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Child Temperamental Flexibility Moderates the Relation between Positive Parenting and Adolescent Adjustment

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Abstract

Temperamental flexibility and lower positive parenting are associated with internalizing and externalizing problems; however, youth varying in flexibility may be differentially affected by positive parenting in the prediction of symptoms. We examined whether children's flexibility moderated prospective relations between maternal and paternal positive parenting and youth internalizing and externalizing symptoms during adolescence. Participants ($N = 775$, 71% male) and their caregivers completed measures when youth were 10-12 and 12-14 years old. Father positive parenting interacted with child flexibility to predict father-reported internalizing and externalizing problems. Consistent with the diathesis-stress model, children lower in flexibility experienced greater symptoms than children higher in flexibility in lower positive parenting contexts. Among children lower in flexibility, lower paternal positive parenting was associated with greater internalizing and externalizing symptoms compared to higher paternal positive parenting. However, among youth higher in flexibility, symptom levels were similar regardless of whether youth experienced lower or higher paternal positive parenting.

Keywords

temperament; parenting; fathers; adolescence; internalizing symptoms; externalizing symptoms

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Internalizing and externalizing symptoms often develop in early and middle childhood and are associated with significant impairment and later psychological problems (Bornstein, Hahn, & Suwalsky, 2012; Fanti & Henrich, 2010). Internalizing problems refer to social withdrawal, anxiety, fearfulness, and depression, whereas externalizing problems manifest as hyperactivity, aggression, defiance, and destructive behavior. Because internalizing and externalizing symptoms may place a child at risk for poor social and behavioral outcomes, it is important to identify children at risk for these problems early in development for timely intervention and prevention of these symptoms, correlates, and sequelae (Fanti & Henrich, 2010; Gilliom & Shaw, 2004).

To understand individual differences in risk for the development of internalizing and externalizing symptoms, many researchers have employed the diathesis-stress model, which proposes that some individuals possess attributes (e.g., difficult temperament, high physiological arousal) that increase their risk of developing psychological problems when faced with a stressor (Belsky, Bakermans-Kranenburg, & van IJzendoorn, 2007; Belsky & Pluess, 2009; Salomon & Jin, 2013). Thus, children with certain attributes are hypothesized to be more likely to be adversely affected by an environmental stressor than those without these attributes. Consistent with the diathesis-stress model, when exposed to more negative parenting practices, children and adolescents with certain features may experience more adverse outcomes (Kochanska, Kim, Barry, & Philibert, 2011; Yaman, Mesman, van IJzendoorn, & Bakermans-Kranenburg, 2010; Zarra-Nezhad et al, 2014).

In addition to the predictions that stem from the diathesis-stress model, the differential susceptibility hypothesis adds that children with certain attributes (e.g., temperament) may not only be at risk for maladjustment in the face of a stressor, but may obtain enhanced benefit from positive environmental circumstances (Belsky, Bakermans-Kranenburg, & van IJzendoorn, 2007). That is, the differential susceptibility hypothesis suggests that children's individual differences may make them more reactive to both positive and negative environmental influences (Pluess & Belsky, 2010). For example, although children with difficult temperaments could become emotionally dysregulated in response to negative parenting practices, these children may benefit disproportionately from positive parenting practices, which may facilitate their self-regulation (Belsky & Pluess, 2010; Gallagher, 2002). This possibility is consistent with evidence that when exposed to more sensitive caregivers, young children with difficult temperaments manifested fewer externalizing problems (Bradley & Corwyn, 2008) and better academic competence and social skills (Stright, Gallagher, & Kelley, 2008) compared to young children with easy temperaments. Despite evidence that younger children with difficult temperaments may benefit disproportionately from positive parenting practices, it is unclear whether exposure to positive parenting practices may result in enhanced adjustment among older children and adolescents. Thus, the purpose of the present study was to investigate whether adolescents varying in temperament exhibited different levels of adjustment, defined as internalizing and externalizing symptom levels, when exposed to positive parenting.

As suggested, one attribute that may affect differential susceptibility to the environment is temperament. According to Thomas and Chess (1977), temperament can be defined as individual differences in behavioral responses across contexts. Based on their model of

temperament, children who withdraw from situations; demonstrate slow adaptability; manifest high negative affect (e.g., fear, anger), high intensity of response, and dysrhythmicity (i.e., irregularity in biological functions) are characterized as possessing a difficult temperament, whereas children without these characteristics are characterized as having an easy temperament (Frick & Morris, 2004; Muris & Ollendick, 2005; Thomas & Chess, 1984). Although children with difficult temperaments are at increased risk for externalizing (Giancola, Mezzich, & Tarter, 1998) and internalizing (Blackson, Tarter, Martin, & Moss, 1994) symptoms, the relation between difficult temperament and maladjustment is likely more complex than these linear associations would suggest (Frick & Morris, 2004; Rettew & McKee, 2005). For example, recent work suggests that, in fact, the lower-order difficult temperament dimension of fear is predictive of internalizing problems, whereas the lower-order difficult temperament feature of anger is predictive of externalizing problems (Rydell, Berlin, & Bohlin, 2003). These findings underscore the importance of considering more specific temperamental facets typically associated with difficult temperament.

Much of the available research examining specific temperamental attributes and internalizing and externalizing problems has focused on affect, withdrawal behaviors, activity level, and dysrhythmicity. Few studies have examined temperamental flexibility and how this characteristic may confer risk or resilience for maladjustment. Temperamental flexibility can be defined as one's ability to adapt pre-existing cognitive or behavioral approaches to new situations (Schultz & Searleman, 2002). Temperamental flexibility may be a reflection of the temperamental constructs of (a) effortful control, which refers to one's volitional ability to shift attention and inhibit dominant responses for alternative or subdominant responses (Eisenberg et al., 2005; Rothbart & Bates, 2006), and (b) reactive control, which refers to more involuntary, automatic responses (e.g., inhibition to novelty, impulsivity) that are influenced by motivational states and emotional experiences (Derryberry & Rothbart, 1997). Specifically, youth lower in temperamental flexibility may be more likely to experience fear and focus on potential threats in the environment. In various environments, youth lower in flexibility may be more likely to experience emotional distress and have difficulty in modulating attention and activating problem solving strategies to reduce anxiety, increasing risk for internalizing problems (Windle & Davies, 1999). Moreover, youth lower in flexibility may be more likely to feel threatened across situations and may respond aggressively to minimize or eliminate the perceived threat, increasing risk for externalizing behaviors (Miller-Lewis et al., 2006). Consistent with these possibilities, research indicates that youth lower in flexibility may be at risk for internalizing and externalizing problems (Schultz & Searleman, 2002).

