IMPACTS OF PARENTAL OVERPROTECTION TO PSYCHOSOCIAL DEVELOPMENT IN CHILDHOOD AND ADOLESCENCE

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The phenomenon of parental overprotection is one of the commonest parent-child relationship disorders. Despite of its incidence it was rarely investigated in the past, and this process was full of definitional problems that disturb the generalisability of earned solutions. In this study we try to summarize shortly the main theories of parental overprotection, and the attempts of empirical research. After that we show the first steps of our investigations in this area.

Keywords: parental overprotection, over-control, internalization, externalization, suicidal thinking

The phenomenon of parental overprotection is one of the commonest parent-child relationship disorders (Thomasgard & Metz, 1993). Despite of its incidence it was rarely investigated in the past, and this process was full of definitional problems that disturb the generalisability of earned solutions (Livianos-Aldana & Rojo-Moreno, 1999).

In everyday conversation and promotional literature there are many kind of terms for parental overprotection. In English descriptions we could find terms like indulgence, pampering, cotton wool kid or helicopter parent (too controlling parent). In scientific studies the investigators use some term interchangeably like overprotection, overindulgence, over-restrictiveness and over-permissiveness, fondling, over-solicitude, domineering, overregulation, babying etc. In some cases even the investigators are not sure that the used construct is more sophisticated than the measure what explored it.

In the first exploration we analyzed the relationship between the parental overprotection and intelligence as well as social status (45 boys, 8 girls, high school students of 9^{th} and 10^{th} grade). The results show partly significant relations, negative correlation between overprotection and general intelligence, and positive correlation between parental control and social status.

The second study investigates the aspects of parental overprotection found in the Child Guidance (the composition of clinical sample in the first step was: 53 persons, 22 girls, 31 boys – 3-18 years old – in the second step was: 14 children and adolescents, 10 boys and 4 girls – 10-17 years old – suffering from sever mental disorders like externalizing and internalizing problems). We found that 3-8 years old children experience more parental overprotection, the parental overprotection was related to conduct problems in boys, while among girls it was related to separation anxiety and enuresis. We found paternal excessive control as risk factor for children's

externalizing behavior (aggression and deviance), while the parental overprotection was risk factor for internalizing behavior and suicidal thinking in children.

The main directions in general investigation of parental overprotection

The scientific community had discovered the issue of parental overprotection since early 1940's. Since then the most important investigators and interpreters of overprotection were David M. Levy (1966), Gordon Parker (1983) and Thomasgard and Metz (1993).

Levy described the "pure" maternal overprotection after studying a small clinical group of selected mothers. He differentiated four areas of parental overprotection: the excessive physical contact, the infantilization, the hindrance of autonomous behavior, and the excess or lack of control (Levy, 1966). He tried to establish the comprehensive theory of maternal overprotection. In this comprehensive theory he described the specific appearance of the phenomena, the background of the maternal overprotection (the "affect hunger" of the mother, the dissatisfying social relations, the ineffective father, etc.), the consequences of overprotection (the anxiety of the child, the disturbed personality development), as well as the psychotherapy possibilities (psychoanalytic therapy approaches, psycho-education and the restructuring of the social environment).

Parker is the only theorist, who wrote a comprehensive handbook based on a wide empirical background (Parker, 1983), as well as he is one of the firsts who designed a well standardized measure of parental overprotection (Parental Bonding Instrument – PBI; Parker et al., 1979). By Parker's contribution to make an instrument with good psychometric properties, have started and accelerated the research of relationship between psychopathologies, as well as other psychological factors and pathogen rearing attitudes. Parker (1983) reveals two overprotective parenting styles: the "affectionate constraint" and the "affectionless control". The second was shown in the background of a variety of psychopathologies (mainly neurotic symptoms, but it may contribute to the severity of psychotic disorders as well), but the importance of the first is not well proved yet (it was detected behind the development of hypochondriasis, asthma, dependent personality trait and in association with some cultural tendencies).

Thomasgard contribute to the examination of parental overprotection with differentiate the construct of parental perception of child vulnerability (Vulnerable Child Syndrome; Thomasgard, 1998). The excessive perception of child vulnerability is a severe risk factor of anxiety disorders in children, and it is related with a number of other parental psychopathology (Thomasgard, 1998).

