP ($\rho = .25$, $p < .01$) and negatively and weakly related to Support-Seeking coping ($\rho =- .12$, $p < .05$), a coping strategy which is most often associated with positive emotional outcomes. Warmth followed the opposite pattern since it was positively but weakly correlated with Extraversion ($\rho =- .23$, $p < .01$) and positively and moderately linked to Cognitive Processing ($\rho = .43$, $p < .01$) and Support-Seeking coping ($\rho = .41$, $p < .01$) but it was also positively related to Distraction coping ($\rho = .16$, $p < .01$) even though this correlation was weak. Warmth was negatively but weakly related to Psychoticism ($\rho = -16$, $p < .01$).

Correlations among personality characteristics followed an expected direction with Neuroticism being positively related to SPP ($\rho = .13$, $p < .05$) and negatively and significantly related to Extraversion ($\rho = .15$, $p < .01$). Albeit significant, all of these correlations were weak. SPP and Self-oriented Perfectionism (SOP) were positively and strongly related to each other to a relatively high degree ($\rho = .53$, $p < .01$). In terms of the links between personality and coping, Neuroticism was only linked to Distraction Coping in a negative direction and the correlation was weak ($\rho = -.12$, $p < .05$). Psychoticism did not show any positive correlations with coping strategies but was negatively and weakly related to Cognitive Processing ($\rho = -.17$, $p < .01$) and Support-Seeking coping ($\rho = -.16$, $p < .01$). SPP was positively and weakly correlated with Avoidance ($\rho = .13$, $p < .05$) and Distraction coping ($\rho = .15$, $p < .01$). No

negative significant correlations were found between SPP and coping. SOP positively but weakly correlated with Cognitive Processing (ρ = .13, p < .05). No significant negative correlations were found between SOP and coping strategies.

Correlations between coping variables showed some unexpected patterns. As expected, Cognitive Processing positively and strongly correlated with Support-Seeking coping (ρ = .61, p < .01). However, Cognitive Processing was also positively and moderately linked to Distraction (ρ = .37, p < .01) and Avoidance coping (ρ = .34, p < .01). Support-Seeking coping was also positively associated with Distraction (ρ = .32, p < .01) and Avoidance coping (ρ = .17, p < .01) to a moderate degree. These correlations were unexpected since active and Support-Seeking coping are considered to be approach oriented coping strategies while Avoidance and Distraction coping are thought to be avoidant oriented coping strategies. Still in the expected direction, a moderate positive correlation between Distraction and Avoidance Coping (ρ = .31, p < .01) was found.

Table 5 shows correlations between all the predictor variables and both outcome variables. Only statistically significant correlations will be reported here. Depression was positively and moderately related to maternal PC (ρ = .35, p < .01) and Rejection (ρ = .42, p < .01) and to the personality variables of Neuroticism (ρ = .45, p < .01), Psychoticism (ρ = .21, p < .01) and SPP (ρ = .25, p < .01). Depression was also negatively and moderately associated with maternal Warmth (ρ = -.35, p < .01), Extraversion (ρ = -.24, p < .01), Cognitive Processing (ρ = -.29, p < .01) and Support-Seeking coping (ρ = -.15, p < .05).

Anxiety showed significant positive correlations with PC (ρ = .23, p < .01), Rejection (ρ = .22, p < .01), Neuroticism (ρ = .45, p < .01), Psychoticism (ρ = .11, p < .05), SPP (ρ = .26, p < .01), SOP (ρ = .24, p < .01), Cognitive Processing (ρ = .21, p < .01) and Support-Seeking coping (ρ = .21, p < .01). Anxiety showed negative correlations only with Extraversion (ρ = .21, p < .01).

In a series of simple linear regression analyses, the above predictors were included as independent variables with depression and anxiety, in turn, as dependent variables. Findings from these analyses (displayed in Table 5) were, as expected, in agreement with findings from the correlation analyses discussed above. The strongest effects (unstandardized regression coefficients - B) for Depression were observed for PC (B = 1.03, p < .01), Rejection (B = 0.47, p < .01), Warmth (B = -0.48, p < .01), Neuroticism (B = 1.76 , p < .01), Extraversion(B = -1.04, p < .01), Psychoticism (B = 0.75, p < .01), SPP (B = 0.29, p < .01), Cognitive Processing (B = -0.12, p < .01) and Support-Seeking Coping (B = -0.11, p < .01). In other words, 1 unit increase in the PC, Rejection, Neuroticism, Psychoticism, and SPP scores

was associated with a 1.03, 0.47, 1.76, 0.75, and 0.29 units increase in the Depression score, respectively. On the other hand, 1 unit increase in the Warmth, Extraversion, Cognitive Processing, and Support-Seeking coping scores, was associated with a 0.48, 1.04, 0.12, and 0.11 units decrease in the Depression score, respectively.

The strongest positive effects for Anxiety were observed with PC ($B = 0.58$, $p < .01$), Rejection ($B = .27$, $p < .01$), Neuroticism ($B = 1.62$, $p < .01$), SPP ($B = 0.28$, $p < .01$) and SOP ($B = .42$, $p < .01$), while a negative effect was observed for Extraversion ($B = -0.66$, $p < .01$). The factors not associated with the outcomes of interest, based on both bivariate correlation and regression analyses, were: a) For depression: SOP, Distraction Coping and Avoidance Coping, and b) For Anxiety: Warmth and Distraction Coping.

Table 4

Correlation Matrix with All the Predictor Variables of Interest

		PC	Warmth	Rejection	Neuroticism	Extraversion	Psychoticism	SOP	SPP	Act. Coping	Supp. Coping	Dist. Coping
PC.	ρ											
	N											
Warmth	ρ	-.29**										
	N	350										
Rejection	ρ	.56**	-.32**									
	N	326	330									
Neuroticism	ρ	.21**	-.10	.22**								
	N	357	356	332								
Extraversion	ρ	.01	.23**	-.04	-.15**							
	N	338	340	319	345							
Psychoticism	ρ	.17**	-.16**	.21**	.03	.03						
	N	347	347	325	354	341						
SOP	ρ	.01	.09	.06	.06	-.01	.00					
	N	347	354	332	361	344	353					
SPP	ρ	.24**	-.08	.25**	.13*	-.07	.13*	.53**				
	N	346	346	326	352	336	346	353				
Act. Coping	ρ	-.14*	.43**	-.08	-.02	.20**	-.17**	.13*	.08			
	N	302	302	284	306	294	299	305	300			
Supp. Coping	ρ	-.10	.41**	-.12*	-.00	.25**	-.16**	.04	.03	.61**		
	N	338	338	315	343	327	336	344	336	294		
Dist. Coping	ρ	-.01	.16**	.03	-.12*	.16**	.04	.04	.15**	.37**	.32**	
	N	341	341	320	347	331	339	348	340	299	335	
Avoid. Coping	ρ	-.03	.04	.05	.00	.02	.00	.03	.13*	.34**	.17**	.31**
	N	330	332	309	336	321	330	336	329	288	322	326

ρ = Spearman's correlation coefficient, N = Number of participants in each pairwise comparison, *Correlation is significant at the .05 level ** Correlation is significant at the .01 level; PC: Psychological control; SOP: Self-Oriented Perfectionism; SPP: Socially-Prescribed Perfectionism.

Table 5

Pairwise Associations Between the Two Dependent Variables of Interest (Depression and Anxiety) and All the Predictor Variables of Interest

		PC	Warmth	Rejection	Neuroticism	Extraversion	Psychoticism	SOP	SPP	Act. Coping	Supp. Coping	Dist. Coping	Avoid. Coping
Depression	ρ	.35**	-.35**	.42**	.45**	-.24**	.21**	.01	.25**	-.29**	-.15*	-.06	.03
	B	1.03**	-0.48**	0.47**	1.76**	-1.04**	0.75**	0.04	0.29**	-0.12**	-0.11*	-0.06	0.06
	N	340	340	318	345	328	338	344	335	292	329	331	322
Anxiety	ρ	.23**	.02	.22**	.45**	-.14**	.11*	.24**	.26**	.13*	.12*	.06	.13*
	B	0.58**	0.03	0.27**	1.62**	-0.66**	0.27	0.42**	0.28**	0.06*	0.10*	0.05	0.17*
	N	350	350	326	355	340	348	355	346	303	339	342	333

ρ = Spearman's correlation coefficient, β = Unstandardized regression coefficient, N = Number of participants in each pairwise association

*Significant at the .05 level **Significant at the .01 level

PC: Psychological control; SOP: Self-Oriented Perfectionism; SPP: Socially-Prescribed Perfectionism

Multivariate Regression Analysis

Multiple Regression with Depression as Outcome

Table 6 shows results for a series of multiple linear regression analyses including all independent, variables of interest, with Depression as the dependent outcome variable. It should be noted that in contrast to the linear regression results presented above, multiple regression results show regression coefficients from analyses were mutual adjustment is made for all the variables included in the model. In other words, the results presented for a single predictor-outcome association, is adjusted for (controlled for) any other predictor included as an independent variable in the model (mutual adjustment).

Firstly, in a multiple regression model which included only the three parenting factors of interest as independent variables and Depression as the dependent variable, all three predictor variables were associated with the outcome of interest (Depression). More specifically, for every 1 unit increase in PC, the Depression scale increased by 0.38 units (95% CI: 0.01; 0.76). In a subsequent model (model 2) including all three parenting factors and all five child personality factors of interest, PC lost its previous (model 1) statistically significant association with Depression. In particular, the regression coefficient of the association between PC and Depression decreased from 0.38 (0.01; 0.76) to 0.14 (-0.20; 0.46). In a third model including all three parenting factors, the five child personality factors and all four child coping strategies of interest, the effect of PC on Depression continued to be nonsignificant with the regression coefficient of the association decreasing further from 0.14 (-0.20; 0.46) in model 2 to -0.07 (-0.45; 0.31) in model 3.

As regards maternal Warmth, in model 1, which included only the three parenting factors of interest as independent variables, it was observed that for every 1 unit increase in the relevant score, the Depression scale decreased by 0.23 units (95% CI: -0.38; -0.08). In Model 2, which additionally included the five child personality factors of interest, Warmth lost its previous (model 1) statistically significant association with Depression. Specifically, the regression coefficient of the association between Warmth and Depression decreased from -0.23 units (95% CI: -0.38; -0.08) to -0.13 (-0.26; 0.01). In the third model which additionally included the four coping strategies of interest, the effect of Warmth on Depression continued to be nonsignificant and the regression coefficient of the association decreased further to -0.15 (-0.31; 0.01).

As regards maternal Rejection, in model 1, it was observed that for every 1 unit increase in the relevant score, the Depression scale increased by 0.28 units (95% CI: 0.12; 0.44). In Model 2 (additionally including child personality factors), the regression coefficient

of the association decreased slightly from 0.28 units (95% CI: 0.12; 0.44) to 0.22 (0.08; 0.37) but retained its statistical significance. In the third model, (additionally including child coping strategies), the effect of Rejection on Depression continued to be strongly significant and the regression coefficient of the association increased slightly from 0.22 (0.08; 0.37) in model 2 to 0.26 (0.09; 0.43). Generally, the effect of Rejection on Depression remained robust to adjustments from model 1 to model 3.

Four out of the five personality factors which were added in model 2 alongside the parenting factors, were associated with the Depression outcome namely Neuroticism, Extraversion, Psychoticism, and SPP. For every 1 unit increase in Neuroticism, the Depression scale increased by 1.28 units (95% CI: 0.94, 1.62). When coping strategies were added in model 3, the regression coefficient of the association between Neuroticism and Depression decreased from 1.28 (0.94; 1.62) to 1.20 (0.80; 1.60) but the association remained significant.

As regards Extraversion, for every 1 unit increase in the relevant score, the Depression scale decreased by -0.63 units (95% CI: -0.97, -0.30) in model 2. In model 3, in which the coping strategies of interest were added alongside the coping and personality factors, the regression coefficient of the association between Extraversion and Depression decreased from -0.63 (-0.97; -0.30) to -0.60 (-0.99; -0.21) but the association remained significant.

As regards Psychoticism, for every 1 unit increase in the relevant score, Depression increased by 0.44 units (95% CI: 0.13; 0.75). In model 3, where the coping strategies were added, the regression coefficient of the association between Psychoticism and Depression decreased from 0.44 (0.13; 0.75) to 0.42 (0.04; 0.79) but the association remained significant.

As regards SPP, for every 1 unit increase in the relevant score, Depression increased by 0.14 units (95% CI: 0.03, 0.25). In model 3, whereby the coping strategies were added, SPP lost its previous (model 2) significant association with Depression. In particular, the regression coefficient of the association decreased from 0.14 (0.03; 0.25) to 0.09 (-0.03; 0.21).

As noted above, the association between each one of the child coping strategies and Depression was tested in model 3 of the multiple regression analysis. From the four coping strategies which were entered in the model alongside the parenting and child personality factors, only Cognitive Processing significantly predicted Depression. In particular, for every 1 unit increase in Cognitive Processing, Depression decreased by 0.07 units (95% CI: -0.13; -

0.01). Support-Seeking Coping, Distraction Coping and Avoidance Coping failed to significantly predict Depression.

Multiple Regression with Anxiety as Outcome

Table 7 shows a series of multiple regression analyses including all parenting, child personality and child coping variables as independent variables and Anxiety as the dependent variable. To begin with, model 1 including only the three parenting factors of interest as independent variables, showed only two of the parenting variables, namely Warmth and Rejection, being associated with the outcome of interest (Anxiety). More specifically, for every 1 unit increase in Warmth, the Anxiety scale increased by 0.22 units (95% CI: 0.07; 0.36). In a subsequent model (model 2) including all three parenting factors and all five personality factors of interest, the effect of Warmth remained robust to adjustment (B = 0.24, 95% CI 0.10; 0.38). In a third model additionally including the four coping strategies of interest, the regression coefficient of the association between Warmth and Anxiety decreased slightly to 0.19 (0.01; 0.37), albeit still remaining significant.

As regards maternal Rejection, for every 1 unit increase in the relevant score in model 1, the Anxiety scale increased by 0.27 units (95% CI: 0.10; 0.43). In Model 2, additionally including all child personality factors, Rejection lost its previous (model 1) statistically significant association with Anxiety with the regression coefficient decreasing from 0.27 (0.10; 0.43) to 0.14 (-0.01; 0.29). In the third model, additionally including all coping strategies of interest, the effect of Rejection on Anxiety remained nonsignificant. PC did not demonstrate a significant association with Anxiety in either of the three models.

In term of personality, only three out of the five personality factors which were added in model 2 alongside the parenting factors, were associated with the Anxiety outcome. These were Neuroticism, Extraversion and SOP. For every 1 unit increase in Neuroticism, the Anxiety scale increased by 1.26 units (95% CI: 0.90, 1.62). When coping strategies were added in model 3, the regression coefficient of the association between Neuroticism and Anxiety decreased from 1.26 (0.90; 1.62) to 1.15 (0.70; 1.59) but the association remained significant.

As regards Extraversion, for every 1 unit increase in the relevant score in model 2, the Anxiety scale decreased by 0.42 units (95% CI: -0.78, -0.06). In model 3, additionally including the four child coping strategies of interest, the regression coefficient of the association between Extraversion and Anxiety increased from -0.42 (-0.78; -0.06) to -0.65 (-1.08; -0.21) and the significance was strengthened.

As regards SOP, for every 1 unit increase in the relevant score in model 2, Anxiety increased by 0.25 units (95% CI: 0.08; 0.43). In model 3, additionally including child coping strategies, the regression coefficient of the association between SOP and Anxiety increased from 0.25 (0.08; 0.43) to 0.33 (0.12; 0.54).

The association between each one of the child coping strategies and Anxiety was tested in model 3 of the multiple regression analysis, which also included the parenting and the personality factors. None of the four coping strategies in the model significantly predicted Anxiety.

Table 6

Multiple Linear Regression Analysis Including All Independent, Mediating variables of interest, with Depression as the Dependent Outcome Variable

Model 1 (parenting factors)	B (95% CIs)	Model 2 (parenting + child personality factors)	B (95% CIs)	Model 3 (parenting + child personality + coping factors)	B (95% CIs)
Psychological control	0.38 (0.01, 0.76)*	Psychological control	0.14 (-0.20, 0.46)	Psychological control	-0.07 (-0.45, 0.31)
Warmth	- 0.23 (-0.38, -0.08)*	Warmth	-0.13 (-0.26, 0.01)	Warmth	-0.15 (-0.31, 0.01)
Rejection	0.28 (0.12, 0.44)*	Rejection	0.22 (0.08, 0.37)*	Rejection	0.26 (0.09, 0.43)**
Model n = 308		Neuroticism	1.28 (0.94, 1.62)***	Neuroticism	1.20 (0.80, 1.60)***
Adjusted R^2 = 0.19		Extraversion	-0.63 (-0.97, -0.30)***	Extraversion	-0.60 (-0.99, -0.21)**
		Psychoticism	0.44 (0.13, 0.75)**	Psychoticism	0.42 (0.04, 0.79) *
		SOP	-0.10 (-0.27, 0.06)	SOP	-0.01 (-0.20, 0.18)
		SPP	0.14 (0.03, 0.25)*	SPP	0.09 (-0.03, 0.21)
		Model n = 281		Cognitive Processing	-0.07 (-0.13, -0.01)***
		Adjusted R^2 = 0.39		Social Support Coping	0.02 (-0.07, 0.12)
				Distraction Coping	0.04 (-0.05, 0.13)
				Avoidance Coping	0.10 (-0.04, 0.24)
				Model n = 210	
				Adjusted R^2 = 0.41	

B (95% CIs): Regression coefficient (95% Confidence Intervals), *p<.05, **p<.01, ***p<.001. PC: Psychological control; SOP: Self-Oriented Perfectionism; SPP: Socially-Prescribed Perfectionism

Table 7

Multiple Linear Regression Analysis Including All Independent, Mediating variables of interest, with Anxiety as the Dependent Outcome Variable

Model 1 (parenting factors)	B (95% CIs)	Model 2 (parenting + child personality factors)	B (95% CIs)	Model 3 (parenting + child personality + coping factors)	B (95% CIs)
Psychological control	0.25 (-0.12, 0.62)	Psychological control	0.17 (-0.16, 0.50)	Psychological control	0.26 (-0.16, 0.68)
Warmth	0.22 (0.07, 0.36)**	Warmth	0.24 (0.10, 0.38)**	Warmth	0.19 (0.01, 0.37) *
Rejection	0.27 (0.10, 0.43)**	Rejection	0.14 (-0.01, 0.29)	Rejection	0.14 (-0.04, 0.33)
Model n = 315		Neuroticism	1.26 (0.90, 1.62)***	Neuroticism	1.15 (0.70, 1.59)***
Adjusted R^2 = 0.08		Extraversion	-0.42 (-0.78, -0.06)*	Extraversion	-0.65 (-1.08, -0.21)**
		Psychoticism	0.20 (-0.13, 0.54)	Psychoticism	0.29 (-0.13, 0.71)
		SOP	0.25 (0.08, 0.43)**	SOP	0.33 (0.12, 0.54)**
		SPP	0.08 (-0.04, 0.19)	SPP	0.02 (-0.12, 0.16)
		Model n = 289		Cognitive Processing	0.04 (-0.03, 0.10)
		Adjusted R^2 = 0.28		Social Support Coping	0.07 (-0.04, 0.18)
				Distraction Coping	0.01 (-0.08, 0.11)
				Avoidance Coping	0.06 (-0.10, 0.22)
				Model n = 218	
				Adjusted R^2 = 0.30	

B (95% CIs): Regression coefficient (95% Confidence Intervals), *p<.05, **p<.01, ***p<.001. PC: Psychological control; SOP: Self-Oriented Perfectionism; SPP: Socially-Prescribed Perfectionism

Path Analysis

As described in the Methods section, hypothesis-driven paths were constructed for the two outcomes of interest (Depression, Anxiety). The hypothesized model for Depression included all three parenting variables (PC, Warmth, Rejection) as exogenous variables, and two groups of serial mediators including five child personality variables (Neuroticism, Extraversion, Psychoticism, SOP, and SPP) and four coping variables (Cognitive Processing, Support-Seeking, Avoidance, and Distraction) respectively. More specifically, parenting strategies are included in the path models as distal predictors of Depression and Anxiety, respectively, through child personality characteristics, and child coping characteristics. The two hypothesized path diagrams for Depression and Anxiety, respectively, are presented in Figures 1 and 2.

As described in the Methods section, a process of running the above models subsequently, keeping only significant paths, until the most parsimonious model with the maximum predictive power (coefficient of determination – R^2) and best model fit, were followed. The criteria for assessing model ft in path analyses are described in detail in the Methods section, in the relevant sub-section.

Path Model with Depression as Outcome

Based on the fit indices used, the model for Depression as presented in Figure 3, fits the data well, with the chi-square statistic satisfying the criterion for goodness of fit (x^2 = 43.44, df = 32, p = .09, CMIN/df = 1.36). CFI was .99, the Normed Fit Index (NFI) was .95, GFI was .98 and TLI was .98 all exceeding the target value of 0.90 which signifies good fit. Root Mean Square Error of Approximation (RMSEA = .03) also satisfied the specified criterion being less than 0.08. The model as presented in Figure 3 generally fits the social-cognitive theory of psychological adjustment which postulates that child's personal characteristics mediate the link between environmental influences (in this case parenting) and emotional outcomes (in this case Depression). However, not all paths were significant and two variables, namely SOP and Distraction coping failed to enter the model. Significant paths were as follows:

PC served only as a distal predictor of Depression through Psychoticism (β = 0.16, p = .002) which in turn negatively predicted Cognitive Processing (β = -0.09, p = .017) which subsequently negatively predicted Depression (β = -0.17, p = < .001).

Warmth served as both a direct (β = -0.11, p = .019) and a distal predictor of Depression through three distinct indirect serial paths. In one path, Warmth was associated with Extraversion (β = 0.21, p < .001) which in turn negatively predicted Depression (β = -

0.14, p < .001). In a second indirect path, Warmth was linked to Cognitive Processing (*β* = 0.23, p <.001) which subsequently negatively predicted Depression (*β* = -0.17, p < .001). In a final indirect path, Warmth predicted Support-Seeking coping (*β* = .34, p = < .001) which in turn led to Cognitive Processing coping (*β* = 0.51, p < .001) which ultimately negatively predicted Depression (*β* = -017, p < .001).

Rejection demonstrated both a direct (*β* = 0.24, p < .001) and an indirect association with Depression through distinct serial paths. In the first instance, Rejection was linked to Neuroticism (*β* = 0.24, p < .001) which in turn predicted Depression (*β* = 0.33, p < .001). In the second instance, the link between Rejection and Neuroticism was followed by the inverse association of Neuroticism with Extraversion (*β* = -0.15, p = .003) with Extraversion ultimately and negatively predicting Depression (*β* = -0.14, p < .001). Extraversion also predicted Depression through its association with Support-Seeking coping (*β* = 0.19, p < .001) which in turn predicted Cognitive Processing coping (*β* = .51, p < .001) ultimately and negatively predicting Depression (*β* = -0.17, p < .001). Rejection also predicted Depression through its association with Socially-Prescribed Perfectionism (SPP) (*β* = 0.27, p < .001) which in turn predicted Depression (*β* = 0.15, p < .001) directly and indirectly through three distinct paths. In one indirect path, SPP was linked to Cognitive Processing coping (*β* = 0.11, p = .005) which in turn negatively predicted Depression (*β* = -0.17, p < .001). In a second path, SPP led to Avoidance coping (*β* = 0.12, p = .02) which in turn predicted Depression (*β* = 0.10, p =.01). In a final path, the association between SPP and Avoidance coping was followed by a link between Avoidance coping and Cognitive Processing coping (*β* = 0.28, p < .001) with Cognitive Processing ultimately negatively predicting Depression (*β* = -0.17, p < .001).

Overall, this path model explained 42% of the outcome of interest (Depression), as estimated by the path analysis (Squared Multiple Correlation = .42).

Path Model with Anxiety as Outcome

Based on the fit indices mentioned above, the model for Anxiety as presented in Figure 4, fits the data generally well. The only exception is the chi-square statistic the significance of which indicates that the Null Hypothesis that the predicted model and observed data are equal is rejected (x^2 = 63.51, df = 26, p < .001, CMIN/df = 2.44). However, the chi-square test is particularly sensitive to sample size with larger sample sizes increasing the probability of the chi square being significant. Given that SEM generally requires large sample sizes, the chi square test is sometimes thought to be a less trustworthy fit indices (Hu & Bentler, 1999). Based on this justification, it is sometimes recommended using the chi-square divided by the degrees of freedom (χ^2/df) as a measure of model fit, with values of 5

or less indicating a good model fit (Schumacker & Lomax, 2010). In the current data, this fit criterion is satisfied. As concerns the rest of the fit indices, CFI was .95, the Normed Fit Index (NFI) was .92, GFI was .97 and TLI was .91, all exceeding the target value of .90 which signifies good model fit. Root Mean Square Error of Approximation (RMSEA = .06) also satisfied the specified criterion being less than .08. The model as presented in Figure 4, just as in the case of Depression, generally fits the social-cognitive theory of psychological adjustment based on which children's personal characteristics mediate the link between parenting and emotional outcomes (in this case Anxiety). However, not all paths were significant. Significant paths were as follows:

PC predicted Anxiety only indirectly through its link with Psychoticism (β = 0.16, p = .002) which subsequently predicted Anxiety (β = 0.11, p = .008). This is in line with the role of PC in the Depression model.

However, unlike the model for Depression, Warmth served only as a distal predictor of Anxiety through a series of different paths. In the first case, Warmth was associated with Cognitive Processing (β = 0.40, p = < .001) which in turn predicted Anxiety (β = 0.23, p < .001). As can be observed, even though Cognitive Processing is, as expected, positively associated with Warmth, which is considered a positive parenting strategy, it is also positively associated with Anxiety, which is a negative emotional outcome. This was not the case with Depression since it was, as expected, negatively associated with Cognitive Processing. Another path from Warmth to Anxiety involves the link between Warmth and Extraversion (β = 0.21, p <.001) which in turn negatively predicted Anxiety directly (β = -0.16, p = <.001). However, when Warmth led to Cognitive Processing (β = 0.40, p <.001), Cognitive Processing positively predicted Anxiety (β = 0.23, p <.001). The same was observed in yet a final path of Warmth whereby Warmth predicted Self-Oriented Perfectionism (SOP) (β = 0.14, p = .001) which in turn led to Anxiety (β = 0.19, p < .001). Thus, both Cognitive Processing and SOP compromised the otherwise positive effects of Warmth on Anxiety.

Just as in the model for Depression, Rejection predicted Anxiety both directly (β = .20, p <.001) and indirectly through a series of different paths. The indirect paths are as follows: Rejection predicted Neuroticism (β = 0.24, p < .001) which in turn predicted Anxiety directly (β = 0.36, p < .001) and indirectly through its negative association with Extraversion (β = -0.15, p = .003). In turn, Extraversion negatively predicted Anxiety directly (β = -0.16, p < .001) or indirectly through its association with Cognitive Processing (β = 0.14, p = .003) which in turn positively predicted Anxiety (β = 0.23, p < .001). Once again, Cognitive Processing seemed to compromise the otherwise positive effects of Extraversion on Anxiety.

Overall, this path model explained 34% of the outcome of interest (Anxiety), as estimated by the path analysis (Squared Multiple Correlation = .34).

Figure 1

Hypothetical Path Model for the Association Between Parenting Strategies (Exogenous Variables) and Depression (Outcome Variable) Through Child Personality Characteristics and Coping Styles (Mediating Variables)

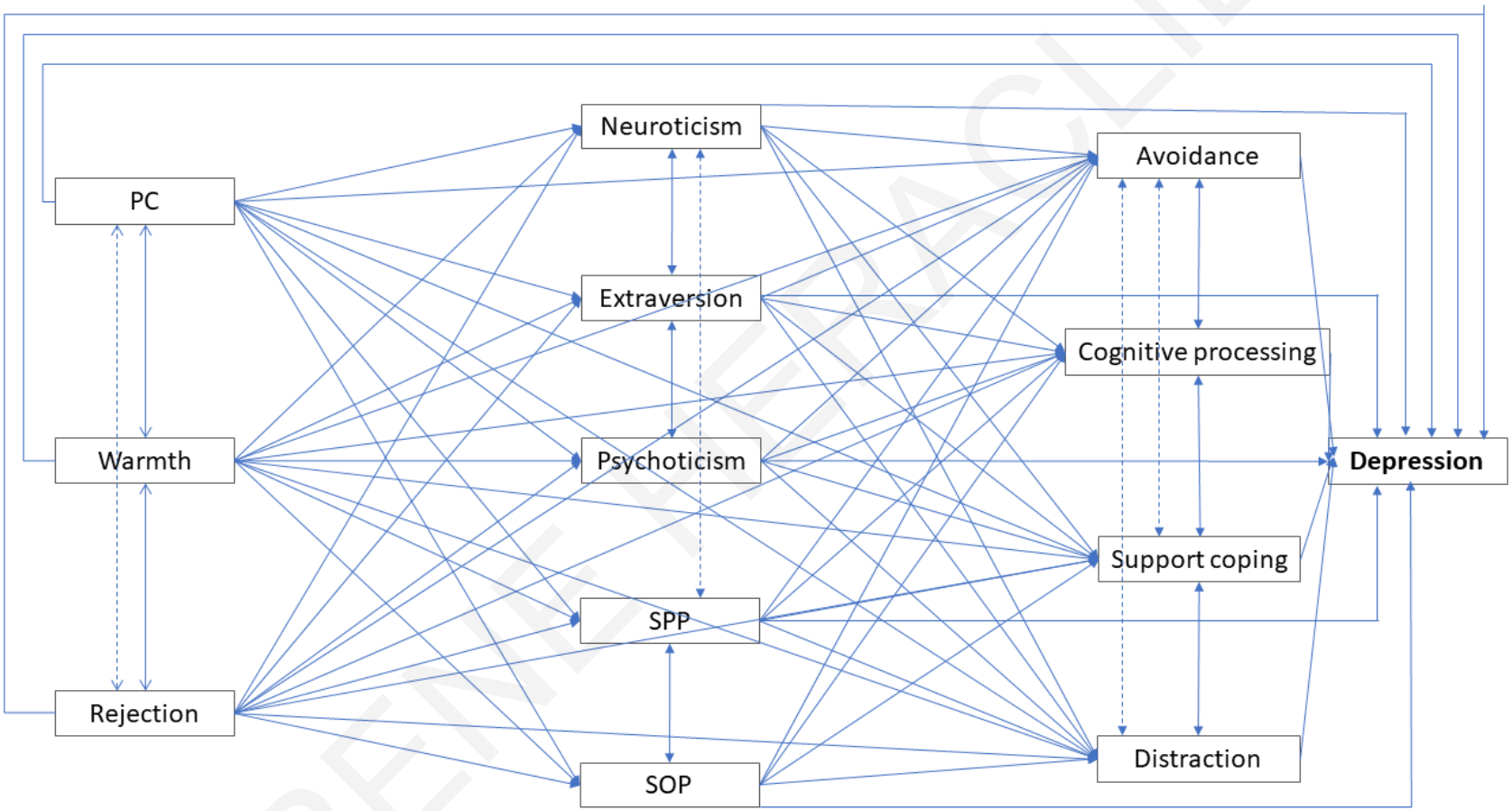


Figure 2

Hypothetical Path Model for the Association Between Parenting Strategies (Exogenous Variables) and Anxiety (Outcome Variable) Through Child Personality Characteristics and Coping Styles Mediating Variables)

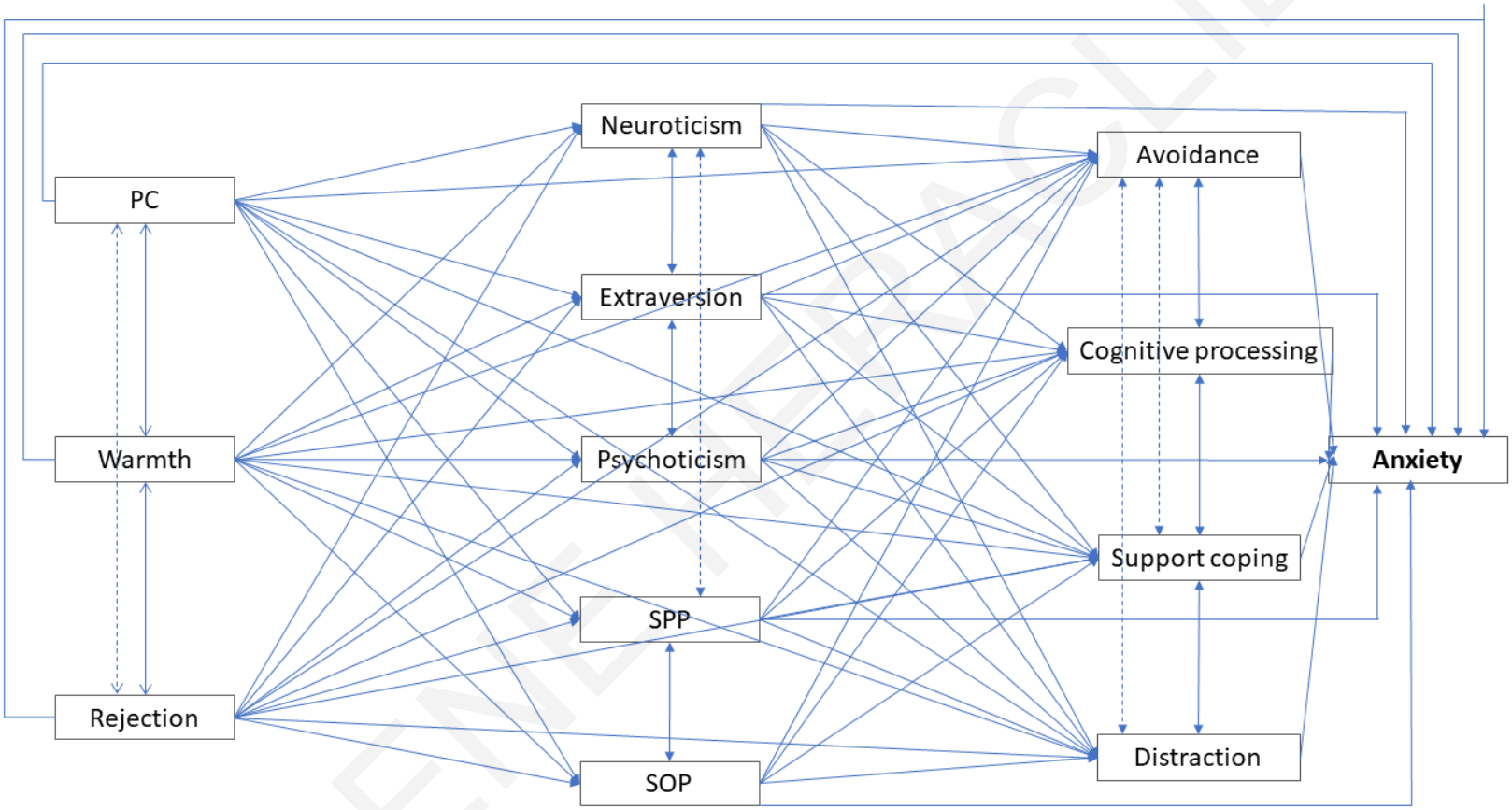


Figure 3

Final (Data-Driven) Path Model for the Association Between Parenting Strategies (Exogenous Variables) and Depression (Outcome Variable) Through Child Personality Characteristics and Coping Styles (Mediating Variables)

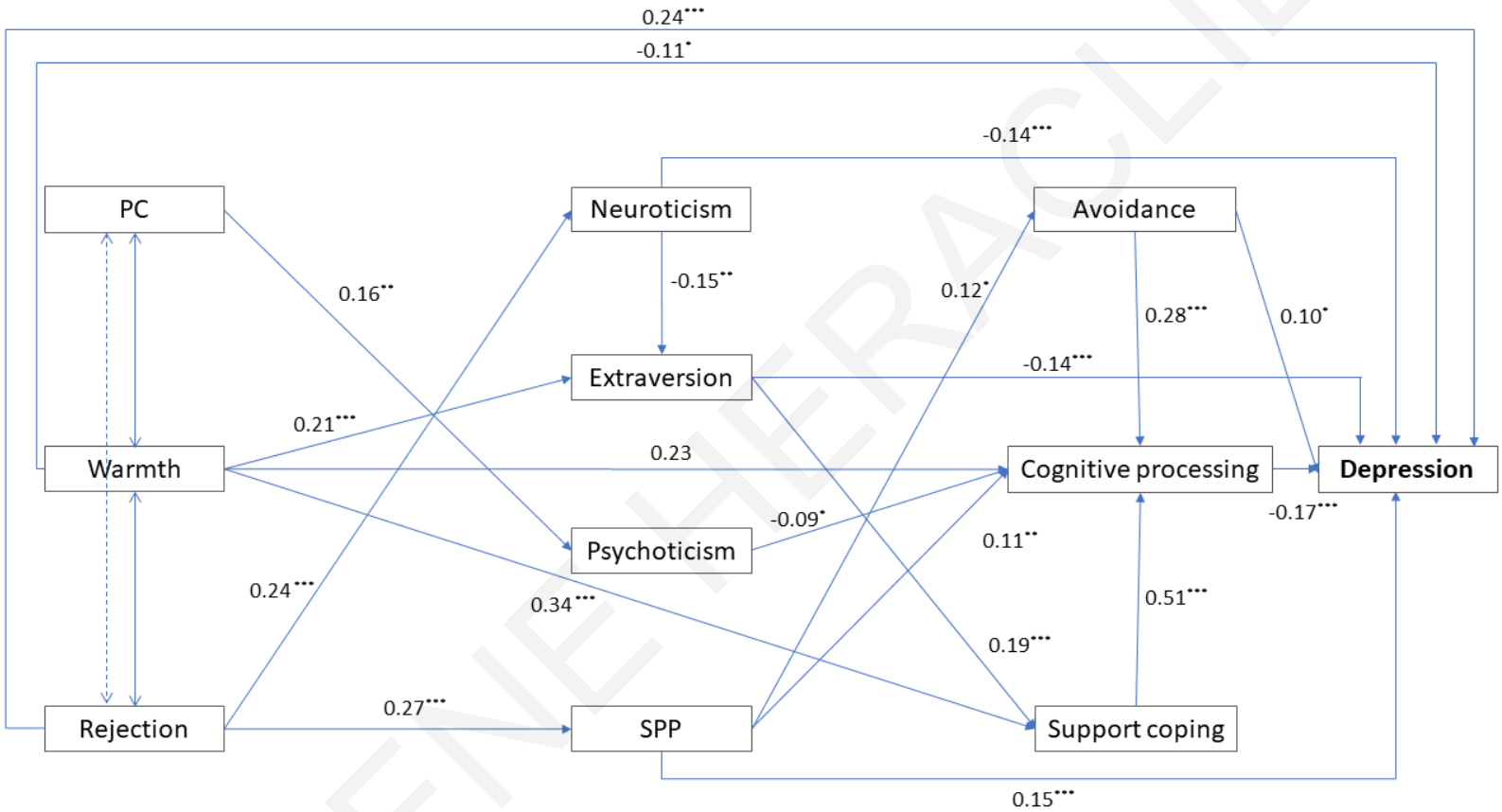


Figure 4

Final (Data-Driven) Path Model for the Association Between Parenting Strategies (Exogenous Variables) and Anxiety (Outcome Variable) Through Child Personality Characteristics and Coping Styles (Mediating Variables)

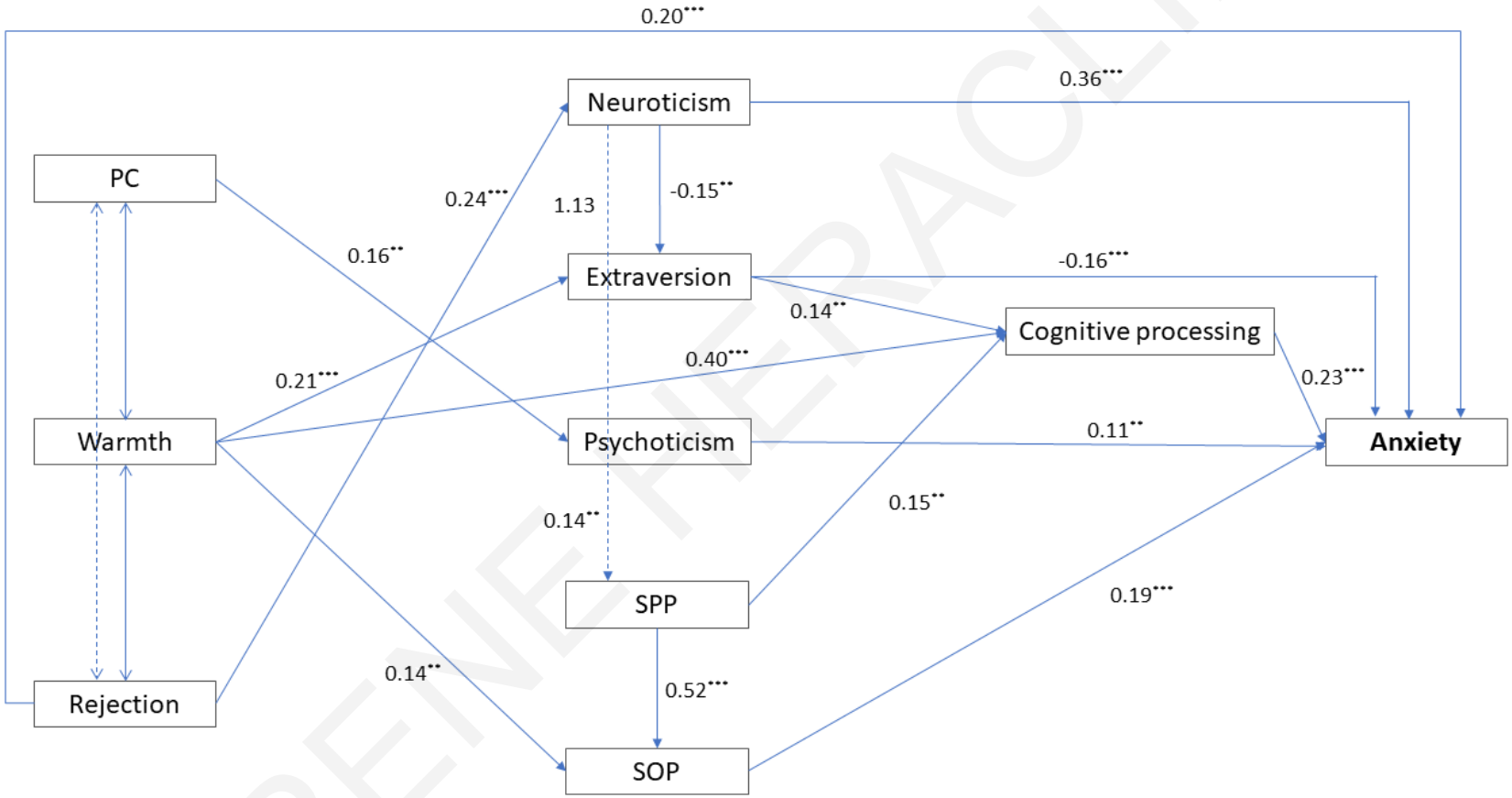


Table 8 displays an overview of direct, (total) indirect, and overall total (direct + indirect) effects from path analysis with Depression as the outcome. These path results are presented for the three major paths of interest: (i) PC to Depression; (ii) Warmth to Depression; and (iii) Rejection to Depression. All major effects leading to Depression, appear to reach statistical significance based on the confidence intervals and corresponding p-values.