Although children with lower temperamental flexibility are at risk for psychological symptoms relative to youth higher in temperamental flexibility, it is likely that contextual factors, such as parenting, influence risk, resilience, and symptom severity among young children and adolescents who differ in temperamental flexibility (Bates, Dodge, Pettit, & Ridge, 1998; Drabick & Steinberg, 2011; Kiff, Lengua, & Bush, 2011). Consistent with a developmental psychopathology framework, the initiation or maintenance of problematic behaviors often occurs through the transactions between an individual's characteristics and his or her environment (Meaney, 2010; Steinberg & Avenevoli, 2000). Much research has

shown that parenting behaviors interact with a child's temperamental features (e.g., negative affectivity, impulsivity) to influence the onset and course of maladaptive behaviors (e.g., Bates et al., 1998; Ellis & Boyce, 2011; Oldehinkel, Veenstra, Ormel, de Winter, & Verhulst, 2006); however, there is a dearth of research examining whether parenting practices exacerbate or diminish risk for symptoms depending on youth varying in temperamental flexibility. Because it may be challenging for youth lower in flexibility to adapt to various settings, these youth may have more limited social opportunities and thus may be more sensitive to socialization by parents than children higher in flexibility (Morris, Silk, Steinberg, Myers, & Robinson, 2007). Parents that engage in positive parenting behaviors such as providing warmth and guidance may help youth lower in flexibility to modify perseverating thoughts and behaviors. These parents may, moreover, provide problem solving and coping skills that could facilitate youth adaptation to novel situations. However, parents that engage in lower positive parenting (e.g., lower levels of encouragement and support) may impair youth's ability to flexibly address problems, potentially increasing the use of ineffective self-regulation processes that may be associated with maladjustment. As such, the differential susceptibility hypothesis suggests that children lower in temperamental flexibility would benefit from positive parenting more than children higher in temperamental flexibility. However, consistent with both the diathesis-stress and differential susceptibility models, when exposed to negative parenting, children lower in temperamental flexibility would be expected to show relatively greater maladjustment compared to children higher in temperamental flexibility (Belsky, Bakermans-Kranenburg, & van IJzendoorn, 2007).

Although children varying in temperamental flexibility may be differentially influenced by parenting across developmental periods (Eisenberg et al., 2005), the transition to adolescence may be of particular interest because this period is characterized by dramatic changes in biology, cognition, emotion, and social interactions (Drabick & Steinberg, 2011; Steinberg & Morris, 2001). These developmental experiences may be perceived as stressful and thus may interfere with a child's emotion regulation abilities (Kerns, Siener, & Brumariu, 2011), particularly among children lower in temperamental flexibility who may have difficulty adapting to novel situations. Thus, the transition to adolescence may contribute to heightened vulnerability for emotional and behavioral problems among youth (Steinberg & Morris, 2001); however, to date, no studies have considered whether children varying in temperamental flexibility are differentially affected by positive parenting behaviors in the prediction of internalizing and externalizing problems during this developmental period.

An additional limitation is the lack of consideration of mothers' and fathers' practices on children lower in temperamental flexibility. This omission is significant given that mothers' and fathers' behaviors may differ during this developmental period, which may have differential effects on children's outcomes (e.g., Stolz, Olsen, & Barber, 2005). For example, during middle childhood and adolescence, youth tend to spend more time with and report feeling greater intimacy with mothers compared to fathers (Kosterman, Haggerty, Spoth, & Redmond, 2004; Repinski & Shonk, 2004). However, mother interactions with youth tend to be more directive and contentious, whereas interactions with fathers tend to be more focused on instrumental goals (e.g., achievement), problem solving, and the development of youth

autonomy (Collins & Russell, 1991; Kosterman et al., 2004). The different relationship dynamics that youth have with mothers and fathers may influence risk or resilience for youth internalizing and externalizing problems, which is consistent with work that indicates higher father-child connectedness and involvement is negatively associated with adolescents' internalizing and externalizing behaviors (Day & Padilla-Walker, 2009). Moreover, the impact of mother and father parenting practices on youth symptoms may further depend on youth's temperament. This possibility is consistent with findings that among youth with difficult temperaments, mothering quality was a stronger predictor of externalizing symptoms, whereas fathering quality was a stronger predictor of internalizing problems (Belsky, Hsieh, & Crnic, 1998). Thus, it is clear that parenting behaviors by mothers and fathers may predict distinct youth outcomes, and the effects of these parenting behaviors may be influenced by children's level of temperamental flexibility.

Moreover, relations among mother and father positive parenting practices with internalizing and externalizing symptoms may depend on not only child temperamental flexibility, but also child sex, although no research to date has explored whether temperamental flexibility differentially moderates positive parenting among boys versus girls in the prediction of youth symptoms. Girls are more likely to exhibit internalizing symptoms, whereas boys are more likely to evidence externalizing symptoms during the transition to adolescence (Daughters, Gorka, Magidson, MacPherson, & Seitz-Brown, 2013). Similarly, research has indicated temperamental differences between boys and girls; for example, girls tend to have higher levels of effortful control than boys (Else-Quest, Hyde, Goldsmith, & Van Hulle, 2006). Given similarities between effortful control and temperamental flexibility, boys lower in effortful control may be lower in temperamental flexibility relative to girls; as such, higher positive parenting may be particularly beneficial among boys for attenuating risk for internalizing and externalizing problems. Thus, sex differences may arise because of differences in the base rates of flexibility or symptom outcomes among boys and girls, and/or differences in the magnitude of prediction from predictors to outcomes (Rutter, Caspi, & Moffitt, 2003). As such, exploring sex differences in the relations between positive parenting and children's symptoms among youth varying in flexibility can inform etiological, intervention, and prevention models among boys and girls who may differentially benefit from positive parenting practices.

A further limitation in the current literature is that few studies have included fathers as informants of child symptoms. Although higher than other informant pairs (e.g., parent-teacher, parent-child), agreement between mothers' and fathers' ratings of child adjustment is generally moderate, indicating differences in maternal and paternal perceptions of the child's behavior (Achenbach, McConaughy, & Howell, 1987; De Los Reyes et al., 2015; Duhig, Renk, Epstein, & Phares, 2000). This finding is consistent with work that suggests fathers are more likely to report young children as more difficult (e.g., more unadaptable, greater fussiness) compared to mothers (Atella, DePietro, Smith, & James-Roberts, 2003). Inter-rater discrepancies are likely a function of actual differences in observed behaviors, child characteristics, the context in which ratings occur, and/or biases in raters' perspectives. Nevertheless, these discrepancies highlight the importance of considering different informants (De Los Reyes et al., 2015).

