Graduate thesis

NTNU
Norwegian University of Science and Technology
Faculty of Social and Educational Sciences
Department of Psychology

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Parental Social Support and Children's Emotional Disorders - a seven wave community study

Graduate thesis in Clinical Psychology
Supervisor: Lars Wichstrøm
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Abstract

Objective: With the increasing prevalence of depression and anxiety among today's youth, effective preventive and therapeutic interventions are crucial. Understanding the root causes of emotional disorders is vital for informing such interventions. This study aims to investigate the relationship between parental social support and anxiety and depression symptoms in their children. We hypothesize that higher parental social support will predict lower levels of anxiety and depression in children.

Method: We utilized data from a longitudinal study of community sample following children from age 4 to 16 years. Anxiety and depression symptoms were assessed through clinical interviews with parents and children, while parental social support was measured via a questionnaire. Structural equation modeling, including a cross-lagged panel model, was utilized to analyze the data, treating anxiety, depression, and social support as both predictors and outcomes.

Results: Higher scores on social support predicted slightly lower levels of anxiety and depression two years later, even after adjusting for prior levels of anxiety and depression.

Conclusion: Although prospective associations between social support and later anxiety and depression were observed, they were characterized by modest effect sizes. Future studies should explore the mechanisms by which the effect of social support is mediated, for example attachment styles, and parent-child interactions. Understanding these mechanisms can lead to interventions aimed at strengthening the support system around the family and thus alleviate or prevent emotional problems in children.

Sammendrag

Mål: På bakgrunn av de høye tallene på depresjon og angst hos unge i samfunnet i dag er det viktig å tilby virksomme forebyggings- og behandlingstiltak. For å gjøre dette, trengs det en bred forståelse av de bakenforliggende årsakene til emosjonelle lidelser. Vi ønsker å undersøke om sosial støtte i foreldrerollen predikerer symptomer på angst og depresjon hos barna deres. Hypotesen vår er at høyere grad av sosial støtte til foreldrene medfører mindre angst og depresjon hos barna.

Metode: Vi brukte data fra en longitudinell studie av et samfunnsutvalg som fulgte barn fra 4 til 16 års alder . Angst- og depresjonssymptomer ble vurdert gjennom kliniske intervjuer med foreldre og barn, mens foreldres sosiale støtte ble målt via et spørreskjema. Strukturell ligningsmodellering, inkludert en kryss-lagd panelmodell, ble brukt til å analysere dataene, der angst, depresjon og sosial støtte ble behandlet både som prediktorer og utfall.

Resultater: Høyere skårer på sosial støtte til foreldrene medførte mindre angst og depresjon to år senere, selv etter justering for tidligere symptomer på angst og depresjon.

Konklusjon: Mens koblinger mellom sosial støtte og både angst og depresjon eksisterer, er effektstørrelsene beskjedne. Fremtidige studier bør se nærmere på hvordan økt sosial støtte, tilknytningsstiler og interaksjoner mellom foreldre og barn kan virke som medierende faktorer for å redusere barns angst og depresjon. Forståelse av disse mekanismene kan føre til intervensjoner rettet mot å styrke støtteapparatet i familien, og forbedre den psykiske helsen til både foreldre og barn.

Acknowledgements

We would like to extend our deepest gratitude to our supervisor, Lars Wichstrøm, whose unwavering support and guidance has been instrumental throughout this journey. You have demonstrated remarkable patience and kindness, especially when you have explained complex statistical concepts, and helped us when we felt utterly lost. Your dedication to our development and your proficiency in your field has not only enhanced our understanding but also sparked our enthusiasm for our topic. We feel incredibly fortunate to have had you as our supervisor, and we have eagerly shared our appreciation for your expertise with others. Thank you, Lars, for your invaluable contributions and for believing in us every step of the way.

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Parental Social Support and Children's Emotional Disorders - a seven wave community study

Emotional disorders are prevalent in children and adolescents, and are associated with a range of impairments. According to the 2018-2019 National Survey of Children's Health (2020), 7.8% of children and adolescents aged 3 to 17 years were identified as currently experiencing an anxiety disorder, and data from 2016 reported that 3.2% of children in the same age span had current depression (Ghandour et al, 2019). Furthermore, approximately one fifth of 12 to 17-year-olds have experienced a major depressive episode (Bitsko et al., 2022). Hence, improvements should be sought after. Such efforts should be based on etiological knowledge.

A range of psychosocial factors have been suggested to play an etiological role in developing emotional problems, among them several relating to parenting (Drake & Ginsburg, 2012). Seminal models of the potential impact of the family advocate, in line with an ecological understanding that the wider context of the family is important for its functioning and thus for the child's mental health. Among such contextual factors, social support to the parents, and of particular relevance—in their parenting role, has been suggested to play a pivotal role (Yan et al., 2023). Despite its theoretical importance, the potential beneficial impact of social support to parents on their children's mental health has received limited research attention. Therefore, filling this empty space is the overarching aim of the present work.

Emotional Disorders

Anxiety and depression among children and adolescents are of critical concern as they pose significant challenges to both individuals and society at large. These disorders have profound implications for school attendance and academic performance (American Psychiatric Association, 2013). In addition, mental disorders account for the largest area of aggregate medical spending ($8.9 billion) among all health disorders that contribute to overall child health expenses (Ghandour et al., 2019). The prevalence of these disorders has been increasing (Wilson & Dumornay, 2022), warranting a comprehensive exploration to understand the underlying factors influencing their emergence.

The surge in the prevalence of anxiety and depression in children and adolescents is a noteworthy trend documented in epidemiological studies. Worldwide, mental disorders affect one out of every seven individuals aged 10-19, constituting 13% of the overall burden of

disease within this demographic (WHO, 2020). According to statistical estimates by World Health Organization (2020), anxiety disorders affect approximately 3.6% of individuals aged 10–14 and 4.6% of those aged 15–19. Similarly, depression is estimated to impact 1.1% of adolescents aged 10–14 and 2.8% of those aged 15–19 (WHO, 2021), emphasizing the urgent need for a nuanced understanding of the factors contributing to this concerning statistic (WHO, 2021).

Anxiety disorders encompass a collection of conditions marked by heightened levels of fear or worry, manifested through both emotional and physical symptoms. Usual characteristics are heightened vigilance, increased sensitivity to potential threats, avoidance behavior, trouble concentrating, feeling irritable, tense or restless, sweating, having heart palpitations, and trembling (American Psychiatric Association, 2013). A Norwegian study conducted by Steinsbekk and colleagues (2022) revealed that specific phobia was the predominant anxiety type among individuals aged 10-14 years. However, as individuals entered adolescence and beyond, generalized anxiety disorder (GAD) became the most prevalent (Steinsbekk et al., 2022). The study noted an increase in GAD from preschool to school age, while social anxiety and specific phobia remained relatively stable during this developmental period. Upon reaching middle childhood (age 8-10 years), participants in the study exhibited elevated rates of specific phobia, social anxiety, and separation anxiety (Steinsbekk et al., 2022).

Another common mental disorder is depression. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (APA, 2013) outlines specific criteria for diagnosing major depressive disorder (MDD), which includes a collection of physical and emotional symptoms. These symptoms must be present for at least two weeks and include changes in sleep patterns, appetite, psychomotor activity, and feelings of worthlessness. Diagnosis requires the presence of depressed mood or anhedonia (loss of interest) and at least four additional of the above symptoms to be present, and the symptoms should cause significant distress or impairment in daily functioning (APA, 2013). However, despite these established criteria, pediatric MDD is frequently overlooked and not adequately treated (Shorey et al., 2022), and research suggests that only half of adolescents with MDD receive a diagnosis before reaching adulthood (Mullen, 2018). Thus, depression is more common among children and adolescents than many realize. In 2016, around 13% of children and teenagers in the United States had one or more major depressive episodes in the previous year (Selph & McDonagh, 2019).

Persistent depressive disorder encompasses several disorders of which dysthymia is the most prevalent (Selph & McDonagh, 2019). Dysthymia is characterized by depressed mood and irritability for at least one year (APA, 2013). Other common symptoms are low self-esteem, feelings of hopelessness, poor appetite or overeating, trouble with sleeping or sleeping too much, fatigue, and poor decision-making and concentration (APA, 2013). Diagnosis of dysthymia in children is more rare than MDD, and there is limited research available. Results from previous studies on the prevalence of dysthymia range from 1.5% to 5.4% for adolescents (Shorey et al., 2022). Although symptoms are milder compared to major depressive disorder, the prolonged duration of depressive symptoms could lead to lasting negative effects on learning social skills and psychosocial functioning, potentially increasing the likelihood of developing MDD later on (Nobile et al., 2003; Shorey et al., 2022).

Heritability

Anxiety and depression in children manifest through intricate interactions of genetic and environmental factors. Results from twin studies indicate that internalizing symptoms, as in anxiety and depression, show a moderately strong genetic component, and roughly 40-50% of variances in internalizing symptoms among individuals are attributed to genetic factors (Jami et al., 2022). Other studies have similar findings, and estimate heritability of anxiety to be ranging from 30-50% (Jami et al., 2022; Shimada-Sugimoto et al., 2015). Meta-analyses of twin studies estimate a heritability rate of 37% for depression (Sullivan et al., 2000). Moreover, environmental factors, including family dynamics, socioeconomic status, and exposure to adverse life events, have been identified as influential contributors to the development of anxiety and depression in youth (Garber & Weersing, 2010), and the remaining 50-70% percent of what causes anxiety and depression may be caused by environmental factors.

Children's Development and Psychopathology in an Environmental Context

There are several models for understanding development and psychopathology in children, and many of these point to the importance of family context. *Ecosystem theory* explains development and growth as a process of mutual influence between the individual and the environment. Children's development and socialization are influenced by various environments around the child, and there are interactions between these environmental factors and the child’s internal factors that ultimately affect their development (Bronfenbrenner, 1979).

Bronfenbrenner's ecological model postulates that human development is shaped by interconnected systems across five levels: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Bronfenbrenner, 1979). The microsystem represents the immediate environment where individuals directly interact, including family, school, peers, and neighborhood. Interactions within this microsystem significantly influence individual development. Moreover, the mesosystem illustrates the connections between different microsystems, such as the interplay between a child's school experiences and family dynamics. Events within one microsystem can impact other microsystems and their associated individuals, thereby influencing individual development. Furthermore, in the exosystem, environments indirectly influence individuals, like a parent's workplace environment or community services affecting family dynamics and consequently, a child's development. Additionally, the macrosystem embodies the broader cultural context, including norms, values, laws, and societal structures. These elements shape other levels of the model, molding development. Lastly, the chronosystem introduces the dimension of time, reflecting changes over time in individuals and their environments, including historical events and personal experiences (Bronfenbrenner, 1979).

Bronfenbrenner's model underscores bidirectional and dynamic interactions among these systems. For instance, parents may be affected by factors in the exosystem, like workplace stress or community resources, impacting their interactions with their children. Moreover, influences can cascade through levels, such as parents' work affecting the parents' stress levels and emotions, thereby influencing interactions with the child. Understanding these interactions is essential for comprehensively assessing children's development and mental health. The support parents receive from their immediate environment can influence their behavior toward their children, and thus the children's mental health. Therefore, considering the outer layers of influence beyond parents is crucial for a holistic understanding of development and mental health.

The Family Stress Model addresses how the associated environment affects the family dynamic, and suggests that the impact of socioeconomic disadvantage on children is mediated through its effect on their parents (Conger et al., 2010). Economic challenges are associated with increased financial pressure leading to heightened emotional distress among parents (Gard et al., 2020). Consequently, this emotional distress can contribute to family conflicts, characterized by parenting practices that can be harsh and lacking in warmth. Parents play a pivotal role in shaping the socioemotional competence of their children

through their emotional expressions (such as anxiety and personal distress) and their responses to child behaviors (including harshness, emotional responsiveness, and warmth). These parental influences can manifest within youth, potentially experiencing internalizing problems like depression or anxiety, as well as externalizing behaviors such as aggression and rule-breaking (Gard et al., 2020).