All three theorists suggest that the parental overprotection has at least two distinct forms: restrictive or permissive (Levy, 1966), characterized by affectionate or affectionless control (Parker, 1983), originated from excessive perception of child vulnerability or from parental negative feelings (anxiety or guilt) (Thomasgard & Metz, 1999).

The relations between the deviances of psychosocial development and parental overprotection

Analyzing the empiric literature we could realize that these studies can be classified in two broad groups. The first group consists of the articles dealing with the wide variety of psychopathologies developed on an overprotective family background. These are mainly the different variations of neurotic disorders like anxiety disorders (Muris et al., 2003; Bogels & van Melick, 2004; Coplan, Reichel & Rowan, 2009), the neurotic types of depression (Parker, 1983; Martin et al., 2004; Avagianou & Zafiropoulou, 2008; Johnstone et al., 2009), and a large number of other disorders, like personality disorders (Carr & Francis, 2010), schizophrenia (Willinger et al., 2002), eating disorders (Eggert, 2008), conduct problems (Jefferis & Oliver, 2006), somatoform disorders (Fisher & Chalder, 2003; Janssens, Oldehinkel & Rosmalen, 2009) etc.

The second group of empirical studies is made up of the articles wrote about the overprotection of chronically ill patients by their caregivers, family members and caring institutions, and about the deleterious outcomes of these processes (Coyne & DeLongis, 1986; Thompson & Sobolew-Shubin, 1993; Mullins et al., 2004; Sanders, 2006). We can make the conclusion, that the overprotection cannot be restricted to the area of parental variety because these processes are common in every caregiver–care-recipient relationships.

In the following part of this article I present my efforts in the research of the parental overprotection issue. The presentation includes two exploratory steps: the first step investigates the general impacts of parental overprotection in a healthy sample, the second step explores the occurrence of overprotection in a clinical sample.

The pilot study of parental overprotection

Preliminary considerations. As previously detailed scientific background showed that the overprotection term is fairly complex, the theorists and the investigators have no clear consensus even in its definition and there's a need of clarifying the research results in its consequences. My first research step in the issue of overprotection was mostly a phenomenological approach, I would like to show the more general traits of the phenomena.

Because the complexity of the phenomena and the varied literature made more harder the empiric operationalizing of overprotection and to work at the huge number of measures exceeded the potentials of my first research step, I tried to unfold the overprotection to commensurable dimensions speculatively. In such a way I got three components: over-worrying, over-controlling and indulging.

In my opinion over-worrying means the way as the parent prevents the dangerous situations threatening his or her child (e.g. over-clothes him or her when it's causeless, worn that he or she doesn't eat enough, even if he or she is already an adolescent, etc.). Over-controlling means the excessive supervision and check-up of the child (e.g. excessively influence the way of the child's spare-time, always asks where does he or she go etc.) In this way indulging means that the parent makes things for the child even if he or she is able and enough old to do that (e.g. gets the breakfast, clean up his or her room, etc).

Hypotheses

The purpose of my empirical study was to unfold the coherency between my overprotection definition and its components and general intelligence as well as the social status of the child in his or her age-group. These two constructs are related with overprotection based on literature but other studies barely specified this relation. My hypotheses were the following:

1. The over-worried, over-controlled, indulged children's general intelligences are lower than their mates'.
2. The over-worried, over-controlled, indulged children's social statuses are much more unfavorable and maybe deflects more to extremities than their mates'.

Methods

Participants. The explored sample consists of high school students. I chose this age because in this age-group increases the importance of peers in case of healthy development (Vikár, 1999). In the time when the opinions of peers get more important, a new identity starts to evolve which is distinct from the parents'. I supposed that the overprotected faces at first in this age the social disadvantages and the weakness of their social competencies which were left without the right experiences by their overprotective environment (Parker, 1983).

In high school age the social status is well measurable and we also can execute smoothly the sociometric test. The sample covered two high school classes, the total number of the participants was 53, 45 boys and 8 girls. I examined students of a 9^{th} and a 10^{th} grade class.

Measures. In this study I tried to collate the results of three measures. Two of these are generally used processes: the Raven Standard Progressive Matrices an intelligence measuring test (Rózsa, 2006) and a sociometric questionnaire made up based on Ferenc Mérei's instructions (Mérei, 2006).