Table 8

Direct, Indirect, and Total Effects from Path Analysis with Depression as the Outcome

PC to DEPRESSION		
	Direct effect (95%CI)	***p-value***
	n/a	n/a
	Total indirect effect (95%CI)	***p-value***
	0.002 (0.001; 0.008)	*.005*
	Total effect (95%CI)	***p-value***
	0.002 (0.001; 0.008)	*.005*
WARMTH to DEPRESSION		
	Direct effect (95%CI)	***p-value***
	-0.111 (-0.233; -0.011)	*.019*
	Total indirect effect (95%CI)	***p-value***
	-0.100 (-0.156; -0.057)	*.020*
	Total effect (95%CI)	***p-value***
	-0.211 (-0.284; -0.122)	*.008*
REJECTION to DEPRESSION		
	Direct effect (95%CI)	***p-value***
	0.241 (0.139; 0.343)	*<.001*
	Total indirect effect (95%CI)	***p-value***
	0.123 (0.076; 0.175)	*.003*
	Total effect (95%CI)	***p-value***
	0.364 (0.245; 0.464)	*.007*

Table 9 displays an overview of direct, (total) indirect, and overall total (direct + indirect) effects from path analysis with Anxiety as the outcome. As in the case of Depression, these comprehensive path results are presented for the three major paths of interest: (i) PC to Anxiety; (ii) Warmth to Anxiety; and (iii) Rejection to Anxiety. All major effects leading to Anxiety, appear to reach statistical significance based on the confidence intervals and corresponding p-values.

Table 9

Direct, Indirect, and Total Effects from Path Analysis with Anxiety as the Outcome

PC to ANXIETY	
Direct effect (95%CI)	***p-value***
n/a	n/a
Total indirect effect (95%CI)	***p-value***
0.019 (0.005; 0.046)	*.007*
Total effect (95%CI)	***p-value***
0.019 (0.005; 0.046)	*.007*
WARMTH to ANXIETY	
Direct effect (95%CI)	***p-value***
n/a	n/a
Total indirect effect (95%CI)	***p-value***
0.092 (0.048; 0.149)	*.004*
Total effect (95%CI)	***p-value***
0.092 (0.048; 0.149)	*.004*
REJECTION to ANXIETY	
Direct effect (95%CI)	***p-value***
0.195 (0.101; 0.289)	*<.001*
Total indirect effect (95%CI)	***p-value***
0.094 (0.049; 0.142)	*.002*
Total effect (95%CI)	***p-value***
0.289 (0.189; 0.382)	*.004*

Qualitative Analysis

Table 10 displays prevalence and frequencies of coding categories and subcategories for mothers high in PC, for mothers high in Rejection and for mothers low in Warmth respectively based on conceptual content analysis. Only the highest frequencies for each parenting practice will be reported here as demonstrated in Figure 5.

Table 10

Frequencies of Factors Influencing Extreme Use of Parenting Practices

	PC **N = 4**	**REJECTION** **N = 4**	**WARMTH** **N = 3**
1. MATERNAL FACTORS	Frequency	Frequency	Frequency
A. Personality and behaviour			
I. Controlling (authoritarian, overprotective)	4 (100%)	2 (50%)	_____
II. Perfectionism	2 (50%)	2 (50%)	2 (67%)
III. Rigidity	3 (75%)	3 (75%)	
IV. Prone to anxiety or anxiety disorder	1 (25%)	3 (75%)	2 (67%)
V. Does not express feelings	1 (25%)	2 (50%)	1 (33%)
VI. Values adherence of rules, schedules and organization	2 (50%)	2 (50%)	
VII. Does not value active listening, communication	2 (50%)	2 (50%)	2 (67%)
B. Emotional difficulties			
I. Anger issues (low patience, takes thinks personally as disrespect)	2 (50%)	3 (75%)	1 (33%)
II. Venting	_____	1 (25%)	2 (67%)
III. Depressive symptoms	1 (25%)	3 (75%)	1 (33%)
IV. Self-esteem issues	1 (25%)	1 (25%)	_____
V. Stress and anxiety	3 (75%)	4 (100%)	3 (100%)
VI. Worries of child's safety	1 (25%)	2 (50%)	_____
VII. Worries about child's social adjustment	2 (50%)	2 (50%)	_____
VIII. Exhaustion, self-neglected	1 (25%)	2 (50%)	2 (67%)
IX. Feels uncomfortable with unconditional expressions of love/affection	1 (25%)	1 (25%)	2 (67%)
X. Does not express feelings	_____	2 (50%)	2 (67%)
C. Mother's childhood			
I. Controlling mother (high PC, rejecting, authoritarian)	4 (100%)	2 (50%)	_____

II. Emotionally cold or distant parents	3 (75%)	2 (50%)	2 (67%)
III. Mother prone to anxiety and a perfectionist	_____	_____	1 (33%)
IV. Mother worked long hours or had multiple responsibilities	3 (75%)	1 (25%)	1 (33%)
V. Father was away (abroad or working long hours)	2 (50%)	_____	1 (33%)
VI. Parents were refugees	1 (25%)	_____	1 (33%)
VII. Guilt feelings and repressed emotions as a child	1 (25%)	_____	1 (33%)
VIII. Behavioural problems as a child/teenager	_____	1 (25%)	_____
2. CHILD FACTORS			
A. Developmental history (premature birth, delays, current difficulties)	2 (50%)	1 (25%)	2 (67%)
B. Health history problems	2 (50%)	2 (50%)	_____
C. Personality and behaviour			
I. Low motivation and self-initiation	1 (25%)	1 (25%)	_____
II. Behavioural Problems (stubbornness, demandingness, impulsiveness)	2 (50%)	1 (25%)	_____
III. Anxiety prone	2 (50%)	2 (50%)	1 (33%)
IV. Perfectionism	1 (25%)	2 (50%)	_____
V. Overly mature	2 (50%)	1 (25%)	_____
VI. Does not express feelings	2 (50%)	1 (25%)	2 (67%)
D. Reactions to maternal negative behaviour			
I. Aggressive/emotional reactions	2 (50%)	2 (50%)	_____
II. Passive reactions	1 (25%)	1 (25%)	1 (33%)
III. Talks about fairness	1 (25%)	2 (50%)	_____
IV. Tries to gain mother's affection/attention	1 (25%)	_____	_____
E. Social problems (no friends, lack of assertiveness, bullying history)	2 (50%)	2 (50%)	2 (67%)
F. Emotional problems (withdrawal, anxiety, low self-esteem)	2 (50%)	2 (50%)	3 (100%)

3. CONTEXTUAL FACTORS			
A. Family issues			
I. More than 2 (50%) children	1 (25%)	_____	1 (33%)
II. Big age gap with other children	_____	1 (25%)	1 (33%)
III. Sibling rivalry and fights	1 (25%)	1 (25%)	_____
IV. Challenging characteristics/behaviours of other children	2 (50%)	2 (50%)	_____
V. Father uninvolved (works long hours, is abroad or does not help)	4 (100%)	4 (100%)	1 (33%)
VI. Couple conflicts/arguments	2 (50%)	3 (75%)	3 (100%)
VII. Mother from another country	_____	_____	2 (67%)
B. Social support network			
I. No support from grandparents	3 (75%)	2 (50%)	1 (33%)
II. No other social support	3 (75%)	3 (75%)	1 (33%)
C. Other stressors			
I. Demanding job/workload	3 (75%)	4 (100%)	_____
II. Time constraints (multiple responsibilities)	3 (75%)	2 (50%)	1 (33%)
III. Financial difficulties	2 (50%)	_____	1 (33%)
D. Past life events			
I. Difficult or unwanted pregnancy or difficult after birth period	3 (75%)	3 (75%)	_____
II. Traumatic past events in family (domestic violence, other child's accident, death child's uncle)	1 (25%)	_____	1 (33%)

For mothers high in PC, all interviewees stated having a personality characterised of ''controlling'' tendencies, having had ''controlling mothers'' in childhood and having an ''uninvolved father'' of their participating child or children. Three out of four (75%) mothers mentioned ''rigidity'' as a personality characteristic of theirs, experiencing ''stress and anxiety'', having emotionally distant or cold parents'' in childhood, having a ''mother working long hours or having multiple responsibilities'', having ''no support from grandparents'' and ''no other social support'', having a ''demanding job/ workload'', experiencing ''time constraints'' and having had an ''unwanted or difficult pregnancy or after birth period'' with their participating child.

Among mothers high in Rejection, all interviewees stated experiencing ''stress and anxiety'', having an ''uninvolved father'' of their participating child and having a ''demanding job/workload''. Three out of four (75%) mothers high in Rejection mentioned being ''rigid'' and ''prone to anxiety or having an anxiety disorder'', having ''anger issues'' and depressive symptoms'', experiencing ''couple conflicts/arguments'', having ''no other social support'' (other than grandparents) and having had an ''unwanted or difficult pregnancy or after birth period''.

For mothers low in Warmth, all interviewees mentioned experiencing ''stress and anxiety'', having ''couple conflicts/arguments'' and their participating child having ''emotional problems''. Two out of three (67%) mothers, stated ''perfectionism'' as one of their personality characteristics, being ''prone to anxiety or having an anxiety disorder'', ''devaluing active listening and communication'', ''venting'' when they face difficulties, experiencing ''exhaustion, self-neglect'', feeling ''uncomfortable with unconditional expression of love/affection'', ''not expressing feelings'', having had ''emotionally cold or distant parents'' in childhood, having dealt with ''developmental difficulties'' of their participating child, ''not expressing feelings'', having their participating child dealing with ''social problems'' and ''being from another country''. Both of the mothers that stated ''being from another country'', mentioned cultural differences in parenting ideologies being a source of stress for them since they valued independence and self-sufficiency more than what they considered is valued in Cyprus. In addition, both stated that they disagreed with their husband on these parenting ideologies. One of them also faced some racial stigma from society vicariously through hearing comments from others about people not speaking Greek. These factors were seen by the mother as influencing her emotional wellbeing. Further, one of the mothers that mentioned her participating child had social problems, explained that her child's lack of assertiveness was something she ''couldn't deal with'' because she ''once was like that'' implying some degree of rejection of the child.

Figure 5

Codes and Categories for the Extreme Scores of Three Parenting Practices, as Identified in Qualitative Analysis

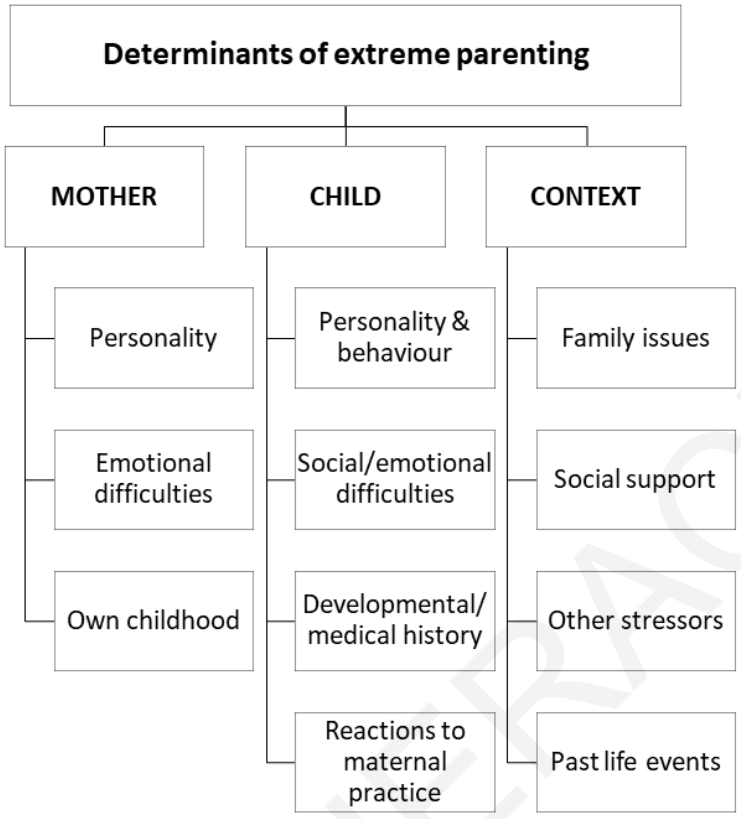
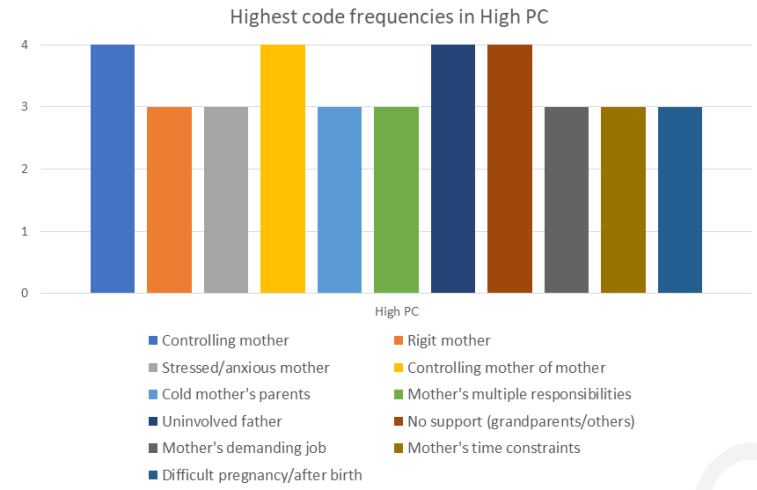


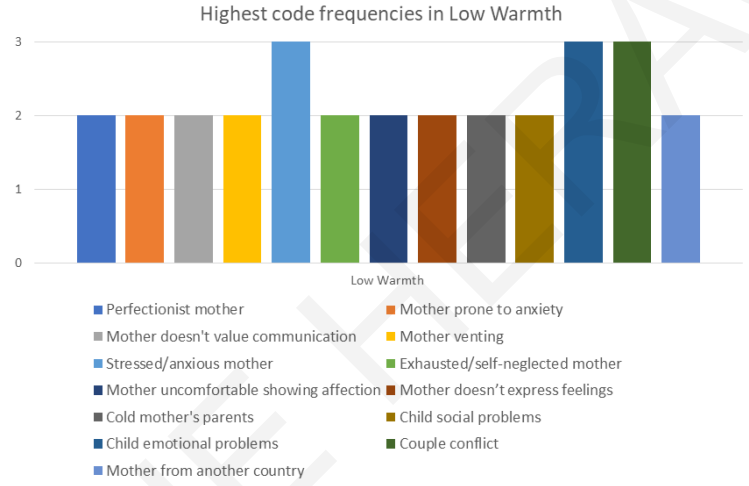
Figure 6

Codes with the Highest Frequency Among the Extreme Scores of the Three Parenting Practices, as Identified in Qualitative Analysis

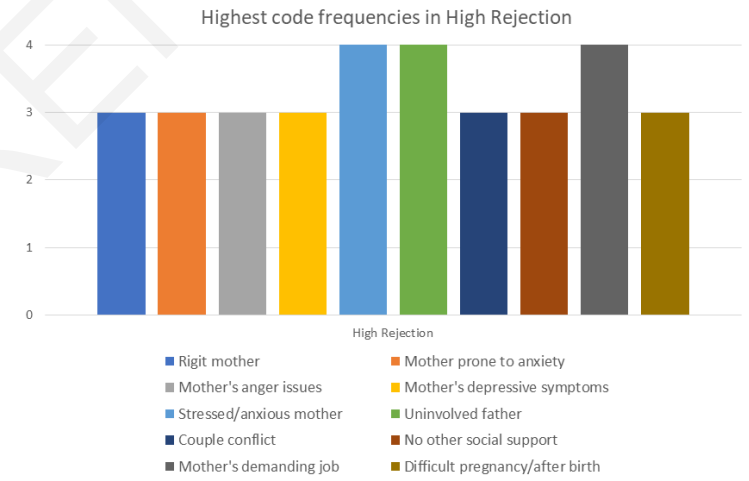
(a)



(b)



(c)



DISCUSSION

Overview

In the current study, it was aimed to test two comprehensive models of children's internalizing problems based on biopsychosocial approaches of behaviour, by incorporating both maternal parenting practices and child personality characteristics and coping strategies. Each model included depression and anxiety as the outcome respectively and was based on social cognitive theory so that children's personality characteristics and coping strategies would mediate the relationship between parenting and depression and anxiety separately. Findings from this quantitative part of the study were then followed by a separate qualitative part, which aimed to investigate determinants of maternal parenting per se, through interviews with mothers whose children had scores on the parenting scales suggestive of extreme use of negative parenting practices.

Main Findings in Light of Previous Research

Quantitative Study

In both models, maternal parenting practices had both a direct and indirect effect on children's internalizing problems through personality characteristics and coping. The model for Depression, as presented in Figure 3 and based on all fit indices used, fitted the data well, explaining 42% of the variance in Depression. From the personality and coping factors, Self-Oriented Perfectionism (SOP) and Distraction coping respectively failed to enter the model. Out of the three maternal parenting practices included in the model, Warmth and Rejection had both a direct and an indirect link to Depression based on various paths. Psychological Control (PC) served only as a distal variable predicting Depression.

In the case of Anxiety, a slightly different model emerged. Based on the fit indices used, the model as presented in Figure 4, fitted the data generally well, explaining 34% of Anxiety and supporting the social-cognitive theory of behaviour. Unlike the model for Depression, only Rejection had both a direct and an indirect effect on the outcome (Anxiety). PC and Warmth served only as distal predictors of Anxiety through a series of different paths.

Results of the quantitative analysis are in line with previous research which has shown children's personality characteristics and coping strategies to mediate the link between parenting and internalizing problems, thus confirming biopsychosocial and particularly social-cognitive perspectives of behaviour and psychological adjustment (e.g. Smith et al., 2006; Segrin et al., 2013; Yeh & Chiao, 2013; Soysa & Weiss, 2014; Schiffrin &

Miriam-Liss, 2017; Loton & Waters, 2017; Guo, Mrug & Knigh, 2019; Yeh & Waters, 2021). However, the current study was one of the first studies to demonstrate a comprehensive model of children's internalizing problems based on the social cognitive paradigm while incorporating the transactional nature of stress and coping in the prediction of internalizing problems by both parenting practices and personality characteristics. In addition, the models were based on cross-sectional data drawn directly from preadolescents and early adolescents.

Considering the findings in more detail, maternal Rejection was the only parental practice that directly predicted both Depression and Anxiety. The importance of Rejection in predicting these internalizing outcomes was highlighted in previous studies (eg. Johnco et al, 2021; Yazdkhasti & Harizuka, 2006; McLeod, Weisz & Wood, 2007; Verhoeven et al, 2012; Mousavi, Low & Hashim, 2016; Miranda et al., 2016; Yue, 2016). However, this study is one of the few, to our knowledge, to examine the impact of Rejection in preadolescence and early adolescence, since most studies have focused on young adults' recollections of parenting (Giaouzi & Giovazolias, 2015; Smout, Lazarus and Hudson, 2019) and a few studies have focused on adolescent samples (Miranda et al., 2016; Mousavi, Low, and Hashim, 2016). Warmth also predicted the outcome directly but only in the model for Depression.

The predictive power of Rejection in the Anxiety model compared to Warmth is supported by a study by McLeod, et al (2007) who found that parental rejection demonstrated stronger links with anxiety than did warmth. In contrast with previous research on the direct link between Warmth and depression, a direct link of warmth with anxiety was only reported in a few studies (e.g. Raudo et al., 2013; Quach et al, 2015; Butterfield et al., 2021) and these were limited in number and have mostly focused on adolescent samples (e.g. Butterfield et al., 2021) or have been retrospective in nature (Lloyd et al., 2017; Matos, Duarte & Pinto-Gouveia, 2017; Piteo & MacKay,2021). McLeod, Wood & Weisz (2006) in their meta-analytic study, found that the connection between parenting and child anxiety was small in magnitude, with parenting statistically accounting for only 4% and Warmth specifically accounting for only 1% of the variance in childhood anxiety. In addition, Verhoeven, Bogels & van der Bruggen (2012) found that parenting played a less important role in child's anxiety during adolescence compared to childhood. Huppert et al. (2010) also found that the effects of parental care on midlife wellbeing were mainly mediated through personality. Considering that the current sample involved only preadolescents and young adolescents and not younger children, this might have weakened the association between warmth and anxiety. Furthermore, findings from a study by Lansford et al. (2014), pose

particular interest, since maternal warmth was found to even exacerbate anxiety symptoms over time, when mothers also used corporal punishment. Yet, the emerging link between Warmth and Depression is well supported by previous and up to date research (e.g. Godleski et al; 2020; Butterfield et al, 2021; Johnco et al, 2021; Zubizarreta, Calvete & Hankin, 2018; Davis, Votruba-Drzal & Silk, 2015; Quach et al, 2015; Ivarsson, et al., 2016; Rothenberg et al., 2020).

The finding that PC did not have a direct effect on neither Depression or Anxiety is inconsistent with previous research which demonstrated such links (e.g. Xu, Cui, & Lawrence, 2020; Frazer, & Fite, 2016; Pettit et al.,2001). However, as already mentioned, previous studies focused mainly on adult and adolescent samples and were retrospective in nature. In addition, PC is a newly developed construct and its effects on psychological outcomes are still being explored. Another reason for PC not directly predicting Depression and Anxiety might be the slightly different form of PC in the current study. In particular, after factor analysing the relevant scale, items that had originally been included in the factor structure of PC, failed to load on the factor and were dropped from further analysis. These items specifically referred to maternal imposition of thoughts and emotions on children. Particularly because the original scale was already composed of only a few items, the omission of these items slightly differentiated it from its original form as used in previous research, albeit still maintaining an adequate internal consistency. What's more, during administration, a few children had asked the PhD student whether questions specifically pertaining to the imposition of feelings or thoughts had a positive or a negative meaning. In fact, children of this age may have not yet entered the developmental stage of adolescence when children particularly oppose authority conventions and impositions. Thus, some children seemed to interpret relevant questions as demonstrating benign concern and mere guidance on the part of the mother. It should be noted that these instances of children asking about implied meaning of items in the questionnaire measuring PC, only concerned the items that were ultimately dropped after factor analysing the data. Yet, one cannot conclude with certainty that some children interpreted at least some of the remaining items in the same way.

Regardless of these issues, PC demonstrated an indirect effect on both outcomes through Psychoticism. Psychoticism in turn, led directly to Anxiety and indirectly to Depression through Cognitive Processing. The link between PC and Psychoticism is partly supported in a study by Flamant et al (2020) who found PC to predict oppositional defiance characteristics in adolescents. Previous research has shown Psychoticism to predict mainly

externalizing and not internalizing problems, thus making its link to Depression and Anxiety important. A few studies are in line with these results. For example, Christensen et al. (2021) found that psychoticism did predict mood and anxiety diagnoses. Similarly, Kotov et al. (2010) found psychoticism to emerge as a predictor of dysthymic and anxiety disorders.

These findings can be explained by the invalidation of feelings and lack of respect for personal opinions and choices involved in maternal PC, which may lead to the development of psychoticism as a defence against vulnerability, loss of trust or shame by reducing empathy and increasing levels of antisocial behaviour. Alternatively, psychoticism could be the result of aggression or ''acting out'' that is generalized to society due to high maternal PC. In turn, psychoticism's characteristics of impulsivity, aloofness, aggression and antisocial behaviour may ultimately lead to unfavourable results leading to increased anxiety. This can be the result of other factors such as subsequent social rejection, or inability to form, maintain or enjoy interpersonal relationships, or through negative consequences coming from delinquency.

In the Depression model, Psychoticism only predicted the outcome indirectly through its negative effect on Cognitive Processing. Cognitive Processing, even though not portrayed in the literature as a distinct coping factor, emerged in the current study after factor analysing the coping scale used. This coping factor included a combination of items referring to "positive restructuring" and "cognitive decision-making", both of which had been accompanied by "problem-focused' items in the original study (Ayers & Sandler, 1999). Nevertheless, in the current study, the "problem-focused" items failed to load on any factor and were dropped altogether leaving only the cognitive aspects of what was originally intended to be an active coping factor (Table 1). Cognitive Processing was predicted by Warmth and Extraversion in both models and was positively predicted by Support-seeking coping and negatively predicted by Psychoticism in the Depression model, all associations suggesting that Cognitive Processing is an adaptive coping strategy. If Cognitive Processing is indeed considered an active coping strategy, its links with Warmth are not surprising, since previous research has demonstrated such links (e.g. Basanez et al, 2014).

The finding that Psychoticism negatively predicted Cognitive Processing, which in turn negatively predicted Depression, again seems reasonable. Yeh and Waters (2021) found problem-focused coping strategies to be predicted by positive personality traits, while they found emotion-focused coping strategies to be predicted by negative personality traits. In addition, they found that problem-focused coping strategies were psychologically-adaptive in contrast to emotion-focused strategies which mere maladaptive. The negative association

between Cognitive Processing and Depression is even in line with a previous study by Harris, Rustin & Lightsey (2005), who found that constructive thinking, a construct similar to Cognitive Processing, fully mediated the relationship between neuroticism and negative affect and emerged as a strong predictor of negative affect (inversely), positive affect, and happiness. Thus, based on this finding, a child who perceives his/her mother to be high on PC may develop Psychoticism as a compensatory mechanism, which may lead him/her to yearn towards more impulsive tendencies instead of thinking through things in a more informed, collected or positive manner (Cognitive Processing). In addition, the aloofness or cynicism to things that may characterize a person high on Psychoticism, may make him less willing to actually take responsibility of his/her own life through reflecting on things and exploring solutions. By failing to do so then and having to deal with the resulting negative consequences, one may experience an increase in depressive symptoms.

Concerning maternal Warmth, this parenting practice predicted Depression both directly (negative association) and indirectly, while predicting Anxiety only indirectly. The indirect association of Warmth with both Depression and Anxiety followed two mediational paths, one through Extraversion and another through Cognitive Processing. Starting with Extraversion, parental warmth was indeed found to have a positive effect on extraversion (Zhong-Hui, Hui-Lan & Jian-Xin, 2006; Slater, 1962), social participation (Slater, 1962) and social competence with peers (Petit et al, 1991). In turn, previous research has supported the buffering effect of extraversion on anxiety and depression (e.g. Kimbrel, 2009; Junker et al, 2019; Lee & Choe, 2020). Taken all together, these findings may be interpreted as warmth possibly contributing to more positive and optimistic attitudes and behaviours relating to self and others and less fear of negative social consequences, such as rejection or criticism, making the child more extraverted. Extraversion then through its positive attributes may be lessening negative affective states. The positive attributes of extraversion are portrayed in a study by Furnham & Cheng (2000) who found that extraversion had both direct and indirect predictive power on happiness.

Moving on to the mediational effect of Cognitive Processing in the relationship between Warmth and the internalizing outcome in each model, these pathways demonstrate some contradictory findings. Even though, as expected, Cognitive Processing, negatively predicted Depression, it served as a positive predictor of Anxiety. Cognitive Processing was also positively related to two seemingly maladaptive factors, namely Socially-Prescribed Perfectionism (SPP) (in both models) and Avoidance coping (in the Depression model). Even though these findings seem paradoxical, after looking closely at the scale items

that loaded on Cognitive Processing, one can observe that items relating to 'cognitive consideration of solutions' do not really refer to planning of actual active steps. Instead, they only refer to thinking about what to do about a problem prior to doing it. This has more of an abstract rather than a tangible, active tone. Therefore, only thinking about the problem and even considering things in a positive tone (i.e. 'positive restructuring') may just be forcing a child to directly think about the stressor without having any foresight or a direct plan with actual steps to take in order to actively solve the problem while avoiding negative consequences. Especially for a child, who has still not fully developed the capacity to regulate his/her emotions about possible negative outcomes, this way of dealing with a problem may actually exacerbate anxiety. Comparing the effect of Cognitive Processing on the outcomes of the two models, it may be assumed that Cognitive Processing coping has a buffering effect on Depression due to the positive outlook involved in positive restructuring and the partial gaining of control of the situation involved in considering possible solutions. This may in turn be boosting self-esteem and providing hope, both of which are possibly related to lower levels of depression but are still not sufficient to decrease anxiety about an ongoing stressor which requires direct action. These cognitive processes may be important in the long run in order to keep a positive attitude and affect but may not be sufficient to buffer anxiety about particular stressors that need to be solved directly in the short run. Alternatively, Cognitive Processing may be considered an emotion-focused coping strategy since it only involves a cognitive component which may aim to make an individual feel better about the stressful situation. In some cases, such as when a stressor in perceived as uncontrollable or overbearing, an emotion-focused coping strategy may be helpful. For example, a study demonstrated that emotion-focused coping was emotionally protective during the outbreak of COVID in Italy, in contrast with problem-focused coping which was found to be dysfunctional (Sebri et al., 2021).

Two additional differences emerged between the two models in the pathways starting from maternal Warmth and leading to the outcome. First, in the Anxiety model, Warmth also predicted the outcome through Self-Oriented Perfectionism (SOP). The finding linking SOP and anxiety is consistent with previous research (e.g. Liu et al., 2013; Koerner, Mejia, & Kusec, 2017). What was an unexpected finding though is the association between Warmth and SOP which was positive, albeit SOP subsequent positively predicting Anxiety. This was an unexpected finding since SOP, being linked to anxiety, is considered a maladaptive construct and would not be expected to emerge as a result of maternal Warmth.

Although not supported by previous research, this finding may be explained by aspects involved in Warmth, such as acceptance, rewarding and encouragement, which may lead a child to develop high expectations for himself and to strive to meet them through SOP. This would ultimately lead a child to experience more anxiety. Another difference in the pathways starting from Warmth in the two models in unique contribution of Support-Seeking coping in the model of Depression. Two pathways led to Support-Seeking coping, one starting from Warmth and leading directly to Support-Seeking and the other starting from Warmth and leading to Support-Seeking through Extraversion. However, in both cases, Support-Seeking only had an indirect association with Depression through its positive association with Cognitive Processing. Watson and Hubbard (1996), in their review on adaptational style and personality traits, found extraversion to be correlated with social support seeking, positive reappraisal, and problem-focused coping. This finding is consistent with the finding of the current study concerning the predictive power of Extraversion on both Support-Seeking and Cognitive Processing coping. It may also throw light on the common ground between these two coping strategies.

Concerning Warmth and Support-Seeking coping, Jang (1999) found that recollections of parental warmth were predictive of perceived amount of social support and satisfaction with that support in adulthood, through current secure attachment style. In addition, Puustinen et al (2007) found that parental warmth increased a child's help seeking behaviour towards the experimenter in an experimental situation. Concerning Extraversion and Support-Seeking coping, Amirkhan, Risinger & Swickert (1995) found extraversion to be related to social support seeking in a mixed method study, combining both a survey and an experimental approach and this relationship also accounted for self-esteem. However, studies examining the aforementioned links were limited in number and many of those which did exist, were either outdated and used mostly adult samples.

Taken together and illustrated in an example, maternal warmth may make a child trust people and be familiar with sharing feelings and satisfying needs through support. At the same time, a child who is more extraverted (due to maternal Warmth) will more readily seek support from others because of his/her familiarity and ease with social interactions. By seeking social support then, a child may be put in a situation to think about possible solutions and view his/her situation more positively (Cognitive Processing), ultimately leading him/her to experience fewer depressive symptoms.

Moving on to maternal Rejection, this parenting practice had both direct and indirect links with both Depression and Anxiety. As a distal predictor, Rejection predicted the

outcome through both Neuroticism and a serial mediation of Neuroticism and Extraversion (negative association) in both models. The emerging links between Rejection, Neuroticism and Depression and Anxiety were as expected and have been encountered in previous research, though not often in children samples. For example, Cundiff et al. (2021) found that parental emotional maltreatment in childhood, including thwarting the child's basic emotional needs of acceptance and positive regard, was associated with neuroticism in adolescence. In turn, the link between Neuroticism and Extraversion, through which Rejection had an effect on the outcomes, is also as expected since these personality factors have some opposite components in their meaning, leading to nonadaptive and adaptive outcomes respectively (Slobodskaya & Akhmetova, 2010; Leto, Petrenko & Slobodskaya, 2019). In fact, Zhang & Tsingan (2014) found that extraversion and neuroticism fully mediated the effect of other personality traits on positive and negative affect respectively, suggesting that these two personality constructs have a basic temperamental effect on affective wellbeing in an opposing direction. Similarly, Lauriola & Iani (2017) found that neuroticism acted as a sort of general negativity factor whereas extraversion acted as a subjective happiness factor. Though Rejection predicted Extraversion through Neuroticism in both models, Extraversion subsequently affected the outcomes through different pathways in the two models. Specifically, Extraversion predicted Anxiety through Cognitive Processing coping. However, Extraversion predicted Depression through Cognitive Processing but this link was mediated by Support-Seeking coping.

Apart from leading to Extraversion, Neuroticism also led to Socially Prescribed Perfectionism (SPP) in the model of Anxiety which then predicted Anxiety through either SOP or Cognitive Processing. This finding the vital role Rejection plays in the development of Neuroticism and how Neuroticism influences the emergence of other personality characteristics leading to various emotional outcomes. The link between SPP and SOP can be explained by the idea that a child who tends to worry about others' expectations of his behaviour (SPP) is affected to also worry about presenting the best version of himself (SOP). Trying then to always be perfect may be making a person struggle excessively in this/her everyday life, thus leading to anxiety.

Moving on to the link between SPP and Cognitive Processing, even though SPP is considered a maladaptive personality characteristic, it is not entirely surprising how it has a positive effect on Cognitive Processing. As already mentioned, Cognitive Processing acts in a maladaptive way in the model for Anxiety. The link between these two constructs can be explained by the controlling tendencies involved in SPP, which may lead a person to engage

in Cognitive Processing, thinking about the problem and possible solutions and trying to view it in a more positive light, in order to gain control over the situation and make it more predictable and familiar.