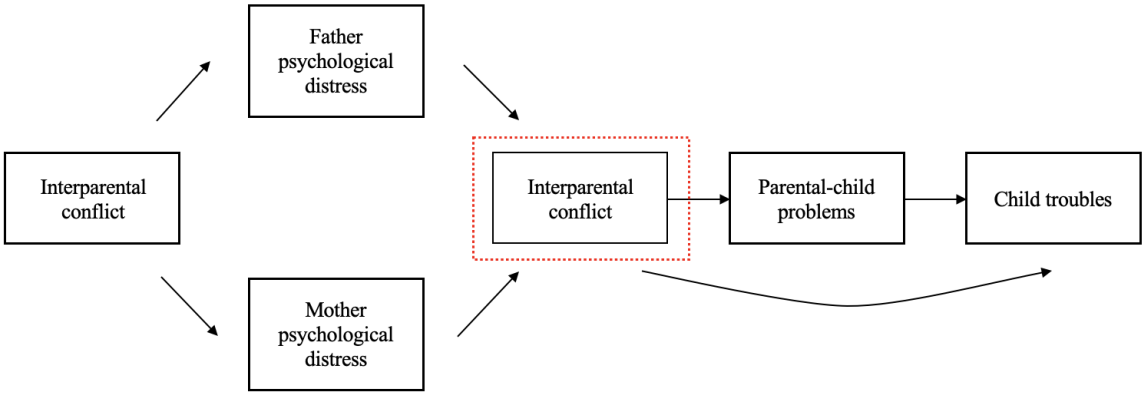


Figure 1. Illustration of The Family Stress Model. Adapted from Conger and colleagues (Conger et al. 2010).

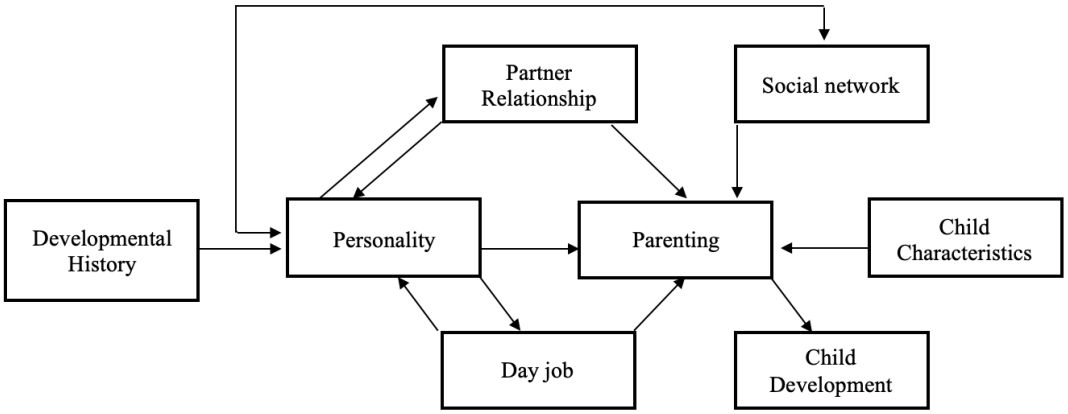


Figure 2. Illustration of Belsky's Determinants of parenting - a process model (Belsky, 1984).

While the Family Stress Model focuses specifically on the impact of socioeconomic disadvantage on parenting practices and child outcomes, Belsky's Determinants of Parenting Model offers a more comprehensive framework that considers a wide range of factors

influencing parenting behavior and child development (Belsky, 1984). Belsky proposes a model to understand the factors that influence parenting behaviors, by focusing on various aspects of family dynamics, parental functioning, and their impact on child development. Factors such as marital satisfaction, social support, parental psychological resources, child temperament, and contextual stressors in shaping parenting behavior and parent-child relationships are highlighted (Belsky, 1984). Here the importance of understanding the complex interplay between these factors is emphasized to promote competent parental functioning and positive child outcomes.

Social Support

As proposed above, social support is one of several factors that can influence both family dynamics and parental satisfaction. Furthermore, the social support parents receive has been proposed as a mediating factor for children's mental health (Belsky, 1984; Gard et al., 2020). According to the American Psychological Association's dictionary, social support entails offering assistance or solace to individuals, usually aimed at helping them navigate biological, psychological, and social challenges (APA, 2015). Such support can originate from various interpersonal connections within an individual's social circle, including family, friends, neighbors, religious communities, colleagues, caregivers, or support groups. It can manifest in practical forms such as aiding with tasks or providing guidance, tangible forms like offering financial or material aid, and emotional forms that foster feelings of being valued, accepted, and understood (APA, 2015). Theoretical models of social support highlight two key dimensions: the structural dimension, involving factors like the size of one's social network and the frequency of social interactions, and the functional dimension, which encompasses emotional aspects (such as receiving love and empathy) and practical components (like financial support or assistance with childcare) (Ozbay et al., 2007). Research has shown that parents of children with a disability, who feel supported in their role tend to exhibit greater emotional stability and coping abilities (Cuzzocrea et al., 2016), which can be translated to a more nurturing and positive caregiving environment for their children (Jones et al., 2021). Social support has been shown to foster parental optimism and parenting effectiveness by providing networks of social ties and sources of emotional, informational, and practical support (Sehmi et al., 2020). When parents are less stressed and better able to manage their own mental health, they are more attuned to their children's needs, responsive to their emotions, and capable of providing a secure and nurturing environment conducive to healthy child development (Bögels et al., 2014).

A recent cross-sectional study done by Yan and colleagues (2023), proposed a chain mediating model that explains how social support positively can impact children's mental health by influencing various family dynamics. Their findings revealed a positive correlation between parents' perceived social support and children's mental health. Put simply, when parents reported higher levels of social support, their young children were less likely to experience mental health disorders, and their overall mental well-being tended to be better (Yan et al., 2023). Cross-sectional studies are valuable for providing insights into associations between variables at a single point in time, but inherently lack the capacity to ascertain causality due to the absence of temporal sequencing.

The inherent limitation lies in the inability to discern the direction of influence; analogous to the proverbial question of whether the chicken or the egg came first. In this context, it is plausible that the psychological difficulties experienced by children may impede their parents' access to social support. A growing body of literature underscores the bidirectional nature of parent-child interactions, where children's behavioral challenges can precipitate heightened conflict among parents(Fosco & Grych, 2008; Lovejoy et al., 2000), leading to increased parental harshness and rigidity (Baker et al., 2011). Conversely, instances such as parents rallying together in times of adversity, such as when caring for sick children, further exemplify the intricate interplay between parental and child experiences (Sloper & Turner, 1993). Despite Yan and colleagues' study being cross-sectional and thus unable to establish causality over time, their findings align with the possibility that social support might be beneficial to children’s mental health (2023).

However, despite the recognized theoretical importance of social support for parents, there remains a gap in the literature regarding whether parents' received social support predicts decreased mental health in their children. Longitudinal studies are imperative to elucidate the dynamic interrelationships between parental social support and offspring mental health, and as far as we know, this has not yet been investigated in the context of parental social support.

We hypothesize that social support is essential for parents in their parenting role as it can significantly impact the mental health and well-being of their children. When parents receive adequate social support, be it from family members, friends, or community networks, it is conceivable to assume that they are better equipped to navigate the challenges of parenthood. Social support can come in various forms, including practical assistance with childcare responsibilities, emotional support during times of stress, or guidance and advice on

parenting strategies. Cohen & Wills (1985) propose a conceptualization of the effects of social support to ascertain the positive association between social support and well-being (The Buffering Model). The buffering model hypothesizes that social support helps shield the individual from possible negative outcomes of stressful circumstances. The buffering model distinguishes between structure and function, whereby structure refers to the extent to which the individual has meaningful interpersonal relationships, and function refers to the extent to which the specific interpersonal relationship acts as a resource (Cohen & Wills, 1985)

Although previous studies on social support and the buffering hypothesis have found social support to play a positive, mediating role in general well-being, the main emphasis is done on specific, selected populations and the results may not be transferable to the parenting role and children's mental health (Olstad et al., 2001; Yan et al., 2022). Among the few studies who have investigated the connection is Nunes & colleagues, who found that parental social support did act as a buffer against unfortunate child psychological adjustment (Nunes et al., 2021). Considering The Buffering Model (1985), parents who have access to supportive relationships, may be less likely to experience feelings of isolation, anxiety, or depression, all of which can have detrimental effects on parenting practices and the parent-child relationship.

By mitigating parental stress and promoting parental well-being, social support can indirectly contribute to positive child outcomes and mental health. In conclusion, it is reasonable to assume that parental social support promotes good mental health in children by providing emotional, instrumental, and social support to parents, thereby enhancing their well-being and caregiving abilities.

Confounding: Parental Mental health

Lack of social support could exacerbate psychological difficulties in parents (Barrera, 1986; Cutrona, 1986), while on the other hand, individuals experiencing anxiety and depression may face challenges in seeking and maintaining social support networks (Hammen, 1991; Paykel et al., 2005). One could also think that parents with emotional problems would be in need of more social support, and therefore seek out more help. Additionally, it is important to acknowledge the heritability of anxiety and depression, suggesting that parental mental health status can directly influence the psychological well-being of their children (Rice et al., 2002; Silberg et al., 1999). In our analysis, we include parents' anxiety and depression as control variables. This decision is motivated by the recognition that social support may co-vary with parents' mental health status. Given these

considerations, it is imperative to account for parents' mental health status to disentangle the potential effects of social support from the influence of parental mental health on child outcomes.

We have implicitly examined potential age-related variations in the influence of parental social support on offspring mental health, because we wonder whether this effect may differ in magnitude or direction between younger children and adolescents. Our inquiry delves into the longitudinal dynamics of causality, particularly regarding the impact of parental social support spanning from early childhood (4 years old) to adolescence (16 years old). This temporal scope allows us to discern whether parental social support maintains significance across developmental transitions, such as the shift from nursery school to formal education (4-6 years), the progression from childhood to adolescence (10-14), and the onset of puberty (12-14). In sum, we hypothesize that social support in the parenting role will predict fewer symptoms of anxiety and depression in their children two years later. Moreover, during periods of transition for the child, from daycare to school (ages 4 to 6) and from middle to adolescence (ages 10 to 12 and 14 to 16) our hypothesis points out that the social support parents receive predict anxiety and depression to a stronger degree than in periods of fewer transitions (i.e., the remaining two-year intervals).