I chose the Raven test because it measures the g-factor of the intelligence according to the users' experiences and this factor is relatively independent from the encyclopedic knowledge. I supposed that the g-factor is related with the overprotecting of the person and this relation is mediated by the weakness of the abilities thanks to overprotection (Rózsa, 2006).

Mérei's sociometry is a useful tool to detect the social status occupied by the subjects in their peer group. Another assumption of the study was that the place took by the overprotected child in his or her group is not optimal because their social skills are underdeveloped. His or her place in the group would be extreme: the subject would take place either in the periphery or would make an effort to occupy a "star-role" in the group. If my hypothesis will prove true the hierarchy by social status would be related with the extent of the overprotection (Mérei, 2006).

I designed a questionnaire to determine the extent of the overprotection based mostly on references of the literature (Parker, 1983; Levy, 1966). The overprotection questionnaire was compiled from the items referring to the three dimensions (over-worrying, over-controlling and indulging) already stated above. And now let's see some examples of the items:

- over-worrying: "Are your parents worried about the little amount of your meal?", "Did your parents ever forbid you from doing a sport or a leisure time activity because they are worried about your physical health?";

- over-controlling: “Do your parents try to influence you in selecting your friends?”, “How often do your parents ask you when you go somewhere that where do you go?”;
- indulging: “Is any housework your duty at home? If yes, what is it?”, “Approximately how old were you when you went at first shopping on your own?”.

Procedure. The investigation was conducted in 2004 from January to March in the Ferenc Kiss Forestry Vocational School in Szeged, Hungary. The students filled up our test just in case their parents consent to the procedure so we fit the requirements of research ethics.

Results

The data were the result of the Raven test, the index-number of the social status arose from sociometry (the sum of mutual relationships weighted by their strength for a subject) as well as the values of the three overprotection dimensions of our questionnaire. The base coding categories were the IQ, the social status, the over-worrying, the over-controlling, the indulging, and the sum of the last three in an overprotection variable.

I didn’t get significant relationships in the whole sample. With Pearson correlation I got that the indulging had a negative effect on the IQ level ($r = -0,23$, $p < 0,089$). A significant correlation was found between the intelligence and the social status of the girls ($r = -0,76$, $p < 0,026$).

In the next step the students of the two classes were detached. In this case Pearson correlation offered a significant result: there was a significant negative relationship between the intelligence and overprotection ($r = -0,40$, $p < 0,042$) in 9th grade. Analyzing the 10th grade data we found a significant positive relationship between the over-control and the social status ($r = 0,39$, $p<0,045$).

Discussion

The relative inefficiency in the whole sample would mean that if we increase the number of subjects or the representatively of the sample, refine the measure of the overprotection, or with a more accurate IQ measure we could affirm our hypothesis that the intelligence have a negative correlation with the indulging, so the indulged child is less intelligent.

The strong negative relationship between the intelligence and social status of the girls means that the higher intelligence a girl has the lower her social status would be, and vice versa. Of course we must handle this result guardedly because the sample was too small and it could be influenced by the sex rate of the sample and the sex stereotypes about “brightness”. It’s interesting that there was no relation between the IQ and the indulging for girls. This could mean that either only boys have this characteristic or this result is a sequel of the small sample size again.

We could prove the relation between the intelligence and the indulging for 9th grade students, and the relation between the overprotection and social status for 10th grade students. The reason of this difference is that the group development in 9th grade class is in a more active phase than in the 10th grade, the quality of the social status would be more important for the 10th grade students. This question would be answered just after a more detailed investigation.

The result that the control and the social status are in positive relation for 10th grade could mean that subjects who have experienced stronger control from their parents would realize a higher social status, in other words subjects with strong parental control need more social reference from their mates (we must be circumspect with far-reaching inferences), because we determined the construct of the social status with the number of relationships. We could ask again that why we could not find this relationship for the whole sample.

On the whole we could pronounce that the hypotheses could be partly proved. The intelligence shows negative relation with the overprotection for the 9th grade students and the control was in positive relation with social status for 10th grade students. Understanding exactly the nature of the outcomes needs further investigations, but it's hopeful from the point of view of the further researches that despite of the methodological weaknesses we got significant and interesting results.