In contrast to the Anxiety model, Rejection predicted SPP directly (and not through Neuroticism) in the Depression model subsequently following four unique pathways to Depression. First, SPP directly predicted Depression. This is consistent with previous research. Flett, Besser & Hewitt (2014) found that SPP predicted Depression through rejection sensitivity. Second, SPP led to Avoidance coping which then predicted Depression directly and through Cognitive Processing (third pathway). This finding is also consistent with previous research (Noble, Ashby & Gnilka, 2014; Richard et al., 2021; Abdollahi, Hosseinian & Asmundson, 2018) and may be explained by a fear of the high SPP child of making mistakes or being rejected which may then lead the child to avoid confronting the stressful situation, ultimately leading to Depression. In line with this finding, a few studies have linked avoidance coping to depression (e.g. Ribadier & Varescon, 2019; Basanez et al, 2014)

Further, the finding that Avoidance coping positively predicted Cognitive Processing may be portrayed in an example as a child avoiding to actively deal or think about a stressor as it is (Avoidance), making him more likely to think about it in more positive terms but without any particular plan (Cognitive Processing). In this way, Cognitive Processing resembles more of a partially avoidant defence mechanism, involving refusal of reality and rationalizations which may actually indeed alleviate depressive symptoms in the end.

Taken all together, the link between Rejection, SPP, Avoidance and Cognitive Processing coping may be illustrated in an example as follows: Maternal Rejection, through its invalidating nature, may predispose a child to actually be overly sensitive to rejection which may ultimately lead to Depression either directly or through trying hard to conform to other's perceived perfectionistic expectations (SPP). Then, the perfectionistic tendencies that emerge as a defence to maternal rejection may lead a child to depression directly or through trying to avoid the situation (Avoidance) which may ultimately lead to depression. However, if a child's avoidance of dealing with the problem also leads him to think about it in a positive light and consider alternative solutions (Cognitive Processing), the depression is minimized. Thus, in this case, trying to control the situation by viewing it in a positive light and by thinking about possible solutions (through Cognitive Processing) may be enough to lessen Depression through feeling more in control and creating a more positive cognitive and affective state without necessarily having to have an actual behavioral plan and to act upon

it. In the case of Anxiety, only thinking about a problem (Cognitive Processing) without any actual plan of action or direct active behaviour, may even exacerbate anxiety.

The finding that SPP was not predicted by any of the parenting factors in the Anxiety model is an unexpected finding since previous research has demonstrated a link between parenting and SPP. However, SPP was mostly predicted by overparenting (eg. Fletcher et al., 2020) and authoritarian parenting (eg. Flett, Hewitt & Singer, 1995) which were not directly measured in the current study. In addition, in a study by Hong et. al. (2017), parenting predicted only SOP and not SPP, while SPP was only predicted by surgency, a temperamental trait that resembles extraversion but also has some common components with Neuroticism (in the reverse direction). In addition, the fact that Avoidance coping only predicted Depression and not Anxiety, may be explained by the assumption that a level of avoidance may be necessary for the still emotionally developing child in order to deal with a stressor. Even though Avoidance did not predict anxiety in neither a positive or a negative direction, its possibly negative effects might have been neutralized due to the child developmental constrains just mentioned. In support of this, Muyan-Yılık and Demir (2020) found that avoidance, and seeking social support had significant direct effects on subjective well-being among young adults. In addition, emotion-focused coping, as opposed to problem-focused coping, has been found to be protective for the development of worry in some cases, especially when a stressor is viewed as uncontrollable (Sebri et al., 2021).

Qualitative Study

Based on the findings of the qualitative part of the study, various maternal intrinsic and extrinsic factors were identified as possible determinants of the extreme use of negative parenting practices. For all mothers irrespective of parenting group, the most prominent contributing factors to excessive use of negative parenting were having perfectionistic tendencies, experiencing stress or anxiety or being prone to anxiety, being exhausted and self-neglected or experiencing time constraints, dealing with couple conflict or having an uninvolved father and having no social support. High PC and high Rejection mothers specifically also shared some contributing factors that did not emerge as often in the narratives of low Warmth mothers. These were tending to act in controlling or rigid ways, having a demanding job, having had an unwanted or difficult pregnancy or after birth period and having had a cold or controlling mother or parents in childhood. The low Warmth group, also narrated some unique contributing factors. These were having difficulty expressing emotions and showing love or affection, not valuing communication and active listening,

having a child with social or emotional difficulties and vicariously experiencing stigma due to being from another country.

Previous research is consistent with current findings on the personality characteristics of maternal perfectionism (Cook & Kearney, 2009; Greblo, & Bratko, 2014; Soenens, et al., 2006) and neuroticism (e.g. Tang, et al, 2016; Verhoeven, et. al, 2007 Oppenheimer et al, 2013) which may also be related to being prone to anxiety as emerged in the current study. In addition, previous research is in line with the finding that negative parenting is affected by maternal emotional states such as stress (Mcfadden & Tamis-Lemonda, 2013; Norizan & Shamsuddin, 2010), anxiety disorders (Thomasgard, 1998) fatigue (Cooklin, Giallo & Rose, 2011) and maternal anxiety and regret (Segrin, et al., 2013; Norizan & Shamsuddin, 2010) which may be related to mothers' reports of unwanted or difficult pregnancies and after birth stressful conditions in the current study.

The link between these characteristics and parenting (most often high PC) may explain their transgenerational nature (e.g. McClure et al., 2001). For example, parents may project their own desires and fears on to children and vicariously experience their children's successes and failures as if they are their own. Perfectionist parents may also communicate to their children that their love for them depends on their flawless performance (Soenens, et al., 2006; Greblo, & Bratko, 2014; Randolph, & Dykman, 1998). The current study contributes to the elimination of a gap in research concerning systematic studies investigating traits and emotional qualities of parents who behave in negative ways (e.g. Greblo, & Bratko, 2014; Randolph, & Dykman, 1998; Soenens, et al., 2006) especially considering that the few existing studies have yielded inconsistent and contradictory results (Clark, et al., 200; Smith, et al., 2007). The current study is unique, to our knowledge, in documenting some influential maternal factors that seem to affect parenting, namely difficulties in expressing emotions or showing affection and valuing organization and rule adherence over communication and active listening. These characteristics were more prevalent in the low Warmth group.

Concerning contextual contributing factors, previous research is also in line with some factors of influence such as partner support (Tomlinson, Cooper, & Murray, 2005), couple stress (Tang, et al., 2016) and culture (Caplan & Baker, 2016). As concerns fathers' parental involvement, past research has shown that father's unsupportive parenting has a detrimental effect on mother's emotional states and own parenting (Godleski et al, 2020; Jaffee et al., 2003). In terms of parental conflict, Garber (2006) found that couple conflict negatively affected mothers' emotional states and parenting which in turn exacerbated couple conflict. Cooklin, Giallo and Rose (2011) have also found parenting to be affected by

the perception of a limited social support system. Griggs et al (2010) have reported on the significance of grandparents in particular in families with parents that are busy and have limited time. A few studies have also documented the importance of mother's own childhood experiences, particularly the parenting style of their own parents, in their subsequent choices of parenting style. Such experiences have been shown to predict increased parenting hostility, maternal emotional unavailability, and decreased maternal sensitivity (Bailey et al., 2012; Fuchs et al., 2015; Pereira et al., 2012 McDonald et al, 2019). The current study contributed to the knowledge of contextual influences in parenting since relevant studies are limited.

Limitations and Suggestions for Future Research

Limitations of the current study include its cross-sectional nature, and the use of only self-report data in the quantitative part of the study and single source data in both the quantitative and the qualitative part of the study. This relates to the risk of obtaining inflated correlations due to response bias and response sets. In addition, both interview and questionnaire measures of parenting were found, in previous research, to underestimate the magnitude of the link between parenting and anxiety in childhood as compared to observational measures (McLeod, Wood & Weisz, 2007). The reason for these limitations was time constraints for the PhD student, limited financial sources and COVID restrictions that affected participation and methodology.

Future research could aim at combining children's data with mothers' data on the same factors along with observations, particularly on parenting and mother-child interactions. Mother's data in the qualitative study could also be compared to their self-report data as well as to corresponding data from children and fathers examining perceptions of parenting behaviours, perceived maternal intentions and other child and parent stressors or family dynamics. For example, it could be useful to consider how children perceive their mothers' intentions and motivation for using negative parenting practices. A child that views their mother's controlling behaviour as coming out of love or an attempt to protect the child, may have different emotional effects from the perception of it as stemming from abuse of power, hostility or devaluation of the child.

In conjunction with this, fathers' data could also be employed to describe maternal parenting behaviour, emotional tone and intentions as well as other stressors and interpersonal dynamics. Fathers' self-report and qualitative data could be used to further strengthen validity of overcompensate for bias in children's and mothers' reports. For example, mothers may be underestimating the quality and/or quantity of their social

support network due to their negative affective states. Kitamura et al (2002) documented that women are likely to think they have a higher availability of supportive people if they are high in extraversion and low in neuroticism. This could also be eliminated by conducting studies which aim to examine links between maternal stressors and looking at both moderations and interactions leading to maternal stress and negative parenting.

In addition, longitudinal studies and prospective data will help provide more causal associations between the factors of interest as well as a direction as to the sequence of relationships. For example, children's personality could be the one affecting parenting and not vice versa. Even though the associations examined could be bidirectional (Yeh and Waters (2021), a longitudinal study could help determine which of the two direction of associations is the most prominent or which factor comes first in the sequence of events. The inclusion of twin studies, genetic data or temperamental characteristics targeting particular dispositions of children in infancy and toddlerhood may as well aid in the clarification of direction of associations. Further, experimental studies that examine children's responses on specific emotional or social stimuli as well as intervention studies could be useful to deal with limitations inherent in the correlational nature of survey studies. Intervention designs could seek to alter parenting patterns to assess the resulting effect on children's internalizing outcomes. Experimental designs could include exposures of children to highly rejecting parental behaviour under a laboratory interaction task or children may be randomly assigned to interact with a "warmth" or "cold" parent while completing a difficult task.

Longitudinal data and prospective studies could also help in comparing different age groups starting from early childhood to adulthood and examine whether associations and model structures differ among the different groups. Longitudinal data and prospective studies could also help in comparing different age groups starting from early childhood to adulthood and examine whether associations and model structures differ among the different groups. Along with this, longitudinal studies could also help clarify the role COVID has played in parenting, child personal characteristics and affective states and maternal and contextual determinants of parenting as well the structure of the models and relevant associations.

Intervention studies could also aid in dealing with another limitation of the study namely the absence of a control group. Particularly in the qualitative study, mothers' data are not compared to those of another group of mothers, such as mothers whose children had low or moderate scores on the parenting scales. Similarly, intervention studies could

also provide the opportunity to compare data from children and mothers of extreme levels of negative parenting before and after a family-based or parenting intervention. In this way, it would be safer to conclude that the relevant associations among parenting and personality factors are indeed representative of mothers with perceived extreme levels of negative parenting.

In addition to this, it would also be useful to compare these data with another group that includes mothers with low or high perceived scores on the parenting dimensions that correspond to high levels of positive parenting. It is possible that associations within this context will take a different structure than associations among groups of mothers with either extreme or moderate levels of negative parenting. This can also be achieved by examining interactions of high versus low and moderate levels of both positive and negative parenting practices with child characteristics and internalizing problems. Alternatively, creating groups of high and low use of positive and negative parenting and turning them into categorical variables to perform analyses based on between-measures designs could also aid in looking at interactions and compare associations between the groups.

Another limitation of the study is the exclusion of perceived paternal parenting practices. Even though not in the scope of the current study, this methodological alteration would require the participation of more subjects which would be difficult considering the low participation rate and other restrictions due to the COVID pandemic. Nevertheless, such inclusion could aid importance comparisons between maternal and paternal parenting and its effect on children's internalizing problems. For example, Verhoeven, Bogels & van der Bruggen (2012) found that only paternal (and not maternal) behaviour was associated with anxiety specifically in adolescence. However, maternal over control was significant in the anxiety of elementary school-aged children even after controlling for levels of paternal parenting. Flouri (2005) also found that paternal involvement was positively associated with prosocial behaviour, irrespective of gender or ethnic group and it was negatively related to peer problems in White British children of both genders. Future research could aim to include both perceived maternal and paternal practices in determining children's internalizing problems and targeting high risk parenting groups to determine personal, child and contextual influences on parenting and their differences based on the gender of each parenting group. In addition, by incorporating fathers in the study, it would be possible to investigate potential bidirectional influences between the couple including how one parent's parenting practices, personality, emotional states and behaviour or other environmental characteristics related to him/her, affect the other parent's intentions and behaviour. For

example, Flouri (2004) found that father's and mother's parental involvement with their adolescent children were strongly interrelated, and this can imply that there are important bidirectional influences among the parenting couple. In a subsequent study, Malmberg and Flouri (2011) found crossover between maternal and paternal depressive symptoms and parenting practices of the other parent. Likewise, Ritchie and Buchanan (2011) found that particular negative parenting styles in one parent, are likely to be found in the other.

Through these interactions, a more detailed analysis of how couple and family dynamics operate to determine parenting would also be possible. Nevertheless, relations between particular maternal stressors, such as the father's limited involvement in household responsibilities, could be associated with other determinants of parenting, such as the mother's controlling tendencies, to determine series of events and bidirectional influences, could be made possible without the inclusion of fathers but with the use of other methods of qualitative analysis, such as relational content analysis. For example, Kitamura et al (2002) suggest that mothers perceived higher quality in their social support system when they had recollections of their own mothers in childhood as being caring. In addition, Yeh (2018) indicated that positive and negative early life family interactions affect adults' personality and the development of anxiety and depression in adults which may then be predictive of their parenting practices. Searching for stressor relationships was again outside of the scope of the current study but could lead to interesting additional findings based on a family systemic approach. This again was outside of the scope of the current study but could lead to interesting additional findings based on a family systemic approach.

Apart from not looking at relationships between different determinants of parenting and not also including data from fathers and children, the qualitative part of the study poses some more shortcomings. First, the analysis did not actually include actual implied meanings. This was done to avoid objectivity and interviewer bias. When a meaning was implied, the interviewer asked the mother whether it is true and whether she thinks this might have affected her parenting. Nevertheless, not all aspects included in mothers' narratives can be conscious and voluntary and a mother cannot always know with certainty if indeed a factor affects her parenting since these kinds of conclusions require a degree of emotional insight. Thus, unconscious or involuntary intentions, thoughts, emotions and behaviours, which might have been even more important than the conscious ones, were not included in the analysis. Along with additional implied meanings and again in order to eliminate objectivity and biases, the qualitative study failed to incorporate important information about the emotional tone of specific parts of the narratives as well as to create a

hierarchy of maternal stressors or determinants of parenting based on intensity and extent to which they affect maternal stress and parenting. A problem with this limitation is that a code that emerges often in mothers' narratives may not imply importance in determining stress and parenting behaviours and be simply the product of chance or relevance to the context, focus and content of the conversation at a particular point in time. Hierarchy of stressors and determinants could be achieved with the use of a self-report scale measuring elicited stress by each stressor of possible determinant of parenting.

In addition, the qualitative analysis did not include thorough information about couple conflict, which emerged as a crucial possible determinant of parenting. Future research may benefit from looking more deeply into particular stressors that were found to play an important role in parenting in the current study, such as stress and anxiety, fatigue and conflict and determine their nature and possible causes.

Another limitation of the current study is the use of some scales in the analyses that had marginally acceptable internal consistency in the current sample. For example, the PCS-YSR scale used in this study failed to incorporate 3 items which all seemed to measure a single factor albeit demonstrating inadequate internal consistency to be able to be entered in the model. Nevertheless, the omitted items referred to the imposition of thoughts and feelings by the mother which may be an important factor in terms of validity of the PC construct. In addition, since the scale only included 8 items altogether, this omission may have been important in determining the PC factor. The remaining items which ultimately did load on the PC factor had only marginal acceptable internal consistency, something which also emerged with the Avoidance coping factor ultimately failing to enter the Depression model. Of course, the omission of Avoidance coping from the Depression model might have been the result of reasons other than its psychometric properties since other coping factors also failed to enter either one or both of the two models. This may have happened because of these factors actually not being important in explaining internalizing problems. Indeed, coping in general did not seem to play an important role in predicting anxiety with the exception of Cognitive Processing which was a better predictor. Nevertheless, Cognitive Processing coping is a new formed consent that seems to involve some contradictory intentions and functions, since it involves both an active and a possible avoidant component. Future research should aim to use different scales possibly more adequate for preadolescent populations in order to attempt clarification of associations. However, it is possible that the emergence of Cognitive Processing is in fact an actual construct that happens naturally but which has not yet been explored in research. Thinking about a problem in more abstract

terms and not necessarily acting upon it, may have crucial effects in determining internalizing problems. Future research could clarify this matter. In addition, more refined coping strategies which include abstract or passive versus planning-oriented or concrete cognitive coping and voluntary versus involuntary coping strategies, as well as more specific emotion-regulation strategies apart from coping, could be used so as to determine whether any of these play a crucial role in the prediction of children's internalizing problems.

A problem with internal consistency emerged with the Eysenck's personality factors which had rather lower internal consistencies than the rest of the personality, coping and internalizing factors. A way to deal with the marginally acceptable internal consistencies in the Eysenck broad personality factors is to use narrower personality constructs which may as well show stronger associations with all parenting, coping and outcome variables. Broad personality constructs are in fact composed of narrower personality characteristics pertaining to preferences and habitual behaviours. For example, a child's tendency to be bold or to enjoy other people's company maybe more relevant to the use of active or support-seeking coping respectively than would be his/her preferences to go to parties and be more outgoing or lively. Similarly, feeling rejected by his/her mother, a child may develop aloofness or cynicism as a defence mechanism which may move him away from asking for social support. However, the same child may develop aggressiveness and impulsivity which may be unrelated to support-seeking behaviours. In addition to the breaking of broad personality factors into narrower ones, other narrow personality characteristics could be added to make a more comprehensive model. Some examples are self-esteem and self-efficacy.

Further, no parental control factor emerged in our analyses after factor analysing the EMBU-C scale. Nevertheless, parental behaviours such as strict adherence of rules, use of punishment in the absence of rewards and repeated reprimands or directions in the absence of child input or negotiations were mentioned quite often in mothers' narratives during the qualitative data phase of the study. Previous research has documented the strongest effects for parental control compared to other parental measures, even rejection, on internalizing problems, especially anxiety (McLeod, Wood & Weisz, 2006). In addition, since Warmth did not seem to play as a significant role in determining anxiety and depression, more specific constructs related to warmth could be of more significance. For example, physical ways of expressing affection could be differentiated from verbal ways and being neglected or avoided by a parent could be differentiated from being cold. McLeod, Wood & Weisz (2006) in their meta-analysis on personality and anxiety suggest that the

subdimensions of aversiveness and withdrawal, which may be considered as the opposites of warmth on the same continuum, had a greater impact on anxiety than the absence of warmth. Future research should aim to develop such scales and to include such narrow dimensions for both parental control and warmth.

Apart from child personality characteristics and coping, the current study did not include in its comprehensive models any environmental or contextual factors which could possibly be stressing the child or undermine his/her emotional health in general. For example, Flouri, Mavroveli and Tzavidis (2010) found that adverse life events predicted psychopathology independently of child characteristics, maternal psychopathology and . Future research could include such factors as traumatic events, bullying, social exclusion, popularity, academic success or sports or artistic achievements. In this case, more objective measures could also be used in conjunction with self-report and interview data, such as school or afternoon activity reports of achievement. In addition, measures of social popularity or exclusion could use other informants' reports coming from other students or teachers. Gender and age of children as well as more detailed demographic characteristics of mothers could also be included in the model to determine differential influences on both children's internalizing problems and maternal parenting practices.

Also, a problem with data collection emerged due to COVID-related restrictions imposed by participating schools. For example, some schools chose to allow access to the school for data collection only under specific conditions, such as having participating children complete the questionnaire at home or having the headmaster or any other member of the school staff to administer the questionnaires. Since there was already a low participation rate possibly due to COVID and sample size too critical to be sacrificed for the purpose of the current study due to the inclusion of multiple variables, no schools could be excluded from participation merely based on COVID restrictions. However, it is reasonable to consider how this data administration conditions could have affected the data since children might have felt uncomfortable to respond at home on the one hand, especially as concerning their mothers' behavior, and they may have tried to pertain themselves in more favorable terms when responding in front of their teacher or headmaster.

Finally, even though particular guidelines were given to school staff and parents prior the administration, one cannot ensure that questionnaires were completed in a silent and distraction-free environment and that confidentiality was indeed respected. In addition, with a researcher not being present during administration, we cannot be completely confident that participating children were not left with unanswered or wrongly answered

questions. Further, the COVID pandemic per se may have influenced responding, thus future research should aim to replicate data in an after-COVID period of time.

Implications

The importance of maternal parenting practices in determining children's internalizing problems both directly and indirectly through children's characteristics, is well documented in the results of the current study. In addition, specific maternal, child and contextual characteristics that seem to influence choice of parenting practices used by mothers are identified. Targeting high risk mothers could be based on both increased use of negative parenting and on personal and environmental factors that could possibly contribute to the use of negative parenting. First, preventive or treatment parenting skills programs could target high risk pregnant women or mothers of small children who experience personal or environmental factors found in the current study to possibly influence their future choice of parenting. These factors should specifically include perfectionistic or controlling tendencies, anxiety proneness, everyday stress and fatigue, demanding jobs or multiple responsibilities, difficulties with feeling expression and showing affection, physical or emotional unavailability of the father due to work demands or personality, having conflicts with their partner, having had an unwanted or difficult pregnancy or after birth period and being from a country which is different than their country of residence.

In the context of these preventative programs, mothers could have the chance to be educated on more favourable parenting practices with emphasis on showing unconditional acceptance to the child and providing the child with emotional warmth and psychological respect and autonomy granting. In addition, based on a cognitive behavioural orientation, mothers could challenge and modify their perfectionistic, anxiety provoking and control related thoughts and beliefs and gradually and behaviourally expose themselves to situations which are perceived as threatening related to the aforementioned cognitive processes. At the same time, mothers could be taught emotion-regulation skills such as feeling expression, relaxation exercises and problem-solving and other functional coping skills. As concerns fatigue and self-neglect related to demanding jobs or multiple responsibilities, mothers could learn planning and prioritizing of tasks and responsibilities, assertiveness skills and ways of self-care. Dysfunctional thoughts concerning overtaking of responsibilities and difficulty in asking for support could also be targeted in this context.

In addition, dealing with thoughts and feelings and being taught basic social skills that could help to deal with racial stigma and adjusting to a culture with differing parenting values could be of use to mothers of a different racial or ethnic origin. Mothers could also

have the opportunity to talk about their own childhood and deal with related suppressed or uncovered feelings about their own parents' behaviour towards them. Concerning couple conflicts and having to deal with an uninvolved father, mothers should be taught communication and conflict resolution skills and learn how to target and seek social support outside their immediate family. Fathers could also enter the program at particular points in time to deal with family issues and work on their communication and conflict resolution skills. Alternatively, family or couple programs could use a more family systemic approach to address the aforementioned issues and also strengthen emotional support within the family.

High risk children could also be targeted on the basis of their mothers' use of negative parenting practices, especially rejection, or their own personality characteristics, particularly neuroticism, extraversion and perfectionism, and coping styles, especially the positive restructuring and planning (involved in Cognitive Processing) since all of these factors were found to play an important role in the experiencing of internalizing problems. As concerns personality factors, preventive and treatment programs could aim at teaching children social and emotion-regulation skills which target both physical symptoms and dysfunctional thoughts relating to perfectionistic thoughts and beliefs (e.g. unrealistic expectation of self, imposed by self and others), catastrophizing, threat appraisals and fear of social rejection or criticism. In terms of coping strategies, groups of children could further be differentiated in high anxiety and high depression groups with children in the high anxiety group being taught how to prevent overthinking of the problem in an abstract way and either use more concrete planning of dealing with problems or act upon the problem directly. Children in the high depression group could similarly be taught how to use positive restructuring techniques and avoid negative thoughts related to the problem and their efficacy in dealing with it, how to seek social support and how to avoid using disengagement strategies such as avoidance of a stressful situation. Again, such programs could take place in the context of either family therapy or include a parenting component whereby mothers either have separate parenting sessions alone, with their partner or father of the child or with the child and/or the whole family.

Conclusion

The current study contributes to the ongoing research concerning social-cognitive models of internalizing problems in children by aiming to develop two comprehensive models of anxiety and depression respectively which demonstrate the effects of parenting on children's internalizing problems as mediated by child personality characteristics and coping skills. In addition, the current study aimed to identify personal, child-related and

contextual influences on extreme levels of negative maternal parenting practices. The study included two parts, one involving quantitative data drawn from preadolescents and measuring maternal parenting practices and child personality characteristics, coping strategies and internalizing problems and another part involving qualitative data drawn from interviews of mothers whose children's scores on the relevant parenting scales were suggestive of extreme levels of negative parenting.

Results of the quantitative study generally supported the study's hypotheses pertaining to two comprehensive models of depression and anxiety based on the social-cognitive paradigm. The models fitted the data generally well but the model for Depression explained a bigger percentage of the variance in the outcome. Child coping strategies were mainly influential in the model for Depression but personality variables played a more important role in both models compared to coping. Parenting was more important in the model for Depression with maternal Rejection playing the most influential role among all the parenting variables in both models. However, Neuroticism demonstrated the strongest effect. In the model for Anxiety, only Rejection predicted anxiety directly but it also predicted anxiety indirectly mainly through Neuroticism. Warmth predicted Anxiety through Extraversion, Self-Oriented Perfectionism and Cognitive Processing. Psychological Control only predicted Anxiety through Psychoticism. In the model for Depression, Rejection and Warmth predicted Depression directly but Rejection once again demonstrated a stronger effect. Rejection also predicted Depression indirectly through Neuroticism and Socially-Prescribed Perfectionism which subsequently affected Depression directly and through Avoidance coping. Warmth inversely predicted Depression directly and indirectly through Extraversion, Support-Seeking coping and Cognitive Processing. PC predicted Depression only indirectly through Psychoticism which then affected Depression through its negative link with Cognitive Processing. On the whole, Rejection, Neuroticism and Cognitive Processing coping played the most important role in predicting the outcomes.

Results of the qualitative part of the study documented the most frequently mentioned influential factors of maternal negative parenting to be perfectionistic and controlling tendencies, rigidity, anxiety proneness, everyday stress and anxiety related to demanding jobs and multiple responsibilities, an uninvolved father, couple conflict and being raised by controlling or cold mothers or parents in childhood. Findings are generally in line with previous research. Limitations of the current study involve its use of single source, self-report data, its cross-sectional nature, some problems with internal consistency of the broad personality factors and Avoidance coping, the omission of important scale items and data

administration restrictions due to the COVID pandemic. Future research should aim to replicate existing findings in an after-COVID period, clarify the nature of the newly emerging Cognitive Processing factor, use more refined dimensions of parenting and personality constructs and make use of multiple-informant data including data stemming from fathers. Implications of the current study include targeting high risk mothers and children and developing family, parenting skills and child-specific prevention and treatment programs to deal with maternal stressing influences and children's dysfunctional thoughts, emotions and behaviours related to their personality and coping skills.

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APPENDICES

Appendix A

Documentation of approvals received for the conduct of the current study

ΚΥΠΡΙΑΚΗ ΔΗΜΟΚΡΑΤΙΑ

ΕΘΝΙΚΗ ΕΠΙΤΡΟΠΗ ΒΙΟΗΘΙΚΗΣ ΚΥΠΡΟΥ

Αρ. Φακ.: ΕΕΒΚ/ΕΠ /2019/106
Αρ. Τηλ.: 22809038 / 22809039
Αρ. Φαξ: 22353878

07 Φεβρουαρίου, 2020

Δρ Παναγιώτης Σταυρινίδης
Επίκουρος Καθηγητής
Τμήμα Ψυχολογίας
Πανεπιστήμιο Κύπρου
Τ.Θ. 20537
1678 Λευκωσία

Ερευνητική πρόταση με τίτλο:
«Γονεϊκότητα και εσωτερικευμένα προβλήματα: Ένα σχέδιο μεικτής μεθόδου»

Επιθυμώ ν΄ αναφερθώ στο πιο πάνω θέμα και να σας πληροφορήσω ότι η Επιτροπή Βιοηθικής Αξιολόγησης Βιοϊατρικής Έρευνας ενεργώντας με βάση την εκχωρηθείσα σ΄ αυτήν αρμοδιότητα από την Εθνική Επιτροπή Βιοηθικής Κύπρου, να αξιολογεί βιοηθικά ερευνητικές προτάσεις που αφορούν την βιοϊατρική έρευνα στον άνθρωπο, έχει πραγματοποιήσει την βιοηθική αξιολόγηση της πιο πάνω ερευνητικής σας πρότασης, η οποία σας αποστέλλεται συνημμένα.

Με εκτίμηση,

Δρ Μυρτάνη Πιερή
Πρόεδρος
Επιτροπής Βιοηθικής Αξιολόγησης
Βιοϊατρικής Έρευνας

Λαέρτου 22, 2365 Άγιος Δομέτιος, Λευκωσία
Ηλεκτρονικό Ταχυδρομείο: cnbc@bioethics.gov.cy, *Ιστοσελίδα:* www.bioethics.gov.cy

ΚΥΠΡΙΑΚΗ ΔΗΜΟΚΡΑΤΙΑ

ΥΠΟΥΡΓΕΙΟ ΠΑΙΔΕΙΑΣ, ΠΟΛΙΤΙΣΜΟΥ, ΑΘΛΗΤΙΣΜΟΥ ΚΑΙ ΝΕΟΛΑΙΑΣ

Αρ. Φακ.: 7.15.01.25.8.2/6
Αρ. Τηλ. : 22800665
Αρ. Φαξ : 22806335
E-mail : dde@moec.gov.cy

5 Μαΐου, 2020

ΕΠΕΙΓΟΝ – ΜΕ ΤΗΛΕΟΜΟΙΟΤΥΠΟ (22345344)

Κυρία
Ειρήνη Ηρακλείδου
Ανδρέα Δημητρίου 33
2024 Στρόβολος

Θέμα: Άδεια για διεξαγωγή έρευνας με μαθητές/μαθήτριες και γονείς δημοτικών σχολείων της επαρχίας Λευκωσίας

Αγαπητή κυρία Ηρακλείδου,

Έχω οδηγίες να αναφερθώ στη σχετική με το πιο πάνω θέμα αίτησή σας προς το Κέντρο Εκπαιδευτικής Έρευνας και Αξιολόγησης, που υποβλήθηκε στις 26 Σεπτεμβρίου 2019, η οποία στάλθηκε για χειρισμό στις 28 Απριλίου 2020, και να σας πληροφορήσω ότι εγκρίνεται το αίτημά σας για διεξαγωγή έρευνας με μαθητές/μαθήτριες και γονείς δημοτικών σχολείων της επαρχίας Λευκωσίας που εσείς θα επιλέξετε, με θέμα *«Γονεϊκότητα και εσωτερικευμένα προβλήματα: Ένα σχέδιο μεικτής μεθόδου»*, την παρούσα σχολική χρονιά 2019-2020. Η απάντηση του Κέντρου Εκπαιδευτικής Έρευνας και Αξιολόγησης σας αποστέλλεται συνημμένα, για δική σας ενημέρωση. Θα πρέπει, επίσης, να παρουσιάζετε το Αναλυτικό Σχέδιο Έρευνας, σε περίπτωση που αυτό σας ζητηθεί.

2. Νοείται, βέβαια, ότι πρέπει να εξασφαλιστεί η άδεια των διευθυντών/ντριών των σχολείων, εκ των προτέρων, ώστε να ληφθούν όλα τα απαραίτητα μέτρα για να μην επηρεαστεί η ομαλή λειτουργία τους. Η έρευνα θα πρέπει να διεξαχθεί με ιδιαίτερα προσεγμένο τρόπο, ώστε να μη θίγεται το έργο των εκπαιδευτικών, το σχολικό περιβάλλον ή οι οικογένειες των μαθητών/τριών και όλες οι δραστηριότητες που θα αναπτυχθούν πρέπει να εμπίπτουν μέσα στο πλαίσιο που καθορίζεται από το Αναλυτικό Πρόγραμμα. Η έρευνα θα διεξαχθεί νοουμένου ότι η απώλεια του διδακτικού χρόνου των μαθητών/τριών θα περιοριστεί στον ελάχιστο δυνατό βαθμό, ενώ για τη συμμετοχή τους χρειάζεται η γραπτή συγκατάθεση των γονιών τους. Οι γονείς πρέπει να γνωρίζουν όλες τις σχετικές λεπτομέρειες για τη διεξαγωγή της έρευνας, καθώς και τα στάδια μέσα από τα οποία θα εξελιχθεί. Σημειώνεται, επίσης, ότι τα πορίσματά σας κρίνεται απαραίτητο να είναι ανώνυμα και οι πληροφορίες που θα συλλέξετε να τηρηθούν απόλυτα εμπιστευτικές και αποκλειστικά και μόνο για τον σκοπό της έρευνας.

3. Η παρούσα έγκριση παραχωρείται με την προϋπόθεση ότι τα πορίσματα της εργασίας, θα κοινοποιηθούν μόλις αυτή ολοκληρωθεί, στη Διεύθυνση Δημοτικής Εκπαίδευσης για σχετική μελέτη και κατάλληλη αξιοποίηση.

Με εκτίμηση,

(Δρ Σοφία Ιωάννου Γεωργίου)
για Γενικό Διευθυντή

ΚΥΠΡΙΑΚΗ ΔΗΜΟΚΡΑΤΙΑ

ΥΠΟΥΡΓΕΙΟ ΠΑΙΔΕΙΑΣ, ΠΟΛΙΤΙΣΜΟΥ, ΑΘΛΗΤΙΣΜΟΥ ΚΑΙ ΝΕΟΛΑΙΑΣ

Αρ. Φακ.: 7.15.01.25.8.1/10
Αρ. Τηλ.: 22800665
Αρ. Φαξ: 22806335
E-mail: dde@moec.gov.cy

13 Οκτωβρίου, 2020

ΕΠΕΙΓΟΝ – ΜΕ ΤΗΛΕΟΜΟΙΟΤΥΠΟ (22345344)

Κυρία
Ειρήνη Ηρακλείδου
Ανδρέα Δημητρίου 33, Διαμ. 101
2024 Στρόβολος

Θέμα: Άδεια για διεξαγωγή έρευνας με μαθητές/μαθήτριες και γονείς δημοτικών σχολείων της επαρχίας Λευκωσίας

Αγαπητή κυρία Ηρακλείδου,

Έχω οδηγίες να αναφερθώ στη σχετική με το πιο πάνω θέμα επιστολή σας, με ημερομηνία 30 Σεπτεμβρίου 2020, και σε συνέχεια της ταυτάριθμης επιστολής μας, με ημερομηνία 5 Μαΐου 2020, να σας πληροφορήσω ότι εγκρίνεται το αίτημά σας για ανανέωση της άδειας που σας έχει παραχωρηθεί για διεξαγωγή έρευνας με μαθητές/μαθήτριες και γονείς δημοτικών σχολείων της επαρχίας Λευκωσίας που εσείς θα επιλέξετε, με θέμα *«Γονεϊκότητα και εσωτερικευμένα προβλήματα: Ένα σχέδιο μεικτής μεθόδου»*, και για την παρούσα σχολική χρονιά 2020-2021.

2. Σημειώστε ότι όλοι οι όροι που αναφέρονται στην αρχική μας επιστολή εξακολουθούν να ισχύουν. Τέλος, επαναλαμβάνω και πάλι ότι η παρούσα έγκριση παραχωρείται με την προϋπόθεση ότι τα πορίσματα της εργασίας σας θα κοινοποιηθούν, μόλις αυτή ολοκληρωθεί, στη Διεύθυνση Δημοτικής Εκπαίδευσης για σχετική μελέτη και κατάλληλη αξιοποίηση.

Με εκτίμηση,

(Δρ Μάριος Στυλιανίδης)
για Γενικό Διευθυντή

Κοιν.: Π.Λ.Ε. Λευκωσίας
Επαρχιακό Γραφείο Παιδείας

AT/AT EREVNES

Appendix B

Questionnaire used for data collection in the current study

Αγαπητά παιδιά,

Αυτό το ερωτηματολόγιο εμπεριέχει κάποιες ερωτήσεις για εσάς. Δεν είναι διαγώνισμα. Δεν υπάρχουν σωστές και λάθος απαντήσεις. Ο καθένας από εσάς θα έχει διαφορετικές απαντήσεις. Βεβαιωθείτε ότι οι απαντήσεις σας δείχνουν πως είναι τα πράγματα στ' αλήθεια. Παρακαλώ μη μιλήσετε για τις απαντήσεις σας με κανένα. Θα κρατήσουμε τις απαντήσεις σας ιδιωτικές και δε θα τις δείξουμε σε κανένα.

Παρακαλώ βεβαιωθείτε να απαντήσετε ΟΛΕΣ τις ερωτήσεις.

_____
_____

Οδηγίες

Πιο κάτω είναι κάποιες απλές ερωτήσεις για εσάς.

Κυκλώστε ή γράψτε κάτω την απάντηση ανάλογα με την περίπτωση. Όταν απαντήσετε τις ερωτήσεις αυτής της σελίδας, γυρίστε στην επόμενη.

1. Είσαι αγόρι ή κορίτσι; (κύκλωσε το σωστό)

   Αγόρι Κορίτσι

2. Πόσων χρονών είσαι; _____

3. Σημείωσε την ημερομηνία γέννησης σου αν την γνωρίζεις ____/_____/_____ (π.χ. 24/06/2009 ή 24 Ιουνίου 2009)

4. Σε ποια τάξη πας; (π.χ. Ε1, Ε2, Στ. 1, Στ.2) _____

5. Ποια είναι η εθνικότητά σου (από ποια χώρα είσαι); (κύκλωσε το σωστό)

   Κυπριακή Ελληνική Άλλη (σημείωσε ακριβώς _____)

6. Έχεις ένα ή περισσότερα αδέλφια; (κύκλωσε το σωστό)

   Ναι (σημείωσε πόσα)_____ Όχι

7. Αν απάντησες «Ναι» στην ερώτηση 6, ποια είναι η σειρά γέννησής σου; (κύκλωσε το σωστό)

Πρώτος Δεύτερος Τρίτος Τέταρτος Πέμπτος και πάνω

Οδηγίες

Πιο κάτω είναι κάποιες προτάσεις οι οποίες περιγράφουν τις συμπεριφορές που εκδηλώνουν κάποιες μητέρες.