Method

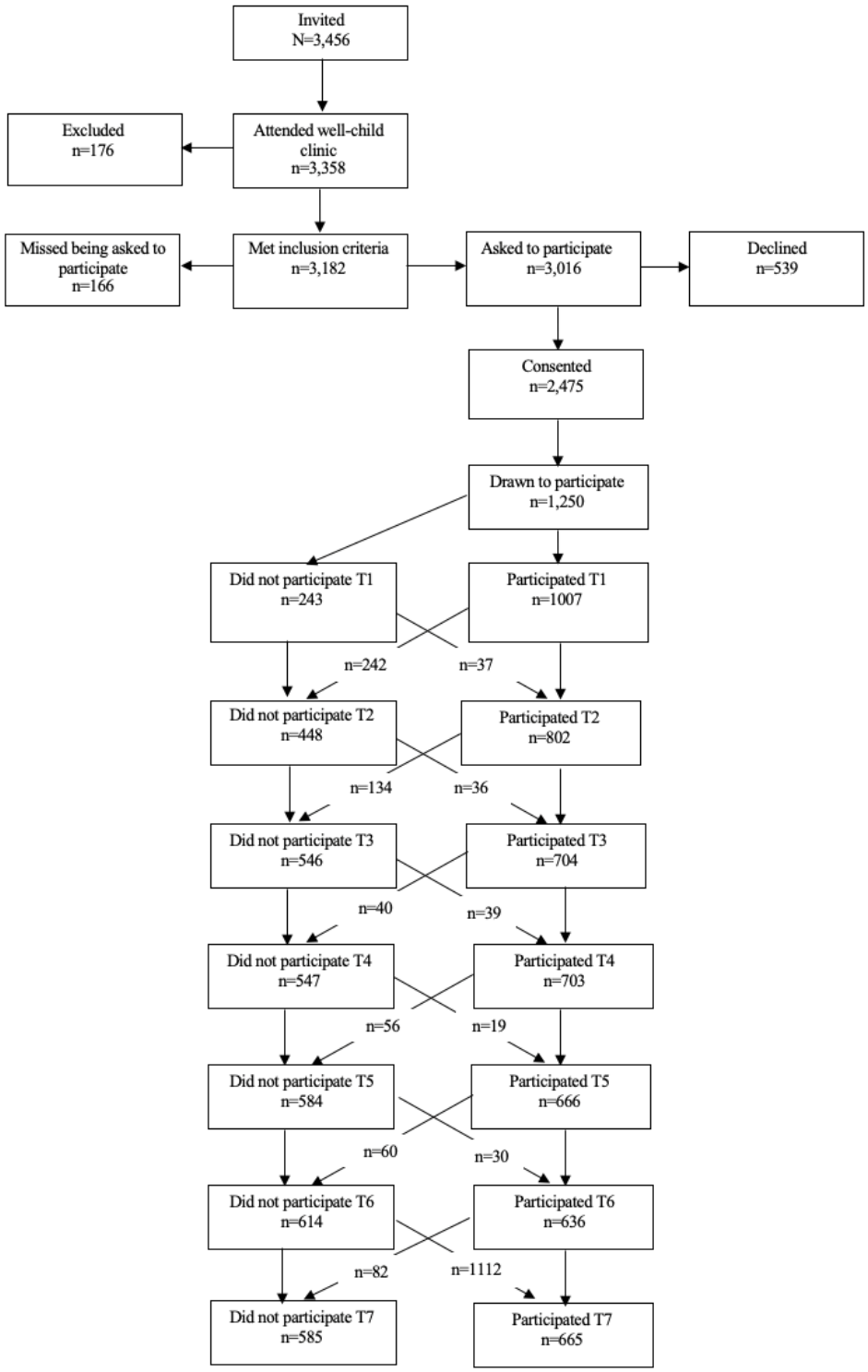
Participants and Procedure

We used data from the Trondheim Early Secure Study (TESS) (Steinsbekk et al., 2018), which is a longitudinal ongoing population study that aims to map factors associated with the development of mental disorders in children. The recruitment of participants was carried out in collaboration with the public healthcare centers in Trondheim. All children born during the years 2003 and 2004, whose guardians were resident in the municipality of Trondheim, were extended an invitation to partake in the investigation (Steinsbekk et al., 2018). Initially parents of 3456 children were informed through a written invitation to the study, in addition to The Strengths and Difficulties Questionnaire (SDQ) version 4-16 (Goodman & Goodman, 2009) via mail, in conjunction with a voluntary municipal health check for four-year-olds. When the parents attended the well child clinic for the routine health check, the nurse informed the parent(s) about the study and obtained written consent for participation. It was further informed that the study had been approved by the Regional Committee for Medical and Health Research Ethics in Mid-Norway (reference number 4.2006.2381).

Out of the 3358 families who met at the health check, 3182 met the inclusion criteria, while 176 were excluded due to insufficient proficiency in the Norwegian Language. 82.2% of those who were asked to partake in the study (n = 3016) consented. The participants were divided into four different groups according to their SDQ scores (cut-offs: 0–4, 5–8, 9–11, and 12–40). Subsequently, a subset (n = 1250) was drawn to participate in a structured diagnostic interview regarding the child's mental health, using a random number generator. Deliberate oversampling of children exhibiting emotional or behavioral issues was conducted by categorizing the participants into four groups based on their SDQ scores (ranging from 0 to 4, 5 to 8, 9 to 11, and 12 to 40). High SDQ scores increased the probability of selection, and a subset of participants (n = 1250) was selected to take part.The oversampling of children with emotional and/or behavioral problems was accounted for in the analyses. The dropout rates remained consistent across different SDQ scores after obtaining consent (p = 0.86) and also did not vary significantly by gender (p = 0.31). The sample corresponds to the general population of Norway in most areas, except for a higher rate of divorced parents (7.6%), compared to 2.1% in the general population. Participation rates and the process of recruitment are described in Figure 3.

We examined any selective attrition according to study variables by means of logistic regression. Higher degree of depression and anxiety in children at 12 years, predicted a lower likelihood of participating in the study at age 14, Odds Ratio (O.R.) = 0.92, p = 0.025). Conversely, a contrasting pattern emerged in relation to parental emotional problems, wherein augmented emotional problems among parents at the children's age of 12 predicted a heightened probability for sustained participation at age 14 (O.R. = 1.10, p = 0.023). No other study variables predicted attrition at any time point. Of note, even though the attrition at age 14 was selective, the combined effect of predictors was small, Cox & Snell R^2 = 0.019.

Figure 3.



Note: Flow chart of recruitment and follow-up. Adapted from Steinsbekk et al. (2018).

Table 1

Sample characteristics at baseline

Characteristics	%
Gender of child	
Male	49.1
Female	50.9
Gender of parent informant	
Male	15.2
Female	84.8
Ethnic origin of biological mother	
Norwegian	93.0
Western countries	2.7
Other countries	4.3
Ethnic origin of biological father	
Norwegian	91.0
Western countries	5.8
Other countries	3.2
Child care	
Official day care center	95.0
Other	5.0
Biological parents' marital status	
Married	56.3
Cohabitating >6 months	32.6
Separated	1.7
Divorced	6.8
Widowed	0.2
Cohabitating <6 months	1.1
Never lived together	1.3
Informant parent's occupational level	
Leader	5.7
Professional, higher level	25.7
Professional, lower level	39.0
Formally skilled worker	26.0
Farmer/fisherman	0.5
Unskilled worker	3.1
Parent's highest completed education	
Did not complete junior high school	0.0
Junior high school (10th grade)	0.6
Some education after junior high school	6.1
Senior high school (13th grade)	17.3
Some education after senior high school	3.4
Some college or university education	7.6

Bachelor degree	6.2
College degree	33.6
Master's degree or similar	20.3
PhD completed or ongoing	4.4
Households' gross annual income	
0-225' NOK (0-40 USD)	3.3
225'-525' NOK (40'-94' USD)	18.4
525'-900' NOK (94'-161' USD)	51.6
900'+NOK (161'+ USD)	26.7

**Classification of parents' occupation is based on the International Standard of Classification of Occupations (ISCO-88). Adapted from Steinsbekk et al. (2018).*

Instruments

Social Support

The Trondheim Early Secure Study (TESS) utilized a social support assessment tool known as the Parent Social Support Questionnaire (PSSQ) (Sarason et al., 1983), which was adapted to address social support in the parenting role, specifically (Steinsbekk et al., 2018). The questionnaire encompassed inquiries regarding informational, practical, and emotional support. Initially, six questions were formulated to gauge social support in the parental role at the ages of 4 to 6 (see Appendix, Questionnaire A3a for the specific questions). In these questionnaires, the parents were asked whom they received social support from in the parental role on a 1-8 scale ranging from *Do not have (1)* to *To an extensive degree (8)*. For example;

> *Who do you entrust the responsibility for your child to when you are unable to take care of them in the evenings or on weekends (due to meetings, travel, cinema, etc.)? 1. The child's other biological parent. 2. Spouse/Partner/Boyfriend/Girlfriend who is not the biological parent. 3. Your siblings. 4. Your parents. 5. In-laws or partners/spouse's parents. 6. Other family members. 7. Friends/Neighbors. 8. Professionals (employees in childcare, public health nurse, doctor, social services, etc.*)

The answers for these eight sources of support were averaged, and the answers to the six questions were thereafter averaged to yield a global measure of social support. From the age of 8 to12 (see Appendix, Questionnaire A3b for the specific questions) the questionnaire was modified to inquire about the extent to which parents had *someone* to receive social support from, as opposed to questions about *whom* they received support from, using a seven-point scale ranging from *To no degree (1)* to *To an extensive degree (7)*. For example;

To what extent do you have someone you can entrust with the responsibility of caring for your child when you are unable to do so in the evenings or on weekends (for example, when you have a meeting, traveling, going to the cinema, etc.)?

The answers to these questions were averaged. To avoid posing developmentally inappropriate questions, practical support questions were omitted when the children reached their teenage years (14-16). Thus, the number of questions was reduced to four questions at ages 14 and 16 (See appendix A3c for the specific questions). Additionally, the topics for seeking advice were slightly modified, shifting from concerns regarding personal computers and screen time to other relevant issues like alcohol use and curfews. The seven-point scale was retained. For example;

To what extent do you have someone you seek advice from about what to do when you are unsure how to handle your teenager when he/she is struggling (angry, sad, uncertain, having difficulties with food and meals, problems with friends, curfews, alcohol, school performance, responsibility for chores, allowance, etc.)?

The answers to these four questions were averaged. Hence, despite slight variations in wording to accommodate expected developmental changes, the study treated them uniformly by utilizing the average of the averages for the various scores to maintain consistency across assessments, irrespective of the number of questions included. As this social support measure is formative (i.e., the *amount* of social support is averaged) and does not capture a latent construct within parents, internal consistency does not apply. The method change resulted in a higher reported social support from 8 years (see Appendix, Questionnaire A3a). From age 4-6 , the average score is lower than the one from the 12-16 year old group, which likely is due to the scale being changed from age 8 onwards. From 8 years onwards, there does not seem to be any change in social support in terms of average scores. The reduction of six questions at ages 4-12, to four at age 14-16 may have influenced the results. It is worth mentioning that parents may have initially scored higher on the two questions that were removed, which may have resulted in the average decreasing. Full display of the questionnaires used is shown in the appendix (Questionnaire A3a, A3b and A3c).

Symptoms of Emotional Disorders

Anxiety symptoms and disorders were evaluated using three assessment instruments: the Preschool Age Psychiatric Assessment (PAPA) for children aged 4 to 6 (DelCarmen-Wiggins & Carter, 2004), the Child and Adolescent Psychiatric Assessment (CAPA) for those aged 8 to 14 (Angold & Costello, 2000) and the Kiddie SADS (Kaufman & Schweder,

2004) for those aged 16. Notably, the PAPA relied solely on parental input, whereas the CAPA and K-SADS involved separate interviews with parents and children. Interviewers utilized structured questions to ascertain symptom severity over a 3-month period, considering criteria such as intensity, frequency, and duration. Symptoms were deemed present if reported by either the child or the parent (Steinsbekk et al., 2022).

For each anxiety disorder, including generalized anxiety disorder, social anxiety, specific phobias, and separation anxiety, the researchers tallied the number of DSM-5-defined symptoms. Utilizing a continuous method, the total count of symptoms as outlined in the DSM-5 for each anxiety disorder was calculated (Steinsbekk et al., 2022). These disorders include generalized anxiety disorder (characterized by six symptoms, with an Intraclass Correlation Coefficient (ICC) of .86), social anxiety (entailing two symptoms, ICC = .78), specific phobias (encompassing four symptoms related to various types: fear of animals, blood/injection/injury, situational triggers such as elevators, and other stimuli such as costumed characters, loud sounds, and choking; ICC = .62), and separation anxiety (comprising eight symptoms, ICC = .82). The DSM-5 criteria for diagnosing anxiety necessitate significant distress or impairment. A total of 336 cases were subjected to blind re-coding by trained evaluators (Steinsbekk et al., 2022), yielding the intra-rater reliabilities reported above.

Furthermore, symptoms of Major Depressive Disorder (MDD) and dysthymia were assessed using the PAPA for ages 4 to 6 and the CAPA for ages 8 and older (Morken et al., 2021), and K-SADS at age 16.. In the case of MDD, additional criteria related to persistent preoccupation with death or self-harm during play were included at ages 4 and 6. As with anxiety assessments, interviews were conducted separately with parents and children, and symptoms were deemed present if reported by either party.

Inter-rater reliability analyses were performed on a subset of cases, involving blinded coders who independently reviewed audiotapes or videotapes of the interviews. These analyses yielded high reliability coefficients, indicating consistency among raters in identifying symptoms of both MDD and dysthymia (Morken et al., 2021). Inter-rater reliabilities among blinded coders of 9% of videotapes of PAPA interviews and 15% of audiotapes of CAPA interviews were .91 and .87, respectively, for MDD symptoms, and .89 and .85, respectively, for dysthymia symptoms (Morken et al., 2021).

When the children were 16 years old, we used the Kiddie Sads (Kaufman & Schweder, 2004) to measure symptoms of anxiety and depression. Children and parents

underwent separate interviews, and independent raters reanalyzed 114 audiotapes. Symptoms indicative of major depressive disorder demonstrated an Intraclass Correlation Coefficient of .81; Social anxiety exhibited an ICC of .85; and Generalized anxiety showcased an ICC of .96 (Steinsbekk et al., 2023).

Parental Emotional Disorder and Social Support

When the children were respectively 4 and 6 years old, we used the Beck Depression Inventory-II (BDI-II) and the Beck Anxiety Inventory (BAI) were applied. These are both 21-item assessments utilizing a 4-point scale. These measures, with respective reliability coefficients of α=0.87/0.87 for BDI-II and α=0.82/0.87 for BAI, were employed to gauge parental symptoms of depression and anxiety. Extensive research across various studies has thoroughly established the psychometric properties of these instruments (Beck et al., 1988; Fydrich et al., 1992).