In the present study, we sought to extend previous research by addressing a number of gaps in the literature. First, we prospectively explored whether temperamental flexibility interacted with father and mother positive parenting, defined as higher child acceptance and child-centeredness, to prospectively predict internalizing and externalizing problems among youth during the transition to adolescence, a developmental period characterized by a myriad of neurobiological, cognitive, and social changes. Because youth varying in flexibility may be differentially affected by positive parenting quality, we specifically explored whether child temperamental flexibility moderated the relation between father and mother positive parenting and subsequent adjustment. Many of the studies to date supporting differential susceptibility have been confirmed among infants and young children (e.g., Stright et al., 2008); however, fewer studies have tested differential susceptibility among older children and adolescents compared to younger children. Second, we included multiple informants, specifically youth, mother, and father reports to minimize mono-rater biases. Third, we examined sex differences in the effect of positive parenting practices on youth varying in temperamental flexibility in the prediction of internalizing and externalizing symptoms.

Different outcomes can be expected based on the explanatory model considered. Consistent with both the diathesis-stress and differential susceptibility models, children lower in temperamental flexibility would be expected to experience greater internalizing and externalizing problems than children higher in temperamental flexibility when exposed to lower levels of positive parenting. Because youth lower in flexibility may be more susceptible to both positive and negative environmental stimuli (Belsky & Pluess, 2009), we expected results to be consistent with the differential susceptibility hypothesis. Specifically, we hypothesized that among children lower in flexibility, higher father and mother positive parenting would provide a greater benefit (i.e., predict lower rates of internalizing or externalizing problems during the transition to adolescence), compared to children higher in flexibility. We also hypothesized that children lower in flexibility (compared to those higher in flexibility) would show higher rates of internalizing and externalizing problems during the transition to adolescence when experiencing lower levels of positive parenting.

Method

Participants

The current study involves a sample recruited from the Center for Education and Drug Abuse Research. Recruitment and baseline assessments began when children were aged 10-12 years (Time 1) and a follow-up assessment occurred when children were 12-14 (Time 2). Sampling methods were designed to recruit youth at high and low risk for substance use disorder (SUD) on the basis of the presence or absence of a lifetime diagnosis of SUD or other psychiatric disorders in the biological father (Tarter & Vanyukov, 2001). Biological fathers with and without histories of psychiatric diagnoses were recruited through substance dependence treatment programs and other venues (e.g., psychiatric hospitals and various other research centers in the Pittsburgh area through newspaper and radio advertisements). Fathers who had a child aged 10-12 years were eligible to participate and were further screened for eligibility (Tarter & Vanyukov, 2001). Youth were classified into one of three

groups according to their biological father's lifetime prevalence of psychological disorders: (a) paternal history of SUD, (b) paternal history of other psychiatric diagnosis not including SUD, or (c) no lifetime paternal history of psychiatric diagnosis. Fathers were considered to have a SUD if they met lifetime *DSM-III-R* criteria (APA, 1987), the most recent edition of the *DSM* when the study was initiated, for substance abuse or dependence.

Youth completed assessments at Time 1 (10-12 years old) and Time 2 (12-14 years old). At Time 1, participants included 775 children ($M = 10.95 \pm 0.88$ years old; 71% male; 76% White, 21% African American, 3% "multiracial"). At Time 2, participants included 631 early adolescents ($M = 12.99 \pm 0.95$ years old, 72% male; 76% White, 21% African American, 3% "multiracial"). The sample contains more males than females because recruitment of females began four years after Center for Education and Drug Abuse Research was underway. Recruitment sources and procedures, as well as inclusionary and exclusionary criteria, are described in detail elsewhere (Tarter & Vanyukov, 2001).

Procedure

The study was approved by a University Institutional Review Board. Prior to study participation, participants were provided with a detailed description of the study. Participants were informed that their privacy was protected by a Certificate of Confidentiality issued to Center for Education and Drug Abuse Research. In addition, a Certificate of Confidentiality from the National Institute on Drug Abuse was obtained. Written informed consent then was obtained from caregivers. All children provided assent. At Times 1 and 2, mothers, fathers, and children completed questionnaires in a fixed order. Participants were financially compensated after the completion of each assessment.

Measures

Father diagnostic status—For the purposes of the present study, we assigned youth into one of two groups: youth with fathers with an SUD or psychiatric disorder (44% of sample) and youth with fathers without an SUD or psychiatric diagnosis (56% of sample) based on an extended version of the Structured Clinical Interview for *DSM-III-R* (Spitzer, Williams, & Gibbon, 1987).

Positive parenting behaviors—Children rated quality of parenting at Time 1 using the Children's Report of Parental Behavior Inventory (CRPBI; Margolies & Weintraub, 1977). The CRPBI is a 56-item scale that assesses children's perceptions of their mothers' and fathers' parenting behaviors. Children answered the same questions regarding their mothers' and fathers' behavior. The measure consists of three factors (two subscales per factor) that assess maternal and paternal acceptance/rejection, encouragement of psychological autonomy/psychological control, and firm control/lax control. Positive parenting was indexed by the maternal and paternal acceptance/rejection factor, which consists of two subscales: mother ($\alpha=.96$) and father ($\alpha=.95$) child acceptance (16 items) and mother ($\alpha=.88$) and father ($\alpha=.87$) child-centeredness (8 items). Sample items from each scale include "My mother/father seems to see my good points more than my flaws" (acceptance subscale) and "My mother/father is always thinking of things that will make me happy" (child-centeredness subscale). Because the acceptance and child-centeredness subscales were

highly correlated (fathers: $r = .82, p = .001$; mothers: $r = .76, p = .001$), the 24 items were added and averaged to produce a score for mother positive parenting ($\alpha = .96$) and father positive parenting ($\alpha = .97$). Higher scores reflect higher maternal and paternal positive parenting. The subscales from the CRPBI have demonstrated good test-retest reliability (Margolies & Weintraub, 1977) and criterion validity related to adolescent self-concept (Litovsky & Dusek, 1985).

Temperamental flexibility—Child temperament was assessed with the Dimensions of Temperament Survey-Revised (DOTS-R; Windle & Lerner, 1986) at Time 1. The DOTS-R is a 54-item measure that includes subscales that assess child flexibility, affect, activity level, and persistence. Mothers completed the DOTS-R. The flexibility subscale ($\alpha = .77$) includes 5 items rated on a scale from 1 (*usually false*) to 4 (*usually true*). A sample item is “It takes my child a long time to adjust to new schedules.” The DOTS-R has demonstrated good internal consistency and moderate levels of test-retest reliability (Windle, 1992).