Διάβασε κάθε πρόταση προσεκτικά και κύκλωσε τον αριθμό που ταιριάζει στη δική σου μητέρα, κάθε φορά.

Η μητέρα μου είναι ένα πρόσωπο που...

	Όχι σαν εκείνη	**Κάπως σαν εκείνη**	**Πολύ σαν εκείνη**
1. Αλλάζει το θέμα, όποτε έχω κάτι να πω.	1	2	3
2. Τελειώνει τις προτάσεις μου όποτε μιλώ.	1	2	3
3. Συχνά με διακόπτει.	1	2	3
4. Συμπεριφέρεται σα να ξέρει τι σκέφτομαι ή τι νιώθω.	1	2	3
5. Θα ήθελε να μπορεί να μου λέει όλη την ώρα πώς να νιώθω ή πως να σκέφτομαι για κάτι.	1	2	3
6. Πάντα προσπαθεί να αλλάξει το πως νιώθω ή πως σκέφτομαι για κάτι.	1	2	3
7. Με κατηγορεί για τα προβλήματα άλλων μελών της οικογένειας.	1	2	3
8. Αναφέρει παλιά μου λάθη όταν με κριτικάρει (κατακρίνει).	1	2	3

Οδηγίες

Πιο κάτω είναι μερικές ακόμα προτάσεις οι οποίες περιγράφουν τον τρόπο που συμπεριφέρονται κάποιες μητέρες. Διάβασε κάθε πρόταση προσεκτικά και κύκλωσε τον αριθμό που ταιριάζει στη δική σου μητέρα, κάθε φορά.

	Όχι, ποτέ	**Ναι, αλλά σπάνια**	**Ναι, συχνά**	**Ναι, τις περισσότερες φορές**
1. Η μητέρα μου θυμώνει μαζί μου χωρίς να μου λέει το λόγο.	1	2	3	4
2. Η μητέρα μου με επαινεί (π.χ. μου λέει «μπράβο»).	1	2	3	4
3. Εύχομαι η μητέρα μου να ανησυχούσε λιγότερο για το τι κάνω.	1	2	3	4
4. Η μητέρα μου χρησιμοποιεί σωματική τιμωρία (με κτυπά) για να με πειθαρχήσει.	1	2	3	4
5. Όταν έρχομαι σπίτι, πρέπει να δίνω αναφορά στη μητέρα μου για το τι έκανα.	1	2	3	4
6. Η μητέρα μου προσπαθεί να κάνει την ηλικία μου να έχει ενδιαφέρον, να με ενθουσιάζει, να μαθαίνω πράγματα (π.χ. δίνοντάς μου καλά βιβλία, κανονίζοντας να πάω σε κατασκηνώσεις, παίρνοντάς με σε αθλητικές δραστηριότητες/ δραστηριότητες συλλόγων).	1	2	3	4
7. Η μητέρα μου με κριτικάρει και μου λέει πόσο τεμπέλης/α και άχρηστος/η είμαι μπροστά στους άλλους.	1	2	3	4
8. Η μητέρα μου μου απαγορεύει να κάνω πράγματα τα οποία επιτρέπονται στους υπόλοιπους συνομήλικούς μου, επειδή φοβάται ότι κάτι μπορεί να μου συμβεί.	1	2	3	4
9. Η μητέρα μου προσπαθεί να με ενθαρρύνει να γίνω ο/η καλύτερος/η.	1	2	3	4
10. Όταν συμπεριφερθώ άσχημα, η μητέρα μου προσπαθεί να με κάνει να νιώσω ένοχος/η (τύψεις) με το να δείχνει λυπημένη για παράδειγμα.	1	2	3	4
11. Η μητέρα μου αγχώνεται υπερβολικά ότι κάτι μπορεί να μου συμβεί.	1	2	3	4

12. Η μητέρα μου προσπαθεί να με παρηγορήσει και να με ενθαρρύνει αν τα πράγματα μου πάνε στραβά.	1	2	3	4
	Όχι, ποτέ	**Ναι, αλλά σπάνια**	**Ναι, συχνά**	**Ναι, τις περισσότερες φορές**
13. Η μητέρα μου μου συμπεριφέρεται σαν το «μαύρο πρόβατο» της οικογένειας.	1	2	3	4
14. Η μητέρα μου χρησιμοποιεί λέξεις και χειρονομίες για να δείξει ότι με συμπαθεί.	1	2	3	4
15. Η μητέρα μου συμπαθεί τον αδελφό/ τους αδελφούς ή/και την αδελφή/τις αδελφές μου περισσότερο από ότι συμπαθεί εμένα.	1	2	3	4
16. Η μητέρα μου μου συμπεριφέρεται με τέτοιο τρόπο που με κάνει να νιώθω ντροπή για τον εαυτό μου.	1	2	3	4
17. Η μητέρα μου μου επιτρέπει να πηγαίνω όπου μου αρέσει, χωρίς να τη νοιάζει υπερβολικά.	1	2	3	4
18. Η μητέρα μου επεμβαίνει σε ότι κάνω.	1	2	3	4
19. Μεταξύ εμένα και της μητέρας μου, υπάρχει ζεστασιά και τρυφερότητα.	1	2	3	4
20. Η μητέρα μου βάζει αυστηρά όρια για το τι επιτρέπεται και τι δεν επιτρέπεται να κάνω και τα ακολουθεί αυστηρά.	1	2	3	4
21. Η μητέρα μου με τιμωρεί σκληρά, ακόμα και για μικρά παραπτώματα (λάθη).	1	2	3	4
22. Η μητέρα μου θέλει να αποφασίζει για το πως πρέπει να ντυθώ ή πως πρέπει να φαίνομαι.	1	2	3	4
23. Η μητέρα μου είναι περήφανη όταν πετύχω σε κάτι που έχω αναλάβει.	1	2	3	4

Οδηγίες

Απάντησε κάθε ερώτηση κυκλώνοντας το «ΝΑΙ» ή το «ΟΧΙ».

Δεν υπάρχουν σωστές ή λάθος απαντήσεις.

Μην σκέφτεσαι υπερβολικά τι σημαίνει ακριβώς η κάθε ερώτηση. Απλά απάντησε αυτό που σου έρχεται πρώτο στο μυαλό.

Παρακαλώ να είσαι όσο ειλικρινής και αληθινός/ή γίνεται.

	ΝΑΙ	**ΟΧΙ**
1. Έχεις παραβιάσει ποτέ κανόνες στο σχολείο;	1	2
2. Θα σου άρεσε να σε φοβούνται τα άλλα παιδιά;	1	2
3. Θα έλεγες ότι μάλλον είσαι ένα ζωηρό, γεμάτο ζωντάνια παιδί;	1	2
4. Θα σου άρεσε να κόβεις ζώα σε κομμάτια στο μάθημα της Επιστήμης;	1	2
5. Πήρες ποτέ οτιδήποτε (ακόμα και μια καρφίτσα ή ένα κουμπί) που άνηκε σε κάποιον άλλον;	1	2
6. Νιώθεις ποτέ «απλά αξιολύπητος» (κακομοίρης) χωρίς να υπάρχει σοβαρός λόγος;	1	2
7. Νιώθεις συχνά ότι η ζωή είναι βαρετή (ανιαρή, πληκτική);	1	2
8. Τελειώνεις πάντα τη σχολική σου μελέτη πριν αρχίσεις να παίζεις;	1	2
9. Μπορείς να κάνεις ένα πάρτι που έχει ήδη αρχίσει, να αποκτήσει ζωντάνια;	1	2
10. Πληγώνεσαι εύκολα όταν οι άνθρωποι βρίσκουν ελαττώματα σε εσένα ή στη δουλειά που κάνεις;	1	2
11. Λες πάντα συγγνώμη όταν έχεις φερθεί με αγένεια;	1	2
12. Θα έλεγες ότι μάλλον απολαμβάνεις να κοροϊδεύεις άλλα παιδιά;	1	2
13. Μπλέκεις σε περισσότερους μπελάδες στο σχολείο από ότι τα περισσότερα παιδιά;	1	2
14. Θα έλεγες ότι τα συναισθήματά σου πληγώνονται μάλλον εύκολα;	1	2
15. Σου αρέσει να κάνεις φάρσες σε άλλους;	1	2
16. Θα προτιμούσες να κάθεσαι και να παρακολουθείς παρά να παίζεις, όταν βρίσκεσαι σε ένα πάρτι;	1	2
17.Νιώθεις συχνά ότι έχεις «μπουχτίσει» (κουραστεί, βαρεθεί, αηδιάσει);	1	2
18. Στην προσευχή ή στη συγκέντρωση στο σχολείο, τραγουδάς πάντα κι εσύ όταν τραγουδούν οι άλλοι;	1	2
19. Μπορείς να αφήσεις τον εαυτό σου ελεύθερο και να περάσεις καλά σε μεγάλο βαθμό, όταν βρίσκεσαι σε ένα ζωντανό πάρτι;	1	2

	ΝΑΙ	**ΟΧΙ**
20. Νιώθεις μερικές φορές ότι η ζωή δεν αξίζει να τη ζεις;	1	2
21. Έγραψες ή έκανες ποτέ μουτζούρα πάνω/μέσα σε ένα βιβλίο του σχολείου ή της βιβλιοθήκης;	1	2
22. Οι άλλοι σε βλέπουν σαν ένα πολύ ζωντανό (ζωηρό) παιδί;	1	2
23. Είσαι πάντα ιδιαίτερα προσεκτικός με τα πράγματα των άλλων;	1	2
24. Θα περιέγραφες τον εαυτό σου σαν «μες την τρελή χαρά» (εύθυμο, ξέγνοιαστο);	1	2

Οδηγίες

Παρακάτω είναι μερικές ακόμα προτάσεις που μπορεί να περιγράφουν τον εαυτό σου.

Διάβασε κάθε πρόταση προσεκτικά και κύκλωσε τον αριθμό που σου ταιριάζει πιο πολύ, κάθε φορά.

Δεν υπάρχουν σωστές και λάθος απαντήσεις. Βεβαιώσου ότι οι απαντήσεις σου δείχνουν το πως είσαι πραγματικά.

	Ψέμα-καθόλου αλήθεια για μένα	**Σχεδόν ψέμα**	**Ούτε αλήθεια ούτε ψέμα**	**Σχεδόν αλήθεια**	**Πολύ αλήθεια για μένα**
1. Προσπαθώ να είμαι τέλειος/α σε ότι κάνω.	1	2	3	4	5
2. Θέλω να είμαι ο/η καλύτερος/η σε ότι κάνω.	1	2	3	4	5
3. Οι γονείς μου δεν περιμένουν πάντα από μένα να είμαι τέλειος/α σε ότι κάνω.	1	2	3	4	5
4. Νιώθω ότι πρέπει να κάνω ότι καλύτερο μπορώ όλη την ώρα.	1	2	3	4	5
5. Υπάρχουν άνθρωποι στη ζωή μου που περιμένουν από μένα να είμαι τέλειος/α.	1	2	3	4	5
6. Πάντα προσπαθώ για τον υψηλότερο βαθμό σε ένα διαγώνισμα ή μια εργασία.	1	2	3	4	5
7. Με ενοχλεί πραγματικά το να μην κάνω ότι καλύτερο μπορώ όλη την ώρα.	1	2	3	4	5
8. Η οικογένειά μου αναμένει από εμένα να είμαι τέλειος/α.	1	2	3	4	5
9. Δεν προσπαθώ πάντα να είμαι ο/η καλύτερος/η.	1	2	3	4	5
10. Οι άνθρωποι περιμένουν από μένα περισσότερα από όσα είμαι ικανός/ή να δώσω.	1	2	3	4	5
11. Θυμώνω με τον εαυτό μου όταν κάνω λάθος.	1	2	3	4	5
12. Οι άλλοι πιστεύουν ότι απέτυχα αν δεν κάνω ότι					

καλύτερο μπορώ όλη την ώρα.	1	2	3	4	5
13. Οι άλλοι πάντα περιμένουν από εμένα να είμαι τέλειος/α.	1	2	3	4	5
	Ψέμα-καθόλου αλήθεια για μένα	**Σχεδόν ψέμα**	**Ούτε αλήθεια ούτε ψέμα**	**Σχεδόν αλήθεια**	**Πολύ αλήθεια για μένα**
14. Αναστατώνομαι αν υπάρχει έστω και ένα λάθος στη δουλειά μου.	1	2	3	4	5
15. Οι άνθρωποι γύρω μου περιμένουν από εμένα να είμαι σπουδαίος/α σε όλα.	1	2	3	4	5
16. . Όταν κάνω κάτι, πρέπει να είναι τέλειο.	1	2	3	4	5
17. Οι δάσκαλοί μου περιμένουν τη δουλειά μου να είναι τέλεια.	1	2	3	4	5
18. Δε χρειάζεται να είμαι ο/η καλύτερος/η σε ότι κάνω.	1	2	3	4	5
19. Πάντα περιμένουν από εμένα να είμαι καλύτερος/η από τους άλλους.	1	2	3	4	5
20. Ακόμα και όταν περάσω, νιώθω ότι έχω αποτύχει αν δεν έχω πάρει ένα από τους υψηλότερους βαθμούς της τάξης.	1	2	3	4	5
21. Νιώθω ότι οι άλλοι ζητάνε υπερβολικά πράγματα από μένα.	1	2	3	4	5
22. Δεν αντέχω το να είμαι κάτι λιγότερο από τέλειος/α.	1	2	3	4	5

Οδηγίες

Παρακάτω είναι κάποιες προτάσεις που περιγράφουν το πώς νιώθετε ή σκέφτεστε.

Παρακαλώ κυκλώστε τον αριθμό που δείχνει πόσο συχνά συμβαίνει σε εσάς το κάθε ένα από αυτά τα πράγματα.

Δεν υπάρχουν σωστές ή λάθος απαντήσεις. Βεβαιωθείτε ότι οι απαντήσεις σας δείχνουν το πως νιώθετε ή σκέφτεστε πραγματικά.

	Ποτέ	**Μερικές φορές**	**Συχνά**	**Συνέχεια**
1. Νιώθω λυπημένος/η ή έχω ένα αίσθημα κενού.	1	2	3	4
2. Ανησυχώ όταν σκέφτομαι ότι μπορεί να μην τα πήγα καλά σε κάτι.	1	2	3	4
3. Φοβάμαι να μείνω μόνος/η στο σπίτι.	1	2	3	4
4. Τίποτα πια δε μου φαίνεται ευχάριστο ή διασκεδαστικό.	1	2	3	4
5. Ανησυχώ μήπως συμβεί κάτι κακό σε μέλος της οικογένειάς μου.	1	2	3	4
6. Φοβάμαι να βρίσκομαι σε μέρη με πολύ κόσμο (όπως σε εμπορικά κέντρα, κινηματογράφους, λεωφορεία, πολυσύχναστες παιδικές χαρές).	1	2	3	4
7. Ανησυχώ για το τι σκέφτονται οι άλλοι για εμένα.	1	2	3	4
8. Δυσκολεύομαι να κοιμηθώ.	1	2	3	4
9. Φοβάμαι να κοιμηθώ μόνος/η μου.	1	2	3	4
10. Έχω προβλήματα σχετικά με την όρεξή μου για φαγητό.	1	2	3	4
11. Ξαφνικά και χωρίς λόγο, ζαλίζομαι ή έχω τάση για λιποθυμία.	1	2	3	4
12. Αισθάνομαι την ανάγκη να κάνω κάποια πράγματα ξανά και ξανά (π.χ. να πλένω τα χέρια μου, να τακτοποιώ τα πράγματα με ορισμένη σειρά).	1	2	3	4
13. Νιώθω ότι δεν έχω ενέργεια να κάνω πράγματα.	1	2	3	4
14. Ξαφνικά και χωρίς λόγο, αρχίζω να τρέμω.	1	2	3	4
15. Δεν μπορώ να σκεφτώ καθαρά.	1	2	3	4
16. Νιώθω ότι δεν αξίζω.	1	2	3	4
17. Αισθάνομαι την ανάγκη να κάνω συγκεκριμένες σκέψεις, όπως το να σκέφτομαι κάποιους αριθμούς ή λέξεις, έτσι ώστε να μη συμβεί κάτι κακό.	1	2	3	4

	Ποτέ	Μερικές φορές	Συχνά	Συνέχεια
18. Σκέφτομαι το θάνατο.	1	2	3	4
19. Νιώθω σα να μην έχω ενέργεια, σα να μη θέλω να κινηθώ.	1	2	3	4
20. Ανησυχώ μήπως τρομάξω ξαφνικά, ενώ στην πραγματικότητα δεν υπάρχει κάτι για να φοβηθώ.	1	2	3	4
21. Νιώθω ότι είμαι πολύ κουρασμένος/η.	1	2	3	4
22. Φοβάμαι μήπως γίνω ρεζίλι μπροστά σε κόσμο.	1	2	3	4
23. Αισθάνομαι την ανάγκη να κάνω κάποια πράγματα με συγκεκριμένο τρόπο για να μη συμβεί κάτι κακό.	1	2	3	4
24. Νιώθω ανήσυχος/η.	1	2	3	4
25. Ανησυχώ μήπως συμβεί κάτι κακό.	1	2	3	4

Οδηγίες

Μερικές φορές τα παιδιά αντιμετωπίζουν προβλήματα ή νιώθουν αναστατωμένα για κάποια πράγματα. Για παράδειγμα, μπορεί να αντιμετωπίσουν ***προβλήματα σε σχέση με τις εργασίες τους στο σχολείο, με τις σχέσεις τους με τα άλλα παιδιά ή με τις σχέσεις τους με πρόσωπα της οικογένειάς τους*** (π.χ. γονείς, αδέλφια). Όταν συμβαίνει αυτό, μπορεί να κάνουν διάφορα πράγματα για να λύσουν το πρόβλημα ή για να νιώσουν καλύτερα.

Αφού φέρεις στο μυαλό σου κάποια προβλήματα που αντιμετώπισες ΕΣΥ κατά τη διάρκεια του περασμένου μήνα, επέλεξε την απάντηση που περιγράφει καλύτερα πόσο συχνά έκανες αυτό που λέει η κάθε δήλωση για να λύσεις τα προβλήματά σου ή για να νιώσεις καλύτερα.

Όταν είχες κάποιο πρόβλημα τον τελευταίο μήνα…	**Ποτέ**	**Κάποιες φορές**	**Συχνά**	**Συνήθως**
1. Κάθισες και σκέφτηκες τι θα μπορούσες να κάνεις, πριν κάνεις κάτι.	1	2	3	4
2. Προσπάθησες να σκεφτείς ή να δώσεις σημασία μόνο στα καλά πράγματα της ζωής σου.	1	2	3	4
3. Προσπάθησες να το αγνοήσεις.	1	2	3	4
4. Μίλησες σε κάποιον για το πως νιώθεις για το πρόβλημα.	1	2	3	4
5. Προσπάθησες να μείνεις μακριά από το πρόβλημα.	1	2	3	4
6. Έκανες κάτι για να βελτιώσεις την κατάσταση (να την κάνεις καλύτερη).	1	2	3	4
7. Μίλησες σε κάποιον που θα μπορούσε να σε βοηθήσει να σκεφτείς τι θα κάνεις.	1	2	3	4
8. Είπες στον εαυτό σου (σκέφτηκες) ότι τα πράγματα θα γίνουν καλύτερα.	1	2	3	4
9. Άκουσες μουσική.	1	2	3	4
10. Υπενθύμισες στον εαυτό σου ότι είσαι σε καλύτερη μοίρα από ότι άλλα παιδιά.	1	2	3	4
11. Φαντάστηκες ότι όλα είναι καλά.	1	2	3	4
12. Πήγες για ποδηλασία.	1	2	3	4
13. Μίλησες για τα συναισθήματά σου με κάποιον που πραγματικά έδειξε κατανόηση.	1	2	3	4
14. Είπες στους άλλους τι θα ήθελες να κάνουν.	1	2	3	4
15. Προσπάθησες να το βγάλεις από το μυαλό σου.	1	2	3	4
16. Σκέφτηκες τι θα γινόταν αν έκανες κάτι, πριν αποφασίσεις να το κάνεις.	1	2	3	4
17. Είπες στον εαυτό σου ότι όλα θα πάνε καλά.	1	2	3	4
Όταν είχες κάποιο πρόβλημα τον τελευταίο μήνα…	**Ποτέ**	**Κάποιες φορές**	**Συχνά**	**Συνήθως**

18. Είπες στους άλλους τι σε έκανε να νιώσεις έτσι όπως ένιωσες.	1	2	3	4
19. Είπες στον εαυτό σου ότι θα μπορούσες να χειριστείς (να λύσεις) αυτό το πρόβλημα.	1	2	3	4
20. Πήγες για περπάτημα.	1	2	3	4
21. Προσπάθησες να μείνεις μακριά από τα πράγματα που σε αναστάτωσαν.	1	2	3	4
22. Είπες στους άλλους με ποιο τρόπο θα ήθελες να λύσεις το πρόβλημα.	1	2	3	4
23. Προσπάθησες να καλυτερεύσεις τα πράγματα με το να αλλάξεις τη δική σου συμπεριφορά.	1	2	3	4
24. Είπες στον εαυτό σου ότι στο παρελθόν έτυχε να διευθετήσεις (να λύσεις) προβλήματα σαν και αυτό.	1	2	3	4
25. Ασχολήθηκες με κάποιο άθλημα.	1	2	3	4
26. Κάθισες και σκέφτηκες το γιατί συνέβηκε αυτό.	1	2	3	4
27. Δεν το σκεφτόσουν.	1	2	3	4
28. Ενημέρωσες άλλους ανθρώπους για το πως ένιωθες.	1	2	3	4
29. Είπες στον εαυτό σου ότι θα μπορούσες να αντιμετωπίσεις οτιδήποτε συμβεί.	1	2	3	4
30. Είπες σε άλλους ανθρώπους τι θα ήθελες να συμβεί.	1	2	3	4
31. Είπες στον εαυτό σου ότι σιγά σιγά τα πράγματα θα λειτουργήσουν (θα γίνουν) για το καλύτερο.	1	2	3	4
32. Διάβασες ένα βιβλίο ή ένα περιοδικό.	1	2	3	4
33. Φαντάστηκες πως θα ήθελες να ήταν τα πράγματα.	1	2	3	4
34. Υπενθύμισες στον εαυτό σου ότι ξέρεις τι πρέπει να κάνεις.	1	2	3	4
35. Κάθισες και σκέφτηκες ποια πράγματα είναι το καλύτερο να κάνεις για να λύσεις το πρόβλημα.	1	2	3	4
36. Απλά το ξέχασες.	1	2	3	4
37. Είπες στον εαυτό σου ότι θα λυθεί από μόνο του.	1	2	3	4
38. Μίλησες σε κάποιον που θα μπορούσε να σε βοηθήσει να λύσεις το πρόβλημα.	1	2	3	4
39. Πήγες για skateboard, πατίνια ή κάτι παρόμοιο.	1	2	3	4

Όταν είχες κάποιο πρόβλημα τον τελευταίο μήνα…	Ποτέ	Κάποιες φορές	Συχνά	Συνήθως
40. Απέφυγες τους ανθρώπους που σε έκαναν να νιώσεις άσχημα.	1	2	3	4
41. Υπενθύμισες στον εαυτό σου ότι σε γενικές γραμμές, τα πράγματα στη ζωή σου πάνε καλά.	1	2	3	4
42. Έκανες κάτι άλλο, όπως το να παίξεις ένα βιντεοπαιχνίδι ή να ασχοληθείς με ένα χόμπι.	1	2	3	4
43. Έκανες κάτι για να λύσεις το πρόβλημα.	1	2	3	4
44. Προσπάθησες να καταλάβεις καλύτερα το πρόβλημα με το να το σκεφτείς περισσότερο.	1	2	3	4
45. Υπενθύμισες στον εαυτό σου όλα τα πράγματα που πάνε καλά στη ζωή σου.	1	2	3	4
46. Ευχήθηκες να μη συνέβαιναν άσχημα πράγματα.	1	2	3	4
47. Κάθισες και σκέφτηκες τι χρειαζόταν να γνωρίζεις για να λύσεις το πρόβλημα.	1	2	3	4
48. Το απέφυγες με το να πας στο δωμάτιό σου.	1	2	3	4
49. Έκανες κάτι για να κερδίσεις ότι μπορούσες περισσότερο μέσα από αυτή την κατάσταση.	1	2	3	4
50. Κάθισες και σκέφτηκες τι θα μπορούσες να μάθεις μέσα από το πρόβλημα.	1	2	3	4
51. Ευχήθηκες τα πράγματα να ήταν καλύτερα.	1	2	3	4
52. Παρακολούθησες τηλεόραση.	1	2	3	4
53. Έκανες γυμναστική.	1	2	3	4
54. Προσπάθησες να καταλάβεις γιατί συμβαίνουν τέτοια πράγματα.	1	2	3	4

ΣΕ ΕΥΧΑΡΙΣΤΟΥΜΕ ΓΙΑ ΤΗ ΣΥΜΜΕΤΟΧΗ ΣΟΥ!!!

Appendix C

Distribution of main variables of interest in quantitative analysis

Psychological control

Figure C1a

*Histogram showing the distribution of the **Psychological control** scale*

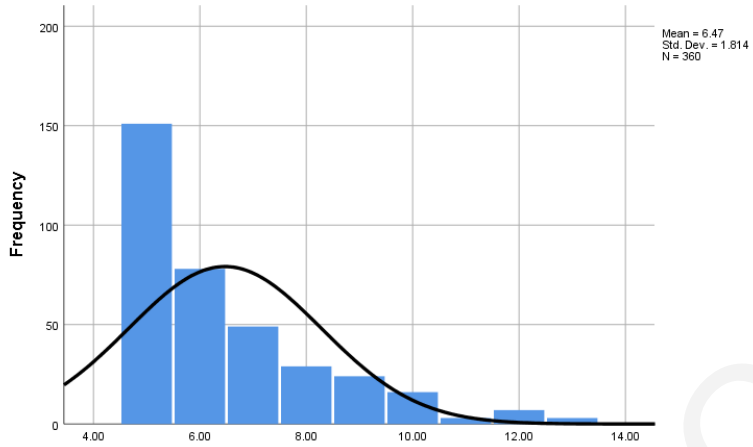


Figure C1b

*Box-plot showing the distribution of the **Psychological control** scale*

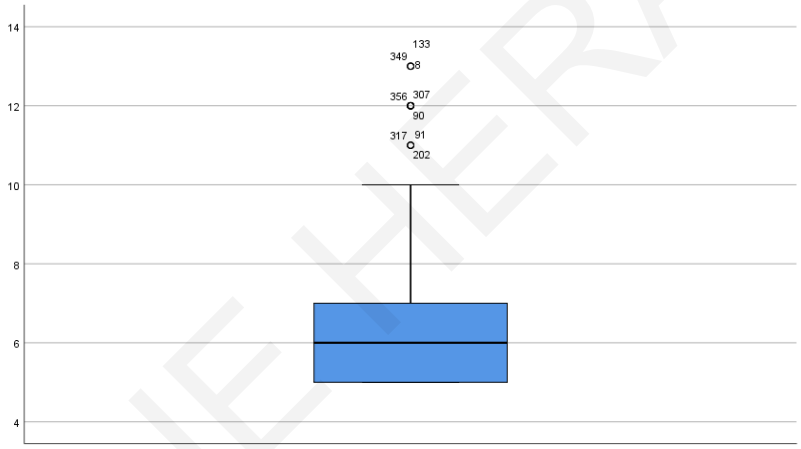
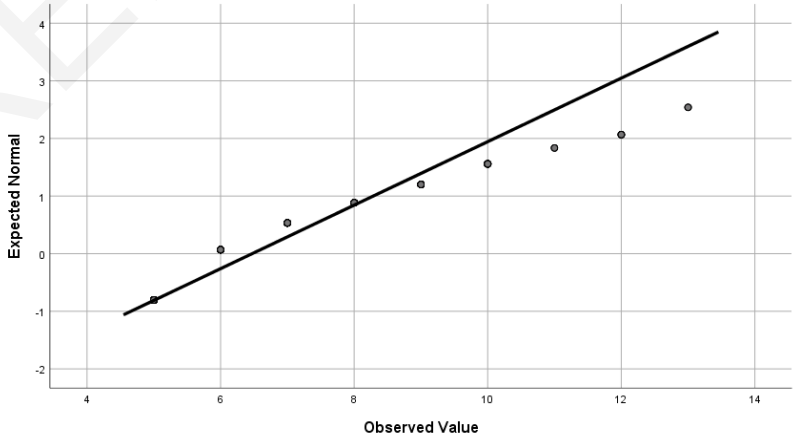


Figure C1c

*Normal Q-Q Plot showing the distribution of the **Psychological control** scale*



Warmth

Figure C2a

*Histogram showing the distribution of the **Warmth** scale*

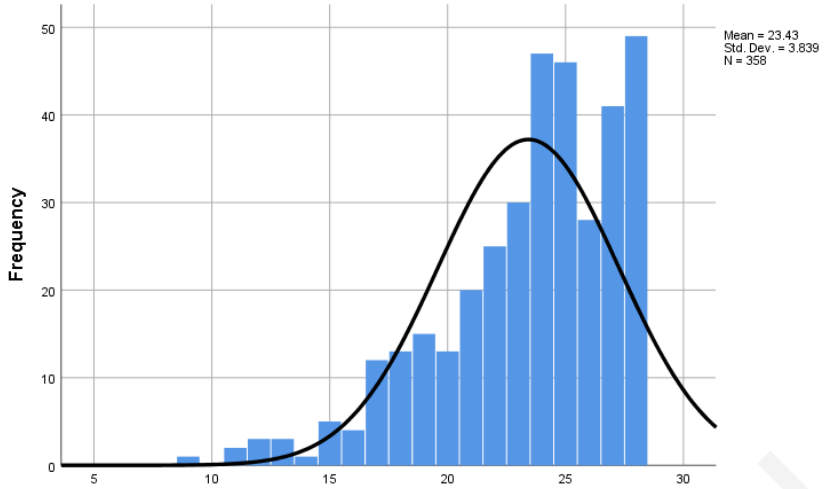


Figure C2b

*Box-plot showing the distribution of the **Warmth** scale*

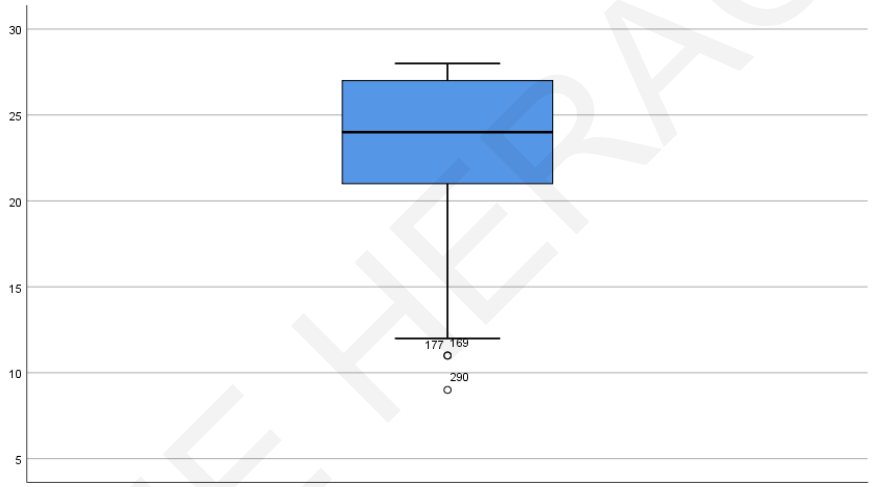
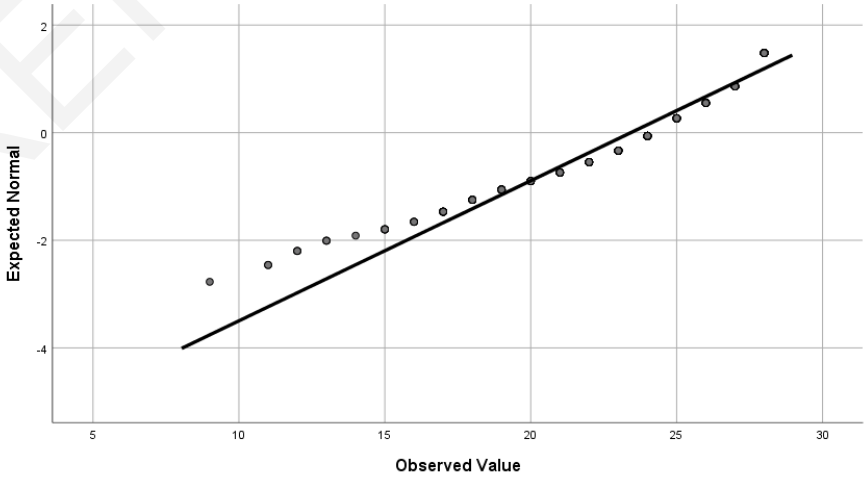


Figure C2c

*Normal Q-Q Plot showing the distribution of the **Warmth** scale*



Rejection

Figure C3a

*Histogram showing the distribution of **Rejection** scale*

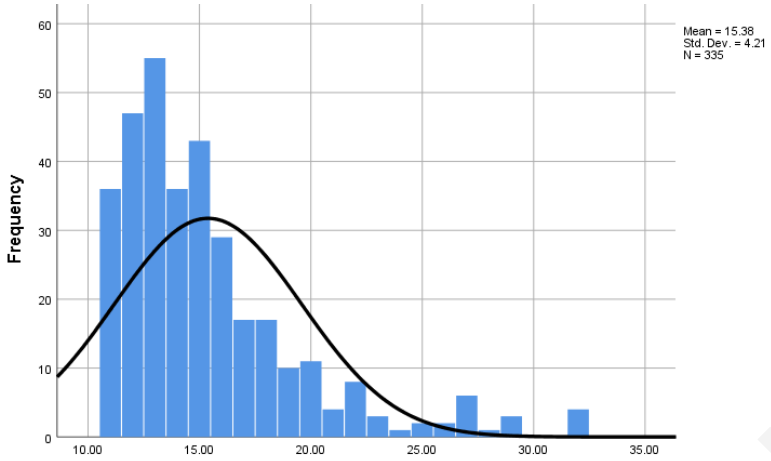


Figure C3b

*Box-plot showing the distribution of the **Rejection** scale*

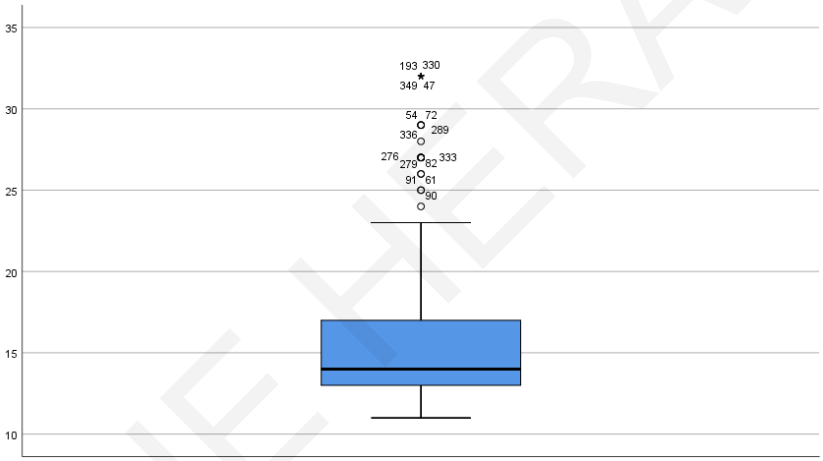
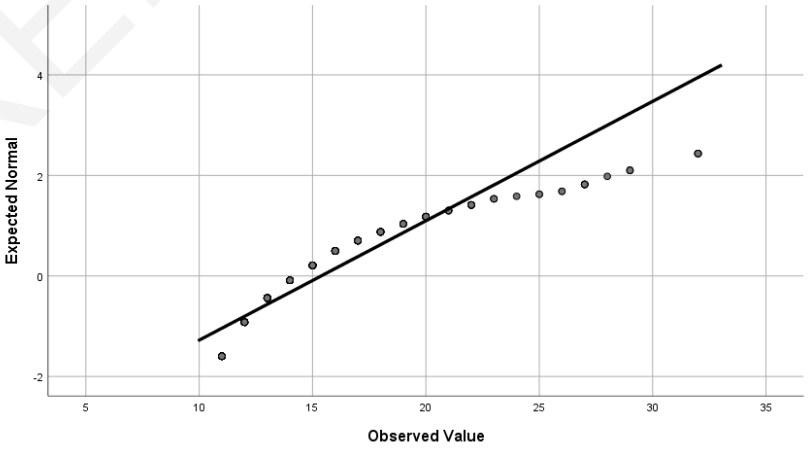