From age 8 onwards, the Hopkins Symptom Checklist (HSCL) was used which is a screening instrument for common psychiatric symptoms (Nettelbladt et al., 1993) of anxiety and depression. Participants evaluated emotional statements using a 4-point Likert scale, ranging from 'not at all' (1), a little (2), quite a bit (3) to 'significantly' (4). The reliability of these evaluations was satisfactory, as indicated by Cronbach's alpha values ranging from .79 to .84 for anxiety and .83 to .86 for depression.

Analysis

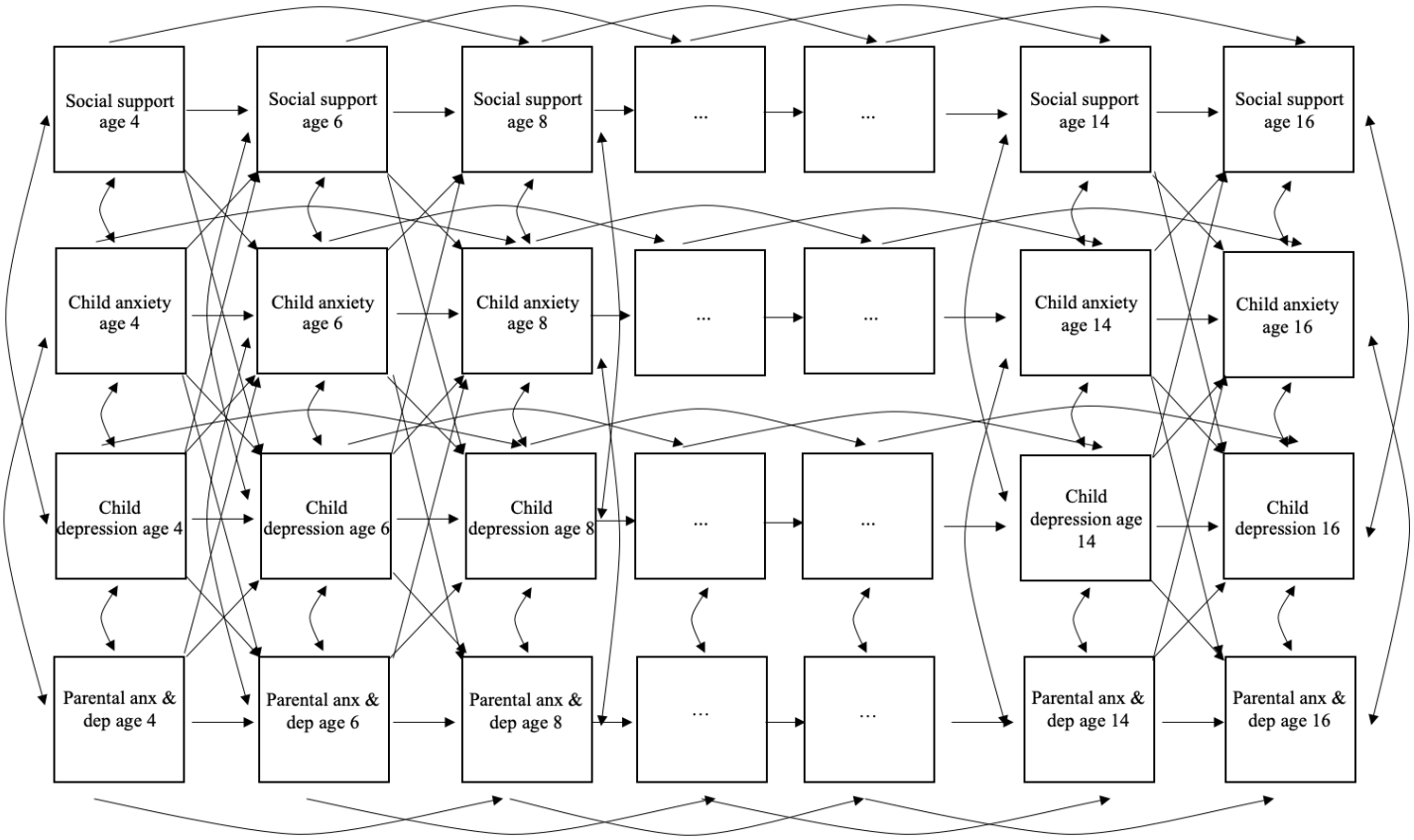
Our main hypothesis is that increased social support to parents predicts reduced anxiety and depression in their children. However, as reviewed above, there are also reasons to expect the other direction of influence; children's problems affecting how much support parents get - thus that higher level of depression and anxiety will predict social support. However, as increased problems may limit access to social support as well as increase the need (and thus seeking it out), we remained open to the sign of any prediction.

These hypotheses were assessed using an autoregressive cross-lagged analysis within structural equation modeling (SEM) in Mplus (Muthén, 2018). In this model social support and the number of symptoms of anxiety and depressive disorders at time point k were regressed on these measures at time point k-1. Moreover, residuals of social support and symptoms at the same time point were allowed to correlate.

To address missing values, Full Information Maximum Likelihood Estimation (FIML) was employed. All models underwent testing using Maximum Likelihood Estimation (MLR) with robust standard errors. For nested model comparisons, the corrected chi-square

difference test was applied (Satorra & Bentler, 2001). The evaluation fit followed the criteria of Hu and Bentler (1999), aiming for Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI) values close to or above .95. Additionally, Root Mean Squared Error of Approximation (RMSEA) values less than .06 was considered indicative of a satisfactory model fit. The testing of age differences was done by comparing the fit of a model where the paths from social support to anxiety were set to be equal over time with a model where they were set to vary, using the Satorra-Bentler scaled chi-square test (Satorra & Bentler, 2001).

Figure 4a



Note: Analytical model displaying examined relations between social support, anxiety symptoms and depression symptoms from age 4 to 16.

Results

Means and Standard Deviations

Means and standard deviations of all variables are presented in Table A1. The highest reported social support was documented at 12 years (M= 5.75, SD=1.03), whereas the lowest reported support was observed at 4 years (M= 3.91, SD= 0.70). From age 4-6, the average score was lower than the one from the 12-16 year old group, which likely is due to the scale

being changed from an eight-point scale to a seven-point scale from age 8 onwards. From 8 years onwards, there does not seem to be any remarkable change in social support in terms of average scores. However, the standard deviation increased, suggesting that as children grow older, the disparity in reported support widens.

The highest reported mean anxiety score, along with the greatest dispersion, was observed at 16 years (M= 1.58, SD= 2.72), whereas the lowest mean score was documented at 4 years (M=0.80, SD= 1.36). Apparently, the depression rates decrease abruptly at age 16 (M = 0.51, SD = 1.75). However, this may be due to the shift in assessment tools from CAPA to K-SADS.

Correlations

Correlations between study variables are shown in the Appendix, Tables A1a,b,c, and d. Social support evinced stability in several of the years, but it appears that the stability is greatest at two-year intervals, and the longer the time between the measurements, the more the stability diminishes. The two-year stability remains relatively high, albeit with a notable decrease observed between the 6 and 8-year intervals, which can at least partly be attributed to alterations in survey questions.

Notably, social support was weakly to moderately correlated with anxiety and depression, both within and between time points. Findings are similar for anxiety and depression. Anxiety and depression display comparatively less stability over time than social support, yet the correlations observed in the data remain statistically significant. While the overall trend reveals small to moderate correlations, the results show significant evidence of a relationship between social support, anxiety and depression.

Social Support Predicting Anxiety and Depression

A cross-lagged model evinced sub-par fit ($\chi 2 = 1305.41$, df = 540, $p < .001$, CFI = 0.895, TLI = 0.836, RMSEA = 0.036, (90% CI 0.034, 0.039). Measurements inherently comprise a true score and an error score, with the latter associated with situational factors on the day of measurement (e.g., experiencing sadness, lack of childcare assistance, or receiving numerous offers of assistance). It is likely that such random measurement errors will not recur at subsequent or prior time points, thereby enhancing the stability over longer time spans, a factor often unaccounted for in models. Inclusion of such extended intervals can significantly enhance model fit. Consequently, we incorporated 4-year intervals to increase good model fit.

A model including 4-year autoregressive paths for depression, anxiety, social support and parental emotional problems fit the data well. $\chi 2 = 777.88$, df = 510, $p < .001$, CFI = 0.963, TLI = 0.939, RMSEA = 0.022 (90% CI 0.019, 0.025). To evaluate whether the cross-lagged paths from social support to anxiety and depression varied over time, the above model was compared to a model where these cross-lagged paths were set to be equal over time, but different for anxiety and depression, respectively. This constrained model fit the data equally well as a freely estimated model as compared with scaled Sattora-Bentler test (Satorra & Bentler, 2001), ($\Delta\chi 2=16.00$, df = 15, $p = .435$) and this constrained model was therefore preferred for parsimonious reasons, ($\chi 2 = 359.46$, df = 236, $p < .001$, CFI = 0.970, TLI = 0.953, RMSEA = 0.022 (90% CI 0.017, 0.026).

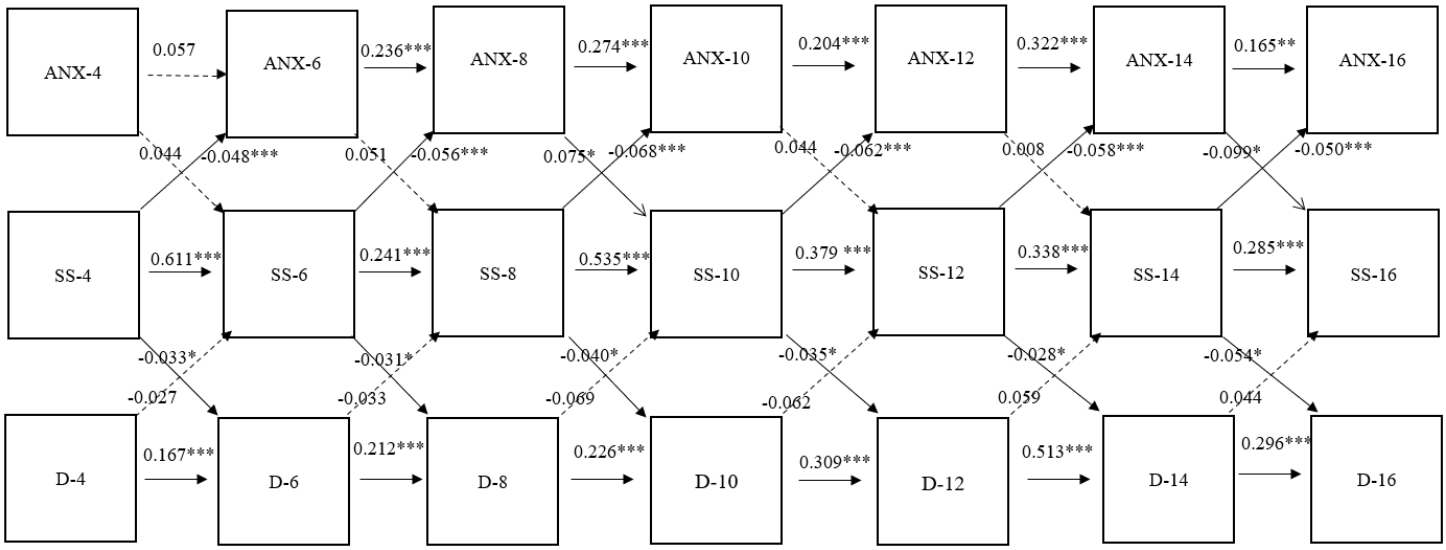
The model depicted below shows that higher scores on social support predicted lower levels of anxiety as well as depression two years later, even when prior levels of anxiety and depression were adjusted for, and anxiety and depression were adjusted for each other. For example, social support parents received when their children were 8 years old, predicted less anxiety and depression in their children when they were 10 years old (anxiety: β -.068, $p < .001$; depression: $\beta = -.040$, $p < .05$).

Parental Mental Health

In our study, parental anxiety and depression were incorporated as control variables in our analytical framework to adjust for the potential correlation between social support and the mental health status of parents. Examination of Table A4a in the appendix reveals that social support consistently did not demonstrate a predictive association with higher or lower levels of anxiety and depression among parents. Detailed findings for all other variables can be found in the Appendix.

Figure 4b

Model Results



Note: Non-significant paths between social support, anxiety and depression are presented as dotted lines, and other non-significant paths, correlations between concurrent residuals, as well as four-year auto-regressive predictions were omitted due to presentation purposes.

[a]D stands for Depression, and D-4 is symptoms of depression when the child is 4 years old, D-6 is when the child is 6 years old etc. SS stands for Social Support, and SS-4 stands for social support the parents received when the child is 4 years old etc, and ANX stands for Anxiety, and ANX-4 is anxiety levels when the child is 4 years old.