Child internalizing and externalizing symptoms—Fathers and mothers completed the Child Behavior Checklist (CBCL; Achenbach, 1991) at Time 2. We used internalizing and externalizing composite scores for boys and girls. Mothers and fathers were asked to rate whether certain behaviors were characteristic of their child in the past six months on a scale from 0 (*never*) to 2 (*almost always*). A sample item from the internalizing scale is “unhappy, sad, or depressed,” and a sample item from the externalizing scale is “disobedient at home.” Among boys, the mother ($\alpha = .89$) and father ($\alpha = .89$) internalizing composite and the mother ($\alpha = .93$) and father ($\alpha = .93$) externalizing composite scores demonstrated good internal consistency. Among girls, the mother ($\alpha = .92$) and father ($\alpha = .89$) internalizing composite and the mother ($\alpha = .92$) and father ($\alpha = .92$) externalizing composite scores also demonstrated good internal consistency. The CBCL is a widely used instrument to assess youth emotional and behavioral symptoms that has been shown to possess strong reliability and discriminant and convergent validity (Nakamura, Ebesutani, Bernstein, & Chorpita, 2009).

Statistical Analyses

Descriptive statistics and bivariate correlations were conducted to examine the relations among predictor and dependent variables using SPSS Version 21. We conducted independent sample *t*-tests to examine potential sex differences for each of the study variables. Further, given that maternal and paternal positive parenting behaviors may be influenced by paternal diagnostic status (Loukas et al., 2003), we examined whether parenting behaviors differed based on paternal psychiatric history. When variances were unequal among boys and girls, we report the adjusted degrees of freedom. Because the *SDs* of internalizing and externalizing symptoms were large relative to the *Ms*, we used the non-parametric Mann-Whitney test for exploring sex differences among those variables. For child sex, males were coded as “0” and females were coded as “1.” A father diagnostic status variable was created by coding fathers with no SUD or psychiatric problems as “0” and fathers with a history of SUD or other psychiatric diagnosis as “1.”

Individuals with missing data on father-reported internalizing and externalizing symptoms differed from individuals with present data on these father-reported symptom variables on child sex, $\chi^2(1) = 9.14, p = .002, \phi = .11$; child age, $t(105.32) = -2.59, p = .011$, Cohen's $d = .31$; child ethnicity, $\chi^2(1) = 10.60, p = .001, \phi = .12$; father diagnostic status, $\chi^2(1) = 18.22, p < .005, \phi = -.15$; child flexibility, $t(762) = -2.00, p = .046$, Cohen's $d = .16$; and mother-reported internalizing problems, $t(591) = -2.81, p = .005$, Cohen's $d = .19$. Further, individuals with missing data on mother-reported internalizing and externalizing symptoms differed from individuals with complete data for the mother-reported symptoms regarding the following variables: child age, $t(71.25) = -4.09, p < .005$, Cohen's $d = .56$; child ethnicity, $\chi^2(1) = 14.58, p < .005, \phi = .14$; and father diagnostic status, $\chi^2(1) = 13.09, p < .005, \phi = -.13$. No additional group differences were found for study variables that had missing data (all t 's < 4.31 , all p 's $> .05$). Thus, individuals with missing data on father-reported and/or mother-reported symptoms tended to be male, younger, higher in flexibility, Caucasian, and a child of a father with a SUD or psychiatric problem.

Primary analyses were conducted using Mplus Version 7.11 (Muthén & Muthén, 1998-2014). Mplus uses Full Information Maximum Likelihood (FIML) estimation to address missing data. Use of other strategies (e.g., complete casewise analysis or listwise deletion, complete case analyses or pairwise deletion, nonresponse weighting, mean imputation) may bias a sample (Graham, 2009; Little & Rubin, 2002; Newman, 2003). FIML employs all available data to estimate model parameters, but does not impute values. This approach allows for utilization of participants with missing data in model estimation and yields smaller errors in parameter estimates and standard errors relative to other missing data strategies (Enders, 2001; Graham, 2009; Newman, 2003).

To determine whether findings were consistent with the differential susceptibility or diathesis-stress models, we conducted regression analyses to examine (a) the main effects of father positive parenting, mother positive parenting, and child flexibility; and (b) whether child temperamental flexibility moderated the relation between father and mother positive parenting and father- or mother-reported internalizing or externalizing problems. In each regression equation, we choose to control for several variables. We controlled for youth ethnicity and sex given evidence of different prevalence rates of internalizing and externalizing symptoms based on these variables (Daughters et al., 2013). Moreover, because level of flexibility may be influenced by pubertal and age-related changes (Posner & Rothbart, 2000), we controlled for age in our analyses. Further, given that participants were recruited based on paternal diagnostic status, we controlled for this variable. Thus, Step 1 included child age, sex, father diagnostic status, mother and father positive parenting, and child flexibility assessed at Time 1. Step 2 included Step 1 variables, the father positive parenting $\times$ child flexibility cross-product interaction term, and the mother positive parenting $\times$ child flexibility cross-product interaction term. To minimize multicollinearity, the independent variables were z -scored ($M=0, SD=1$) before inclusion in the regression equations and interaction terms were created from the z -scored variables (Aiken & West, 1991). In total, four regression analyses were conducted, which included father- and mother-reported internalizing and externalizing symptoms as outcome variables. Because analyses

involved four dependent variables, we used a Bonferroni corrected p -value ($.05/4=.0125$) for determining whether the interaction terms were significant.

For significant interaction terms, post-hoc probing was conducted using the procedures outlined by Dearing and Hamilton (2006) and Roisman et al. (2012). Although some researchers use visual inspection to determine whether findings are consistent with diathesis-stress or differential susceptibility models, this approach has been criticized because of its subjective nature (Kochanska et al., 2011; Roisman et al., 2012). An alternative approach involves examining *regions of significance*, a statistical tool that provides a range of values of the predictor variable (positive parenting) for which the moderator (flexibility) is significantly associated with the outcome variable (internalizing or externalizing symptoms) (Dearing & Hamilton, 2006). This method provides upper and lower bounds of regions of significance; that is, for the present study, the values of positive parenting below and above which the regression lines for the two groups (higher and lower flexibility) significantly differ on father- or mother-reported internalizing or externalizing symptoms. Because we standardized the predictor and moderator variables, the regions of significance values generated were standard deviation values. We investigated interaction effects within $\pm 2 SD$ from the mean of the positive parenting variable, consistent with recommendations by Roisman et al. (2012), which allowed us to explore 95% of the sample. Evidence for diathesis stress occurs when the relation between the moderator and the outcome variable(s) is significant only at the low end of the range of the predictor. However, support for differential susceptibility occurs when the relation between the moderator and outcome variable is significant at the low and high levels of the predictor variable (Roisman et al., 2012).