Figure C3c

*Normal Q-Q Plot showing the distribution of the **Rejection** scale*



Neuroticism

Figure C4a

*Histogram showing the distribution of the **Neuroticism** scale*

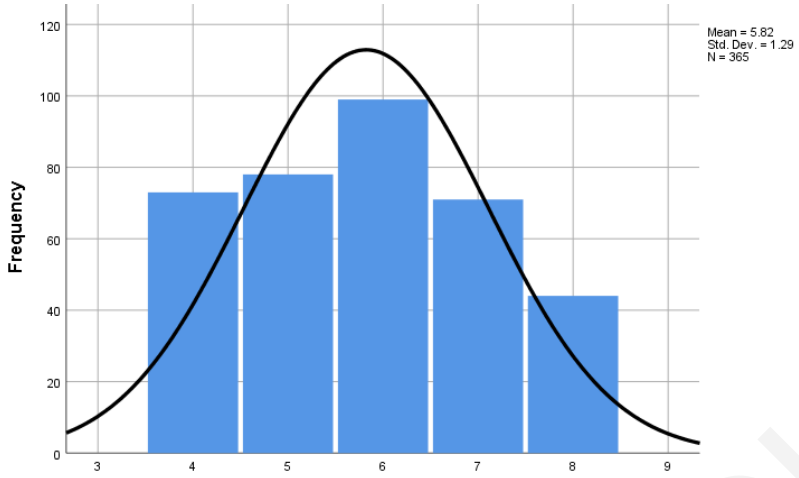


Figure C4b

*Box-plot showing the distribution of the **Neuroticism** scale*

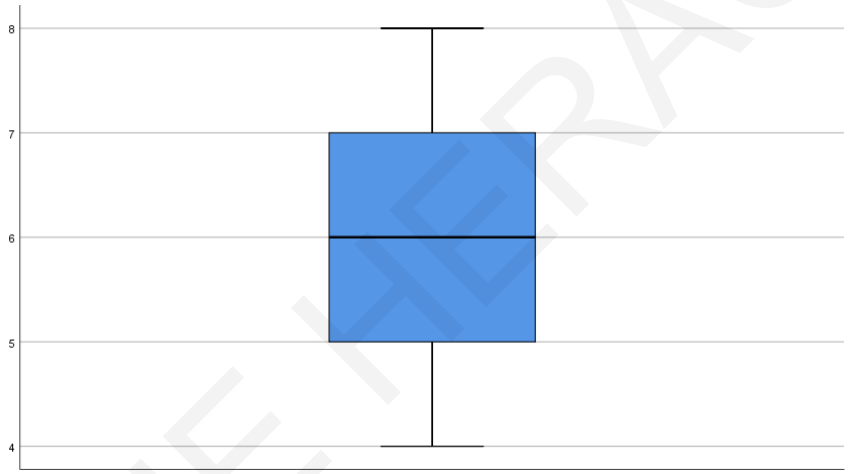
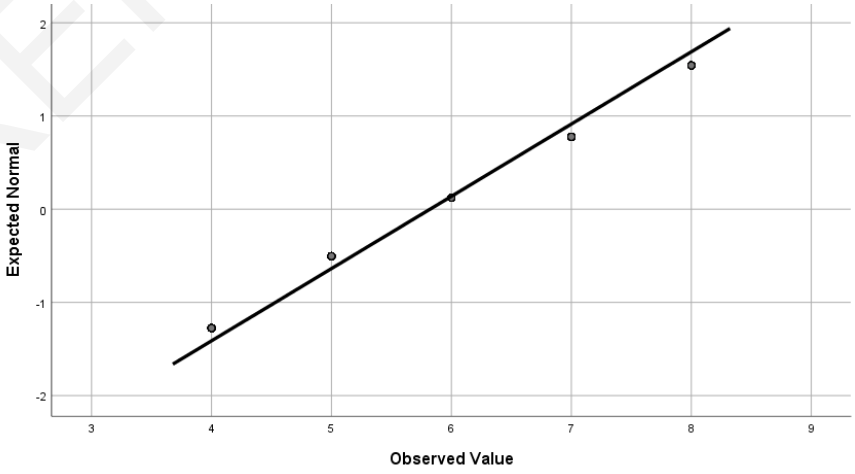


Figure C4c

*Normal Q-Q Plot showing the distribution of the **Neuroticism** scale*



Extraversion

Figure C5a

*Histogram showing the distribution of the **Extraversion** scale*

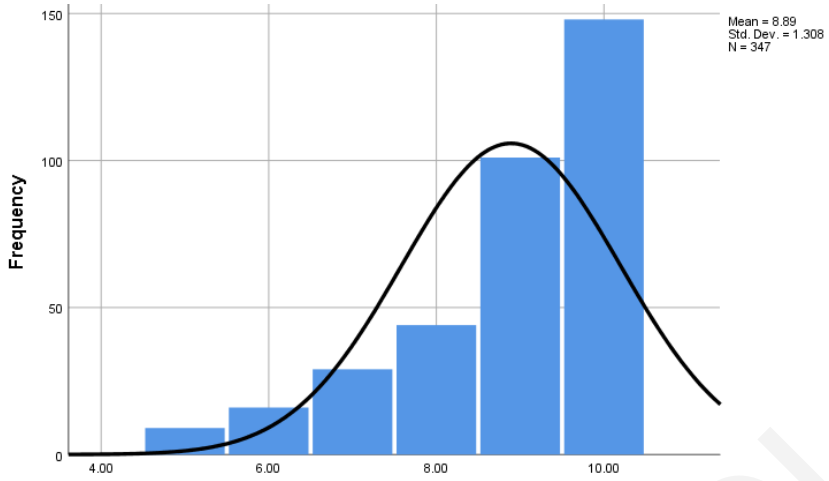


Figure C5b

*Box-plot showing the distribution of the **Extraversion** scale*

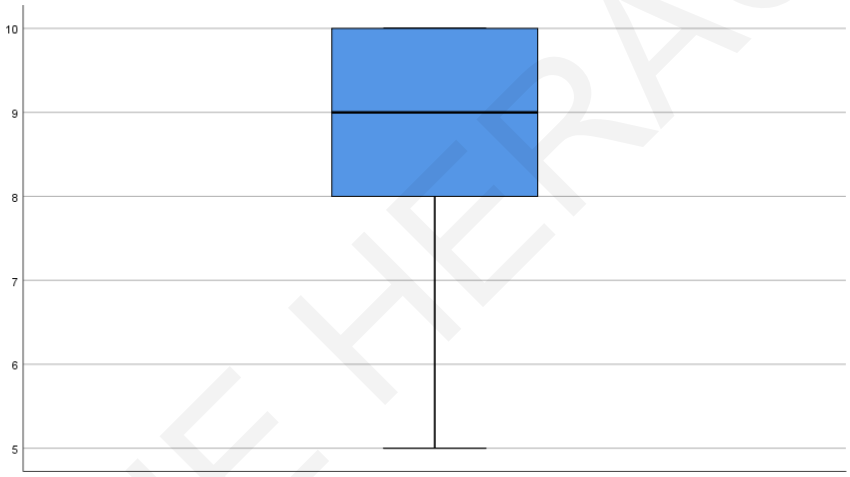
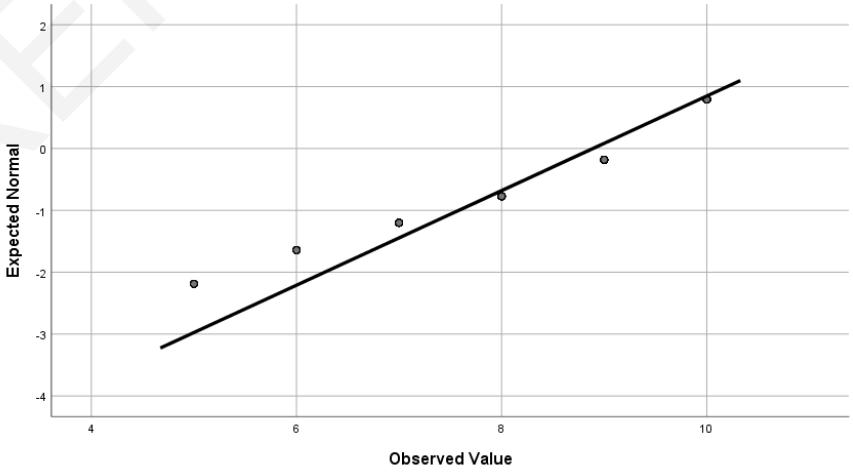


Figure C5c

*Normal Q-Q Plot showing the distribution of the **Extraversion** scale*



Psychoticism

Figure C6a

*Histogram showing the distribution of the **Psychoticism** scale*

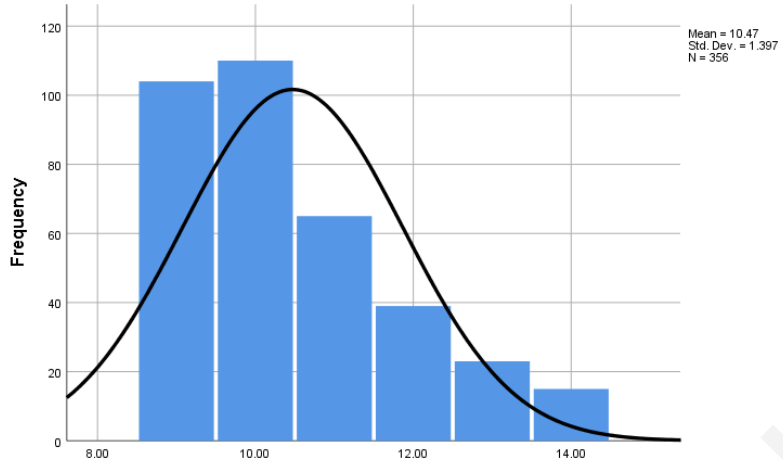


Figure C6b

*Box-plot showing the distribution of the **Psychoticism** scale*

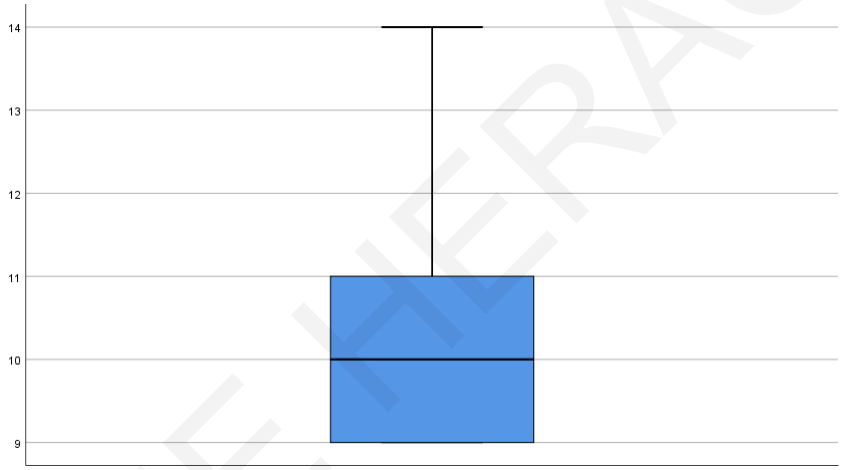
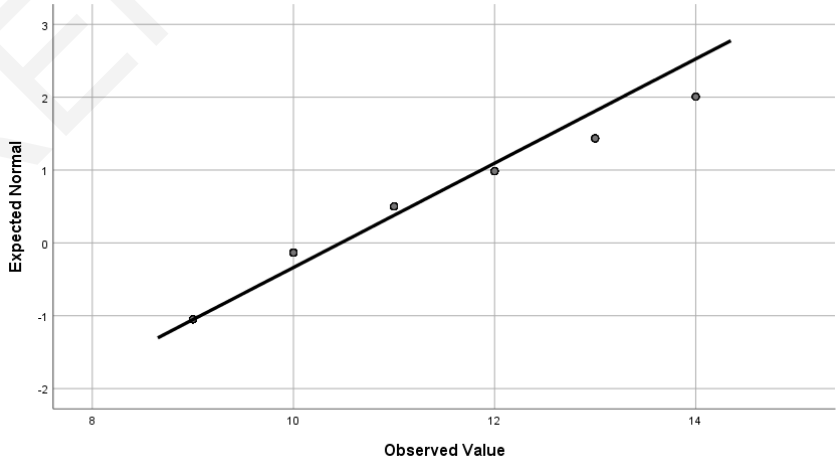


Figure C6c

*Normal Q-Q Plot showing the distribution of the **Psychoticism** scale*



Self-Oriented Perfectionism

Figure C7a

*Histogram showing the distribution of the **SOP** scale*

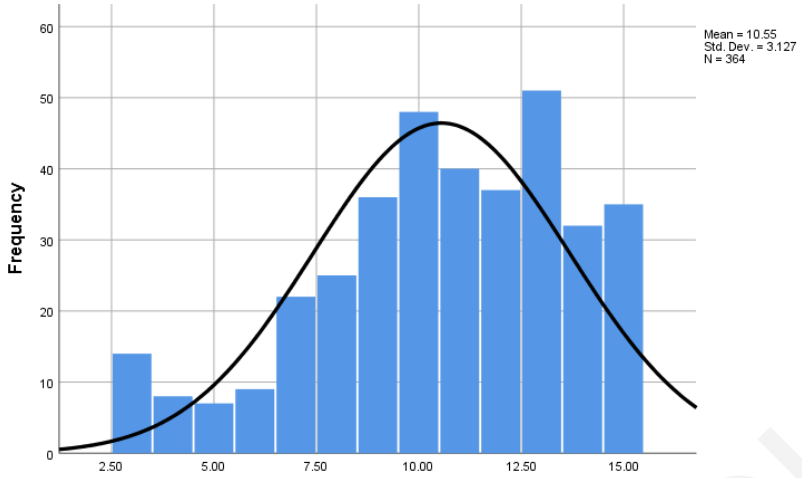


Figure C7b

*Box-plot showing the distribution of the **SOP** scale*

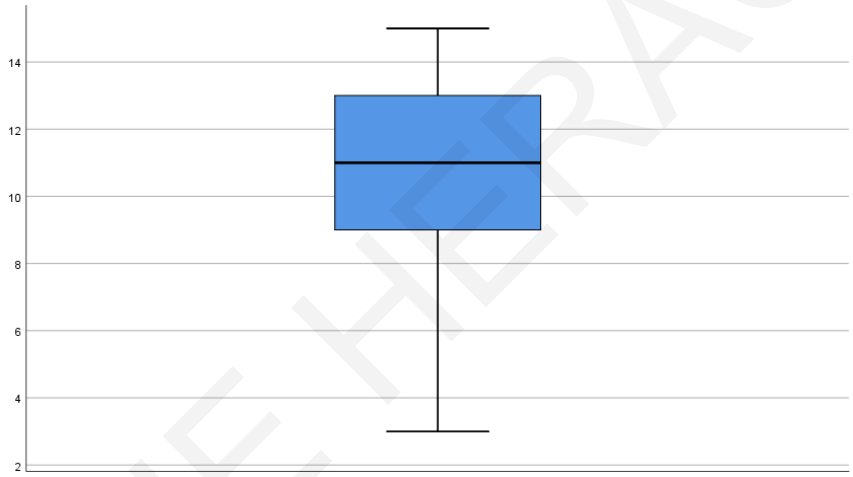
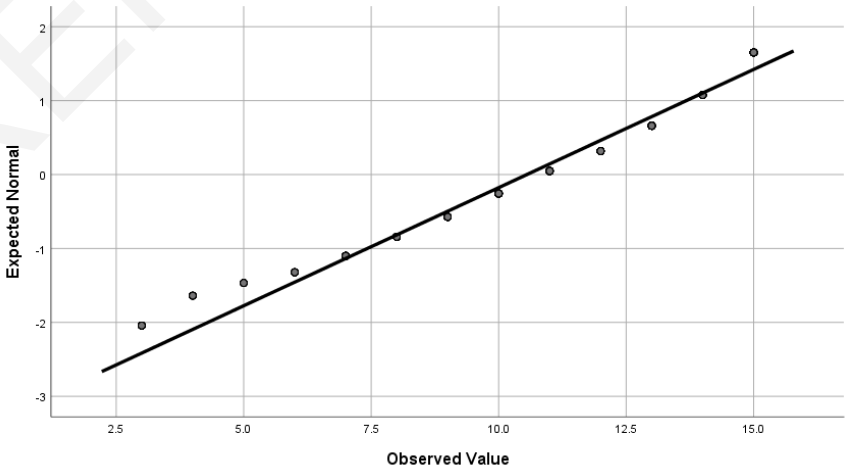


Figure C7c

*Normal Q-Q Plot showing the distribution of the **SOP** scale*



Socially-Prescribed Perfectionism

Figure C8a

*Histogram showing the distribution of the **SPP** scale*

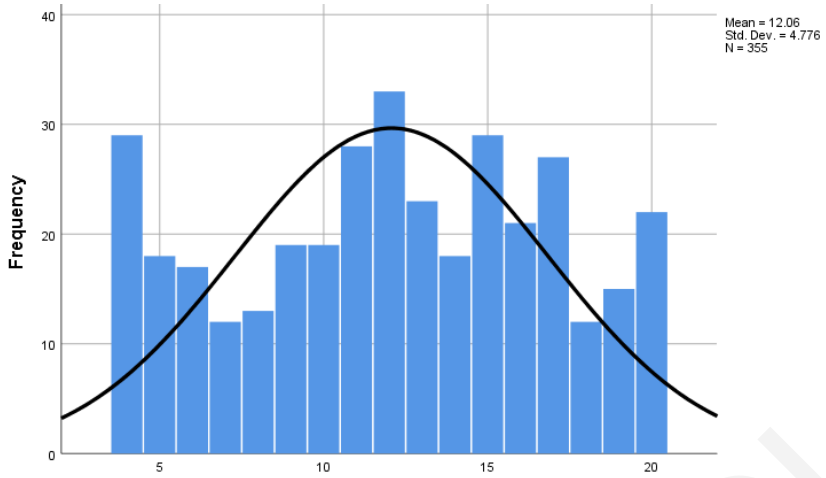


Figure C8b

*Box-plot showing the distribution of the **SPP** scale*

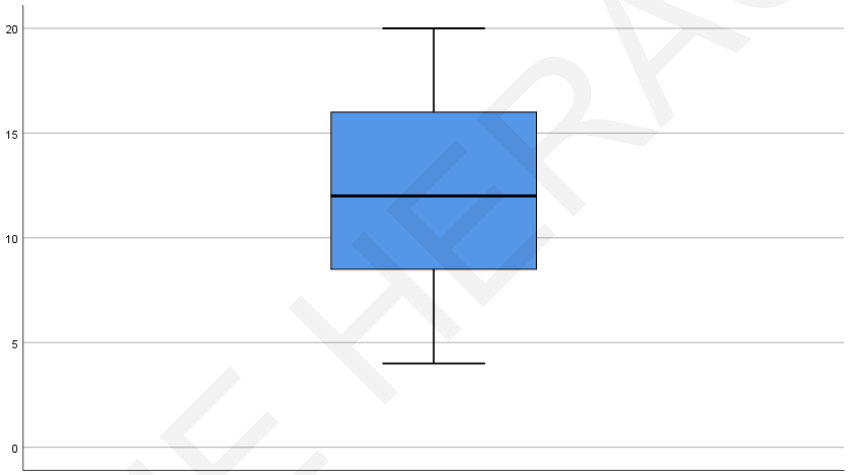
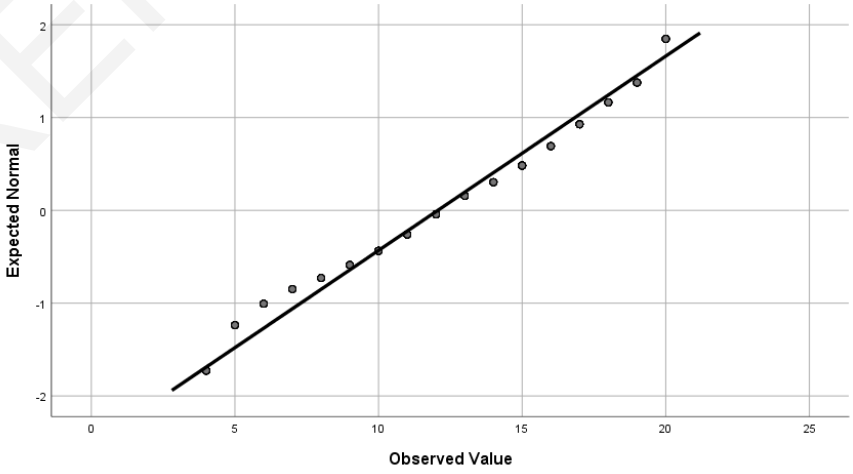


Figure C8c

*Normal Q-Q Plot showing the distribution of the **SPP** scale*



Cognitive Processing

Figure C9a

*Histogram showing the distribution of the **Cognitive Processing** scale*

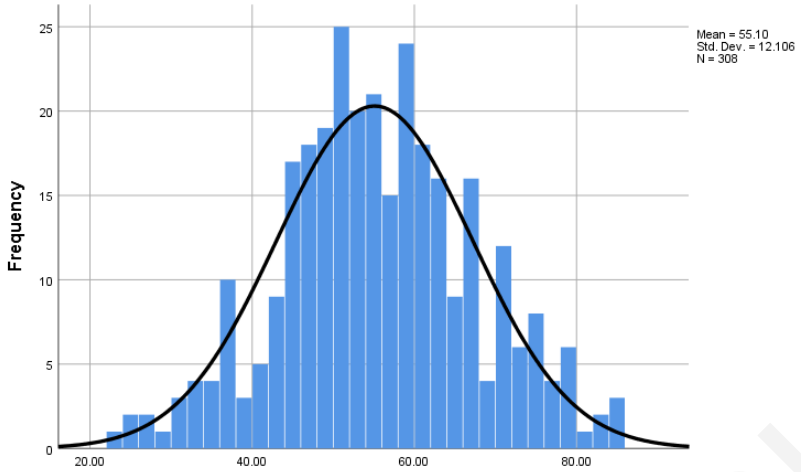


Figure C9b

*Box-plot showing the distribution of the **Cognitive Processing** scale*

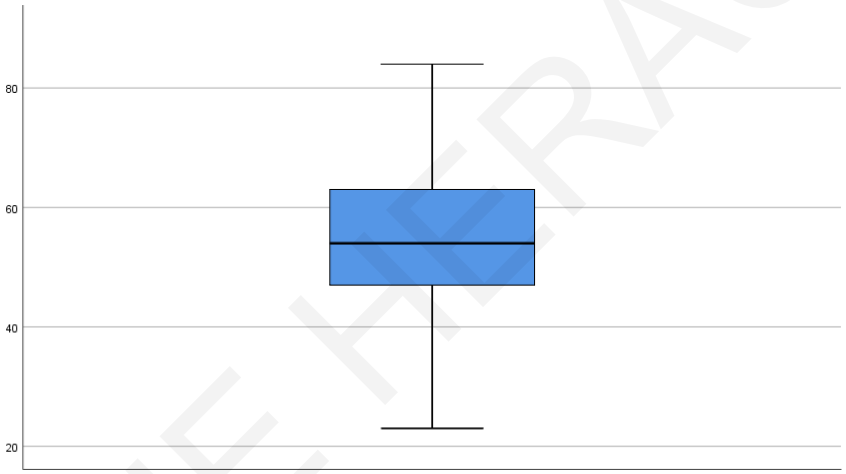
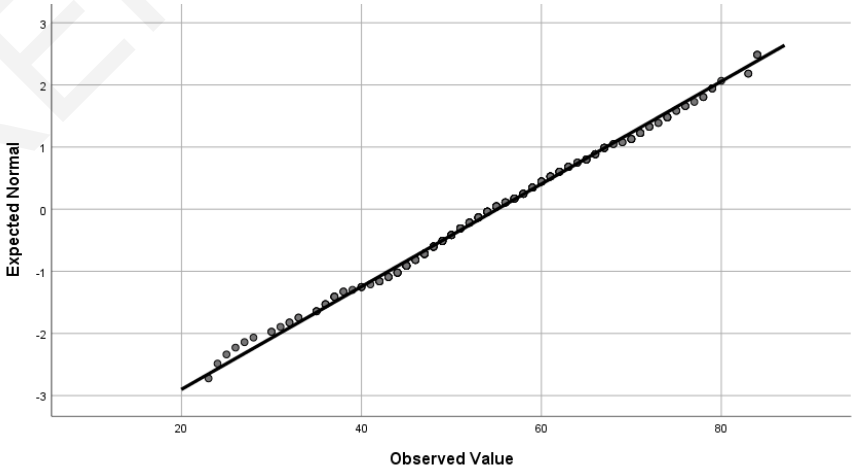


Figure C9c

*Normal Q-Q Plot showing the distribution of the **Cognitive Processing** scale*



Support Seeking Coping

Figure C10a

*Histogram showing the distribution of the **Support Seeking Coping** scale*

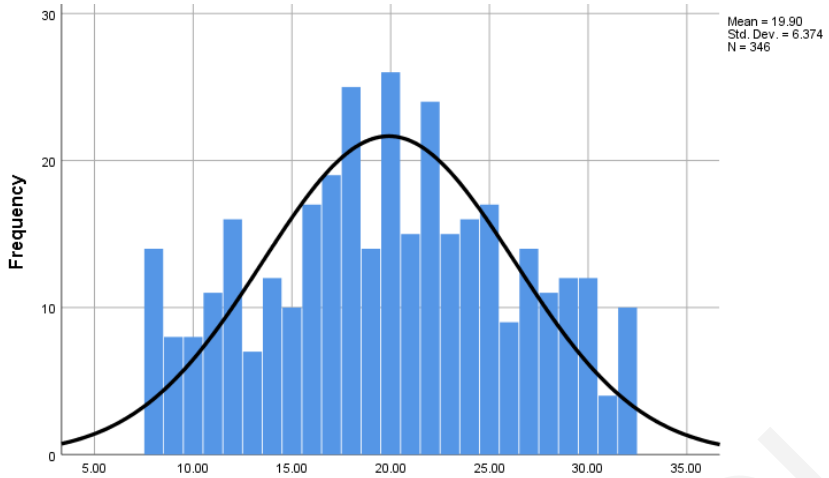


Figure C10b

*Box-plot showing the distribution of the **Support Seeking Coping** scale*

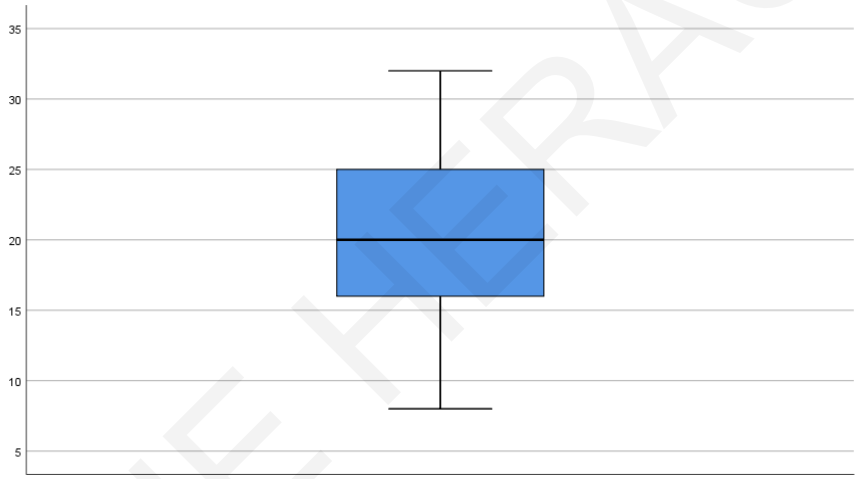
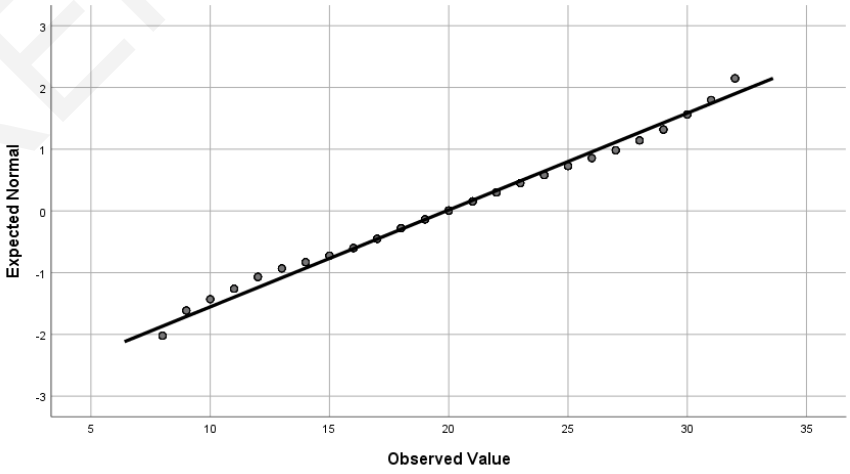


Figure C10c

*Normal Q-Q Plot showing the distribution of the **Support Seeking Coping** scale*



Distraction Coping

Figure C11a

*Histogram showing the distribution of the **Distraction Coping** scale*

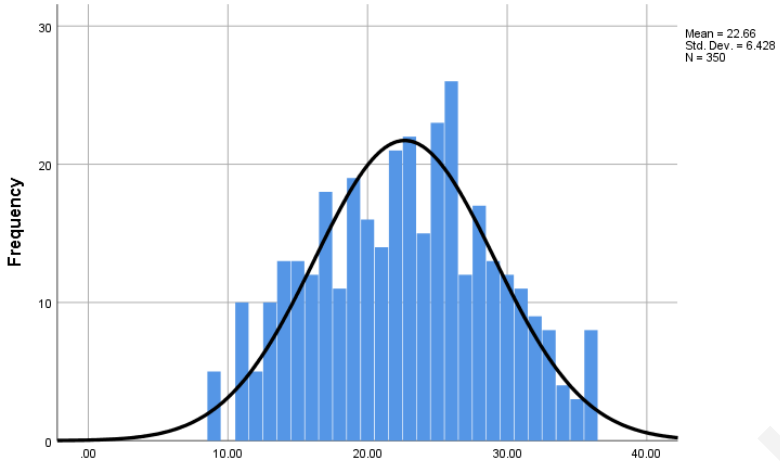


Figure C11b

*Box-plot showing the distribution of the **Distraction Coping** scale*

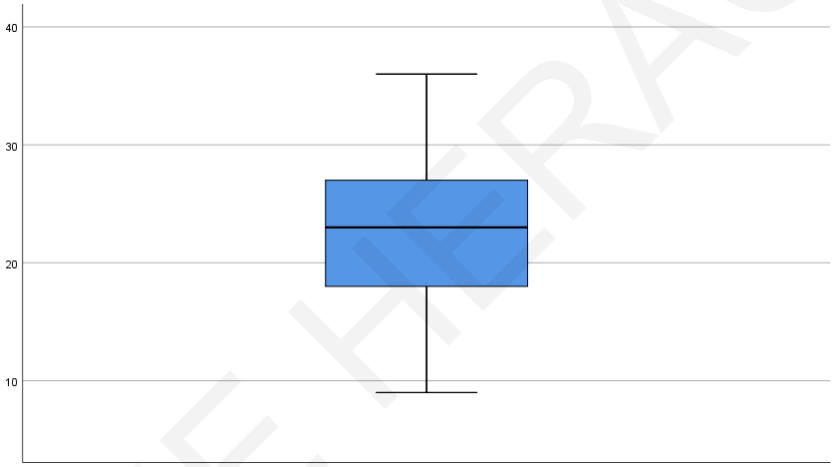
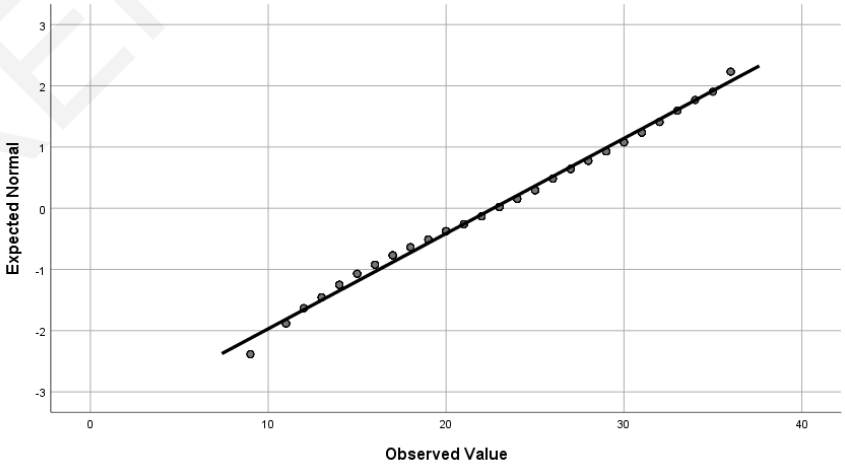


Figure C11c

*Normal Q-Q Plot showing the distribution of the **Distraction Coping** scale*



Avoidance Coping

Figure C12a

*Histogram showing the distribution of the **Avoidance Coping** scale*

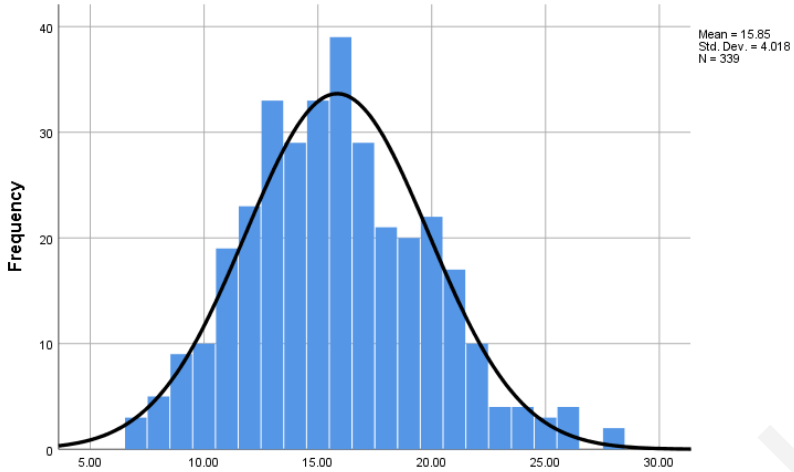


Figure C12b

*Box-plot showing the distribution of the **Avoidance Coping** scale*

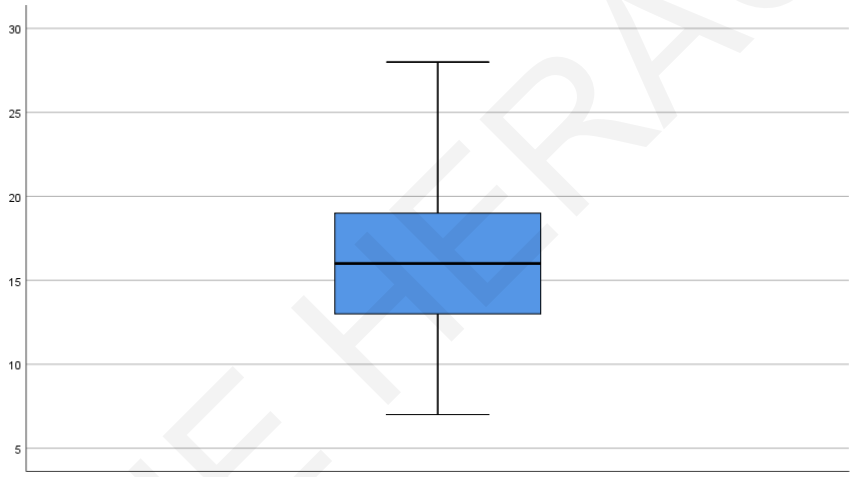
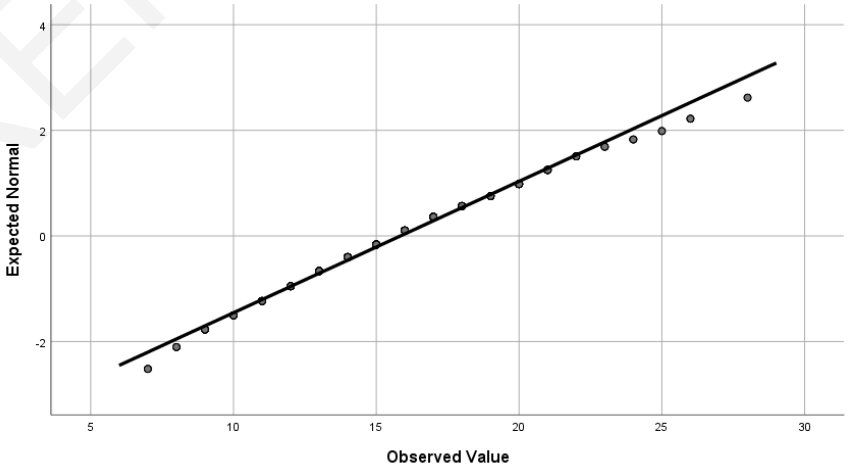


Figure C12c

*Normal Q-Q Plot showing the distribution of the **Avoidance Coping** scale*



Depression

Figure C13a

*Histogram showing the distribution of the **Depression** scale*

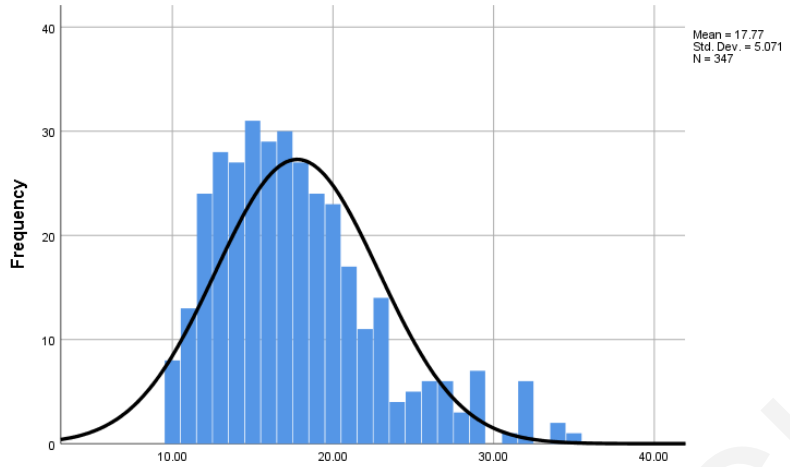


Figure C13b

*Box-plot showing the distribution of the **Depression** scale*

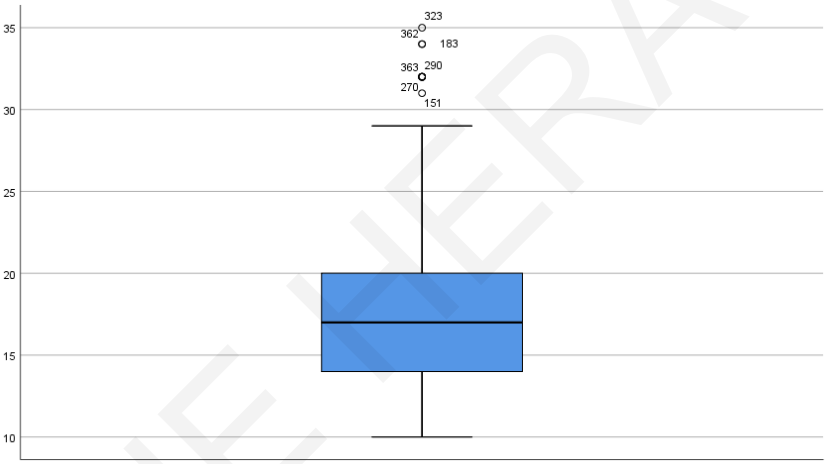
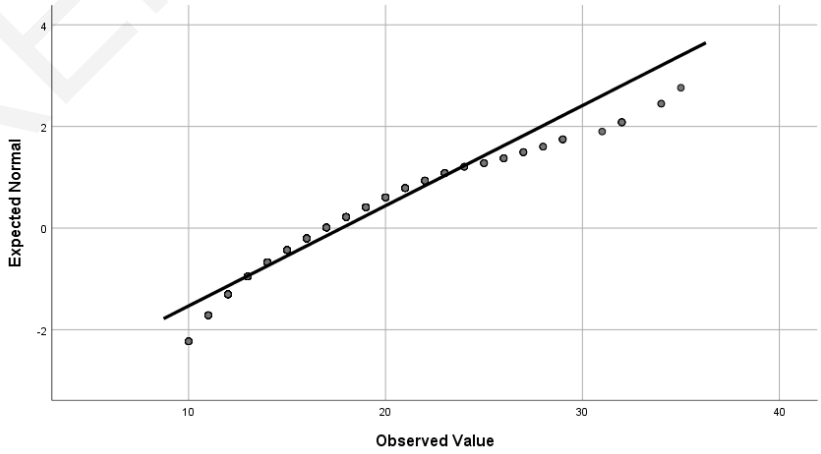


Figure C13c

*Normal Q-Q Plot showing the distribution of the **Depression** scale*



Anxiety

Figure C14a

*Histogram showing the distribution of the **Anxiety** scale*

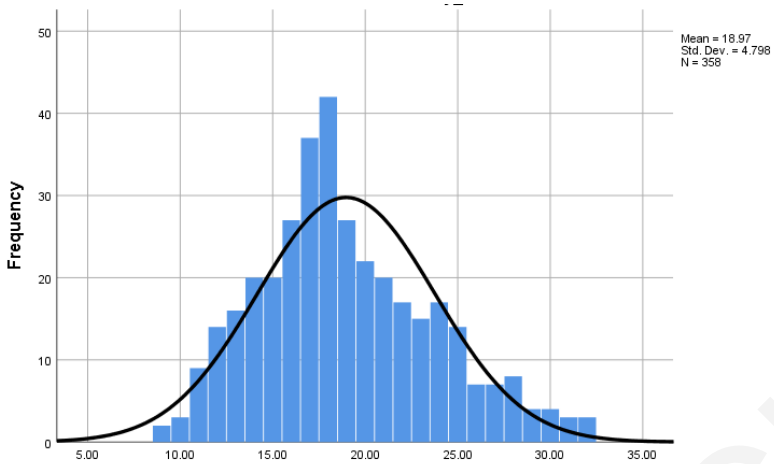


Figure C14b

*Box-plot showing the distribution of the **Anxiety** scale*

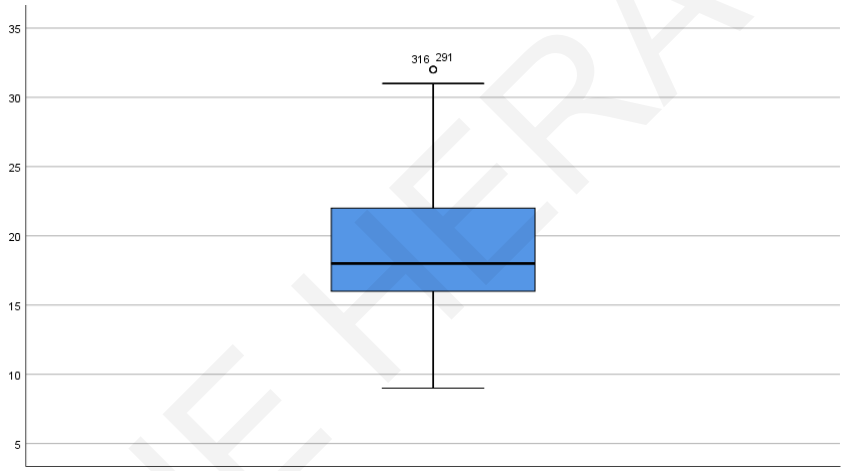
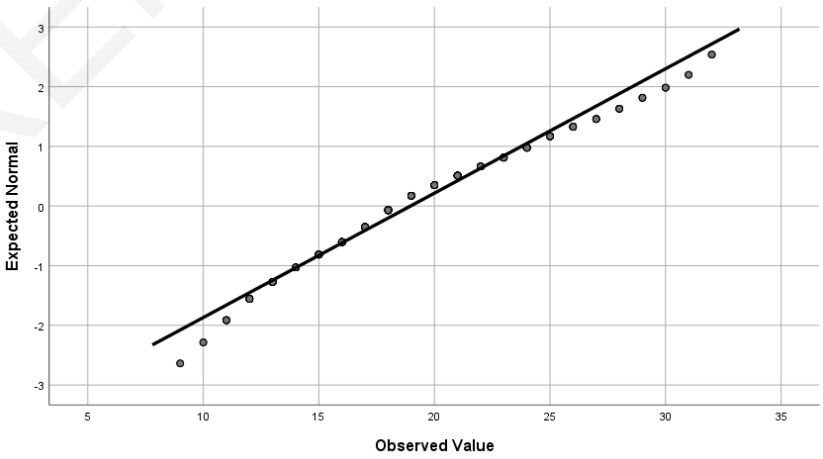


Figure C14c

*Normal Q-Q Plot showing the distribution of the **Anxiety** scale*



Appendix D

Regression assumptions and diagnostics for the models presented in Tables 6 and 7

Model 1 with Depression as the dependent variable (parenting factors as independent)

Table D1.