** Standardized estimates. * = p < .05, ** = p < .01, *** = p < .001.*

Discussion

Drawing on existing ecological family models of psychopathology, it is reasonable to assume that social support in the form of both emotional and practical help, helps parents manage stress better, and promotes positive mental health in children. This support is believed to improve parental well-being and caregiving abilities, which can subsequently influence the mental health of their children. However, there is still a gap in understanding whether the support parents receive directly forecasts better mental health outcomes in their offspring. Longitudinal studies are crucial for exploring the complex relationship between parental social support and children's mental health, an area that remains largely unaddressed in current research.

Our hypothesis was that increased social support for parents predicts reduced anxiety and depression in their children. Our findings indicated that heightened social support predicts reduced levels of anxiety and depression in children, even when prior levels of anxiety and depression were adjusted for and anxiety and depression were adjusted for each other. However, the linkage between social support and emotional problems is only characterized by small to modest effect sizes.

Conversely, associations between anxiety and depression with social support are predominantly depicted as non-substantial, denoted by dashed lines, due to their lack of statistical significance. In other words, more symptoms of anxiety and depression did not predict an increase in social support. Nevertheless, a notable finding emerges from the prediction of anxiety and social support during childhood and adolescence (ages 8 and 14), wherein heightened anxiety correlates with increased social support at ages 10 and 16. However, this association only marginally surpasses the conventional significance threshold of $p < .05$, implying a 5% probability of chance occurrence. Given the multitude of connections examined, it is anticipated that some significant associations may arise, although they may not offer substantial insights. This scenario would contrast markedly if the significance threshold was set at $p < .001$. It is therefore uncertain whether these predictions are actually real or whether they may be attributable to random chance. Hence, before speculating on underlying causes, replications of these findings are necessary.

Parental Social Support Predicting Anxiety and Depression

Several plausible mechanisms may explain the relationship between parental social support and children's mental health outcomes. One of them revolves around the notion that parental mental health serves as a mediator in this relationship. While it is conceivable that increased social support might positively impact parental mental health (Yan et al, 2023), our results suggest that this pathway did not fully account for the observed effects on children's anxiety and depression. However, other avenues warrant exploration, such as the role of parental attachment security. Borelli and colleagues (2021) suggests that secure attachment fosters emotional stability in parents, which, in turn, may facilitate their ability to seek and utilize social support effectively. Future studies should investigate whether increased social support enhances parental attachment security, thereby indirectly mitigating children's anxiety and depression.

Another plausible mechanism pertains to the influence of social support on parent-child interaction dynamics. It stands to reason that heightened social support may improve the

quality of parent-child interactions by providing parents with resources and coping strategies to navigate stressful situations more effectively (Fierloos et al., 2023). Indeed, prior research by Russell et al. (2023) indicates that positive parent-child interactions are associated with reduced levels of child anxiety and depression. Therefore, it is imperative to explore whether improvements in parent-child interaction mediate the relationship between parental social support and children's mental health outcomes.

In our analysis, we emphasize the importance of disentangling the directionality of effects between parental social support and children's mental health. While it is reasonable to assume that a child's anxiety and depression could strain parental resources and affect the support they receive, our findings did not find evidence supporting this idea.

We hypothesized that social support in the parenting role is especially important in periods of transition for the child. However, our research did not show results specifically in times of transition, but showed an overall small to moderate effect over time. Given the marginal effect sizes, this study will contribute just to a smaller degree to understand the rise of anxiety and depression in children and adolescents. Numerous factors can contribute to anxiety in children; it is not solely contingent upon whether parents receive social support or not. Anxiety and distress in children stem from a multitude of sources, ranging from genetic predispositions, to peer relationships, and broader socio-economic factors (Grills-Taquechel & Ollendick, 2012). Parental social support, while possibly influential, operates within this intricate web of influences, contributing to but not solely determining children's mental health outcomes. Moreover, the nature of familial relationships extends beyond mere provision of social support. Communication patterns, parenting styles, attachment dynamics, and the quality of the parent-child relationship all play pivotal roles in shaping children's emotional well-being (Bowlby, 1997). While family and social networks are complex, a weak connection in one aspect does not necessarily reduce the overall importance of the findings. Our research highlights the potential role of parental social support and stresses the need for a thorough understanding of family dynamics in addressing children's mental health.

Strengths and Limitations

Our study possesses several notable strengths that enhance its validity and reliability. Firstly, the inclusion of a diverse population sample spanning seven waves provides an understanding of the longitudinal relationship between parental social support and children's mental health. This extended duration allows a nuanced exploration of developmental trajectories and ensures robustness in our findings. Additionally, the detailed measurement of

social support, encompassing various dimensions such as emotional and practical assistance, contributes to the richness of our data. Moreover, the utilization of clinical interviews for assessing anxiety and depression ensures diagnostic accuracy and minimizes the risk of misclassification bias. Additionally, the broad sample from the general child population can be seen as a strength, but also as a limitation as recruitment took place from one city only.

Despite the strengths outlined above, our study also has significant limitations, which warrant consideration. For example, confounding effects may provide alternative explanations for the observed associations. While we have endeavored to clarify the directionality of effects, thereby establishing a criterion for causality, it is possible that other factors, such as genetics, may explain the observed connections. Available research suggests the presence of a common genetic factor influencing both the ability to access social support and the heritability of anxiety and depression, thereby confounding the observed associations (Rhee & Ronald, 2014; Wade & Kendler, 2000).

Personality factors also represent a potentially confounding variable, as individual differences in personality traits can influence parental behaviors and interactions with children (Harandi et al., 2017). Furthermore, a parent's mental health status and personality could influence the availability and perception of social support he or she is getting (Harandi et al., 2017).

Additionally, life events such as divorce or relocation may disrupt social support networks, thereby influencing the observed associations between parental social support and children's mental health outcomes. Indeed, the proportion of divorced parents was higher in the study population than in the general population. Recent research by Caksen (2022) highlights the increased risk of anxiety and depression among children of divorced parents. Similarly, frequent relocations or changes in social networks may diminish the accessibility of social support, thereby exacerbating children's vulnerability to mental health difficulties.

Our sample primarily consists of Norwegian children from the city of Trondheim, reflecting specific cultural and societal norms regarding social support networks. The density and structure of social networks, as well as the prevalence of anxiety and depression, vary significantly across different countries and cultures. For instance, research by Barreto et al. (2021) highlights cultural differences in the prevalence of social support networks between the USA and Norway. Therefore, caution must be exercised when extrapolating our results to other cultural contexts, as the relevance and impact of social support may differ markedly.

As mentioned earlier, questions regarding social support were formulated somewhat differently for the age groups of 4-8 years, 10-12 years, and 14-16 years; and in the age group 14-16, two questions were removed. This may influence how we interpret the reports. For instance, in the questions for ages 4, 6, and 8, parents are asked about who provides practical social support (such as who can take care of the child when childcare is needed), where a high number of reported supporters yield a high score, and a low number of reported supporters yield a low score. The number of supporters does not necessarily define the degree of how available the help is, and how often the parent receives social support; for example, an individual who receives assistance solely from one source (such as a grandparent) can get its needs for social support covered but still receive a low score. In contrast, for the age groups of 10-12 years and 14-16 years, the questions primarily inquire to which degree the parents use the social support they have available, and not who they can ask for help. From age 10 and up, social support in this study was not measured by how many people one can ask for help, but to what degree the need for social support is covered, and how much the parents use the help they have available. The variances in measurements could have potentially led to the connections between anxiety and depression to be different. However, despite these measurement disparities, the effects remained consistent over time. Consequently, it is difficult to explain how differences in measurements could have led to similar effects, suggesting that the outcomes weren't compromised by having different measurements.

TESS (The Early Secure Study) transitioned from using the CAPA (Child and Adolescent Psychiatric Assessment) (Angold & Costello, 2000) to the K-SADS (Kiddie Schedule for Affective Disorders and Schizophrenia)(Kaufman & Schweder, 2004) clinical interview to measure symptoms of depression and anxiety from ages 14 to 16. The K-SADS imposes slightly stricter criteria for symptoms of depression. For instance, for a symptom to be considered indicative of depression, it must have been present for at least 50% of the day. In contrast, CAPA only requires symptoms to be present for one hour a day. When compared to other assessments of depression within these age groups, a decline in depression symptoms from age 14 to 16 seems unusual with sample scores lower than expected. Typically, depression increases during early adolescence (Merikangas et al., 2010). This variance in criteria could explain why our findings diverge from other assessments of depression symptoms in the 16-year-old age group, and may explain a misleading representation of a decline in depression symptoms from age 14 to 16.

While the assessment of depression might have been somewhat stricter at age 16, this does not necessarily mean that the relationship between depression and social support changes. Instead, the findings indicate consistency in this association compared to when less stringent criteria were applied. However, it remains plausible that the results might have differed, either becoming stronger or weaker, had the same criteria been utilized at age 16 as well. While our study provides valuable insights into the longitudinal relationship between parental social support and children's mental health, we acknowledge the inherent limitations and alternative explanations that may influence the observed associations. Future research endeavors should control for such relevant third variables.

Implications

Various interventions have indeed been developed to strengthen social networks and improve social support among parents, often in specific populations. For instance, community-based programs tailored to the needs of immigrant women or newly divorced individuals have been implemented to facilitate social integration and provide avenues for building supportive relationships. One such initiative is the "Parenting in a New Culture" program developed by the Northern Migrant Resource Center in Australia (Lewig et al., 2010). This initiative targeted three migrant community groups—Arabic, Chinese, and Samoan—whose cultural and social norms regarding parenting differ from mainstream Australian social values. The project's primary goal was to provide culturally sensitive support to navigate the challenges of acculturation and integration into a new society while raising their children (Lewig et al., 2010). Services centered around families that recognize and build upon the skills and strengths of refugee families have the capacity to enhance the mental health and overall well-being of all family members. Moreover, these services can help create a supportive home environment that helps children grow up well (Dunst et al., 2002).

Additionally, community-level initiatives such as extended maternity group sessions have shown efficacy in fostering social connections and reducing maternal isolation (Tandon et al., 2008). Similarly, the Strengthening Families Program (SFP) has been widely adopted in various countries, offering parent training, family skills development, and community-building activities to enhance social support and resilience (Kumpfer et al., 2002). In terms of interventions for newly divorced individuals, the "New Beginnings Program" focuses on promoting effective co-parenting strategies and rebuilding social networks after a divorce (Wolchik et al., 2002).

While universal measures for all parents may be beneficial to some extent, it is essential to recognize the importance of targeted support for specific demographics, such as isolated parents or those facing challenges related to immigration or relocation. By focusing on the most marginalized and underserved groups, interventions can effectively address disparities in social support and contribute to overall mental health and well-being. The present findings align with the supposition that increased social support to parents might not only be beneficial to parents but eventually also improve their offspring's mental health.

Conclusion

In this study we found that more social support in the parental role predicted lower levels of anxiety and depression in children, with similar effect sizes across the age span from 4 to 16 years of age. The effects were small in magnitude. Future studies should evaluate other mediating factors, such as whether increased social support improves parental attachment security, indirectly reducing children's anxiety and depression, or whether enhancements in parent-child interaction mediate the relationship between parental social support and children's mental health. The significance of this research work lies in its potential to guide interventions aimed at strengthening family support systems and thereby potentially reducing symptoms of anxiety and depression in children.