Thus, in the current study, the regions of significance approach identifies positive parenting values for which the regression lines for high and low flexibility are significantly different from each other. However, it does not indicate whether youth higher (or lower) in flexibility exhibited different symptom levels in the context of different levels of positive parenting, which requires a test of whether the slope for the regression lines is significantly different from zero. In other words, to test whether the relation between different levels of the moderator (flexibility) and the outcome (father- or mother-reported internalizing or externalizing symptoms) was significantly different from zero and dependent on the predictor variable (positive parenting), we computed simple slopes (i.e., $\pm 1 SD$ from the mean of child flexibility) consistent with the recommendations of Aiken and West (1991) and Roisman et al. (2012). Support for differential susceptibility may occur if the slope of one of the groups (higher or lower flexibility) is significantly different from zero and steeper than the slope for the other group (Belsky et al., 2007). Last, because research has indicated that the effect of mother and father parenting practices on internalizing and externalizing symptoms may differ not only based on youth's temperamental flexibility, but also sex (Karreman et al., 2009), we conducted three-way interactions (maternal (or paternal positive parenting) $\times$ child flexibility $\times$ child sex) to examine these relations.

Results

Bivariate correlations, means, standard deviations, and *ns* for the study variables are presented in Table 1. Father acceptance and child-centeredness were negatively correlated with father-reported and mother-reported internalizing and externalizing problems. Similarly, mother acceptance and child-centeredness were negatively related to father-reported and mother-reported internalizing and externalizing symptoms.

With regard to sex differences among study variables, fathers rated boys as having lower levels of internalizing symptoms ($Mdn = 6.00$) than girls ($Mdn = 7.00$), $U = 24581.50$, $z = -3.79$, $p < .005$. In addition, fathers rated boys ($Mdn = 8.00$) as having higher levels of externalizing symptoms than girls ($Mdn = 4.00$), $U = 24454.50$, $z = -3.87$, $p < .005$. Mothers rated boys ($Mdn = 7.00$) as experiencing higher levels of internalizing symptoms than girls ($Mdn = 6.00$), $U = 31206.50$, $z = -2.40$, $p = .017$, and boys ($Mdn = 8.00$) as having higher levels of externalizing symptoms than girls ($Mdn = 6.00$), $U = 28018.00$, $z = -4.09$, $p < .005$. Boys reported higher levels of maternal positive parenting than girls, $t(698) = 3.43$, $p = .001$, Cohen's $d = .29$. No other sex differences were found among child age, ethnicity, father diagnostic status, positive parenting quality, or flexibility (all t 's < 3.43 , all p 's $> .05$).

In regard to father diagnostic status, paternal positive parenting was slightly higher among youth with a father without a psychiatric problem or SUD ($M = 2.28$, $SD = .68$) than youth with a father with a psychiatric problem or SUD ($M = 2.19$, $SD = .54$), $t(543.42) = 1.99$, $p = .047$, Cohen's $d = .16$, although the magnitude of this difference was small. Maternal positive parenting was also greater among youth with a father without a psychiatric problem or SUD ($M = 2.10$, $SD = .50$) than youth with a father with a psychiatric problem or SUD ($M = 2.07$, $SD = .50$), $t(698) = 2.94$, $p = .003$, Cohen's $d = .24$, although the magnitude of this difference was also rather small. Results of the primary analyses involving multiple regressions are presented next, grouped by outcome.

Mother-reported internalizing symptoms

There were main effects for father diagnostic status ($\beta = -.15$, $p < .005$)¹ and child flexibility ($\beta = -.26$, $p < .005$), but not child sex ($\beta = .06$, $p = .145$). There was no significant main effect for father positive parenting ($\beta = .05$, $p = .425$) or mother positive parenting ($\beta = .04$, $p = .521$) on mother-reported internalizing symptoms (top of Table 2). The child flexibility $\times$ father positive parenting interaction term ($\beta = -.04$, $p = .440$) and child flexibility $\times$ mother positive parenting interaction term ($\beta = -.11$, $p = .050$) did not predict mother-reported internalizing problems based on the Bonferroni corrected p -value.

Mother-reported externalizing symptoms

There were main effects for child sex ($\beta = -.12$, $p = .003$), father diagnostic status ($\beta = -.18$, $p < .005$), and child flexibility ($\beta = -.25$, $p < .005$). There was a significant main effect for

¹Because father diagnostic status was a significant predictor of mother-reported and father-reported internalizing and externalizing symptoms, we conducted four, three-way interactions examining father diagnostic status $\times$ child flexibility $\times$ father (or mother) positive parenting. None of the three-way interactions was significant in predicting youth behavior problems (all β s $< .09$, all p s $> .291$).

mother positive parenting ($\beta = .12, p = .038$), but not father positive parenting ($\beta = .04, p = .443$) on mother-reported externalizing symptoms (middle of Table 2). The child flexibility $\times$ mother positive parenting interaction term ($\beta = .01, p = .895$) and the child flexibility $\times$ father positive parenting interaction term ($\beta = -.10, p = .056$) did not predict mother-reported externalizing symptoms.

Father-reported internalizing symptoms

There was a main effect for child sex ($\beta = -.12, p = .005$), father diagnostic status ($\beta = -.12, p = .003$), and child flexibility ($\beta = -.19, p < .005$). There were no significant main effects for father positive parenting ($\beta = .09, p = .170$) or mother positive parenting ($\beta = .00, p = .963$) on father-reported internalizing symptoms (middle of Table 2). The child flexibility $\times$ mother positive parenting interaction term did not predict father-reported internalizing symptoms ($\beta = .11, p = .046$) based on the Bonferroni corrected p -value. The child flexibility $\times$ father positive parenting interaction term predicted father-reported internalizing problems ($\beta = -.22, p < .005$).