Evaluating for the collinearity assumption (Depression model 1)

Independent factors in model	Collinearity statistic (Variance Inflation Factor[a])
PC	1.76
Warmth	1.20
Rejection	1.92
Maximum Cook's distance[b]	*0.15*

PC: Psychological control

a. VIF < 10 indicates no multicollinearity in model

b. Cook's distance < 4/(n – number of predictors - 1) indicates no highly influential values (Bruce and Bruce 2017)

Figure D1a

Normal P-P plot of observed vs expected cumulative probability for model 1 (depression as dependent)

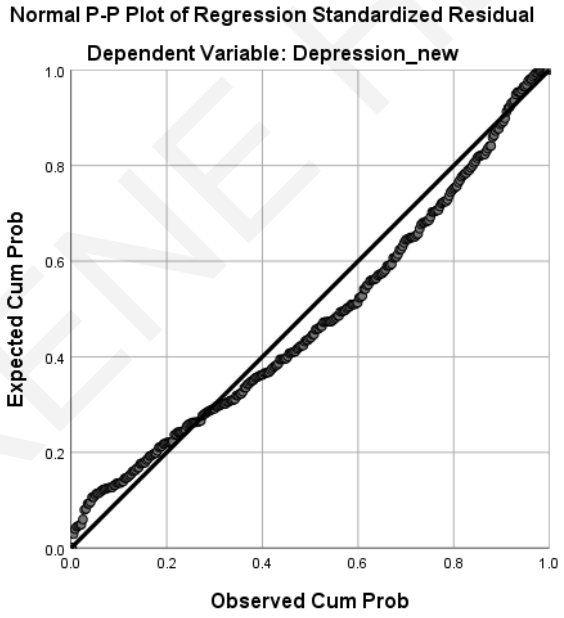
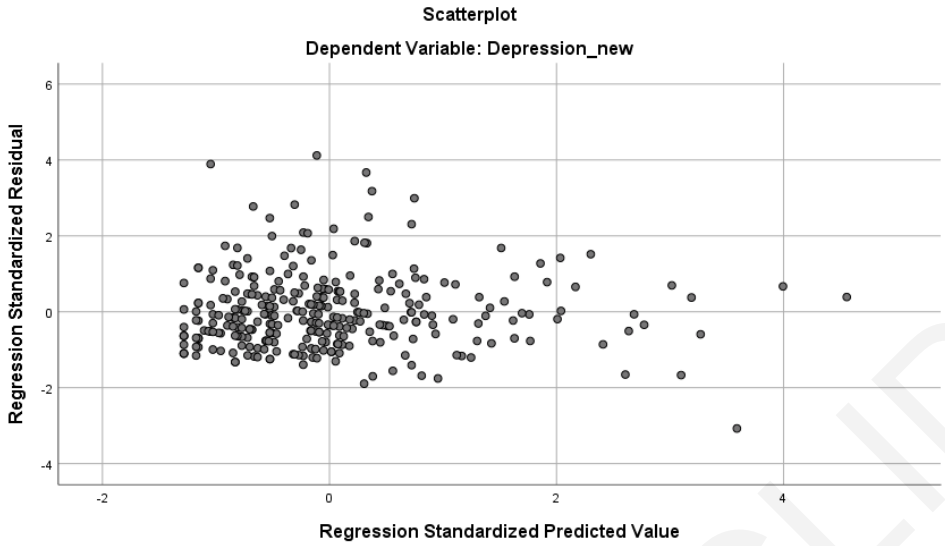


Figure D1b

Residuals vs predicted values plot for model 1 (depression as dependent)



No multicollinearity assumption: **Met**.

- Variance Inflation Factor < 10, indicating no collinearity between the independent variables in the model.

Normality of residuals assumption: **Met**.

- Normal P-P plot (figure 1a): Residual data points roughly overlap the straight diagonal solid line, without any major deviations, indicating roughly normally distributed residuals.

Linearity assumption: **Met**.

- Residuals vs predicted values plot (figure 1b): Data points roughly randomly scattered, with no clear pattern apart from some extreme datapoints in the right-hand side of the plot, indicating roughly linear relationship between independent variables and dependent variable.

Homoscedasticity (homogeneity of variance) assumption: **Met**.

- Residuals vs predicted values plot (figure 1b): No evidence for major differing (heterogenous) variance of standardized residuals over predicted values, apart from some anomalies in the right-hand side of the plot, indicating assumption is met.
- Breusch-Pagan test (H0: homoscedasticity): p=0.46

No highly influential data points: **Met**.

- Maximum Cook's distance = 0.15 which is larger than cut-off of 0.011 => 4/(369 - 3 - 1), indicating that outliners and high leverage values are not highly influential in the model.

Model 2 with Depression as the dependent variable (parenting + child personality factors as independent)

Table D2

Evaluating for the collinearity assumption (Depression model 2)

Independent factors in model	Collinearity statistic (Variance Inflation Factor[a])
PC	1.73
Warmth	1.30
Rejection	1.96
Neuroticism	1.10
Extraversion	1.09
Psychoticism	1.05
SOP	1.46
SPP	1.50
Maximum Cook's distance[b]	*0.08*

PC: Psychological control; SOP: Self-Oriented Perfectionism; SPP: Socially-Prescribed Perfectionism

a. VIF < 10 indicates no multicollinearity in model

b. Cook's distance < 4/(n – number of predictors - 1) indicates no highly influential values (Bruce and Bruce 2017)

Figure D2a

Normal P-P plot of observed vs expected cumulative probability for model 2 (depression as dependent)

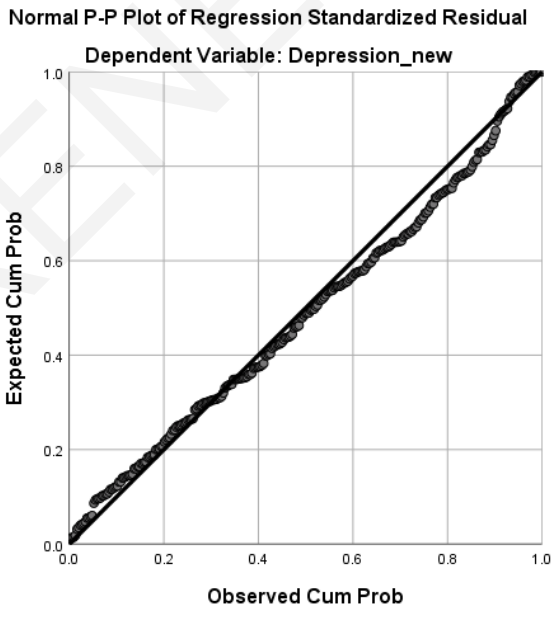
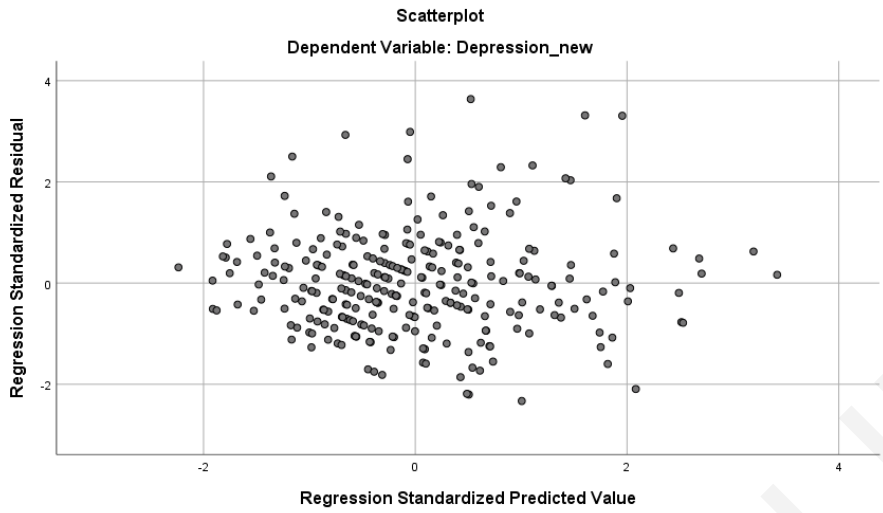


Figure D2b

Residuals vs predicted values plot for model 2 (depression as dependent)



No multicollinearity assumption: **Met**.

- Variance Inflation Factor < 10, indicating no collinearity between the independent variables in the model.

Normality of residuals assumption: **Met**.

- Normal P-P plot (figure 2a): Residual data points overlap the straight diagonal solid line, without any major deviations, indicating normally distributed residuals.

Linearity assumption: **Met**.

- Residuals vs predicted values plot (figure 2b): Data points randomly scattered, with no clear pattern, indicating linear relationship between independent variables and dependent variable.

Homoscedasticity (homogeneity of variance) assumption: **Met**.

- Residuals vs predicted values plot (figure 2b): No evidence for differing (heterogenous) variance of standardized residuals over predicted values, indicating assumption is met.
- Breusch-Pagan test (H0: homoscedasticity): p=0.13

No highly influential data points: **Met**.

- Maximum Cook's distance = 0.08 which is larger than cut-off of 0.011 => 4/(369 - 8 - 1), indicating that outliners and high leverage values are not highly influential in the model.

Model 3 with Depression as the dependent variable (parenting + child personality + coping factors as independent)

Table D3

Evaluating for the collinearity assumption (Depression model 3)

Independent factors in model	Collinearity statistic (Variance Inflation Factor[a])
PC	1.66
Warmth	1.42
Rejection	1.93
Neuroticism	1.18
Extraversion	1.22
Psychoticism	1.14
SOP	1.49
SPP	1.56
Cognitive Processing	1.95
Support Seeking Coping	1.71
Distraction Coping	1.39
Avoidance Coping	1.33
Maximum Cook's distance[b]	*0.08*

PC: Psychological control; SOP: Self-Oriented Perfectionism; SPP: Socially-Prescribed Perfectionism

a. VIF < 10 indicates no multicollinearity in model

b. Cook's distance < 4/(n – number of predictors - 1) indicates no highly influential values (Bruce and Bruce 2017)

Figure D3a

Normal P-P plot of observed vs expected cumulative probability for model 3 (depression as dependent)

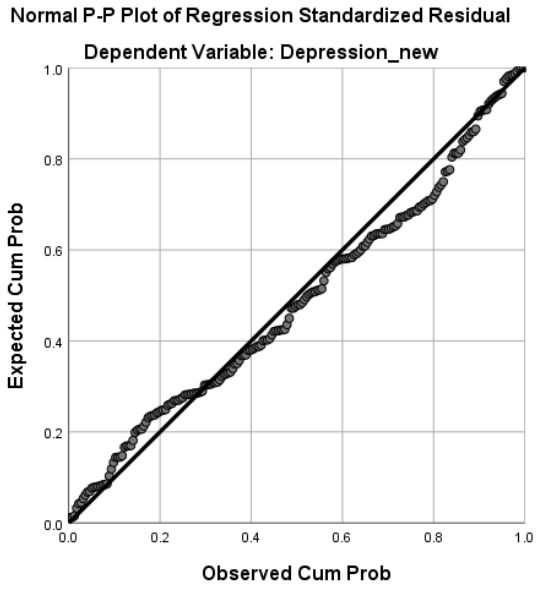
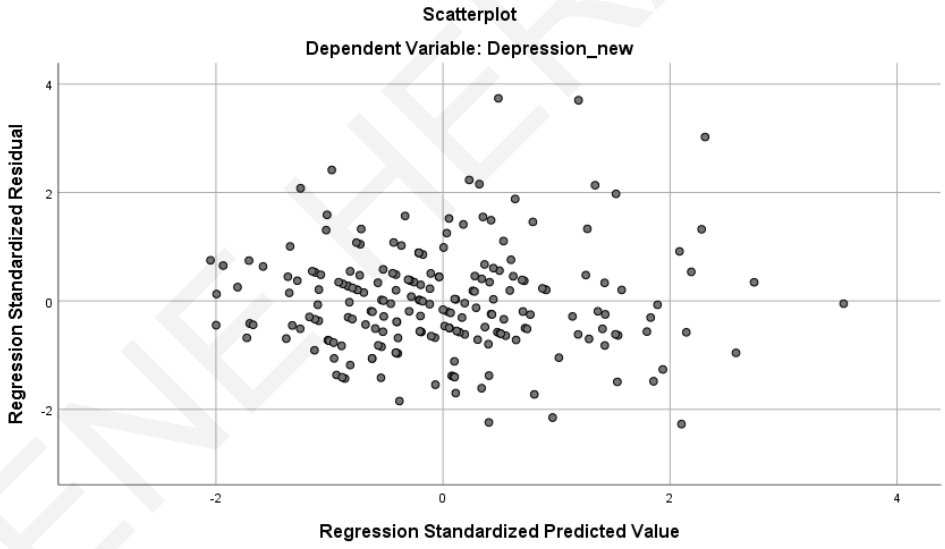


Figure D3b

Residuals vs predicted values plot for model 3 (depression as dependent)



No multicollinearity assumption: **Met**.

- Variance Inflation Factor < 10, indicating no collinearity between the independent variables in the model.

Normality of residuals assumption: **Met**.

- Normal P-P plot (figure 3a): Residual data points overlap the straight diagonal solid line, without any major deviations, indicating normally distributed residuals.

Linearity assumption: **Met**.

- Residuals vs predicted values plot (figure 3b): Data points roughly randomly scattered, with no clear pattern, indicating linear relationship between independent variables and dependent variable.

Homoscedasticity (homogeneity of variance) assumption: **Met**.

- Residuals vs predicted values plot (figure 3b): No evidence for differing (heterogenous) variance of standardized residuals over predicted values, indicating assumption is met.
- Breusch-Pagan test (H0: homoscedasticity): p=0.14

No highly influential data points: **Met**.

- Maximum Cook's distance = 0.08 which is larger than cut-off of 0.011 => 4/(369 - 12 - 1), indicating that outliners and high leverage values are not highly influential in the model.

Model 1 with Anxiety as the dependent variable (parenting factors as independent)

Table D4

Evaluating for the collinearity assumption (Anxiety model 1)

Independent factors in model	**Collinearity statistic (Variance Inflation Factor[a])**
PC	1.67
Warmth	1.64
Rejection	1.83
Maximum Cook's distance[b]	*0.07*

PC: Psychological control

a. VIF < 10 indicates no multicollinearity in model

b. Cook's distance < 4/(n – number of predictors - 1) indicates no highly influential values (Bruce and Bruce 2017)

Figure D4a

Normal P-P plot of observed vs expected cumulative probability for model 1 (anxiety as dependent)

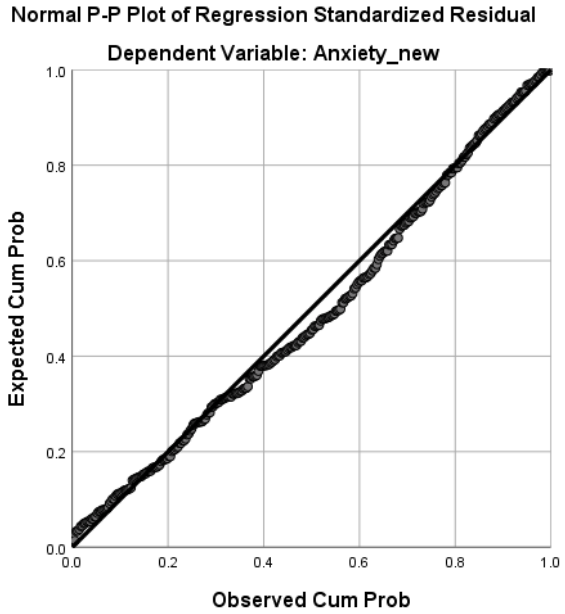
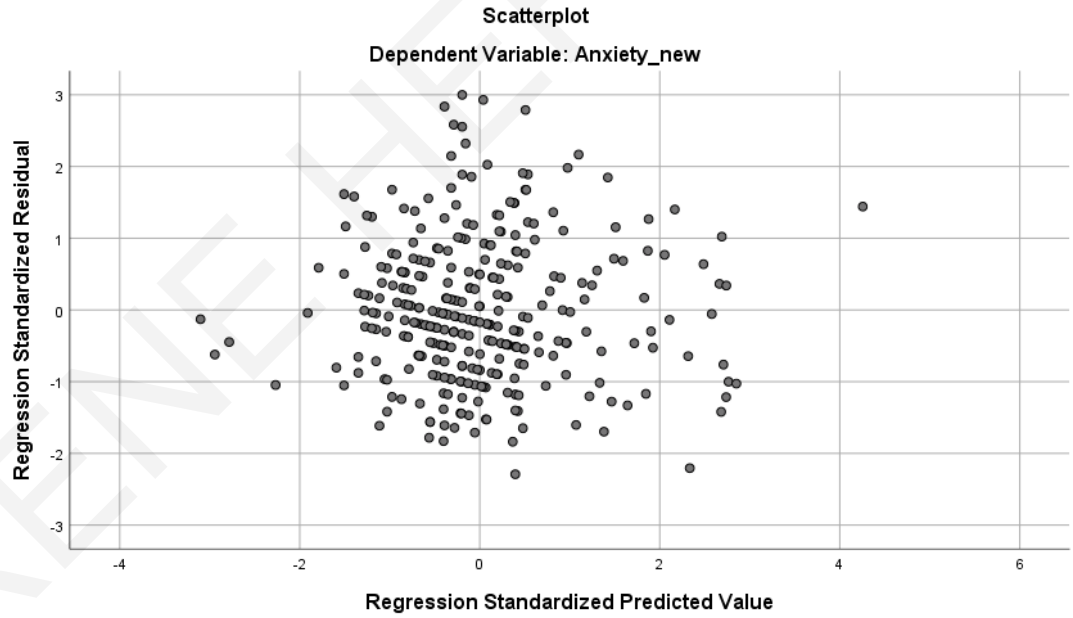


Figure D4b

Residuals vs predicted values plot for model 1 (anxiety as dependent)



No multicollinearity assumption: **Met**.

- Variance Inflation Factor < 10, indicating no collinearity between the independent variables in the model.

Normality of residuals assumption: **Met**.

- Normal P-P plot (figure 4a): Residual data points overlap the straight diagonal solid line, without any major deviations, indicating normally distributed residuals.

Linearity assumption: **Met**.

- Residuals vs predicted values plot (figure 4b): Data points randomly scattered, with no clear pattern apart from one extreme datapoint in the right-hand side of the plot, indicating linear relationship between independent variables and dependent variable.

Homoscedasticity (homogeneity of variance) assumption: **Met**.

- Residuals vs predicted values plot (figure 4b): No evidence for major differing (heterogenous) variance of standardized residuals over predicted values, indicating assumption is met.
- Breusch-Pagan test (H0: homoscedasticity): p=0.17

No highly influential data points: **Met**.

- Maximum Cook's distance = 0.07 which is larger than cut-off of 0.011 => 4/(369 - 3 - 1), indicating that outliners and high leverage values are not highly influential in the model.

Model 2 with Anxiety as the dependent variable (parenting + child personality factors as independent)

Table D5

Evaluating for the collinearity assumption (Anxiety model 2)

Independent factors in model	**Collinearity statistic (Variance Inflation Factor[a])**
PC	1.63
Warmth	1.24
Rejection	1.87
Neuroticism	1.10
Extraversion	1.08
Psychoticism	1.05
SOP	1.47
SPP	1.50
Maximum Cook's distance[b]	*0.04*

PC: Psychological control; SOP: Self-Oriented Perfectionism; SPP: Socially-Prescribed Perfectionism

a. VIF < 10 indicates no multicollinearity in model

b. Cook's distance < 4/(n – number of predictors - 1) indicates no highly influential values (Bruce and Bruce 2017)

Figure D5a

Normal P-P plot of observed vs expected cumulative probability for model 2 (anxiety as dependent)

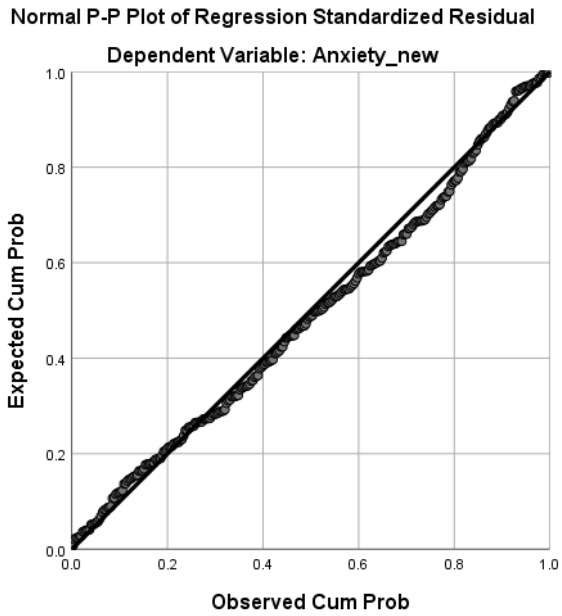
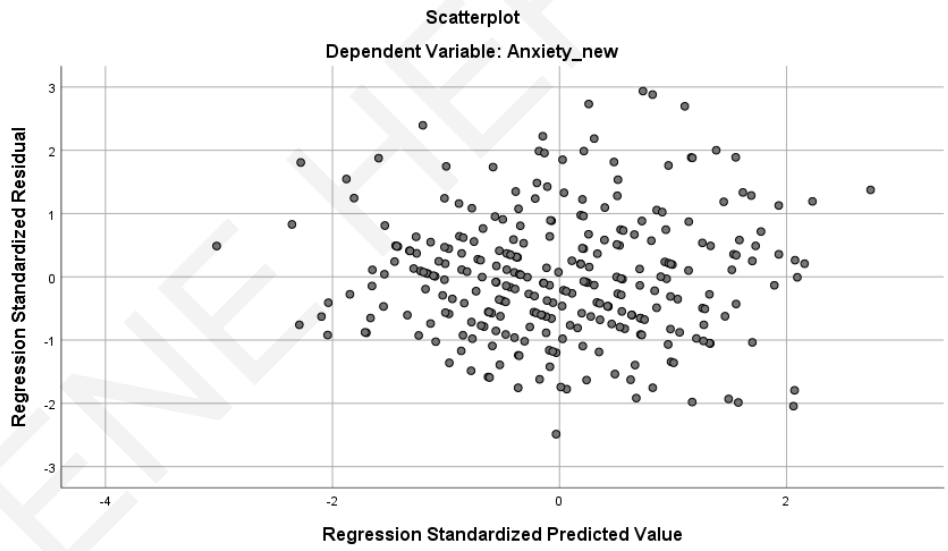


Figure D5b

Residuals vs predicted values plot for model 2 (anxiety as dependent)



No multicollinearity assumption: **Met**.

- Variance Inflation Factor < 10, indicating no collinearity between the independent variables in the model.

Normality of residuals assumption: **Met**.

- Normal P-P plot (figure 5a): Residual data points overlap the straight diagonal solid line, without any major deviations, indicating normally distributed residuals.

Linearity assumption: **Met**.

- Residuals vs predicted values plot (figure 5b): Data points randomly scattered, with no clear pattern, indicating linear relationship between independent variables and dependent variable.

Homoscedasticity (homogeneity of variance) assumption: **Met**.

- Residuals vs predicted values plot (figure 5b): No evidence for differing (heterogenous) variance of standardized residuals over predicted values, indicating assumption is met.
- Breusch-Pagan test (H0: homoscedasticity): p=0.24

No highly influential data points: **Met**.

- Maximum Cook's distance = 0.04 which is larger than cut-off of 0.011 => 4/(369 - 8 - 1), indicating that outliners and high leverage values are not highly influential in the model.

Model 3 with Anxiety as the dependent variable (parenting + child personality + coping factors as independent)

Table D6

Evaluating for the collinearity assumption (Anxiety model 3)

Independent factors in model	**Collinearity statistic (Variance Inflation Factor[a])**
PC	1.60
Warmth	1.40
Rejection	1.90
Neuroticism	1.20
Extraversion	1.22
Psychoticism	1.14
SOP	1.51
SPP	1.58
Cognitive Processing	1.97
Support Seeking Coping	1.77
Distraction Coping	1.39
Avoidance Coping	1.33
Maximum Cook's distance[b]	*0.04*

PC: Psychological control; SOP: Self-Oriented Perfectionism; SPP: Socially-Prescribed Perfectionism

a. VIF < 10 indicates no multicollinearity in model

b. Cook's distance < 4/(n – number of predictors - 1) indicates no highly influential values (Bruce and Bruce 2017)

Figure D6a

Normal P-P plot of observed vs expected cumulative probability for model 3 (anxiety as dependent)

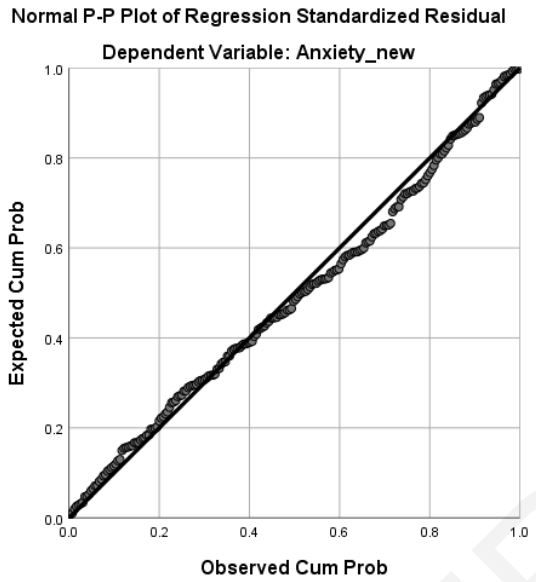
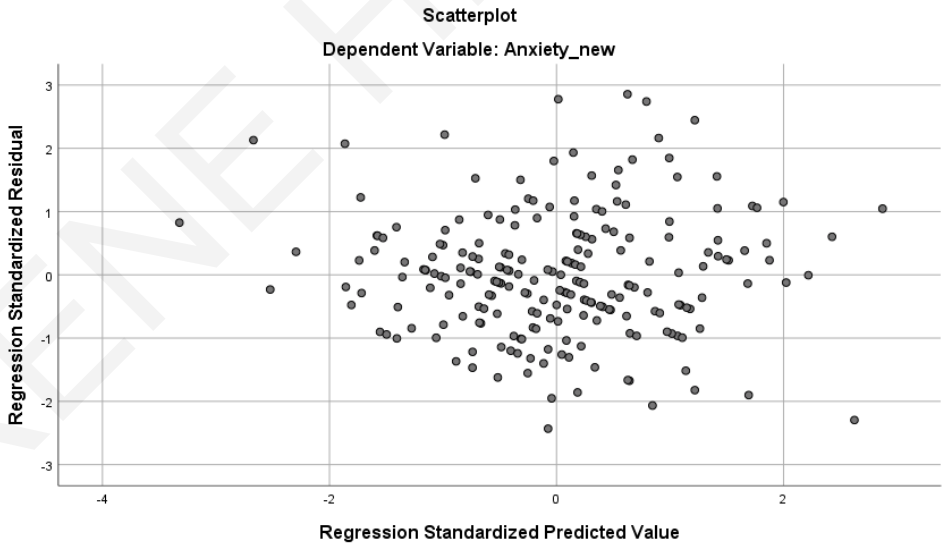


Figure D6b

Residuals vs predicted values plot for model 3 (anxiety as dependent)



No multicollinearity assumption: **Met**.

- Variance Inflation Factor < 10, indicating no collinearity between the independent variables in the model.

Normality of residuals assumption: **Met**.

- Normal P-P plot (figure 6a): Residual data points overlap the straight diagonal solid line, without any major deviations, indicating normally distributed residuals.

Linearity assumption: **Met**.

- Residuals vs predicted values plot (figure 6b): Data points randomly scattered, with no clear pattern, indicating linear relationship between independent variables and dependent variable.

Homoscedasticity (homogeneity of variance) assumption: **Met**.

- Residuals vs predicted values plot (figure 6b): No evidence for differing (heterogenous) variance of standardized residuals over predicted values, indicating assumption is met.
- Breusch-Pagan test (H0: homoscedasticity): p=0.17

No highly influential data points: **Met**.

- Maximum Cook's distance = 0.04 which is larger than cut-off of 0.011 => 4/(369 - 12 - 1), indicating that outliners and high leverage values are not highly influential in the model.