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Appendix

Table A1

Descriptive Statistics for Parental Social Support, Child Anxiety Disorder Symptoms and Child Depression Symptoms

Variable	Mean	SD
SS social Support		
4 years	3.91	0.70
6 years	3.84	0.68
8 years	5.69	0.96
10 years	5.72	1.02
12 years	5.75	1.03
14 years	5.38	1.32
16 years	5.27	1.44
ANX Child Anxiety Disorder Symptoms		
4 years	0.80	1.36
6 years	0.87	1.52
8 years	0.88	1.24
10 years	1.10	1.47
12 years	1.23	1.68
14 years	1.40	1.82
16 years	1.58	2.72
D Child Depression Symptoms		
4 years	0.80	1.36
6 years	0.94	1.55
8 years	0.94	1.57
10 years	1.08	1.76
12 years	1.21	2.10
14 years	1.62	2.69
16 years	0.51	1.75

Table A2a

Correlations Between Perceived Parental Support in the Parenting Role and Study Variables

Variables	Social support						
	4 years	6 years	8 years	10 years	12 years	14 years	16 years
SS 4 years	-	.62***	.23***	.19***	.12*	.10*	.14**
SS 6 years		-	.28***	.26***	.21***	.16**	.16**
SS 8 years			-	.57***	.48***	.31***	.25***
SS 10 years				-	.53***	.36***	.30***
SS 12 years					-	.04***	.33***
SS 14 years						-	.37***
SS 16 years							
				Anxiety			
SS 4 years	.06	-.03	.02	-.06	-.05	-.1	.01
SS 6 years	.10*	.00	-.08	-.01	-.05	-.03	.00
SS 8 years	.03	.08	-.05	-.15**	-.01	.05	.07
SS 10 years	-.06	.07	.08	-.16**	.03	.03	-.04
SS 12 years	.04	.12**	.03	-.08	.05	.02	.03
SS 14 years	.03	.06	-.02	-.05	.04	-.01	-.05
SS 16 years	-.05	.04	.03	-.01	.01	-.08	-.07
				Depression			
SS 4 years	-.04	-.07	.01	.02	.06	.09	-.11**
SS 6 years	-.03	-.08	.04	-.05	.05	.02	-.09
SS 8 years	.00	-.02	-.05	.04	-.01	-.07	.01
SS 10 years	-.01	-.70	-.09	.07	.01	-.08	.03
SS 12 years	-.00	-.10	-.04	-.00	-.05	-.06	-.02
SS 14 years	-.03	-.04	.01	-.00	.05	.02	-.02
SS 16 years	.01	.01	-.06	.03	.03	.04	-.01
				Parental anxiety and depression			
SS 4 years	-.15**	-.04	-.00	-.05	-.00	.03	.05
SS 6 years	-.10*	-.02	.01	-.02	-.03	-.03	.02
SS 8 years	.00	-.06	-.19***	-.05	-.06	.02	.04
SS 10 years	-.05	.04	-.08	-.15*	-.08	.01	.07
SS 12 years	-.01*	.04	-.05	-.02	-.18*	-.01	.03
SS 14 years	-.00	.05	-.04	-.02	-.09	-.04	.03
SS 16 years	-.02	-.06	.00	.05	-.10	-.03	.01

Note. SS= Parental Social Support

Table A2b

Correlations Between Symptoms of Child Anxiety and Study Variables

Variables	Social support						
	4 years	6 years	8 years	10 years	12 years	14 years	16 years
Anx 4 years	.02	.08	.03	-.13**	.08*	.04	-.07*
Anx 6 years	.00	-.04	.01	.02	.12**	.01	-.01
Anx 8 years	.07	-.09	-.09*	.08	.06	-.02	.01
Anx 10 years	-.02	.01	-.01	-.11	.07	.00	.03
Anx 12 years	-.04	-.02	-.04	-.01	.08	.02	-.03
Anx 14 years	-.08*	.02	.03	.00	.03	.00	-.07
Anx 16 years	-.02	.00	.11*	-.07	.05	-.05	-.06
	Anxiety						
Anx 4 years	-	.06	.18**	.16**	.22***	.13**	.04
Anx 6 years		-	.26***	.15**	.08	.05	.07
Anx 8 years			-	.30***	.26***	.13**	.08
Anx 10 years				-	.31***	.17**	.16***
Anx 12 years					-	.31***	.23***
Anx 14 years						-	.24***
Anx 16 years							-
	Depression						
Anx 4 years	.35***	.01	.04	.06	-.01	.00	-.01
Anx 6 years	-.00	.40***	.06	-.02	.06	-.02	.08
Anx 8 years	.10*	.08*	.43***	.03	.08	-.04	-.01
Anx 10 years	.10*	.06	.12*	.34***	.03	.01	.03
Anx 12 years	.10**	.01	.13**	.16***	.43***	.00	.05
Anx 14 years	.07	.01	.04	.12**	.11*	.56***	-.03
Anx 16 years	.01	-.06	.03	.22***	.11	.14*	.32***
	Parental anxiety and depression						
Anx 4 years	-.00	.02	-.02	-.02	.06	-.06	.06
Anx 6 years	-.04	.04	.13*	.02	.13	-.19*	.05
Anx 8 years	.04	.04	.02	.01	-.09	-.00	.14*
Anx 10 years	.05	.00	-.07	.07	-.00	-.02	-.02
Anx 12 years	.04	-.05	-.14**	.04	.14**	-.00	-.01
Anx 14 years	.00	-.04	.01	.10*	-.07	-.09**	.06
Anx 16 years	.10*	-.07	-.10	.04	.15*	-.14*	.10

Note. ANX= Child Anxiety Symptoms

Table A2c

Correlations Between Symptoms of Child Depression and Study Variables

Variables	Social support						
	4 years	6 years	8 years	10 years	12 years	14 years	16 years
D 4 years	-.05	-.03	.06	-.02	-.03	-.03	.05
D 6 years	-.05	-.03	.03	-.02	-.11*	-.01	.05
D 8 years	-.03	.04	-.01	-.01	-.01	.04	-.01
D10 years	.04	-.07	.00	.06	-.06	-.01	.05
D12 years	.06	.01	-.04	.01	-.08*	.05	.04
D 14 years	.06	-.02	-.03	-.03	-.07	.04	.04
D16 years	-.06	-.06	.01	.04	-.03	-.01	.01
	Anxiety						
D 4 years	.34***	.01	.05	.07	-.02	.01	.02
D 6 years	.02	.40***	.02	.03	.03	.05	-.03
D 8 years	-.01	.02	.42***	.04	.08	.06	.03
D10 years	.02	-.01	-.03	.31***	.11*	.16***	.23***
D 12 years	-.08*	.07	.01	-.02	.39***	.18**	.07
D14 years	-.04	.03	-.06	.00	.02	.58***	.14**
D16 years	.02	.09	-.08	.01	.07	.04	.37***
	Depression						
D 4 years	-	.12**	.14**	.07	-.03	.02	.07
D 6 years		-	.17**	.11**	.10*	.10**	.05
D 8 years			-	.14**	.17**	.14*	.01
D10 years				-	.23***	.27***	.15**
D12 years					-	.46***	.13
D14 years						-	.24**
D16 years							-
	Parental anxiety and depression						
D 4 years	.09*	.10	.12*	-.07	.02	.04	-.02
D 6 years	.07	.14*	.03	-.02	.12	-.09	-.05
D 8 years	-.01	.14**	.03	-.09	.05	.06	-.11
D10 years	-.00	.03	.11*	.02	-.03	.07	-.11*
D12 years	-.07	.07	-.07	-.08	.12	.29***	-.18*
D14 years	-.03	.10	-.06	-.10	.04	.18***	-.09
D16 years	-.07	-.02	.04	-.10	-.02	.14	.12

Note. D= Child Depression Symptoms

Table A2d

Correlations Between Symptoms of Parental anxiety and depression and Study Variables

Variables	Social support						
	4 years	6 years	8 years	10 years	12 years	14 years	16 years
P 4 years	-.13**	-.02	-.00	-.02	-.12*	.04	-.03
P 6 years	-.08	.00	-.13**	.01	-.04	.06	-.08
P 8 years	-.02	.01	-.18***	-.03	-.05	-.02	.01
P 10 years	-.08	.03	-.08	-.13**	-.05	.00	.03
P 12 years	-.03	.03	-.08	-.05	-.13*	-.02	-.03
P 14 years	-.00	-.01	-.07	-.02	-.10*	.00	-.04
P16 years	-.01	.02	-.08	.00	-.07	-.00	-.05
				Anxiety			
P 4 years	-.01	-.03	.10	.01	.00	-.04	.07
P 6 years	.02	.08	.14**	-.03	-.07	-.04	.02
P 8 years	.00	.15**	.09	-.05	-.11	.06	.00
P10 years	.00	.10*	.07	-.00	-.01	.02	.04
P 12 years	.03	.15*	.03	-.05	.01	-.09	.09
P 14 years	-.02	.06	.09	-.04	.02	-.10	.04
P 16 years	.03	.09	.16*	-.07	.00	-.02	.08
				Depression			
P 4 years	.16***	.14**	.00	.02	-.00	.04	-.05
P 6 years	.17***	.16**	.06	.02	.03	.08	-.03
P 8 years	.19***	.08	.01	.09*	.03	-.07	.04
P 10 years	.11*	.10*	-.06	.07	.02	-.04	-.02
P12 years	.15**	.12*	-.00	-.01	.15**	.10	.05
P14 years	.18***	.03	-.01	.01	.18***	.04	.11
P16 years	.12**	.06	-.04	.01	.04	-.02	.13
				Parental anxiety and depression			
P 4 years	-	.54***	.39***	.36***	.34***	.42***	.38***
P 6 years		-	.48***	.47***	.43***	.44***	.47***
P 8 years			-	.63***	.56***	.56***	.53***
P 10 years				-	.61***	.55***	.53***
P 12 years					-	.69***	.61***
P 14 years						-	.68***
P 16 years							

Note. P= Parental Anxiety and Depression

A3a Questionnaire 1.

Age of 4-6.

1. Hvem overlater du ansvaret for barnet ditt til når du ikke kan ta deg av det på kveldstid eller i helgene (du skal på møte, reise, kino el.l.)?

	Har ikke 1	*I ingen grad, ingen støtte/hjelp* 2	*I svært liten grad* 3	*I liten grad* 4	*I ganske liten grad* 5	*I ganske stor grad* 6	*I stor grad* 7	*I svært stor grad* 8
1. Barnets andre biologiske forelder	☐	☐	☐	☐	☐	☐	☐	☐
2. Ektefelle/samboer/kjæreste som ikke er biologisk forelder	☐	☐	☐	☐	☐	☐	☐	☐
3. Dine søsken	☐	☐	☐	☐	☐	☐	☐	☐
4. Dine foreldre	☐	☐	☐	☐	☐	☐	☐	☐
5. Svigerforeldre eller kjæreste/samboers foreldre	☐	☐	☐	☐	☐	☐	☐	☐
6. Øvrig familie	☐	☐	☐	☐	☐	☐	☐	☐
7. Venner/naboer	☐	☐	☐	☐	☐	☐	☐	☐
8. Profesjonelle (ansatte i barnehagen, helsesøster, lege, sosialtjenesten el.l.)	☐	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds 1	*Utilfreds* 2	*Litt utilfreds* 3	*Litt tilfreds* 4	*Tilfreds* 5	*Svært tilfreds* 6
Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

2. Hvem hjelper til eller er sammen med barnet rundt praktiske ting, lek eller samvær på ettermiddagstid eller kveldstid (etter arbeid/skole) og i helgene?

	Har ikke 1	*I ingen grad, ingen støtte/hjelp* 2	*I svært liten grad* 3	*I liten grad* 4	*I ganske liten grad* 5	*I ganske stor grad* 6	*I stor grad* 7	*I svært stor grad* 8
1. Barnets andre biologiske forelder	☐	☐	☐	☐	☐	☐	☐	☐
2. Ektefelle/samboer/kjæreste som ikke er biologisk forelder	☐	☐	☐	☐	☐	☐	☐	☐
3. Dine søsken	☐	☐	☐	☐	☐	☐	☐	☐
4. Dine foreldre	☐	☐	☐	☐	☐	☐	☐	☐
5. Svigerforeldre eller kjæreste/samboers foreldre	☐	☐	☐	☐	☐	☐	☐	☐
6. Øvrig familie	☐	☐	☐	☐	☐	☐	☐	☐
7. Venner/naboer	☐	☐	☐	☐	☐	☐	☐	☐
8. Profesjonelle (ansatte i barnehagen, helsesøster, lege, sosialtjenesten el.l.)	☐	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds 1	*Utilfreds* 2	*Litt utilfreds* 3	*Litt tilfreds* 4	*Tilfreds* 5	*Svært tilfreds* 6
Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

3. Hvem søker du råd hos om hva du skal gjøre når du er usikker på hvordan du skal håndtere barnet ditt når det har vansker (trassig, sint, lei seg, redd, usikker, vansker i forhold til mat og måltider, søvnproblemer, tisser på seg eller annet)?