Post hoc examination of this significant interaction indicated that the lower bound of regions of significance was .23, which corresponds to the father positive parenting raw score of 2.37. The upper bound of regions of significance was 3.68, which exceeded the range of ± 2 SD from the mean of father positive parenting; thus, only a lower bound of regions of significance was observed among the present sample. The number of children with positive parenting scores below .23 was 434 (56% of sample). These findings indicate that the two regression lines (high and low flexibility) were significantly different for all possible scores when father positive parenting was below .23 SD s from the father positive parenting raw mean of 2.23. Thus, when paternal positive parenting was at or below .23 SD s, youth lower in flexibility exhibited elevated internalizing problems compared to youth higher in flexibility. Post hoc probing of the child flexibility $\times$ father positive parenting interaction term indicated that the simple slope was significant among youth lower in flexibility ($B = -1.97, p < .005$), but not higher in flexibility ($B = 0.90, p = .858$) (Figure 1a). Among youth lower in flexibility, lower paternal positive parenting was associated with heightened internalizing problems relative to higher paternal positive parenting. Nevertheless, when exposed to higher levels of positive parenting, youth lower in flexibility experienced an attenuation of internalizing symptoms. However, among youth higher in flexibility, lower paternal positive parenting was associated with similar levels of symptoms as higher paternal positive parenting.

Father-reported externalizing symptoms

There was a main effect for child sex ($\beta = -.12, p = .003$), father diagnostic status ($\beta = -.15, p < .005$), and child flexibility ($\beta = -.15, p < .005$). There was not a significant main effect for father positive parenting ($\beta = .07, p = .281$) or mother positive parenting ($\beta = .06, p = .345$) on father-reported externalizing symptoms (bottom of Table 2). The child flexibility $\times$ mother positive parenting interaction term did not predict father-reported externalizing symptoms ($\beta = .12, p = .023$) based on the Bonferroni corrected p -value; however, the child flexibility $\times$ father positive parenting interaction term predicted father-reported externalizing symptoms ($\beta = -.26, p < .005$).

Post hoc examination of the significant interaction term indicates that the lower bound of regions of significance was .32, which corresponds to a father positive parenting raw score of 2.42. The upper bound of regions of significance was 2.29, which exceeded the range of $\pm 2 SD$ from the mean of father positive parenting and thus, only a lower bound of regions of significance was observed among the present sample. The number of children with positive parenting scores below .32 was 453 (58% of the sample). These findings indicate that the two regression lines (high and low flexibility) were significantly different for all possible scores when father positive parenting was below .32 *SDs* from the father positive parenting raw mean of 2.23. Thus, when paternal positive parenting was at or below .32 *SDs*, children lower in flexibility exhibited higher externalizing symptoms than youth higher in flexibility. Post-hoc probing of the child flexibility $\times$ father positive parenting interaction indicated that the simple slope was significant for low flexibility ($B = -2.93, p < .005$), but not high flexibility ($B = 0.21, p = .738$) in the prediction of externalizing symptoms (Figure 1b). Thus, similar to the findings for father-reported internalizing symptoms, among youth lower in flexibility, lower paternal positive parenting was associated with heightened externalizing problems compared to higher paternal positive parenting. However, when youth lower in flexibility were exposed to higher positive parenting practices, they evidenced an attenuation of externalizing symptoms. In contrast to youth lower in flexibility, youth higher in flexibility displayed similar levels of externalizing symptoms regardless of the levels of paternal positive parenting experienced.

Last, ancillary analyses investigated whether child sex moderated the relations between mother and father parenting practices and children's flexibility in the prediction of father- and mother-reported internalizing and externalizing symptoms. None of the sex $\times$ child flexibility $\times$ positive parenting interactions predicted symptoms (β s ranged from .02-.11; p s ranged from .052-.698). Thus, no post-hoc probing was conducted for the three-way interactions.

Discussion

The present study extends previous research by examining internalizing and externalizing symptoms among children with different levels of the lower-order temperamental feature of flexibility when exposed to positive parenting. Moreover, the current study expands extant research on diathesis-stress and differential susceptibility by examining adjustment among youth lower in flexibility when exposed to positive parenting practices during the transition to adolescence. Results from the present study indicate that the interaction between child temperamental flexibility and father positive parenting predicted father-reported internalizing and externalizing symptoms. Specifically, among youth lower in flexibility, lower paternal positive parenting was associated with elevated father-reported internalizing and externalizing behaviors compared to higher paternal positive parenting. Although youth lower in flexibility experienced lower symptom levels in the context of high vs. low paternal positive parenting, these youth did not exhibit lower internalizing and externalizing symptoms than youth higher in flexibility, which would have been necessary to provide support for the differential susceptibility hypothesis. Among youth higher in flexibility, lower and higher paternal positive parenting predicted relatively equivalent levels of symptoms. Although the child flexibility $\times$ mother positive parenting was significant at $p < .$

05, the cross-product interaction term did not meet criteria for post-hoc probing based on the Bonferroni corrected p value. Nevertheless, findings regarding paternal parenting are consistent with the diathesis-stress model.

Results from the present analyses indicate significant main effects of child flexibility, child sex, and father diagnostic status. Specifically, temperamental flexibility was negatively associated with both internalizing and externalizing symptoms. Youth lower in temperamental flexibility may exhibit fear and distress in novel contexts and may experience difficulty modulating these emotions, exacerbating risk for internalizing symptoms (Schultz & Searleman, 2002). Moreover, children lower in flexibility may feel threatened in novel situations and respond with aggression to mitigate perceived threats, conferring risk for externalizing behaviors (Miller-Lewis et al., 2006). In regard to the main effect of child sex, boys were more likely to evidence mother-reported and father-reported internalizing and externalizing symptoms compared to girls. These findings are consistent with the independent sample t -tests for mother-reported, but not father-reported, symptoms. Last, there was a main effect of father diagnostic status such that youth with a father without a psychiatric problem or SUD were at elevated risk for behavior problems. Although unexpected, the magnitude of the β s was generally low; nevertheless, this finding suggests that other contextual or intrapersonal features may have increased risk for symptoms beyond having a father who met lifetime diagnostic criteria for a psychiatric disorder or SUD.

Overall, results of the present study are more consistent with the diathesis-stress model than the differential susceptibility hypothesis. These findings are similar to past research indicating that exposure to adverse parenting contexts may result in increased risk for internalizing and externalizing problems among children with difficult temperaments (Kochanska et al., 2011; Yaman et al., 2010; Zarra-Nezhad et al., 2014). Consistent with biological sensitivity to context models (Ellis & Boyce, 2011), youth lower in temperamental flexibility may experience challenges modulating their arousal and attention. Exposure to lower positive parenting may impair these children's abilities to regulate themselves, increasing risk for internalizing and externalizing symptoms (Schultz & Searleman, 2002). Although we also expected that maternal positive parenting would attenuate symptoms among youth lower in flexibility, results were not consistent with this hypothesis. Mothers may be just as likely as fathers to engage in positive parenting behaviors such as encouraging and supporting youth; however, the positive influence of mothers may be mitigated by more frequent mother-child discord (Collins & Russell, 1991; Kosterman et al., 2004). Indeed, during the transition to adolescence, youth interactions with mothers may be more directive and conflictual relative to fathers' interactions with youth (Repinski & Shonk, 2002).