Appendix E

Path regression weights (coefficients) for the different datasets used in path analysis

Table E1

*Standardized regression coefficients for bivariate paths in the final model with **Depression** as the outcome variable, in the original dataset (complete-case analysis, n=210) and the five imputed datasets (n=369, each)*

			Original dataset estimate	Imputed dataset 1 estimate	Imputed dataset 2 estimate	Imputed dataset 3 estimate	Imputed dataset 4 estimate	Imputed dataset 5 estimate
Neuroticism	<---	Rejection	0.248	0.247	0.250	0.239	0.243	0.240
Extraversion	<---	Warmth	0.210	0.209	0.207	0.200	0.198	0.208
SPP	<---	Rejection	0.270	0.267	0.265	0.260	0.257	0.270
Extraversion	<---	Neuroticism	-0.129	-0.148	-0.150	-0.157	-0.153	-0.150
Psychoticism	<---	PC	0.176	0.160	0.165	0.162	0.164	0.163
Avoidance coping	<---	SPP	0.113	0.117	0.111	0.130	0.120	0.121
Support coping	<---	Warmth	0.344	0.344	0.342	0.337	0.336	0.337
Support coping	<---	Extraversion	0.194	0.197	0.199	0.204	0.204	0.189
Cognitive Processing	<---	Warmth	0.189	0.225	0.222	0.226	0.231	0.225
Cognitive Processing	<---	Psychoticism	-0.138	-0.079	-0.087	-0.082	-0.085	-0.089
Cognitive Processing	<---	SPP	0.096	0.107	0.101	0.098	0.101	0.105
Cognitive Processing	<---	Support coping	0.502	0.499	0.509	0.505	0.500	0.509
Cognitive Processing	<---	Avoidance	0.267	0.279	0.274	0.276	0.283	0.275
Depression	<---	Warmth	-0.091	-0.112	-0.112	-0.129	-0.119	-0.111
Depression	<---	Rejection	0.231	0.232	0.236	0.226	0.222	0.241
Depression	<---	Cognitive Processing	-0.192	-0.172	-0.174	-0.159	-0.155	-0.172
Depression	<---	SPP	0.167	0.153	0.156	0.159	0.155	0.154
Depression	<---	Extraversion	-0.131	-0.130	-0.122	-0.132	-0.135	-0.137
Depression	<---	Neuroticism	0.332	0.328	0.328	0.334	0.326	0.331
Depression	<---	Avoidance	0.108	0.099	0.099	0.092	0.097	0.103

Table E2

*Standardized regression coefficients for bivariate paths in the final model with **Anxiety** as the outcome variable, in the original dataset (complete-case analysis, n=218) and the five imputed datasets (n=369, each)*

			Original dataset estimate	Imputed dataset 1 estimate	Imputed dataset 2 estimate	Imputed dataset 3 estimate	Imputed dataset 4 estimate	Imputed dataset 5 estimate
Neuroticism	<---	Rejection	0.252	0.247	0.250	0.239	0.243	0.240
Extraversion	<---	Neuroticism	-0.136	-0.148	-0.150	-0.157	-0.153	-0.150
Extraversion	<---	Warmth	0.209	0.209	0.207	0.200	0.198	0.208
SPP	<---	Neuroticism	0.132	0.131	0.128	0.130	0.125	0.135
Cognitive Processing	<---	Warmth	0.389	0.394	0.395	0.394	0.401	0.395
Cognitive Processing	<---	Extraversion	0.131	0.149	0.132	0.157	0.131	0.140
Cognitive Processing	<---	SPP	0.129	0.153	0.143	0.150	0.150	0.147
SOP	<---	Warmth	0.141	0.138	0.142	0.140	0.137	0.144
SOP	<---	SPP	0.545	0.522	0.524	0.523	0.520	0.523
Psychoticism	<---	PC	0.176	0.160	0.165	0.162	0.164	0.163
Anxiety	<---	Neuroticism	0.361	0.358	0.353	0.357	0.356	0.356
Anxiety	<---	Rejection	0.155	0.186	0.190	0.172	0.186	0.195
Anxiety	<---	Extraversion	-0.148	-0.149	-0.152	-0.167	-0.157	-0.161
Anxiety	<---	Cognitive Processing	0.198	0.230	0.231	0.234	0.232	0.231
Anxiety	<---	SOP	0.207	0.193	0.193	0.184	0.191	0.193
Anxiety	<---	Psychoticism	0.090	0.103	0.107	0.111	0.109	0.114

Appendix F

Calculation of indirect and total effects from path analysis conducted in the final imputed dataset

Table F1

*Standardized regression coefficients for individual, indirect, direct, and total paths in the final model with **Depression** as the outcome variable*

PC to DEPRESSION	**Individual path coefficients**				**Specific path indirect effect**	
PC > PSYCHOTICISM > ACTIVE COPING > DEPRESSION	0.163	-0.089	-0.172		0.002	
					Total indirect effect (95%CI)	***p-value***
					0.002 (0.001; 0.008)	*.005*
					Total effect (95%CI)	***p-value***
					0.002 (0.001; 0.008)	*.005*

WARMTH to DEPRESSION	**Individual path coefficients**				**Specific path indirect effect**	
WARMTH > DEPRESSION (**Direct Effect**)	-0.111					
WARMTH > ACTIVE COPING > DEPRESSION	0.225	-0.172			-0.039	
WARMTH > SUPPORT COPING > ACTIVE COPING > DEPRESSION	0.337	0.509	-0.172		-0.030	
WARMTH > EXTRAVERSION > DEPRESSION	0.208	-0.137			-0.028	
WARMTH > EXTRAVERSION > SUPPORT COPING > ACTIVE COPING > DEPRESSION	0.208	0.189	0.509	-0.172	-0.003	
					Total indirect effect (95%CI)	***p-value***
					-0.100 (-0.156; -0.057)	*.020*
					Total effect (95%CI)	***p-value***
					-0.211 (-0.284; -0.122)	*.008*

REJECTION to DEPRESSION	**Individual path coefficients**					**Specific path indirect effect**	
REJECTION > DEPRESSION (**Direct Effect**)	0.241						
REJECTION > NEUROTICISM > DEPRESSION	0.240	0.331				0.079	
REJECTION > NEUROTICISM > EXTRAVERSION > DEPRESSION	0.240	-0.150	-0.137			0.005	
REJECTION > NEUROTICISM > EXTRAVERSION > SUPPORT COPING > ACTIVE COPING > DEPRESSION	0.240	-0.150	0.189	0.509	-0.172	0.001	
REJECTION > SPP > DEPRESSION	0.270	0.154				0.042	
REJECTION > SPP > ACTIVE COPING > DEPRESSION	0.270	0.105	-0.172			-0.005	
REJECTION > SPP > AVOIDANCE COPING > DEPRESSION	0.270	0.121	0.103			0.003	
REJECTION > SPP > AVOIDANCE COPING > ACTIVE COPING > DEPRESSION	0.270	0.121	0.275	-0.172		-0.002	
						Total indirect effect (95%CI)	***p-value***
						0.123 (0.076; 0.175)	*.003*
						Total effect (95%CI)	***p-value***
						0.364 (0.245; 0.464)	*.007*

Table F2

*Standardized regression coefficients for individual, indirect, direct, and total paths in the final model with **Anxiety** as the outcome variable*

PC to ANXIETY	**Individual path coefficients**				**Specific path indirect effect**	
PC > PSYCHOTICISM > ANXIETY	0.163	0.114			0.019	
					Total indirect effect (95%CI)	***p-value***
					0.019 (0.005; 0.046)	*.007*
					Total effect (95%CI)	***p-value***
					0.019 (0.005; 0.046)	*.007*

WARMTH to ANXIETY	**Individual path coefficients**				**Specific path indirect effect**	
WARMTH > ACTIVE COPING > ANXIETY	0.395	0.231			0.091	
WARMTH > EXTRAVERSION > ANXIETY	0.208	-0.161			-0.033	
WARMTH > EXTRAVERSION > ACTIVE COPING > ANXIETY	0.208	0.140	0.231		0.007	
WARMTH > SOP > ANXIETY	0.144	0.193			0.028	
					Total indirect effect (95%CI)	***p-value***
					0.092 (0.048; 0.149)	*.004*
					Total effect (95%CI)	***p-value***
					0.092 (0.048; 0.149)	*.004*

REJECTION to ANXIETY	**Individual path coefficients**				**Specific path indirect effect**	
REJECTION >ANXIETY (**Direct Effect**)	0.195					
REJECTION > NEUROTICISM >SPP> SOP>ANXIETY	0.240	0.135	0.523	0.193	0.003	
REJECTION > NEUROTICISM >SPP> ACTIVE COPING>ANXIETY	0.240	0.135	0.147	0.231	0.001	
REJECTION > NEUROTICISM > ANXIETY	0.240	0.356			0.085	

REJECTION > NEUROTICISM > EXTRAVERSION>ANXIETY	0.240	-0.150	-0.161	0.006	
REJECTION > NEUROTICISM > EXTRAVERSION>ACTIVE COPING>ANXIETY	0.240	-0.150	0.140	-0.001	

	Total indirect effect (95%CI)	***p-value***
	0.094 (0.049; 0.142)	*.002*
	Total effect (95%CI)	***p-value***
	0.289 (0.189; 0.382)	*.004*

Appendix G

Semi-structured interview conducted among 10 mothers with extreme levels of negative parenting, for the qualitative part of the study

<u>2η Φάση: Ποιοτική Έρευνα</u>

Ημιδομημένη συνέντευξη με επιλεγείσες μητέρες

Εισαγωγή:

«Όπως γνωρίζετε, το παιδί σας το οποίο φοιτά στην Ε΄/Στ΄τάξη του Χ σχολείου, έλαβε μέρος στην έρευνά μας τον Χ μήνα απαντώντας σε κάποια ερωτηματολόγια. Ο σκοπός της πρώτης αυτής φάσης της έρευνάς μας ήταν να αναδείξει ποια προσωπικά χαρακτηριστικά των παιδιών και ποιες συμπεριφορές των μητέρων τους μπορούν να επηρεάσουν τη συναισθηματική κατάσταση των παιδιών, δηλαδή το κατά πόσο και σε τι βαθμό βιώνουν συναισθήματα άγχους ή κατάθλιψης. Αφού λοιπόν μαζέψαμε τα δεδομένα από όλα τα παιδιά που συμμετείχαν, τα αναλύσαμε σε στατιστικό πρόγραμμα και εντοπίσαμε κάποιες μητέρες των οποίων τα παιδιά απάντησαν τα ερωτηματολόγια που αφορούν στις γονεϊκές πρακτικές των μητέρων τους με τρόπο που η γενική τους βαθμολογία σε κάποιες από τις μητρικές αυτές πρακτικές να βρίσκεται σε ένα ακραίο σημείο σε σχέση με το μέσο όρο βαθμολογιών. Στη δική σας περίπτωση, η βαθμολογία του παιδιού σας στη γονεϊκή πρακτική Χ ήταν πολύ ψηλή/χαμηλή. Αυτό ουσιαστικά μας δείχνει ότι το παιδί αντιλαμβάνεται τη συμπεριφορά σας ως εξής:…… Κάποιες φορές οι απαντήσεις των παιδιών στα ερωτηματολόγια δεν είναι ίδιες με το πώς ο ίδιος ο γονιός τους βλέπει τα πράγματα. Τις περισσότερες φορές όμως, ο γονιός συμφωνεί με το παιδί του ως επί τω πλείστον, στην ουσία τουλάχιστον των πραγμάτων. Όπως και να έχει, τα παιδιά φαίνεται να επηρεάζονται συναισθηματικά όταν τα ίδια αντιλαμβάνονται ότι ο γονιός τους συμπεριφέρεται με κάποιο τρόπο, θετικό ή αρνητικό. Μέσα από αυτή τη συνέντευξη, θέλουμε να σας δώσουμε την ευκαιρία να δώσετε κι εσείς τη δική σας οπτική για τα πράγματα όπως εσείς τα βιώνετε και να δούμε ποιες καταστάσεις επηρεάζουν τη συμπεριφορά σας προς το παιδί σας είτε θετικά είτε αρνητικά. Σκοπός μας δεν είναι σε καμία περίπτωση να σας αξιολογήσουμε ως γονείς αλλά να συνεργαστούμε μαζί σας ώστε να εντοπίσουμε τα πράγματα που μπορεί να επηρεάζουν ένα γονιό, τα συναισθήματά του, τις συμπεριφορές του και κατ' επέκταση τα παιδιά του και τη γενικότερη λειτουργία της οικογένειάς του. Αυτή η συνέντευξη θα γίνει υπό τη μορφή συζήτησης με απόλυτο σεβασμό στην εμπιστευτικότητα των πληροφοριών που θα μας δώσετε και με απόλυτη επίγνωση των δυσκολιών και προκλήσεων που έχει μια σύγχρονη μητέρα να αντιμετωπίσει στα πλαίσια της οικογενειακής της ζωής. Αντιλαμβανόμαστε ότι στις περισσότερες περιπτώσεις, ο κάθε γονιός κάνει ότι καλύτερο μπορεί κάτω από τις συνθήκες στις οποίες καλείται να το κάνει. Στο τέλος της συνέντευξης αυτής και χρησιμοποιώντας τις πληροφορίες που θα μου δώσετε, θα είμαι σε θέση να σας κάνω μια εξατομικευμένη συμβουλευτική ως προς το πώς θα μπορούσατε σαν μητέρες να χειριστείτε κάποιες προκλήσεις σχετικά με το μητρικό σας ρόλο (στην περίπτωση που έχει δηλώσει ότι το επιθυμεί). Πριν ξεκινήσουμε, θα θέλατε να με ρωτήσετε οτιδήποτε σχετικά με τη διαδικασία ή γενικότερα την έρευνα;»

Ερωτήσεις:

1. «Η βαθμολογία η οποία προκύπτει από τις απαντήσεις του παιδιού σας στα ερωτηματολόγια, δείχνει ότι το παιδί σας αντιλαμβάνεται ότι χρησιμοποιείτε πολύ/λίγο (αναφέρω τη συγκεκριμένη θετική ή αρνητική γονεϊκή πρακτική που αρμόζει). Εσείς πως το κρίνεται αυτό; Είναι κάτι που αισθάνεστε ότι όντως τείνετε να κάνετε;»
2. «Ο κάθε γονιός έχει το δικό του τρόπο να δείχνει/ γίνεται/ ασκεί (αναφέρω τη γονεΙκή πρακτική). Με ποιο τρόπο ακριβώς θα λέγατε ότι εσείς εκφράζετε αυτή σας την τάση; Πείτε μου κάποια παραδείγματα από τη συμπεριφορά σας που ενδεχομένως να δείχνουν στο παιδί σας ότι το κάνετε.»
3. «Τις στιγμές που συμπεριφέρεστε με αυτό τον τρόπο, πως βλέπετε το παιδί σας συνήθως να αντιδρά;»
4. «Και εσείς μετά πως αντιδράτε πίσω σε αυτή την αντίδραση του παιδιού σας;
5. «Πολλές φορές οι γονείς έχουν ένα θετικό κίνητρο πίσω ακόμα και από τις πιο αρνητικές τους συμπεριφορές. Στην περίπτωσή σας, τι σας κινητοποιεί για να συμπεριφέρεστε με αυτό τον τρόπο; Ποιες επιθυμίες ή φόβοι σας παρακινούν;»
6. «Τι αποτέλεσμα έχει τελικά η συμπεριφορά σας; Γίνεται τελικά αυτό που επιθυμείτε για το παιδί σας εκείνη τη στιγμή ή όχι; Τι έκβαση παίρνουν τελικά τα πράγματα;»
7. «Πέραν της αντίδρασης του παιδιού σας, ποιες άλλες δυναμικές επηρεάζονται στην οικογένεια λόγω της συμπεριφοράς σας και των όσων ακολουθούν; Για παράδειγμα, τα υπόλοιπα μέλη της οικογένειας, πως επηρεάζονται; Η καθημερινότητά σας;»
8. «Μακροχρόνια, πως παρατηρείτε να επηρεάζονται τα πράγματα μέσα από αυτές τις αλυσίδες συμπεριφορών και γεγονότων που μόλις περιγράψατε να συμβαίνουν μέσα στην οικογένειά σας; Για παράδειγμα, κάποιες μητέρες παρατηρούν ότι αυξάνεται/μειώνεται το στρες τους ή τα κίνητρά τους να συνεχίσουν να προσφέρουν στην οικογένειά τους. Άλλες μητέρες βλέπουν τις σχέσεις τους με τα παιδιά τους ή/και το σύντροφό τους να βελτιώνονται/ δυσχεραίνουν μέσα από αυτές τις καταστάσεις. Στη δική σας περίπτωση τι βλέπετε να συμβαίνει σε βάθος χρόνου;»
9. «Θα ήθελα τώρα να δούμε τις καταστάσεις που ενδεχομένως να επηρεάζουν τη συμπεριφορά σας απέναντι στο παιδί σας. Ας πάρουμε πρώτα τον εαυτό σας. Όλοι οι γονείς κουβαλάμε και την προσωπικότητά μας, την υπόστασή μας σαν άτομα πέραν του μητρικού μας ρόλου. Και αυτό, όσα πράγματα και να γνωρίζουμε ή όχι σε σχέση με τη γονεϊκότητα, είναι λογικό να επηρεάζει πολλές φορές τη συμπεριφορά μας απέναντι στα παιδιά μας. Δεν είμαστε εδώ για να μιλήσουμε για κακά και καλά χαρακτηριστικά αλλά για το ότι είμαστε όλοι διαφορετικοί μεταξύ μας και αυτό είναι εντάξει. Κάποιοι γονείς είναι εσωστρεφείς, κάποιο τελειομανείς, κάποιοι αγχώδεις, ευαίσθητοι. Εσείς ποια χαρακτηριστικά προσωπικότητας νομίζετε ότι διαθέτετε που μπορεί να έχουν επηρεάσει το πόσο (αναφέρω τη γονεϊκή πρακτική) είστε με το παιδί σας;»
10. (Αν η μητέρα δυσκολεύεται να αναφέρει κάποια συγκεκριμένα χαρακτηριστικά της ή δεν αναφέρει τα χαρακτηριστικά που αναμένουμε βάση των ερευνητικών μας υποθέσεων): «Αυτό που γνωρίζουμε είναι ότι πολλές μητέρες που συμπεριφέρονται με αυτό τον τρόπο είναι γενικά πιο/λιγότερο αγχώδεις/ ευαίσθητες/ τελειομανείς/ ειλικρινείς (κι ας ξέρουν ότι μπορεί να στεναχωρήσουν το παιδί τους)/ παρορμητικές/

τρυφερές/ εκφραστικές. Εσείς θα συγκαταλέγατε τον εαυτό σας σε αυτές; Νιώθετε δηλαδή ότι αυτό το χαρακτηριστικό ταιριάζει με την προσωπικότητά σας σαν άνθρωποι; (Αναφέρω ένα-ένα χαρακτηριστικό δίνοντάς της τη δυνατότητα να απαντήσει).»

11. «Η ζωή είναι γεμάτη προκλήσεις και δυσκολίες, ειδικά για τις μητέρες που καλούνται να αναλάβουν πολλά πράγματα. Για αυτούς τους λόγους αλλά και άλλους πιο προσωπικούς, πολλές μητέρες αντιμετωπίζουν δυσκολίες με τα συναισθήματά τους, όπως κακή διάθεση, πολύ άγχος, χαμηλή αυτοεκτίμηση κ.α. Είναι αυτό κάτι που βιώνετε κι εσείς; Πείτε μου περισσότερα.»
12. «Πολλές μητέρες παραπονιούνται ότι αναλαμβάνουν μόνες τους πολλά πράγματα. Ότι ο σύζυγος, ο σύντροφός ή ο πατέρας του παιδιού τους δεν τις στηρίζει πρακτικά με το να βοηθά στις δουλειές του σπιτιού, ή να συνεισφέρει οικονομικά στο σπίτι ή να εμπλέκεται στη ζωή του παιδιού του ενεργά ή ακόμα και απλά να τις στηρίζει συναισθηματικά. Είναι κάτι αυτό που συμβαίνει και σ' εσάς; Πως είναι αυτό το κομμάτι για εσάς;»
13. «Λόγω της έλλειψης αυτής της στήριξης από το σύντροφό τους αλλά και για άλλους προσωπικούς τους λόγους, πολλές μητέρες έρχονται σε σύγκρουση με το σύντροφό τους με αποτέλεσμα να υπάρχει ένταση στο σπίτι. Πως είναι η δικής σας σχέση και επικοινωνία με το σύντροφο/σύζυγο/πατέρα του παιδιού σας;»
14. «Μια άλλη δύσκολη κατάσταση που καλούνται να αντιμετωπίσουν οι μητέρες στη σύγχρονη εποχή είναι η ανεργία των ίδιων η του συντρόφου τους και οι οικονομικές δυσκολίες. Αυτές οι συνθήκες πολλές φορές δημιουργούν περεταίρω ένταση σε ένα ζευγάρι αλλά και συναισθηματική φόρτιση στις ίδιες τις μητέρες. Εσείς αντιμετωπίζετε κάτι τέτοιο;»
15. «Ζώντας στην Κύπρο πολλές οικογένειες έχουν την τύχη να λαμβάνουν στήριξη από κοντινούς συγγενείς, όπως γιαγιάδες και παππούδες, οι οποίοι μπορεί να αναλαμβάνουν να τους βοηθούν με το μαγείρεμα ή «κούρσες» των παιδιών τους στα ιδιαίτερα τους μαθήματα. Άλλες πάλι οικογένειες δεν έχουν αυτή την πολυτέλεια, έτσι αναγκάζονται να τα κάνουν όλα μόνοι τους ανεξάρτητα από το πόσες πολλές ευθύνες έχουν στη δουλειά και στο σπίτι τους. Στη δική σας περίπτωση τι συμβαίνει;»
16. «Πέραν της στενής οικογένειας, είναι και φίλοι, γνωστοί, ακόμα και πιο μακρινοί συγγενείς, οι οποίοι μπορούν να στηρίζουν συναισθηματικά ή πρακτικά μια οικογένεια ώστε να μη μένει κοινωνικά απομονωμένη. Νιώθετε ότι έχετε ως οικογένεια ή άτομο ένα κοινωνικό υποστηρικτικό δίκτυο;»
17. «Ανήκετε σε κάποια φυλετική ή άλλη μειονότητα; Αν ναι, πως είναι αυτή η εμπειρία για εσάς και τι προκλήσεις καλείστε να αντιμετωπίσετε;»
18. Κάτι που αναγκάζει πολλές μητέρες να συμπεριφέρονται με υπερπροστατευτικότητα προς τα παιδιά τους είναι το ότι μένουν σε περιοχές όπου υπάρχει αυξημένη εγκληματικότητα ή άλλοι φυσικοί κίνδυνοι, όπως επικίνδυνοι δρόμοι κλπ. Τι συμβαίνει στη δική σας περίπτωση όσον αφορά το χώρο διαμονής σας;»
19. «Οι γυναίκες σήμερα καλούνται να αναλάβουν πολλαπλούς ρόλους, όπως να εργάζονται σε εργασίες πλήρους απασχόλησης, να μεγαλώνουν τα παιδιά τους αναλαμβάνοντας την κύρια ευθύνη για τη φροντίδα τους και να αναλαμβάνουν το νοικοκυριό του σπιτιού. Πολλές μητέρες νιώθουν μάλιστα ένα άγχος για το τι αναμένεται από αυτές ως γυναίκες με αποτέλεσμα να επιβαρύνονται

συναισθηματικά παράλληλα με τη σωματική τους κούραση. Άλλες γυναίκες πάλι δεν αισθάνονται την πίεση αυτή της κοινωνίας και έχουν άλλη φιλοσοφία για τα πράγματα και το χειρισμό τους. Εσείς πως αντιλαμβάνεστε τις απαιτήσεις της σύγχρονης κοινωνίας όσον αφορά το ρόλο της γυναίκας; Πόσο συμφωνείτε με αυτές τις απαιτήσεις και ποιες είναι οι δικές σας πεποιθήσεις όσον αφορά τις υποχρεώσεις και το ρόλο σας ως μητέρα. Πως αντιδράτε στις απαιτήσεις της κοινωνίας;»

20. «Αφού συζητάμε για τους πολλαπλούς ρόλους της μητέρας και το πόσο δύσκολο είναι για πολλές να τα συνδυάσουν όλα και να προσπαθούν να τα κάνουν όλα καλά, θα ήθελα να μάθω μερικά πράγματα για την εργασία σας. Καταρχάς εργάζεστε; Τι ευθύνες έχετε στη δουλειά σας, τι φόρτο και απαιτήσεις έχετε να αντιμετωπίσετε; Πως αυτό επηρεάζει τη συναισθηματική σας κατάσταση, τη συμπεριφορά σας και γενικότερα την οικογενειακή σας ζωή;»
21. «Πέραν της εργασίας σας έχετε κάποιες άλλες υποχρεώσεις στη ζωή σας οι οποίες απαιτούν χρόνο και κόπο; Ποιες είναι αυτές;»
22. «Πάμε τώρα καθαρά στο κομμάτι της μητρότητας. Σε τι ηλικία γίνατε για πρώτη φορά μαμά; Σε τι ηλικία κάνατε το παιδί σας το οποίο συμμετείχε στην έρευνά μας; Πως ήταν αυτό για εσάς; Πολλές φορές οι γυναίκες ταλαιπωρούνται όταν παντρεύονται ή όταν προσπαθούν να κάνουν παιδί Από τη μία γιατί οι συνθήκες που παντρεύτηκαν τις επιβαρύνουν για κάποιο λόγο και από την άλλη γιατί η απόκτηση παιδιού δεν ήταν για τις ίδιες εύκολη υπόθεση, είτε λόγω ηλικίας (πολύ μικρές ή πολύ μεγάλες) ή λόγω άλλων συνθηκών. Για εσάς πως ήταν τα πράγματα; Ήταν οι συνθήκες κάτω από τις οποίες έγιναν όλα ομαλές ή αντιμετωπίσατε οποιαδήποτε προβλήματα;»
23. «Ξέρετε, εκτός από μητέρες είμαστε όλες και άνθρωποι, όπως αναφέραμε στην αρχή της συζήτησης. Και είμαστε άνθρωποι με τα δικά μας βιώματα, τη δική μας προσωπική ιστορία και κάποτε υπήρξαμε εμείς οι ίδιοι παιδιά. Για άλλους τα παιδικά τους χρόνια ήταν εύκολα, για άλλους ήταν δύσκολα. Άλλων οι γονείς συμπεριφέρονταν με έναν τρόπο και άλλων οι γονείς με άλλο τρόπο. Στη δική σας περίπτωση πως ήταν τα παιδικά σας χρόνια και πως συμπεριφέρονταν οι δικοί σας γονείς απέναντί σας (δίνω έμφαση στη γονεϊκή πρακτική στην οποία βρεθήκαν οι ίδιοι να έχουν ακραία τιμή αλλά και σε γονεϊκές πρακτικές και βιώματα που μπορεί να επηρεάσουν τη υιοθέτηση της συγκεκριμένης πρακτικής)»
24. «Κάποιες άλλες συνθήκες μπορεί να φέρουν σε δύσκολη θέση τους γονείς και όλη την οικογένεια, όπως για παράδειγμα πράγματα που αφορούν στο αναπτυξιακό και ιατρικό ιστορικό του παιδιού. Έχει το παιδί σας περάσει από όλα τα αναπτυξιακά στάδια, όσον αφορά τη γλώσσα, την κίνηση, την αυτοεξυπηρέτηση, τον έλεγχο των σφιγκτήρων ομαλά ή παρουσίασε κάποια καθυστέρηση ή άλλη δυσκολία; «
25. «Μαθησιακά πως ανταποκρινόταν το παιδί μετά τη φοίτησή σου για πρώτη φορά σε σχολείο;»
26. «Από ιατρικής άποψης, πέρασε το παιδί κάποια ασθένεια ή είχε κάποιο ατύχημα που ενδεχομένως να σας έκανε να φοβηθείτε για τη σωματική του ακεραιότητα; Τέτοια θέματα μπορεί να συμβούν από την εγκυμοσύνη και τον τοκετό μέχρι και την τωρινή φάση της προεφηβείας.»
27. «Πέραν του παιδιού σας, μήπως πέρασε κάποιο άλλο κοντινό σας άτομο ή ακόμα και εσείς η ίδια κάποια τραυματική εμπειρία είτε από κάποιο απρόβλεπτο ατύχημα είτε από άλλη σοβαρή ασθένεια; Ή μήπως ζήσατε κάποια φυσική απώλεια δικού σας

προσώπου; Πως ήταν αυτή η εμπειρία για εσάς; Πως επηρέασε την κατοπινή σας ζωή, τον τρόπο που βλέπετε τα πράγματα και τον τρόπο συμπεριφοράς σας προς τα αγαπημένα σας πρόσωπα (π.χ. τα παιδιά σας);»

28. «Όσον αφορά τα τραυματικά βιώματα και τις δύσκολες συνθήκες ζωής, μήπως το παιδί σας έχει ζήσει κάποια αρνητικά πράγματα που ενδεχομένως να σας κάνουν να αισθάνεστε ότι τον έκαναν πιο ευάλωτο ή εύθραυστο; Τέτοιες εμπειρίες μπορεί να είναι ο σχολικός εκφοβισμός (bullying), κοινωνικός αποκλεισμός, ένας χωρισμός ή οι διαμάχες των γονιών, έλλειψη εμπλοκής του πατέρα στη ζωή του ή εγκατάλειψη, βία στην οικογένεια ή εκτός, φυσικές απώλειες κλπ.»
29. «Τέλος, υπάρχουν κάποια χαρακτηριστικά του ίδιου του παιδιού σας που αισθάνεστε ότι ενδεχομένως να επηρεάζουν τον τρόπο με τον οποίο του συμπεριφέρεστε; Για παράδειγμα, είναι το παιδί σας πολύ εσωστρεφές, ευαίσθητο- ή αγχώδες; Είναι απόμακρο ή αντιμετωπίζει προβλήματα συμπεριφοράς και θέματα ανυπακοής; Ποια στοιχεία του παιδιού σας νιώθετε ότι ενεργοποιούν την τάση σας να…. (αναφέρω τη γονεϊκή πρακτική στην οποία έχουν ακραία τιμή)».

«Σας ευχαριστώ πάρα πολύ για το χρόνο σας και που μοιραστήκατε όλες αυτές τις πολύτιμες πληροφορίες για εσάς και την οικογένειά σας. Όλα όσα είπαμε στα πλαίσια της συνεδρίας αυτής, θα παραμείνουν ανώνυμα και απολύτως εμπιστευτικά και όλες οι γραπτές σημειώσεις και το υλικό που συλλέχθηκε θα καταστραφεί μέχρι το Δεκέμβριο του 2020 οπότε και λήγει το ερευνητικό πρόγραμμα. Οι πληροφορίες που δώσατε θα μας βοηθήσουν να βγάλουμε κάποια συμπεράσματα σε σχέση με τους προσωπικούς και κοινωνικούς παράγοντες που μπορεί να επηρεάζουν τον τρόπο που ασκούν το γονεϊκό τους ρόλο οι γονείς.»

- Εάν η μητέρα το επέλεξε, θα ακολουθήσει εξατομικευμένη συμβουλευτική ανάλογα με τις απαντήσεις που δόθηκαν).
- Να σημειωθεί ότι θα γίνεται επιλογή ερωτήσεων κάθε φορά από τη λίστα ερωτήσεων, ανάλογα με τις ανάγκες της κάθε περίπτωσης.
- Η συνέντευξη θα γίνει σε κλίμα κατανόησης, αποδοχής και σεβασμού προς την κάθε μητέρα, όπως ακριβώς γίνεται στα πλαίσια μιας επαγγελματικής κλινικής συνέντευξης η οποία πληρεί τα απαιτούμενα δεοντολογικά κριτήρια.

Appendix H

Transcripts from the interviews conducted among 10 mothers, for the qualitative part of the study

High PC mother (1)

Mother's verbal answers on the PC questionnaire showed lower use of PC than the use of PC as shown in the child's questionnaire.

I: Based on your child's responses on the questionnaires, it seems that the child perceives your parenting practices as indicative of you using high levels of psychological control. This parenting practice involves trying to control the child's feelings, thoughts and behaviours by means of interruption, finishing the child's sentences, imposing what the child should feel and think and showing disregard of his own viewpoints. Would you say you also perceive your behaviour as sometimes indicative of these strategies?

M1: Well, sometime I do behave in this way, I have to admit.

I: In what ways do you try to psychologically control your child?

M1: Well, I do it with my facial expressions, with being firm and consistent, sometimes silent and by giving a lot of reprimands.

I: And how does your child respond to that?

M1: Well not in the best way I would say. She screams and shouts, she curses and slams doors.

I: And then what do you do in response to that?

M1: I just ignore her.

I: What would you say motivates you to use this parenting strategy?

M1: She needs to learn to behave herself in order to integrate with society using the right behaviours. She can also stay safe with the right behaviours.

I: After she continues shouting and reacting intensely as you said to your behaviour, what are the consequences? Does she get her way in the end? Do you give up?

M1: No, definitely not. She never gets her way. I only sometimes allow for a negotiation or a slight settlement to take place.

I: What makes it so important for you to keep controlling her behaviour even after she reacts so intensely?

M1: I get really angry because her younger sister tends to imitate her, so I don't want her to be a bad influence to her as well. They both have ADHD and their behaviours are challenging anyway. Their father also lives abroad after we separated, so I have the full responsibility on them. And it is not easy to follow through especially with their challenges. A strict schedule must be followed! I can only do it if we are organized enough. Unfortunately, she consumes a lot of time playing Play Station as well, she I do not approve.

I: What are some of your personal characteristics that may influence your behaviour and later interactions?

M1: I can be consistent. I am always like that as a person. I don't bend easily. I can be rigid. I also deal with a lot of anger issues due to menopause unfortunately. I cannot help not getting mad about things.

I: How is your husband involved in all of this? You said he is abroad and you have separated, so how do these or other factors affect his behaviour?

M1: Well let me tell you, he only provides child support. He is emotionally distant from the kids. Their relationship is more superficial.

I: And how to you feel and react about that?

M1: I've gotten used to it. We don't have any fights with each other because we don't talk much, if not at all. We have a really distant and cold relationship between us.

I: What are some other stressors you would say affect your emotions and behavior towards the child?

M1: Well, my job does not allow for a stable salary. It depends on the funding I get. So I periodically face financial difficulties.

I: And how do you deal with that?

M1: My mother helps me financially f I really need it, but that's just it.

I: And do you get any support from your parents or anyone else in any other form also?

M1: I'm just too proud to ask. I don't even ask my mother for the financial support she is willing to give. I prefer to do the best I can by myself.

I: Do you or your family belong to any kind of minority?

M1: No.

I: Are there any particular physical conditions in your surroundings that make you feel the need to control the child more? For example, some mothers become more controlling when they feel a threat from the dangerous neighborhood they live.

M1: No, I don't think so. Nothing like that.

I: Many women nowadays take on a lot of responsibilities by themselves and try to do it all while also working and doing all the housework. And this is sometimes encouraged by society based on the expectations they have of women. What do you think of that and how do you deal with it?

M1: To me this is normal. I have come to terms with it. I just prioritize things and follow rigid schedules to be able to follow through.

I: Apart from your job and home, do you have any other responsibilities to take care of?

M1: No, I don't think so.

I: Let's now talk a little bit about the conditions under which you got pregnant with your child. Was it something you wanted? Did you face any difficulties before or while pregnant or just after you gave birth?

M1: Everything was okay I think.

I: Now, I'd like us to discuss a little bit about the time you were a child. How was your childhood and how was you relationship with your parents?

M1: I only had my mother. She did everything by herself. My father was abroad. It is funny how the same thing happened to me as a mother.

I: And how was your mother's behavior towards you?

M1: She was really strict!

I: How did you feel about that.

M1: I did not think I was allowed to have any feelings whatsoever. Me needs were not as important because I saw my mother working and trying to manage it all. So I kind of swallowed my feelings.

I: Lt's talk a bit about your child. Are there any characteristics of her that you think influence you parenting practices, especially in terms of control?

M1: She has ADHD as I mentioned earlier.

I: How does that affect your behavior?

M1: I try to be as scheduled and organized as possible. I also provide them with a lot of afternoon activities so that they take out some of their energy! This has me always on the move and my time is even more restricted. My relatives had been saying to me to stop doing that. That their activities are too many. But I did not want to do otherwise. I also take them to a therapist.

I: Does her difficulties affect your behavior and feelings in any other way?

M1: I think that I become more directing and telling them what to do and how to do it. I struggle with my patience with her because she is hyperactive! And I think I am more overprotective because I fear for her safety due to her impulsive behavior and absent mindedness.

I: Apart from ADHD did or does your child face any health related or developmental issues?

M1: No just the ADHD.

I: What about another relative or friend of yours, did they go through something difficult that you had to see?

M1: No, I don't think so.

I: Are there any conditions that you feel may have made to see your child as more vulnerable?

M1: The fact that her father is away. But I don't feel guilty about divorcing him. He had bitten me, and this is the reason I left him.

I: How old was the child at the time?

M1: She was a few months old.

I: Are there any other things that you think may have influenced or maintained your behavior that you wish to mention?

M1: No, I think we have covered everything. That's just about it.

I: Thank you so much for your participation.

M1: Thank you!

High PC mother (2)

Mother's verbal responses on the child's questionnaire on PC, yielded a lower score than that of the child.

I: The reason for this interview is to explore some of the conditions under which you behave in certain ways towards your child as part of your parenting practices. Your child's responses indicate that she perceives some of your parenting practices to be highly psychologically controlling. These behaviors include attempts to control the child's behavior through imposition or invalidation of thoughts and feelings or interruptions of his talk and finishing of her sentences. Would you say these behaviors are indeed used by you in the home?

M2: Yes, sometimes I do behave in such ways. But not very often I think.

I: What personal factors do you think influence this behavior of yours?

M2: Well, I would say I am a perfectionist. I want her to do well at school. I expect her to have good grades and deal with all her responsibilities in the way she should! She needs to have control over that. I also do not express my feelings, I am an introvert in this sense. And I need to have a way to show her what she should do and not do!

I: Would you say you are also anxiety or stress prone?

M2: No, I don't think so. I just need to have control over things.

I: Sometimes mothers' feelings and emotional situation also affects their parental behaviors. How would you explain your emotional state?

M2: Well, I deal with a lot of everyday stress. That is for sure. The situations make me like that.

I: What are some of these situations?

M2: Well first of all, I am separated from my husband. We did not get a formal divorce yet but we are separated. So I have to do everything myself. And I mean everything. I also work long hours, during the afternoons as well. So I don't have enough time to do it all. This is really pressuring me and makes me want to have control over the situation even more.

I: How would you say is your relationship with your ex husband apart from him not being involved in the house responsibilities?

M2: We don't fight anymore…But we don't talk either. We don't have any communication with each other. We are cold and distant.

I: Are there any other stressors or factors in your life that may influence your feelings and behavior?

M2: Yes, definitely the financial issue. I struggle a lot financially and I do get anxious about it.

I: Do you happen to have any support financially or in any other way from grandparents or anyone else close to you?

M2: Well, I do have some help from my parents, they take the kids to some of their afternoon activities, but that's just about it. I don't have any other help. They are also still working themselves.

I: And do you have any support from anyone else apart from your parents?

M2: Well, just a bit I would say.

I: Are there any conditions in your environment that make you increase your control over the child, for example living in a dangerous neighborhood or any other condition?

M2: No, nothing like that.

I: Women nowadays are expected by society to lead multiple roles and responsibilities, working and managing the household etc. What do you think of this reality or this social ideology even?

M2: Well, it should not be like that. I disagree with it.

I: Talking about multiple roles, I understand you are a working mother. How is your job in terms of workload, requirements and pressure? Or any other work conditions that you consider important?

M2: Working during the afternoons and having kids is very difficult. It gives me little time to be with the kids. Also, in terms of salary I am not very satisfied. This brings me a lot of stress. Having to work all these hours away from my kids and having all these responsibilities for just a small salary.

I: Do you have any other responsibilities apart from work and home responsibilities?

M2: No, I don't think I do.

I: Let me take you back to the conditions that surround your pregnancy with your child. Was it something you wanted? Did you face any difficulties?

M2: Not at all, everything was good.

I: What about your own childhood. How was it? And how was your relationship with your parents?

M2: Well I felt secured but only in a practical sense. I mean I knew I would have food to eat and clean clothes and stuff like that. But I did not feel I was close to my parents emotionally. They were rather cold in this sense. My mother was also very psychologically controlling, like what you described in the beginning. She was also working in the afternoons. My grandmother actually raised me. She was also psychologically controlling. I had to think and feel and act the way she thought was right. That's the only thing we knew back then.

I: Is there anything else about the way you were raised that you think might have affected you in any way?

M2: No, I don't think so…

I: Okay, let's talk a bit now about your child's history and characteristics. Did she face any developmental difficulties growing up?

M2: Well, she was born prematurely, both of my children were. She was also a late talker maybe because of her prematurity. She still has some articulation problems.

I: What about any learning difficulties maybe due to these issues?

M2: Yes, I was expecting she would have some. She finds it hard to organize her thinking and comprehend what she reads or hears. But she is also not motivated to study, she finds it boring and does not put the effort she needs to. She does not study on her own, she needs me to do it with her.

I: How do you feel about this? How is this affecting you and your behavior?

M2: Well, it does affect me because I need to have things under control and she does not make it any easy on me!

I: Did she face any medical conditions at any point in her life?

M2: Yes, she had tendonitis and was given a wheelchair two years ago. At the time I was less demanding but now that she is free of that I am more demanding.

I: What do you think are some of your child's characteristics that you think may be triggering your controlling tendencies and the behaviors we have been talking about?

M2: Well, she is a powerful personality but she needs a lot of pushing! She needs boundaries and structure! She does not do her homework or tidy her room or watch over her appearance without me telling her over and over again. She is also very reserved with me. She doe not open up to me to tell me anything. Especially after me and her father separated she withdrew to herself. She wants to be left alone. And she does not have many friends or something.

I: How would you say that affects you?

M2: It makes it difficult for me to know what is going on in her life and in her mind. I just try to lead the way for her by telling her what is right and what is wrong.

<u>High PC mother (3)</u>

Mother's verbal responses on the child's questionnaire on PC, yielded a lower score than that of the child.

I: The reason for this interview is to explore some of the conditions under which you behave in certain ways towards your child as part of your parenting practices. Your child's responses indicate that she perceives some of your parenting practices to be highly psychologically controlling. These behaviors include attempts to control the child's behavior through imposition or invalidation of thoughts and feelings or interruptions of his talk and finishing of her sentences. Would you say these behaviors are indeed used by you in the home?

M3: Not to a big extent but I sometimes do it yes.

I: When you do present that behavior, how does your child react?

M3: It depends how fair she thinks it is. If she thinks something is not fair she is assertive now. She did not used to be assertive a couple of years ago.

I: And how do you react to that?

M3: I don't sit and discuss with her. I just say that we disagree. But my word will always be the last one to be told. What I say will happen in the end and there is no discussion about it.

What do you think motivates you do behave the way you do?

M3: I feel like I am responsible and I have control over the house and taking care of them the way I think is right. Her father lives abroad. So everything passes from my hands.

I: How does that affect you?

M3: Deep down I like the fact that he is away in that he might have a different opinion about things that involve the children, and I would not accept that. I would like us to be more independent and have things my way.

I: How many children do you have?

M3: I have three children. She is the youngest.

I: How is it for you to have three children and doing it all alone?

M3: Oh, it's really hard. I don't have enough time for everything. And I don't have time to sit and listen to her or discuss about things or play with her etc. I just do what I have to do.

I: How is she affected by this? What are some consequences for these interactions?

M3: Well, she takes the role of the mother because I cannot do it all. She bosses around her sister. She wakes her up, tells her what to do and not do. She helps around the house. She has become overly mature I would say. And she has become bossier and more self-sufficient. She wants to be a doctor now. And she also says she wants to be a mum.

I: What are some motives of yours that you think influence you to not discuss with her when she expresses her disagreement on something?