	Har ikke 1	*I ingen grad, ingen støtte/hjelp* 2	*I svært liten grad* 3	*I liten grad* 4	*I ganske liten grad* 5	*I ganske stor grad* 6	*I stor grad* 7	*I svært stor grad* 8
1. Barnets andre biologiske forelder	☐	☐	☐	☐	☐	☐	☐	☐
2. Ektefelle/samboer/kjæreste som ikke er biologisk forelder	☐	☐	☐	☐	☐	☐	☐	☐
3. Dine søsken	☐	☐	☐	☐	☐	☐	☐	☐
4. Dine foreldre	☐	☐	☐	☐	☐	☐	☐	☐
5. Svigerforeldre eller kjæreste/samboers foreldre	☐	☐	☐	☐	☐	☐	☐	☐
6. Øvrig familie	☐	☐	☐	☐	☐	☐	☐	☐
7. Venner/naboer	☐	☐	☐	☐	☐	☐	☐	☐
8. Profesjonelle (ansatte i barnehagen, helsesøster, lege, sosialtjenesten el.l.)	☐	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds 1	*Utilfreds* 2	*Litt utilfreds* 3	*Litt tilfreds* 4	*Tilfreds* 5	*Svært tilfreds* 6
Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

4. Hvem søker du råd hos eller snakker du med om praktiske forhold rundt det å ha ansvaret som forelder (barnesykdommer, klær, mat, TV, leggetider, tannpuss, valg av leker, påkledning etc.)?

	Har ikke 1	*I ingen grad, ingen støtte/hjelp* 2	*I svært liten grad* 3	*I liten grad* 4	*I ganske liten grad* 5	*I ganske stor grad* 6	*I stor grad* 7	*I svært stor grad* 8
1. Barnets andre biologiske forelder	☐	☐	☐	☐	☐	☐	☐	☐
2. Ektefelle/samboer/kjæreste som ikke er biologisk forelder	☐	☐	☐	☐	☐	☐	☐	☐
3. Dine søsken	☐	☐	☐	☐	☐	☐	☐	☐
4. Dine foreldre	☐	☐	☐	☐	☐	☐	☐	☐
5. Svigerforeldre eller kjæreste/samboers foreldre	☐	☐	☐	☐	☐	☐	☐	☐
6. Øvrig familie	☐	☐	☐	☐	☐	☐	☐	☐
7. Venner/naboer	☐	☐	☐	☐	☐	☐	☐	☐
8. Profesjonelle (ansatte i barnehagen, helsesøster, lege, sosialtjenesten el.l.)	☐	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds 1	*Utilfreds* 2	*Litt utilfreds* 3	*Litt tilfreds* 4	*Tilfreds* 5	*Svært tilfreds* 6
Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

5. Hvem går du til eller snakker du med hvis du føler deg mislykket, "lang nede", fortvilet eller usikker som forelder?

	Har ikke (1)	I ingen grad, ingen støtte/hjelp (2)	I svært liten grad (3)	I liten grad (4)	I ganske liten grad (5)	I ganske stor grad (6)	I stor grad (7)	I svært stor grad (8)
1. Barnets andre biologiske forelder	☐	☐	☐	☐	☐	☐	☐	☐
2. Ektefelle/samboer/kjæreste som ikke er biologisk forelder	☐	☐	☐	☐	☐	☐	☐	☐
3. Dine søsken	☐	☐	☐	☐	☐	☐	☐	☐
4. Dine foreldre	☐	☐	☐	☐	☐	☐	☐	☐
5. Svigerforeldre eller kjæreste/samboers foreldre	☐	☐	☐	☐	☐	☐	☐	☐
6. Øvrig familie	☐	☐	☐	☐	☐	☐	☐	☐
7. Venner/naboer	☐ (1)	☐ (2)	☐ (3)	☐ (4)	☐ (5)	☐ (6)	☐ (7)	☐ (8)
8. Profesjonelle (ansatte i barnehagen, helsesøster, lege, sosialtjenesten el.l.)	☐	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds (1)	Utilfreds (2)	Litt utilfreds (3)	Litt tilfreds (4)	Tilfreds (5)	Svært tilfreds (6)
Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

6. Hvem viser at de godtar og respekterer deg fullt og helt som forelder?

	Har ikke (1)	I ingen grad, ingen støtte/hjelp (2)	I svært liten grad (3)	I liten grad (4)	I ganske liten grad (5)	I ganske stor grad (6)	I stor grad (7)	I svært stor grad (8)
1. Barnets andre biologiske forelder	☐	☐	☐	☐	☐	☐	☐	☐
2. Ektefelle/samboer/kjæreste som ikke er biologisk forelder	☐	☐	☐	☐	☐	☐	☐	☐
3. Dine søsken	☐	☐	☐	☐	☐	☐	☐	☐
4. Dine foreldre	☐	☐	☐	☐	☐	☐	☐	☐
5. Svigerforeldre eller kjæreste/samboers foreldre	☐	☐	☐	☐	☐	☐	☐	☐
6. Øvrig familie	☐	☐	☐	☐	☐	☐	☐	☐
7. Venner/naboer	☐	☐	☐	☐	☐	☐	☐	☐
8. Profesjonelle (ansatte i barnehagen, helsesøster, lege, sosialtjenesten el.l.)	☐	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds (1)	Utilfreds (2)	Litt utilfreds (3)	Litt tilfreds (4)	Tilfreds (5)	Svært tilfreds (6)
Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

A3b Questionnaire 2.

Age of 8-12.

	I ingen grad, ingen støtte/hjelp 1	I svært liten grad 2	I liten grad 3	I ganske liten grad 4	I ganske stor grad 5	I stor grad 6	I svært stor grad 7
1a. I hvilken grad har du noen du kan overlate ansvaret for barnet ditt til når du ikke kan ta deg av det på kveldstid eller i helgene (du skal på møte, reise, kino el.l.)?	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds 1	Utilfreds 2	Litt utilfreds 3	Litt tilfreds 4	Tilfreds 5	Svært tilfreds 6
1b. Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

	I ingen grad, ingen støtte/hjelp 1	I svært liten grad 2	I liten grad 3	I ganske liten grad 4	I ganske stor grad 5	I stor grad 6	I svært stor grad 7
2a. I hvilken grad har du noen som hjelper til eller er sammen med barnet rundt praktiske ting, hjelp med lekser eller samvær på ettermiddagstid eller kveldstid (etter arbeid/skole) og i helgene?	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds 1	Utilfreds 2	Litt utilfreds 3	Litt tilfreds 4	Tilfreds 5	Svært tilfreds 6
2b. Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

	I ingen grad, ingen støtte/hjelp 1	I svært liten grad 2	I liten grad 3	I ganske liten grad 4	I ganske stor grad 5	I stor grad 6	I svært stor grad 7
3a. I hvilken grad har du noen du søker råd hos om hva du skal gjøre når du er usikker på hvordan du skal håndtere barnet ditt når det har vansker (sint, lei seg, redd, usikker, vansker i forhold til mat og måltider, søvnproblemer, problemer med venner eller klassekamerater)?	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds 1	Utilfreds 2	Litt utilfreds 3	Litt tilfreds 4	Tilfreds 5	Svært tilfreds 6
3b. Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

	I ingen grad, ingen støtte/hjelp 1	I svært liten grad 2	I liten grad 3	I ganske liten grad 4	I ganske stor grad 5	I stor grad 6	I svært stor grad 7
4a. I hvilken grad har du noen du søker råd hos eller snakker med om praktiske forhold rundt det å ha ansvaret som forelder (barnesykdommer, lekser, mat, TV/PC-bruk, leggetider etc.)?	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds 1	Utilfreds 2	Litt utilfreds 3	Litt tilfreds 4	Tilfreds 5	Svært tilfreds 6
4b. Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

	I ingen grad, ingen støtte/hjelp 1	I svært liten grad 2	I liten grad 3	I ganske liten grad 4	I ganske stor grad 5	I stor grad 6	I svært stor grad 7
5a. I hvilken grad har du noen du snakker med hvis du føler deg mislykket, «langt nede», fortvilet eller usikker som forelder?	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds 1	Utilfreds 2	Litt utilfreds 3	Litt tilfreds 4	Tilfreds 5	Svært tilfreds 6
5b. Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

	I ingen grad, ingen støtte/hjelp 1	I svært liten grad 2	I liten grad 3	I ganske liten grad 4	I ganske stor grad 5	I stor grad 6	I svært stor grad 7
6a. I hvilken grad har du noen som viser at de godtar og respekterer deg fullt og helt som forelder?	☐	☐	☐	☐	☐	☐	☐

	Svært utilfreds 1	Utilfreds 2	Litt utilfreds 3	Litt tilfreds 4	Tilfreds 5	Svært tilfreds 6
6b. Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?	☐	☐	☐	☐	☐	☐

A3c Questionnaire 3.

Age 14-16.

1a. I hvilken grad har du noen du søker råd hos om hva du skal gjøre når du er usikker på hvordan du skal håndtere ungdommen din når hun/han har vansker (sint, lei seg, usikker, vansker med mat og måltider, problemer med venner, innetider, alkohol, skole-prestasjoner, ansvar for husarbeid, ukepenger etc.)?	*I ingen grad, ingen støtte/hjelp* 1 ☐	*I svært liten grad* 2 ☐	*I liten grad* 3 ☐	*I ganske liten grad* 4 ☐	*I ganske stor grad* 5 ☐	*I stor grad* 6 ☐	*I svært stor grad* 7 ☐	
		Svært utilfreds 1	*Utilfreds* 2	*Litt utilfreds* 3	*Litt tilfreds* 4	*Tilfreds* 5	*Svært tilfreds* 6	
1b. Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?.....		☐	☐	☐	☐	☐	☐	
2a. I hvilken grad har du noen du søker råd hos eller snakker med om praktiske forhold rundt det å ha ansvaret som forelder (lekser, mat, TV/PC-bruk, leggetider etc.)?.....	*I ingen grad, ingen støtte/hjelp* 1 ☐	*I svært liten grad* 2 ☐	*I liten grad* 3 ☐	*I ganske liten grad* 4 ☐	*I ganske stor grad* 5 ☐	*I stor grad* 6 ☐	*I svært stor grad* 7 ☐	
		Svært utilfreds 1	*Utilfreds* 2	*Litt utilfreds* 3	*Litt tilfreds* 4	*Tilfreds* 5	*Svært tilfreds* 6	
2b. Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?.....		☐	☐	☐	☐	☐	☐	
3a. I hvilken grad har du noen du snakker med hvis du føler deg mislykket, «langt nede», fortvilet eller usikker som forelder?	*I ingen grad, ingen støtte/hjelp* 1 ☐	*I svært liten grad* 2 ☐	*I liten grad* 3 ☐	*I ganske liten grad* 4 ☐	*I ganske stor grad* 5 ☐	*I stor grad* 6 ☐	*I svært stor grad* 7 ☐	
		Svært utilfreds 1	*Utilfreds* 2	*Litt utilfreds* 3	*Litt tilfreds* 4	*Tilfreds* 5	*Svært tilfreds* 6	
3b. Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?.....		☐	☐	☐	☐	☐	☐	
4a. I hvilken grad har du noen som viser at de godtar og respekterer deg fullt og helt som forelder?	*I ingen grad, ingen støtte/hjelp* 1 ☐	*I svært liten grad* 2 ☐	*I liten grad* 3 ☐	*I ganske liten grad* 4 ☐	*I ganske stor grad* 5 ☐	*I stor grad* 6 ☐	*I svært stor grad* 7 ☐	
		Svært utilfreds 1	*Utilfreds* 2	*Litt utilfreds* 3	*Litt tilfreds* 4	*Tilfreds* 5	*Svært tilfreds* 6	
4b. Hvor tilfreds er du, alt i alt, med denne støtten/hjelpen?.....		☐	☐	☐	☐	☐	☐	

Table A4a

Two Year Predictions of Parental Social Support and Parental Emotional Problems

Standardized Estimates

		Estimate	S.E.	Est./ S.E.	Two-Tailed P-Value
SS7	ON				
D6		0.044	0.049	0.897	0.370
ANXS6		-0.099	0.049	-2.025	0.043
SS6		0.285	0.053	5.374	0.000
P6		-0.037	0.039	-0.959	0.338
SS5		0.218	0.053	4.073	0.000
P7	ON				
D6		-0.055	0.051	-1.070	0.285
ANXS6		0.055	0.049	1.135	0.256
SS6		0.003	0.029	0.096	0.924
P6		0.508	0.073	6.916	0.000
P5		0.280	0.074	3.770	0.000
SS6	ON				
D5		0.059	0.042	1.392	0.164
ANXS5		0.008	0.041	0.198	0.843
SS5		0.338	0.055	6.142	0.000
P5		-0.020	0.040	-0.497	0.619
SS4		0.187	0.056	3.348	0.001
P6	ON				
D5		0.101	0.037	2.725	0.006
ANXS5		-0.022	0.032	-0.687	0.492
SS5		-0.011	0.027	-0.397	0.691
P5		0.561	0.066	8.509	0.000
P4		0.215	0.071	3.020	0.003
SS5	ON				
D4		-0.062	0.044	-1.414	0.157
ANXS4		0.044	0.037	1.177	0.239