Although youth lower in flexibility experienced lower levels of internalizing and externalizing behaviors in the context of higher vs. lower paternal positive parenting, these youth did not exhibit lower levels of symptoms relative to youth higher in flexibility. These results conflict with research supporting the differential susceptibility hypothesis; this previous research suggests that young children with difficult temperaments displayed fewer externalizing problems and higher levels of social competence in the context of supportive, responsive parenting relative to children with easier temperaments (Bradley & Corwyn,

2008; Stright et al., 2008). There are several reasons to account for this finding. First, it is possible that younger children are more malleable to contextual factors, such as parenting, compared to adolescents (Belsky & Pluess, 2009). That is, young children's regulation of arousal and emotions is often dependent on their caregivers' provision of responsiveness and support (Bronson, 2000); however, as children age, opportunities for learning regulatory skills from parents may become more limited as youth spend more time outside of the home, thus limiting the effect that parenting may have on youth's adjustment (Drabick & Steinberg, 2011). Second, because youth lower in flexibility may experience challenges with regulating their emotions and behaviors, these youth may exhibit lower levels of social competence and greater rates of peer rejection (Iyer, Kochenderfer-Ladd, Eisenberg, & Thompson, 2010). Because the transition to adolescence often involves greater focus on peer relationships, higher levels of peer rejection may be particularly harmful among youth lower in flexibility, potentially diminishing the benefits of positive parenting practices and increasing risk for internalizing and externalizing symptoms.

The present results suggest that intervention and prevention efforts to attenuate youth symptoms by improving parenting practices may be more effective among youth lower in flexibility. Such an approach could improve identification of youth who may benefit from existing interventions or require modifications to intervention targets, goals, and/or components to facilitate beneficial outcomes among youth lower in flexibility (McKee et al., 2014; Presnall, Webster-Stratton, & Constantino, 2014). Although Belsky (2014) and others have suggested that intervention and prevention efforts should target youth based on behavioral and/or genetic markers that may engender greater sensitivity to the environment (Belsky, 2014), these markers are mutually influenced by contexts (e.g., parenting; Meaney, 2010). Thus, social policy and programs aimed at mitigating internalizing and externalizing symptoms among youth should strive to capitalize on an individual's degree of malleability based on their behavioral or genetic attributes, as well as consider the person-context relations that may influence various symptoms.

The current study is one of the first to examine the relations between positive parenting among children varying in temperamental flexibility and the development of internalizing and externalizing symptoms during the transition to adolescence. This study builds on previous work by including both mother and father parenting, as well as both mother and father reports of their children's functioning, to capture differences in youth's behavior that may occur across contexts. As noted, the present results suggest that father-reported internalizing and externalizing behaviors were predicted by father positive parenting. There are several possible reasons for these differences between father- and mother-reported outcomes. First, consistency in the adult caregiver considered might have contributed to these associations, given that children reported on parental behavior for the same parent/informant for whom outcomes were significant. Second, because mothers and fathers may spend different amounts of time with their children, these discrepancies may lead to differential awareness of problems or cause parents to be more biased in their perceptions of the child's behavior (e.g., looking for convergent evidence of problematic behavior; Grietens et al., 2004; Renk & Phares, 2007). Third, it is possible that children behave differently around mothers and fathers, resulting in rating discrepancies (De Los Reyes et al., 2015). Consistent with this possibility, mothers reported higher levels of externalizing behaviors

than fathers, $t(539) = 3.88, p < .005$, Cohen's $d = .04$, though the magnitude of the effect size was small. It is possible that children are more likely to obey their fathers compared to their mothers and thus, fathers may be less likely to observe disruptive behavior among youth (Campbell, 2002; Duhig et al., 2000). Further, mothers and fathers may have different thresholds or tolerance for what they identify as problematic child behavior, which may contribute to rating discrepancies (De Los Reyes et al., 2015).

There are several limitations of the study. One limitation was that youth internalizing and externalizing symptoms were not available at Time 1 and thus, we were unable to control for these symptoms. It is possible that youth flexibility and parenting behaviors predicted symptoms at Time 1 and that the symptoms observed at Time 2 reflect carry-over effects from Time 1. Future research should consider controlling for earlier symptoms to determine whether there is incremental prediction across time points using a prospective design. Another limitation was the decision to focus solely on children's temperamental flexibility, an important yet understudied feature of behavioral self-regulation, rather than other child-specific factors that are affected by the parenting context (e.g., negative affectivity, impulsivity; Belsky & Pluess, 2009). Nevertheless, the current study highlights that youth lower in flexibility may be more responsive to positive parenting and evidence attenuated symptoms. Future work should explore children varying in other temperamental facets and whether these youth exhibit enhanced adjustment in positive rearing environments. An additional limitation was that the sample included disproportionately more male children; thus, future work should examine these relations among samples that include higher proportions of girls to determine whether the findings generalize to both sexes. Another limitation is the reliance on questionnaires to assess the constructs of interest. Future work should incorporate other means of assessment such as observations, interviews, or laboratory-based assessments to increase the generalizability of the findings and to minimize concerns regarding mono-method biases. Moreover, in our sample, there were low-to-moderate correlations between the moderator (flexibility) and dependent variables (father- and mother-reported symptoms) likely due to shared method variance. A more stringent test of differential susceptibility would require no correlation between the moderator and dependent variable under study. Further, we examined mother- and father-reported internalizing and externalizing symptoms during the transition to adolescence; future work should explore whether these systems persist or abate during later adolescence and early adulthood. Another limitation was that half the youth in the sample had more significant contextual risk; thus, subsequent research should explore whether findings from the current sample hold among samples that differ in regard to their level of risk. Lastly, although there was missing data among some of the study variables, we used FIML to estimate model parameters for available data.

Despite these study limitations, the present study has several strengths. First, the current sample is relatively large and diverse. Second, the current study extends previous research by examining the impact of mother and father positive parenting on children who differ in terms of their temperamental flexibility, something that no studies to date have explored. Third, we considered mother- and father-reported internalizing and externalizing symptoms to capture children's behavior across settings using a prospective design. Fourth, consistent

with the recommendations of Stolz, Olson, and Barber (2005), we controlled for maternal or paternal positive parenting when examining the contributions of each parent's behaviors and considered both parents' behaviors concurrently with children's flexibility in the interaction terms. Fifth, we considered whether positive parenting buffered the association between internalizing and externalizing symptoms among youth varying in flexibility using regions of significance testing rather than mere visual inspection to infer differential susceptibility or diathesis-stress. Last, we explored potential sex differences in the relations among positive parenting on youth varying in temperamental flexibility in the prediction of internalizing and externalizing symptoms.