M3: I just view her words as not taking accountability of things. When she says "It is not my fault" or "But I…", I view these as playing the victim and just searching for excuses. I hate self-victimization for her.

I: What would you say are some of your personal characteristics that affect your maternal practices, particularly of control?

M3: I would say I am anxiety prone but I don't think I am that much anymore. I have more control over myself now. I am just a person who likes to have control over things. I like having rules and restrictions, like her not going out and things like that. I just tell her "No,

this is the way it will be done!" And that's the end of it. But I do have quite a lot of anxiety at work. And I vent a lot. Whatever I feel, believe me, you would know! At home, I do express myself a lot, exactly as I feel it. I'm a bit impulsive as a person. But I am not affectionate as a person. I know I lag behind in this. I think it is because I have some trust issues and I don't want to let people in, not even my children. I can tell that I am not an affectionate mother because I compare myself with my dad who was very touchy and tender. I never hug. I only do high-fives.

I: How does your child react to that? Does she tell you anything or reacts in any other way because of it?

M3: Well, she respects me on that I think. But she tries to bring the affection out of me. She does it in her own way.

I: What are some ways that you do express affection?

M3: I just tell her "I love you but you did this wrong" or "You don't listen to me and this is what happens!". I don't really hold back on what I say.

I: And what about your controlling characteristics that you described before. How does she react to that?

M3: When she is right, she cries, she says things like "you always do that" or "you never do that" and compares my behavior towards her with my behavior toward her sister. This usually brings conflicts between them as well. She also gives me the silent treatment. She doesn't talk to me and looks mad. She does have a thing with being treated unfair, it's her sensitive part. When she thinks I was wrong, she keeps reminding me of that in future interactions.

I: You said before that your husband lives abroad. What is his contribution to the house responsibilities and things that have to do with the kids? Do you feel supported, is he involved as a father and partner?

M3: Well, he is away. His absence makes it all more difficult, I have to say. There are good intentions on his part, when he is here he is positive. He wants to talk and listen to them. He is also a teacher so he knows how to encourage them. But because he is away, he practically cannot help me. And because he is different in his ways from me, there is a power imbalance which I do not like. He asserts his way and the kids think that he is just nicer than me. They

always favor him and say that he is the one who is right, not me. I hate that because I am very sensitive to others not respecting me.

I: Do you have conflicts between you because of these different perspectives or for any other reasons?

M3: No, I would not say so.

I: What about any other factors that may be affecting you. For example, some parents face financial difficulties.

M3: Well, there has been a time when one of us was unemployed and it was hard. But now it is not the case. Financially we are okay.

I: Do you have any support from your parents or other family members or friends? It could be practical or emotional support.

M3: We don't have help from grandparents like most parents in Cyprus. My parents were away and they were old, so it just came by itself. It just was their choice. I do have some fights with them from time to time. But my child loves them, and they love her too.

I: What about any support from anyone else in your circle?

M3: No, no support whatsoever.

I: Do you belong to any minority group of any sort?

M3: No.

I: And are there any conditions outside the house that make you want to have more control over the kids, even for safety reasons, such as children with behavioral difficulties or dangerous neighborhood etc?

M3: No, I don't think so.

I: Women nowadays face a lot of challenges, since they take on multiple roles and have multiple responsibilities and it seems that society expects them to do it all as good as possible. What do you think about that? Do you agree or disagree and how do you deal with it?

M3: Well, I accept it because it is what it is. But I always tell my girls that we can do anything we set our minds to. And it is not okay to have all these expectations from anyone. Not

because I myself I'm a woman. When her dad is in Cyprus, I tell him what to do. I tell him to cook, to take the kids to their activities etc.

I: Some women face a lot of pressure at work too. I know you are a working woman. How does that work for you?

M3: This is the biggest issue of all. I have too much workload, too much pressure. I am constantly on the phone and on the computer even when I am home. I periodically suffer from burnouts. Kids know. They can tell when they hear me sign in despair. And they tell me that.

I: Now let's go back to the conditions under which you got pregnant with your child. Were they easy, did you face any challenges at the time or just after that?

M3: Well, she is my youngest so it was easier than the first ones. I wanted her. But it is always hard. With my firsts I was very young I think and I did not know a lot of things. I was tired. I was also tired with her of course.

I: How was your own childhood? Your relationship with your own parents when you were a child?

M3: My parents were refugees. They felt like they were foreigners and they passed it on to us. I also had a twin brother and he was considered as the price of the family because he was a boy. I always felt like I was not important to them. They criticized me all the time. We had a lot of fights. I did not get what I wanted. So, I had to marry very young, just nineteen years old to escape home.

I: Did your child face any developmental or learning difficulties?

M3: No, thankfully, not?

I: What about her siblings?

M3: No, again nothing.

I: Did they face any medical conditions?

M3: Yes, she was born with a heart problem and she still has to have yearly checks for that.

I: How did that affect you?

M3: I was not too much stressed about it, it was okay. But still it was a thing. I had to have control over things once again. Her brother had also had a serious accident. And he stills get medical checks for it.

I: How did that affect the family?

M3: She has become overprotective of her siblings since then. We had a difficult time and I had to deal with everything.

I: Are there any other characteristics of your child that influence your behavior and you consider important to mention?

M3: I just worry that she is overly mature. I do not want her to try to have control over everything. She is giving and sensitive as a person.

I: Thank you very much for your participation.

M4: Thank you!

<u>High Rejection mother (4)</u>

Mother's verbal responses on the child's questionnaire on PC, yielded a lower score than that of the child.

I: The reason for this interview is to explore some of the conditions under which you behave in certain ways towards your child as part of your parenting practices. Your child's responses indicate that he perceives some of your parenting practices to be highly rejecting. These behaviors include criticizing and invalidation of the child's feelings. Would you say these behaviors are indeed used by you in the home?

M4: I try not to do it but sometimes I do I'm afraid. I have a lot of things to take care of.

I: We will talk about these in a while. How do you think you demonstrate that behavior?

M4: Well I try not to shout. I take away things he likes. I think I show I am mad. I have some anger issues. And not so much patience.

I: How does your child react?

M4: He talks about me being unfair. Especially in relation to his brother. This brings some rivalry between them and he is jealous of him.

I: And how do you react to that?

M4: Well, it depends. Sometimes I explain to him and other times I just tell him to calm down.

I: What do you think makes you act the way you do?

M4: He irritates his sister now. He challenges her!

I: And do you get your way with him in the end, or do you give in?

M4: I definitely get my way. I do not accept for anything else to happen. There is no room for discussion.

I: What are some of your personal characteristics that you think affect your behavior towards your child?

M4: Well, I am overly sensitive. I get emotional and cry very easily when I see an animal in need or a touching movie. I am also very touchy. I get offended very easily if my child does something I do not approve or if my husband says something about me, even in a funny way. We have some arguments in front of the kids. I am also very consistent. When I say something, I stick to it.

I: Some mothers go through emotional challenges, especially with the difficulties of modern society. You said you are oversensitive as a person. Do you face any emotional difficulties?

M4: Yes, I do, definitely. I go through phases of depression and I sometimes give up on things. I also have a height phobia. The kids know about it.

I: How does that affect your behavior in the house?

M4: Well, it makes things harder, because I don't have the patience needed to deal with everything, especially the kids.

I: A lot of women feel as if they are doing everything by themselves and that their husband doesn't help around the house or with responsibilities surrounding the kids. How is this for you?

M4: Unfortunately, my husband works long hours and I don't have the support I wish to have. But we spend the weekends together as a family.

I: How does that affect your behavior.

M4: Again, it makes things more difficult of course. More pressure is placed on me.

I: Some mothers say that they have some conflicts with their husbands and that stresses them even more. What is the case in your relationship?

M4: We do have some conflicts, yes. But I think he does the best he can. These last months, our fighting has increased I can say. And kids have noticed.

I: Do you face any financial issues?

M4: Only to a small extent I would say.

I: In Cyprus, we find a lot of grandparents helping parents, especially with things that have to do with the children. Do you have their support?

M4: Thankfully, very much so.

I: What about other relatives or friends. Do you have a support network from that side?

M4: Maybe on an emotional level. But apart from this, I have always felt they were my responsibilities. I did not want to burden anyone else.

I: Did your child or your other children face any developmental, learning or health challenges while growing up?

M4: No, everything was fine.

I: How do you feel about societal ideologies that expect mothers to perform well at multiple roles, such as working, doing the housework and taking care of the kids?

M4: I don't really care about what society has to say. I have help with cleaning the house and I think I manage.

I: What about your work conditions? Are you satisfied with your job, do you face any challenges?

M4: A lot of challenges. I have a lot of workload. It burdens me a lot.

I: And how does that affect your behavior around the house? Do you think it influences you in any way?

M4: Definitely so. It makes me exhausted. I have to be like a robot all day performing all the things I have to do. I do a lot of things mechanically, even when I am at home. I am too tired to be mindful of things. And I lose all my patience because of it.

I: Apart from work, do you have any other responsibilities outside home?

M4: No, I don't think so.

I: Let me take you back to the time you got pregnant with your child. Was it an easy period? Did you face any challenges like being too young or having difficulty conceiving or being emotionally burdened?

M4: I was 30 years old then, which I thought was fine. I did want to get pregnant and I did not face any serious difficulties other than a lot of vomiting. I had some emotional ups and downs with my first child though.

I: Now let's talk a little bit about your own childhood. How was it? And how was your relationship with your own parents?

M4: They were affectionate but were overprotective. And we did not talk much, we had no real communication between us. They were fighting a lot and I remember myself crying about it. I was also a difficult teenager. Me and my husband always tried to keep it between us when we fought, even though not always successful I must admit. I do feel guilty about it.

I: Did your child face any developmental, learning or medical difficulties? And what about your other child?

M4: No, everything was fine. Apart from him falling out of bed one time, but it was not serious after all. And also, he had ticks because his teacher was shouting a lot and it made him stressed.

I: Are there any characteristics of your child that you think may be influencing your behavior?

M4: I don't think so. But I myself have some guilt for leaving him with his dad to go to the gym when he was a few months old.

I: Is there anything else on a personal level or in terms of your child characteristics or family or social circumstances which you think may have affected you in any way and influenced your maternal behavior?

M4: No, I think we have covered everything.

I: Thank you very much for your time and participation.

M4: Thank you, I hope I could help. Good luck!

High Rejection mother (5)

Mother's verbal responses on the child's questionnaire on PC, yielded a similar score than that of the child.

I: The reason for this interview is to explore some of the conditions under which you behave in certain ways towards your child as part of your parenting practices. Your child's responses indicate that he perceives some of your parenting practices to be highly rejecting. These behaviors include criticizing and invalidation of the child's feelings and controlling the child's behavior in a strict way. Would you say these behaviors are indeed used by you in the home?

M5: Yes, I must admit I am strict as a mother.

I: How would you say you specifically demonstrate those behaviors?

M5: Well, I prohibit him going out much. And when she goes, she has to be under supervision. And she has to watch her diet and go to and study for his French lessons. When he reacts to my boundaries, I shout at him and we fight. I use punishments in the form of him losing something he likes, such as the Play Station. He has some freedoms and rewards but not more often than once a week. He gets punished about five times more than he gets rewarded.

I: How does the child react to these behaviors?

M5: He reacts intensively. He shouts back and slams doors.

I: And then how do you react to that?

M5: I shout even more!

I: What about his brother? How is their relationship? Do they have any rivalry with each other?

M5: Definitely. He tells me that his brother has more freedoms than him. And he does because he is older. And his brother tells me that I used to be stricter with him when he was his age. The fight with each other because of those things.

I: What are some of your personal characteristics that you think influence your behavior as a mother, especially the rejecting one that we talked about?

M5: Well, I do have an anxiety disorder. I feel especially anxious about deadlines. I am always outside of home working. I used to go to work trips since my child was 2 years old. I have had depression and anger issues. My child's teacher was calling me from school when my child went to preschool and was telling me negative behaviors she saw in her. And that made me feel worse. I am also a perfectionist and the fact that I have only limited time to do this makes it even more difficult for me.

I: A lot of mothers face challenges like the ones you just told me and face emotional difficulties because of them or other issues of their own. How would say is your emotional situation?

M5: I have a lot of stress as I told you. And some depression from time to time. I am also anxious about being separated from them, especially when they are away from me for a long time. I have a lot of guilt about not having enough time with her. And about not being the classic mum that meets other mums and their kids for play dates etc. But in general, I am good. I express myself and explain to them that I am stressed out because of this and that.

I: A lot of mothers say that their husband does not help them around the house and with responsibilities that involve the kids. How is your situation at home?

M5: My husband is away most of the time. He works long hours. And I do most of the things myself. But other than that, we have good communication between us. I have the control of things and I like that as difficult as it is. But if I need anything, he supports me.

I: Everyday living makes it difficult to communicate. Are there any conflicts between the two of you?

M5: We do have conflicts between us, and it also happens in front of the kids. But they know that I get mad because I am pressured by a lot of responsibilities and little time. And they can see that their dad is also quick-tempered.

I: Do you happen to have any financial issues as a family?

M5: No, we are good.

I: From the interviews, I hear a lot of mothers getting some help from her parents or her in-laws. Do you have this support?

M5: My husband's parents are from Greece, so I don't have their support as much as I needed. My mother in law is also very against any mother working and pursuing a career. She thinks the place of the mother is only the home raising her kids and taking care of her

husband. This creates a lot of guilt in me and stresses me out. We go to conferences abroad a lot of times and I had hired a nanny at a time. My mother just helps with taking the kids to their activities. But other than that. She did not want to help either. She does not cook for me or anything like that.

I: Do you have support maybe from other relatives or friends?

M5: My twin brother helps by watching the kids sometimes or taking them to the beach.

I: Are you or any member of your family a member of a minority group?

M5: Yes, my husband is from Greece.

I: Some mothers sometimes become more controlling in the way they set boundaries because of conditions outside of them that make it dangerous for the child to live in. For example, living in dangerous neighborhoods or having kids around that have behavioral problems. Do you face any of that?

M5: Well, we live near the green line, so I get a lot of anxiety from the possibility of them being abducted and taken to the occupied site. I had heart of a case when someone kidnapped a little girl and took it to the other side. I never let him go anywhere by himself.

I: Women nowadays have multiple roles and responsibilities and are expected from society to do so and do it well in all areas. How do you feel about this?

M5: I definitely feel a lot of stress and pressure from this.

I: Tell me a little bit about your work situation. A lot of mothers have told me that they feel a lot of pressure at work, especially while having kids to care about at the same time.

M5: My job is really demanding. It puts a lot of pressure on me. I have a lot of administrative responsibilities because I have a high job position.

I: Now let me take you back to the conditions of your pregnancy and giving birth. Was it easy for you? Was it something you wanted? Did you face any challenges?

M5: It was really hard when I had both of my kids. Even though it was a mindful decision to have them. First, I was crying because we had just moved to Cyprus and had adjustment difficulties. Then with my second child, I had a lot of stress because of my new job. My workplace was new at the time and I had to do a lot of work and organize things and deal with a lot of gaps at the organization. So, my son experienced this stress of mine unfortunately. And that started a competition between the two kids. Because the second

child brought more stress and pressure to my life. While I was pregnant, it was also very difficult health wise. I had pregnancy diabetes and I was taking progesterone. I was also working really hard at the time.

I: Did your child face any developmental, learning, or medical challenges while growing up?

M5: No, nothing like that.

I: Did you or any other family member or other person close to you face any traumatic experiences, such as accidents, illnesses or even death of a loved one?

M5: No, thankfully not.

I: And did your child experienced something negative that may have made you see him as more vulnerable or in need of control?

M5: Yes, I would say that him having been a victim of bullying has made me worry about his emotional situation. And it did make me overprotective to an extent. Also, I hear a lot of health issues at work and I fear for his health. I don't want anything bad happening to him.

I: What are some of your child's characteristics that you think may be influencing your behavior towards him, especially the controlling and rejecting aspects of your parenting practices?

M5: Well, he is very impulsive and daring and has no patience whatsoever!

I: Let's take you some more years back when you yourself were a child. How was your childhood? Under what conditions did you grow up and how was your relationship with your parents?

M5: It was awful. My mother was very strict, to an excessive degree. She was also really cold. She did not give me any affection whatsoever. She also still criticizes me to this day. I have always felt rejected by her. Of course, I realized that afterwards and managed to find myself in the end. I know that my anger issues are rooted back then.

I: Is there any other factor that is either characteristic of you or your child or your family or other social situations that you think may be affecting your maternal practices, particularly the more controlling ones?

M5: No, I think that's about it. We covered a lot of issues.

I: Thank you very much for your time and participation.

M5: Thank you! It was really helpful for me to go through these things and realized some things about myself.

High Rejection mother (6)

Mother's verbal responses on the child's questionnaire on PC, yielded a similar score than that of the child.

I: The reason for this interview is to explore some of the conditions under which you behave in certain ways towards your child as part of your parenting practices. Your child's responses indicate that he perceives some of your parenting practices to be highly rejecting. These behaviors include criticizing and invalidation of the child's feelings. Would you say these behaviors are indeed used by you in the home?

M6: Yes, I must admit. I punish him a lot. And I shout a lot. I don't have much patience these last years. He fights with his brother and it makes me mad. I have to go after them all the time!

I: How does the child react to this?

M6: He reacts very intensely. He gets mad, he shouts, he kicks!

I: And then what do you do?

M6: I shout back but I try not to. It is not always easy.

I: What do you think motivates your behavior? What makes you act this way?

M6: I just try to protect him. By having him act the right way.

I: Does your behavior work in terms of getting the result you want from him.

M6: No, I would say it does not work. But I also don't know any other way.

I: How do these interactions affect things in the family?

M6: Well, it affects our everyday life. And my husband's emotional situation. We have a lot of tension in the house.

I: Do you think it affects things long-term in any way?

M6: I'm not sure. Things will show. The sure thing is that I see myself getting more and more tired with this situation. And I have started to give up.

I: What would you say are some of your personal characteristics that may be affecting your behavior, in terms of control and rejection towards the child?

M6: Well, I definitely am prone to anxiety. And I know I pass it on to him. I repeat things a lot, I tell him what to do many times. I am also a perfectionist, especially when it comes to work. And I pass it on to him as well. I expect him to do the same, be perfect at school and at all his duties.

I: Some mothers also state they face emotional difficulties as well. In terms of their mood particularly. How are you doing emotionally? How is your mood?

M6: I do have a lot of emotional lability. And this affects my patience and the way I act towards him. I also have a lot of anxiety because I have to do everything on my own. And I have a lot of guilt because I don't play with him as much as I should and I shout way too much.

I: What about your husband? Do you feel supported by him? Does he help around the house?

M6: He works long hours. So, he cannot be there a lot of the time. I have to do it by myself. But fortunately, we have a good cooperation. We follow the same parenting line although he is a bit more tolerant than I am.

I: Do you have any conflicts as a couple?

M6: No, thankfully not.

I: Are you facing any financial difficulties?

M6: No, we are fine with that.

I: A lot of mothers in Cyprus seem to have the support of their parents or in laws. Do you have any of that support?

M6: No, unfortunately not. My in-laws live far away and my parents have some health issues and are not able to help.

I: How does that affect you?

M6: Well, my freedoms are restricted. I have to cook everyday and do everything by myself. This makes me more anxious and then I feel guilty for not having enough time and losing my temper.

I: Do you have support from anyone else, such as other relatives or friends?

M6: No, just from my sister.

I: How do you deal with this?

M6: I vent on my husband, that is for sure.

I: Do you belong in any minority group?

M6: No.

I: And is their anything in the place you live or other conditions that make you more controlling and in need to set strict boundaries? Or that makes you anxious and/or rejecting?

M6: No, I wouldn't say so.

I: Women nowadays are expected by society to perform multiple roles and do it all well. We are sometimes expected to be good mothers, good career women and do all the housework. How do you feel about that?

M6: Well, I think about this and I disagree of course but I prioritize things and just move back some of these roles.

I: A lot of women state that they are pressured at work for various reasons. How is your work situation? Are you satisfied? Do you face any challenges?

M6: I face a lot of challenges. My job is very stressful. I have to deal with kids, parents, principals and constant evaluations. I have to prepare every day for the next day. It's really hard.

I: How would you say that affects you as a mother?

M6: It definitely does affect me. I don't have much patience. I am tired a lot.

I: Do you have any other responsibilities outside work?

M6: I also have work in the afternoons. I create timetables and stuff. It is never ending.

I: How was your pregnancy? Was it wanted? Were the conditions favourable or did you face any challenges?

M6: Yes, everything was good.

I: Did your child face any developmental, learning or medical conditions?

M6: He was born prematurely. This brought me a lot of stress. I researched it a lot to see if everything was okay. It really made me overprotective of him. I needed to have control over the situation. I took him to speech and occupational therapy to deal with everything. He also had some sensory issues. All these made me be stricter with him. In terms of school work and everything else. I did not want him to fail. I am not so demanding with his younger sister. Now he is doing really good at school. I am a teacher and this is important for me. But I also want him to be happy and accepted by his peers. I worry about these things.

I: Let's go back to your own childhood. How was it like being a child in your family? How was your relationship with your parents?

M6: My parents were overprotective. They did everything for us but they were very strict. There was a lot of shouting. They were very authoritarian. Especially my mother. I was very restricted. I was not allowed to go anywhere, or meet anyone. They wanted to know everything. They were very rigid. They did not hear anything and never changed their minds. When I shout at my son and tell him off, I feel as if I hear my mum.

I: Did your child have to go through any traumatic experience in his life? Either health wise, or in his social life or any physical loss?

M6: I have always been worried if he was bullied. Because of his developmental difficulties. For example, he did not speak very clearly and other kids may not have understood him. Or he is afraid to play rackets because he doesn't have the motor skills to do it well.

I: Do you think any of your child's personality characteristics influence your behavior towards him?

M6: Yes, definitely. He is very procrastinating. And very slow to do things. He needs a lot of reminders! To do his homework, to tidy up his room, to do any of his obligations. He also has some attention and concentration difficulties. I tell him what the time is and what time he has to do something or how much time he is left, but he doesn't do anything. He gets stressed about pressure and time limits. But he does like to succeed. He reminds me a lot of

times that he as well brings home good marks, not just his sister. He feels I expect too much from him.

I: Is there anything else that you feel we haven't talked about but is worthy of mentioning in relation to your parenting practice?

M6: No, I think we are good. We talked about a lot.

I: Thank you so much for your time and contribution.

M6: Thank you!

<u>High PC & Rejection mother (7)</u>

Verbal responding of the mother on questionnaire items of PC and Rejection did not match those of the child: The mother reported using those strategies to a lesser extent than did the child.

Interviewer (I): How would you rate yourself in terms of parental overprotection on a scale from 1-10;

M7: I would say a 7.

I: How does your child respond to that, and I mean generally to the controlling and rejecting behaviors we mentioned in the beginning?

M: She doesn't react and doesn't demand anything. She has known from a very young age that she needed to have boundaries.

I: And how do you react on that?

M: I'm satisfied with it. I just continue doing what I'm doing.

I: What makes you act the way you do?

M: Nothing really. I just don't know any other way. And she goes along with it.

I: What are some of your personal characteristics that you think influence your behavior towards your child? In terms of strictness, rejection or overprotection?

M: Well, I try to adapt to my child's behavior. I do not always act the same. I am quite careful of how to act in a given moment. But she is tidy as a person, so I don't need to do much. I am also very *tidy and organized* in my everyday life, I don't know if she models that or if she thinks I also expect her to be this way. She is a perfectionist I would say. And I do *demand* things from her to a certain degree. I am also quite *prone to anxiety* but I've worked through this the last few years and I'm doing better. And when I feel sad or annoyed about something, I *withdraw* to myself. And then *she worries* about me. She is so *mature*. She had to be mature because I raised her myself. My husband was always working and I didn't have any help from any of the grandparents whatsoever. I also had my other daughter who is 7 and a half years older than her. She has ADHD and was difficult to handle. But I also had boundaries with her. She could not buy anything she wanted. And I did not allow her to curse. When she was 8 years old I was beating her when she misbehaved and then I explained to her why I was doing it. My older sister was also going to a demanding and difficult high school. We did homework while in the car and stuff. It was tough. Still my older child doesn't let her sister talk, she is much more assertive and reactive than the young one is.

I: What about any emotional difficulties you may be facing, such as low self-esteem or feeling down, worried, or depressed?

M: Well, I do not show my feelings. I rarely ever go out of control. I do some times but not too much.

I: A lot of mothers say that they do not get they support they need from their husband and sometimes argue with him about things. How is this going for you?

M: I would say we are fine now. He used to wok until late at night but after my second daughter was born, he stopped. We share responsibilities now, he cooks and stuff. We are quite organized. At one point he was going to college so he came home at 9pm, sometimes even later.

I: What about in his role as a parent?

M: Well, he is not much involved. He doesn't help with homework nor does he communicate with her teachers etc. We do have some arguments in general but not to a big extent. Just like all couples I think.

I: So you said you had no support from grandparents when your kids were growing up. What about other relatives or friends? Did you have anyone to talk to or ask something tangible in times of need?

M: No, no one. I was always alone. Our whole family was alone.

I: Do you belong in a social/cultural/religious/ethnic minority?

M: No.

I: And do you face any financial difficulties or deal with unemployment?

M: No, luckily no.

I: Is there anything about the area you live or the context or circumstances under which you live that make you more afraid of your children's safety or behavior which can in turn influence your strictness, overprotection or other forms of control?

M: No, I don't think so. Other than the support I don't have by anyone.

I: As women, we usually have multiple roles to take on, such as a mother, a worker, a wife etc. Society also expects many things from us in terms of housework, maintaining good physical appearance etc. How do you view and handle this?

M: I never put myself first. I don't do anything for myself. I also don't have the energy to do it. I don't react to these societal expectations in any way. And I don't push things, I just set my priorities straight.

I: What about your work responsibilities? Do you have a lot of workload or other demands? How are you doing in your workplace?

M: Well, I do have workload. But in general, the work environment is good. I've gotten used to it.

I: Do you have any other responsibilities outside home or work, such as taking care of an older relative, or anything?

M: No, I don't think so.

I: Let's talk a little bit about the circumstances under which you got pregnant. Were you very young or older than societally expected? Did you phase any difficulties at the time?

M: Well, I actually did not want to get pregnant the second time. I was facing difficulties. I don't do as much for my second child. But I don't feel guilty about it. When she was little she

used to cry a lot because she did not know how to express herself. But I stopped her from doing so, because she saw that she couldn't get me to do what she wanted. She could not manipulate me.

I: How was your childhood? Do you remember any challenges you had to face because of your parents' behavior? Do you remember them being strict or controlling in any way?

M: My mother was very strict. This is the only thing I've known. She got mad at me for no reason and I remember thinking how unfair it was. She did not express herself like I do. She was never warm with me and we never had a good communication with each other. She was judgmental. I used to be like that with my first child. But I try to not be like that now. With my second child I think I was more successful with that.

I: Did you child have any developmental or medical challenges to face? Or any learning difficulties etc.?

M: No nothing. Only my first had.

I: Did your child had to go through any social or other challenges, such as bullying that made you look at her as more vulnerable?

M: No, I don't think so. But it does worry me that she doesn't seem to have any stable real friendships. And also, that other kids have no boundaries at home.

I: Did anyone from your environment face any traumatic experiences that made you fear of the unexpected and what could happen to your children if you don't watch them closely?

M: No.

I: Are there any of your child's characteristics that you feel may be influencing the way you view and behave towards her?

M: That she does not react. She accepts anything from anyone without saying a word. She is not assertive at all. She is also anxious and a perfectionist.

Low Warmth mother (8)

Mother's verbal responses on the child's questionnaire on the Warmth subscale of the s-EMBU-c, yielded a higher score than that of the child.

I: The reason for this interview is to explore some of the conditions under which you behave in certain ways towards your child as part of your parenting practices. Your child's responses indicate that he perceives some of your parenting practices to be low in emotional warmth. These behaviors include showing to the child affection and tenderness through words of encouragement, reward and acceptance and also nonverbally through physical affection. Where do you personally feel you stand on these behaviors?

M8: Well, I don't think I don't show him affection. Maybe it's the way I show it that is different than what he expects. I never thought of it to be honest. He is very sensitive and always afraid of failure.

I: What are some of your personality characteristics that you feel are affecting your maternal behaviors in terms of expressions of warmth particularly?

M8: Well, I am a perfectionist to begin with. So, this creates a lot of stress and pressure. But I try not to pass it on to him. I would rather him be happy and have fun. I am also very sensitive. I cry very easily. I get disappointed if someone is rude to me for example.

I: Because of many everyday challenges and other issues, a lot of mothers face emotional difficulties and changes in their mood? Would you say you face any problems with your mood?

M8: I think I do yes. I have a lot of stress now, especially after COVID. I also deal with depression. I don't enjoy my job, I would like to have done more things that I do like.

I: A lot of mothers say that they don't have the support they need from their husband. Is this something that happens in your situation?

M8: Well, me being from Russia, I am a perfectionist as I said. And I and my husband have different approaches on parenting. I want my children to be independent and not have everything ready for them. And I believe that husbands must help. My husband has learned a different way. He is also overprotective with our son. But he does support me when I need it.

I: With all the everyday responsibilities and pressures, a lot of couples have their arguments. How is your relationship?

M8: We do have our fights, I must say.

I: Do you face any financial difficulties?

M8: I would say we are average on that.

I: Do you have any help and support from relatives, such as grandparents or from friends?

M8: We do have some support from my husband's parents. Mine are in Russia. And we do have support from friends if we need it.

I: How is it being from another country and living in Cyprus? Have you experienced any challenges?

M8: No, I can say I am blessed. I did not experience any racism or discrimination.

I: Women are expected nowadays to acquire multiple roles and responsibilities and do it all well. How do you react to that?

M8: Well to me it is difficult. Because I myself want everything to be perfect. But this is not possible. I say that whenever I feel they expect me to do more.

I: How are your work conditions? Do you face any challenges?

M8: Well, I don't really like my job as I told you. It does not fulfill me. But at least I don't have much stress now. I am responsible for myself.

I: Do you have any other responsibilities outside home and work?

M8: My husband has had an operation and is still in bed. So, I take care of him also.

I: Tell me a little bit about your conditions of pregnancy. Was it something that you wanted and was prepared about? Did you face any challenges during that time and afterwards?

M8: I really wanted him. I had a c-section.

I: Did your child face any developmental, learning or health difficulties?

M8: No, everything was fine.

I: Let me take you back to your own childhood. How was it, and how was your relationship with your parents?

M8: It was nice. My parents were warm.

I: What are some of your son's characteristics that you think may be influencing the way you behave towards him?

M8: He is very sensitive and shy. And this make me want to help him be independent and strong. I don't want him to lean on me about everything. Maybe this is the reason I don't show my affection so openly. I want to make him tougher and self-sufficient.

I: Is there anything else that you think is relevant with your parenting behavior and interactions within the family and you think it is important to mention?

M8: No, I don't think there is anything else.

I: Thank you for your time!

M8: Thank you, it was nice talking to you.

<u>Low Warmth mother (9)</u>

Mother's verbal responses on the child's questionnaire on the Warmth subscale of the s-EMBU-c, yielded a higher score than that of the child.

I: The reason for this interview is to explore some of the conditions under which you behave in certain ways towards your child as part of your parenting practices. Your child's responses indicate that he perceives some of your parenting practices to be low in emotional warmth. These behaviors include showing to the child affection and tenderness through words of encouragement, reward and acceptance and also nonverbally through physical affection. Where do you personally feel you stand on these behaviors?

M9: Well, I think he knows I love him but I am not the type of person to hug and kiss and do all that stuff.

I: What are some of your personality characteristics that you feel influence the way you behave towards your child?

M9: I have a lot of patience as a person. I don't bring the stress from work home. Their father does that. And he does not have much patience. I am also very sensitive, even though I never show it. I don't like showing my emotions because I don't like others degrading me. I

say some things verbally but I do not want to show weakness. I feel I look weak when I show my emotions.

I: How do you think that affects your behavior towards your child?

M9: Well, maybe this is the reason he feels I am not warm. I don't show my feelings so much. That is the truth. But I love my kids.

I: And how does your child react to that?

M9: He does not come by himself to ask for affection or anything. He does not show it to me. He is the middle child and it is true that the youngest takes most of my attention.

I: A lot of mums say they have difficulties with their emotions and mood. Is it something that you have to deal this?

M9: I am generally calm and aware. We are okay as we are. But I feel really tired to be honest. It is difficult having three boys. I also got angry when I helped them with homework.

I: Some mums feel that they don't get the support they need from their husband, especially in helping with the children and the housework. How is your situation?

M9: I would say he is okay. But he never helps with the homework. I do all that work. And it is not easy.

I: Do you, like many couples have any conflicts between the two of you?

M9: We do yes. We have some conflicts. I express myself there.

I: Do you face any financial difficulties?

M9: No, we don't.

I: Do you have any support from family and/or friends?

M9: Grandparents help us if we need. We are okay. We didn't need to ask for help from anyone else.

I: Are you a part of a minority group?

M9: No

I: Mothers nowadays sometimes have to deal with many responsibilities and roles and they are expected to do it all well. How do you feel about this?

M9: What I do is a separate work from home. I stopped stressing about work at home. I feel the pressure until the night. But I manage.

I: How are your work conditions? Are you satisfied, do you face any difficulties?

M9: I have set my boundaries.

I: Do you have any other responsibilities outside of work?

M9: No, I don't think so.

I: Some mothers face challenges when they get pregnant. They are either going through a stressful period of their lives or they were not ready to have a child or they were too young or perceived themselves too old. What about your pregnancy?

M9: I was 27 years old when I had my first. It was my choice.

I: Did your child face any developmental, learning or medical issues while growing up?

M9: Well, in class he did not talk, he was too shy to express himself. And he did not react much. His brother was not like that. At first, I worried about this because I used to be like him. I could not bear him not being assertive. I cared about him having high self-esteem. Now he is better, he is the classroom's boss.

I: In terms of learning?

M9: Well, he needs a lot of repetitions to take in new knowledge. He is not the type that gets it from the classroom.

I: And concerning his physical health?

M9: He had dust sensitivity. But other than that, nothing else.

I: Did you or child or family had to go through any loss, accidents, illnesses of loved ones or other traumatic experiences?

M9: My husband's brother died when my kids were little.

I: Anything else, like bullying, that your son went through that you can think of?

M9: His older brother used to bully him. I generally leave them alone. When they need me, I can be there. But I am not there all the time.

I: Talk to me a little bit about your own childhood. How were you raised and how was your relationship with your own parents?

M9: My parents were refugees. Only my father worked. And he worked on shifts. He was a nurse. My mother did everything herself. And she always ran out of time. None of my parents were warm. They did not show any emotions towards us. I also was the middle child so I did not get much attention. I wanted to manage things on my own. I did not want to need anyone. That is what I learned. My mother was not strict. But she was prone to anxiety and a perfectionist. Maybe it is hereditary or something. Because I am like that.

Low Warmth mother (10)

Mother's verbal responses on the child's questionnaire on the Warmth subscale of the s-EMBU-c, yielded a higher score than that of the child.

I: The reason for this interview is to explore some of the conditions under which you behave in certain ways towards your child as part of your parenting practices. Your child's responses indicate that he perceives some of your parenting practices to be low in emotional warmth. These behaviors include showing to the child affection and tenderness through words of encouragement, reward and acceptance and also nonverbally through physical affection. Where do you personally feel you stand on these behaviors?

M10: I think I show them love but in my own way. Maybe because in my country we show love differently, I don't know.

I: How to people in your country, you are from Africa, right? How do people in your country show their affection?

M10: Well, for example my mum showed us love. She called us all the time after we came to Cyprus and she talked to us about everything.

I: What are some of your personality characteristics that may be influencing your behavior towards your child?

M10: I am sensitive and I express myself. I vent sometimes.

I: What about your emotions? A lot of mothers have difficulties with their mood.

M10: I do have a lot of stress. Sometimes I think about what is going on, life is not the same after COVID. But in Cyprus we are generally lucky. Life here is not so stressful.

I: What other factors you think may be affecting your parenting practices, especially in terms of showing warmth?

M10: I think that the fact that I have 4 children is the most difficult part of all. You just cannot make them happy. I also work. I do have some time but I don't sit and play for example.

I: What about your husband? Does he help with everyday chores?

M10: No…I do too much myself. My husband only goes to the supermarket. In my country things are different. Everyone helps around the house. And they make us independent. Here it is different. Kids don't help either here.

I: And what about decisions that have to do with the kids. Is he involved?

M10: I would say yes, he is. We discuss and decide together.

I: Do you have any conflicts or arguments with your husband?

M10: Yes, we do, sometimes.

I: Women nowadays are expected to have multiple roles and many responsibilities and they are sometimes expected by society to do everything right. How do you feel about that?

M10: I do not like it at all. It is too much. I can feel the stress coming from it. As I said in my country things are different. We should be sharing responsibilities.

I: What about financially? Do you face any difficulties?

M10: That makes me stressed, yes. It is stressful to think if money will be enough for the month. But we manage. The most important thing is that we talk with each other and we find solutions.

I: Do you face any struggles at work? Is your job demanding?

M10: No, it is fine I can say.

Do you have any support from grandparents or other relatives or friends?

M10: My parents supported me as much as they could. They called me a lot. But of course, they live far away. My in laws are also supportive. I used to feel alone for many years. Now we try to make some friends.

I: You are from Africa. Did this affect you in any way while living in Cyprus?

M10: Well, me personally no. But I do here some comments while at the office about others not speaking Greek. I don't pay much attention to that. I just work to keep my kids happy.

I: What were your conditions of pregnancy? Was is easy, did you face any challenges?

M10: I was young, just 21. But I wanted to have children. I came to Cyprus with three children. I am here 16 years now. I had my last child here in Cyprus.

I: Did tour child face any developmental, learning or medical challenges?

M10: Well, he had a delay in walking. At the beginning I was scared but the doctor said it was fine. I am not sure about any learning difficulties. His first year at school, he went to a private school and he had some difficulties with Greek. But his teacher told me not to worry.

I: Are there any personality characteristics of your child that you think influence your feelings and behavior towards him?

M10: Well, he is a good kid. The only thing is he is a bit insecure. He has some self-esteem issues. I'm not sure if that influences my behavior towards him. I think that having four kids and trying to do it all does. And that I want him to become independent. His other siblings are much older though.

I: How was your own childhood and the relationship with your parents?

M10: My parents were warm, I was okay.

I: Is there anything else you consider important to share?

M10: No, I think we talked about the important things.

I: Thank you very much!

M10: Thank you! Good luck with your work.