	SS4		0.379	0.055	6.943	0.000
	P4		-0.033	0.034	-0.955	0.340
	SS3		0.275	0.050	5.527	0.000
P5		ON				
	D4		0.049	0.049	0.998	0.318
	ANXS4		0.012	0.033	0.377	0.706
	SS4		-0.049	0.031	-1.550	0.121
	P4		0.393	0.054	7.293	0.000
	P3		0.350	0.056	6.254	0.000
SS4		ON				
	D3		-0.069	0.039	-1.756	0.079
	ANXS3		0.075	0.036	2.077	0.038
	SS3		0.535	0.040	13.259	0.000
	P3		-0.042	0.032	-1.294	0.196
	SS2		0.128	0.036	3.582	0.000
P4		ON				
	D3		-0.049	0.039	-1.234	0.217
	ANXS3		-0.001	0.035	-0.018	0.986
	SS3		-0.025	0.029	-0.854	0.393
	P3		0.527	0.079	6.710	0.000
	P2		0.248	0.069	3.601	0.000
SS3		ON				
	D2		-0.033	0.042	-0.785	0.433
	ANXS2		0.051	0.045	1.129	0.259
	SS2		0.241	0.056	4.269	0.000
	P2		-0.161	0.038	-4.213	0.000
	SS1		0.092	0.058	1.593	0.111
P3		ON				
	D2		0.025	0.043	0.590	0.555
	ANXS2		0.118	0.049	2.421	0.015

	SS2	-0.020	0.031	-0.641	0.522
	P2	0.354	0.075	4.730	0.000
	P1	0.234	0.065	3.591	0.000
SS2	ON				
	D1	-0.027	0.032	-0.843	0.399
	ANXS1	0.044	0.031	1.414	0.157
	SS1	0.611	0.031	19.494	0.000
	P1	-0.049	0.032	-1.555	0.120
P2	ON				
	D1	0.122	0.045	2.714	0.007
	ANXS1	0.036	0.024	1.506	0.132
	SS1	-0.013	0.032	-0.395	0.693
	P1	0.541	0.044	12.318	0.000

Note: "SS" =Social Support, "SS1"= Social Support at Time 1. "P" stands for Parental Anxiety and Depression, "P1"=Parental Anxiety and Depression at Time 1. STDYX standardization.

Table A4b

Predictions of Child Anxiety symptoms

Standardized Estimates

		Estimate	S.E.	Est./ S.E.	Two-Tailed P-Value
ANXS7	ON				
D1		0.122	0.045	2.714	0.007
ANXS6		0.036	0.024	1.506	0.132
SS1		-0.013	0.032	-0.395	0.693
P1		0.541	0.044	12.318	0.000
ANXS6	ON				
D6		0.237	0.063	3.779	0.000
ANXS5		0.322	0.054	5.982	0.000
SS5		-0.058	0.015	-3.913	0.000
P5		-0.060	0.041	-1.457	0.145
ANXS4		0.100	0.049	2.047	0.041
ANXS5	ON				
D4		0.222	0.042	5.281	0.000
ANXS4		0.204	0.052	3.903	0.000
SS4		-0.062	0.016	-3.949	0.000
P4		0.025	0.041	0.600	0.548
ANXS3		0.193	0.047	4.089	0.000
ANXS4	ON				
D3		0.110	0.044	2.515	0.012
ANXS3		0.274	0.067	4.073	0.000
SS3		-0.068	0.017	-3.933	0.000
P3		0.000	0.044	-0.003	0.997
ANXS2		0.112	0.042	2.683	0.007
ANXS3	ON				
D2		0.059	0.046	1.282	0.200
ANXS2		0.236	0.067	3.532	0.000
SS2		-0.056	0.014	-3.894	0.000
P2		0.174	0.054	3.232	0.001
ANXS1		0.168	0.054	3.099	0.002

ANXS2	ON				
D1		0.091	0.062	1.479	0.139
ANXS1		0.057	0.039	1.480	0.139
SS1		-0.048	0.013	-3.759	0.000
P1		0.063	0.042	1.521	0.128

Note: "ANXS" stands for Anxiety, "ANXS1"= Anxiety at Time 1. STDYX Standardization.

Table A4c

Predictions of Child Depressive symptoms

Standardized Estimates

		Estimate	S.E.	Est./S.E.	Two-Tailed P-Value
D7	ON				
D6		0.296	0.089	3.334	0.001
SS6		-0.054	0.023	-2.326	0.020
P6		0.154	0.059	2.628	0.009
D5		-0.005	0.084	-0.064	0.949
D6	ON				
D5		0.513	0.052	9.809	0.000
SS5		-0.028	0.012	-2.304	0.021
P5		-0.016	0.041	-0.394	0.694
D4		0.147	0.062	2.385	0.017
D5	ON				
D4		0.309	0.046	6.741	0.000
SS4		-0.035	0.015	-2.269	0.023
P4		0.044	0.041	1.079	0.281
D3		0.125	0.059	2.137	0.033
D4	ON				
D3		0.226	0.042	5.354	0.000
SS3		-0.040	0.018	-2.206	0.027

	P3		0.073	0.039	1.868	0.062
	D2		0.104	0.038	2.739	0.006
D3		ON				
	D2		0.212	0.056	3.788	0.000
	SS2		-0.031	0.013	-2.328	0.020
	P2		0.157	0.056	2.822	0.005
	D1		0.120	0.045	2.684	0.007
D2		ON				
	D1		0.167	0.044	3.758	0.000
	SS1		-0.033	0.014	-2.299	0.022
	P1		0.176	0.041	4.252	0.000

Note: "D" stands for depression, "D1"= Depression at Time 1. STDYX Standardizations.

Table A4d

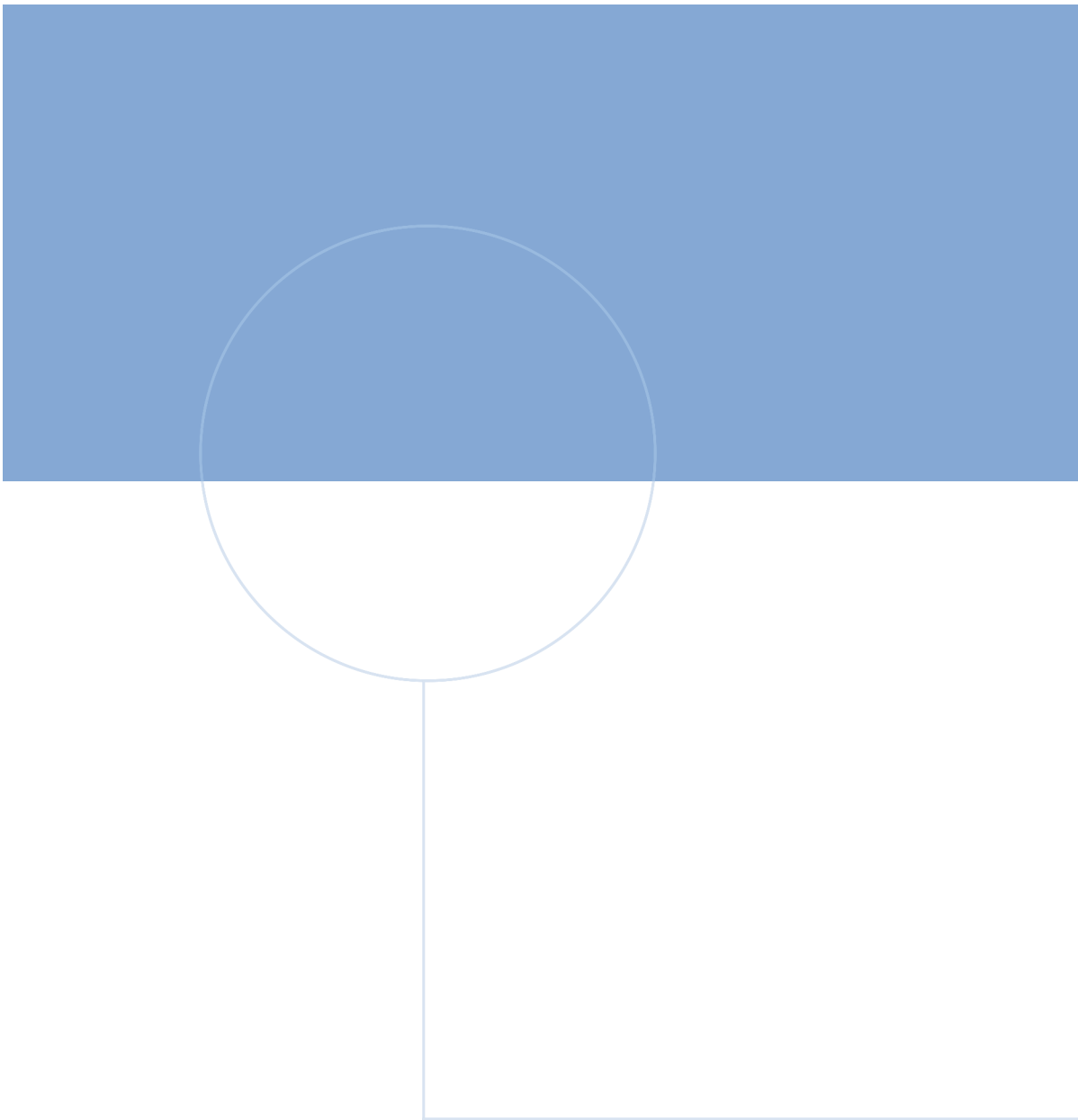
Correlations Between Concurrent Residuals

		Estimate	S.E.	Est./ S.E.	Two-Tailed P-value
D7	WITH				
ANXS7		0.327	0.061	5.377	0.000
SS7		-0.016	0.027	-0.604	0.546
P7		0.092	0.084	1.100	0.271
ANXS7	WITH				
SS7		-0.047	0.045	-1.050	0.294
P7		0.060	0.052	1.159	0.246
SS7	WITH				
P7		-0.017	0.042	-0.398	0.691
D6	WITH				
ANXS6		0.514	0.048	10.610	0.000
SS6		0.029	0.041	0.712	0.476
P6		0.021	0.044	0.488	0.626
ANXS6	WITH				
SS6		-0.004	0.037	-0.107	0.915
P6		-0.050	0.037	-1.347	0.178
SS6	WITH				
P6		-0.001	0.042	-0.030	0.976
D5	WITH				
ANXS5		0.433	0.066	6.565	0.000
SS5		-0.069	0.037	-1.836	0.066
P5		0.248	0.060	4.133	0.000
ANXS5	WITH				
SS5		0.008	0.041	0.198	0.843
P5		0.232	0.050	4.624	0.000

SS5	WITH				
P5		-0.124	0.056	-2.209	0.027
D4	WITH				
ANXS4		0.351	0.057	6.198	0.000
SS4		-0.004	0.034	-0.122	0.903
P4		0.051	0.042	1.196	0.232
ANXS4	WITH				
SS4		-0.107	0.040	-2.711	0.007
P4		0.077	0.042	1.821	0.069
SS4	WITH				
P4		-0.125	0.041	-3.009	0.003
D3	WITH				
ANXS3		0.419	0.040	10.595	0.000
SS3		-0.081	0.040	-2.050	0.040
P3		0.003	0.043	0.071	0.943
ANXS3	WITH				
SS3		-0.076	0.041	-1.851	0.064
P3		0.019	0.042	0.452	0.651
SS3	WITH				
P3		-0.173	0.037	-4.745	0.000
D2	WITH				
ANXS2		0.434	0.037	11.815	0.000
SS2		-0.067	0.042	-1.583	0.113
P2		0.170	0.058	2.946	0.003
ANXS2	WITH				
SS2		-0.029	0.039	-0.741	0.459
P2		0.174	0.053	3.319	0.001

SS2	WITH				
P2		-0.035	0.037	-0.956	0.339
D1	WITH				
ANXS1		0.370	0.035	10.531	0.000
SS1		-0.086	0.033	-2.589	0.010
P1		0.209	0.042	5.021	0.000
ANXS1	WITH				
SS1		0.002	0.039	0.058	0.954
P1		0.081	0.037	2.212	0.027
SS1	WITH				
P1		-0.178	0.035	-5.071	0.000

Note: "D" stands for depression, "D1"= Depression at Time 1. "SS" stands for Social Support, "SS1"= Social Support at Time 1. "ANXS" stands for Anxiety, "ANXS1"= Anxiety at Time 1. "P" stands for Parental Anxiety and Depression, "P1"=Parental Anxiety and Depression at Time 1. STDYX standardizations.



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