In sum, although much of the research to date has examined how temperamentally difficult children are more adversely affected by negative parenting behaviors, consistent with the diathesis-stress model, our work explored whether children lower in temperamental flexibility may, in fact, benefit disproportionately from positive parenting consistent with the differential susceptibility hypothesis. Our findings suggest that children lower in temperamental flexibility evidenced greater internalizing and externalizing symptoms when exposed to lower positive parenting compared to higher positive parenting. Moreover, although youth lower in flexibility experienced an attenuation of internalizing and externalizing behaviors when exposed to higher paternal parenting, these youth exhibited similar, but not significantly lower, levels of symptoms relative to youth higher in flexibility. These findings thus support the diathesis-stress model. Future studies should employ a multidimensional approach by examining specific temperamental dimensions and assessing these features using multiple indices (e.g., psychophysiological measures). Additionally, future work should incorporate multiple reporters of early adolescent adjustment, such as teachers and youth, to address reporter biases and assess the generalizability of the findings across informants and settings. Furthermore, future research should examine how other positive parenting variables, such as parental encouragement or parental support, impact children lower in temperamental flexibility not only during the transition to adolescence, but across multiple developmental periods. Future research examining youth lower in temperamental flexibility and their adjustment in positive rearing contexts may enrich our understanding of child-specific and contextual factors that may confer risk or resilience for psychological adjustment.

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Highlights

- We explored positive parenting on youth low in flexibility in predicting symptoms.
- Findings are largely consistent with the diathesis-stress model.
- Youth lower in flexibility had more symptoms in low positive parenting contexts.
- Youth lower in flexibility were more affected by context than flexible youth.
- Intervention and policy implications are discussed.

Figure 1.

a. The relation between father positive parenting and father-reported internalizing symptoms. The shaded areas represent the region of significance (lower bound = .23). b. Child flexibility moderates the relation between father positive parenting and father-reported externalizing symptoms. The shaded areas represent the region of significance (lower bound = .32).

Table 1

Bivariate correlations, means, SDs, and n's for study variables

Variable	1	2	3	4	5	6	7	8	9
1. Child Sex	--								
2. Child Age	.05	--							
3. Child Flexibility	.01	.04	--						
4. Mother Positive Parenting	-.13**	.09*	.01	--					
5. Father Positive Parenting	-.06	.08*	.03	.65**	--				
6. Father-Reported Internalizing Symptoms	-.14**	-.04	-.20**	.10*	.10*	--			
7. Father-Reported Externalizing Symptoms	-.15**	-.06	-.17**	.14**	.13**	.78**	--		
8. Mother-Reported Internalizing Symptoms	-.08	-.04	-.28**	.09*	.09*	.55**	.49**	--	
9. Mother-Reported Externalizing Symptoms	-.14**	-.06	-.28**	.17*	.17**	.49**	.68**	.79**	--
<i>M</i>	.29	10.95	15.78	2.12	2.23	7.93	9.62	8.47	10.22
<i>SD</i>	.45	.88	2.80	.50	.60	7.76	9.45	8.20	9.98
<i>n</i>	775	775	732	700	700	568	568	593	593

Note. The mother positive parenting scale includes the mother acceptance and mother child-centeredness subscales.

The father positive parenting scale includes the mother acceptance and mother child-centeredness subscales.

* $p < .05$

** $p < .01$.

Table 2

Summary of hierarchical regression analyses predicting mother- and father-reported internalizing or externalizing problems from child flexibility, mother positive parenting, and father positive parenting

Variable	Step 1					Step 2				
	B	SE B	B	R ²	f ²	B	SE B	B	R ²	f ²
Mother-Reported Internalizing Problems										
Sex	-1.03	.71	-.06	.11	.13	-.90	.71	-.05	.13	.15
Age	-.10	.36	-.01			-.08	.36	-.01		
Father Diagnostic Status	-2.52	.65	-.15**			-2.66	.65	-.16**		
Father Positive Parenting	.38	.48	.05			.37	.48	.05		
Mother Positive Parenting	.32	.50	.04			.40	.50	.05		
Child Flexibility	-2.15	.32	-.26**			-2.16	.32	-.26**		
Child Flexibility × Mother Positive Parenting						-.85	.43	-.04		
Child Flexibility × Father Positive Parenting						-.33	.44	-.11		
Mother-Reported Externalizing Problems										
Sex	-2.52	.85	-.12**	.15	.18	-2.42	.85	-.11**	.16	.19
Age	-.36	.43	-.03			-.32	.43	-.03		
Father Diagnostic Status	-3.51	.78	-.18**			-3.69	.78	-.18**		
Father Positive Parenting	.43	.56	.04			.28	.56	.03		
Mother Positive Parenting	1.20	.58	.12*			1.37	.59	.14		
Child Flexibility	-2.54	.38	-.25**			-2.51	.38	-.25**		
Child Flexibility × Mother Positive Parenting						.07	.52	-.01		
Child Flexibility × Father Positive Parenting						-.97	.51	-.10		
Father-Reported Internalizing Problems										
Sex	-2.02	.72	-.11**	.08	.09	-1.92	.72	-.11**	.12	.14
Age	-.13	.36	-.01			-.10	.35	-.01		
Father Diagnostic status	-1.93	.65	-.13**			-2.15	.64	-.13**		
Father Positive Parenting	.02	.50	.00			.78	.52	.10		

Variable	Step 1					Step 2				
	B	SE	B	R ²	f ²	B	SE	B	R ²	f ²
Mother Positive Parenting	.72	.52	.09			-.03	.50	-.00		
Child Flexibility	-1.46	.32	-.19			-1.40	.32	-.18		
Child Flexibility × Mother Positive Parenting						.85	.43	.11		
Child Flexibility × Father Positive Parenting						-1.70	.49	-.22		
Father-Reported Externalizing Behaviors				.09	.10				.14	.16
Sex	-2.56	.88	-.12			-2.39	.87	-.11		
Age	-.38	.44	-.04			-.34	.43	-.03		
Father Diagnostic status	-2.94	.79	-.15			-3.26	.78	-.17		
Father Positive Parenting	.66	.62	.06			.73	.61	.08		
Mother Positive Parenting	.56	.59	.07			.53	.59	.06		
Child Flexibility	-1.41	.40	-.15			-1.34	.39	-.14		
Child Flexibility × Mother Positive Parenting						1.14	.51	.12		
Child Flexibility × Father Positive Parenting						-2.49	.58	-.26		

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