The child guidance study of parental overprotection

The children and their parents sent to and voluntarily asking for help in the Child Guidance Services could be treated as a clinical group because of their psychological difficulties. On the grounds of clinical studies could be declare that the generalisability of the results gained from clinical samples could be equivocal because many clinical studies showed that the correlations experienced in clinical sample are not at all or just partly effectual in non-clinical samples (Lőke, 2005).

After all we investigate a clinical sample because all Levy's (1966), Parker's (1983) and Thomasgard's and Metz's (1993) research experiences hold the observation that the clinical sample shows stronger the consequences of the parental overprotection then the non-clinical sample. Because these results could be generalize just partly further we expect from them the tracing of the conduct lines for the subsequent investigations and primarily preliminary appraisals.

The first step of the study

Our first investigation step aimed the children and the youth who got psychotherapy or counsel in a child guidance service in a year. Henceforth we'll detail the circumstances and the results of this investigation.

Preliminary considerations. From point of view of the symptoms a heterogeneous group appears both in type and severity in the consulting hours of a child guidance service in a year, but these requests represent well the range of childhood psychiatry disorders in an average community. We supposed if the literature observations are valid for Hungarian circumstances then we could find several characteristics of the parental overprotection in the research sample.

Hypotheses. Starting from the Levy's (1966) and Parker's (1983) clinical approach we were looking for answers that in which ratio the psychopathological cases were related with the phenomena of parental overprotection in the clinical group of children. We hypothesized that in approximately the half of the clinical group we could find the outcomes of some types of parental overprotection (over-permissiveness vs. over-control).

Methods

Participants. In the study 53 children were examined who appeared in child guidance consulting hours. This amount of subjects were children who appeared in diagnostic and psychotherapeutic occasions of a child guidance service in a school year. The ratio of the sexes was the following: 22 girls (41.51%) and 31 boys (58.49%). Children from the 3-18 age-group have appeared in our consulting hours according to usual child guidance recipients. In child guidance practice the professionals divide usually children and youth in three wide age-groups according to the required age-specific therapeutic interventions (Horányi & Hoffmann, 1999). The distribution of the age-group was the following: age 3-8 – 30,19%; age 9-13 – 37,72%; age 14-18 – 32,08%. The distribution of sexes in different age-groups was: age 3-8 – girls 53% and boys 47%; age 9-13 – girls 15% and boys 85%; age 14-18 – girls 58% and boys 41%. We can see that in the youngest peer group there are no significant differences between sexes, but in second age-group the boys and in third age-group the girls are the remarkable majority. These deviations proved themselves to be significant ($\chi^2 = 9{,}32$, df = 2, $p < 0{,}009$).

Measures. The assessment forms usually used in child guidance work (CBCL, SDQ, CDI, STAI-C, JEPQ) were applied to affirm the different diagnoses. To separate the overprotected and non-overprotected groups we used anamneses and hetero-anamneses. In anamnestic data we were looking for the Levy's (1966) four overprotection components (excessive physical contact, infantilization, prevention from the development of the autonomy, excessive vs. inefficient control) in the course of a child's life. In case of accentuated occurrence of just one component we rated the child in the overprotected group. The rating was executed by two independent professionals and a child was left in the overprotected group just he or she was selected concordantly.

Procedure. We met the children and their parents in time of child guidance occupation and we send the assessment form to teachers by parents. Both anamneses and assessment forms were filled up in time of the diagnostic phase of the therapies. Parents agreed with the anonymous and just for research purposes usage of data.

Results

On the grounds of rating the ratio of the overprotection for the whole sample was 45%. The most frequently given main diagnoses according to ICD-10 (2004) diagnostic categories were:

- F32.0 Mild depressive episode
- F91.9 Conduct disorder, unspecified
- F93.0 Separation anxiety disorder
- F91.3 Oppositional defiant disorder

The Figure 1. demonstrates the distribution of main diagnoses in the sample. To handle easier the main diagnoses we rate them according to ICD-10 categories:

- mental retardation
- performance disorders
- conduct disorders
- excretional symptoms
- emotional disorders

The Figure 2 shows the percent distribution of subjects from the specific diagnostic categories. In several age-groups there's a significant difference between the ratio of overprotected children (χ^2 = 8,97, df = 2, p < 0,011) as demonstrated in Figure 3. You can see that the ratio of overprotected is decreasing in time.

When we split the sample according to sexes (Figure 4) found that there is no significant age-dependent changing in overprotection for boys (χ^2 = 1,2, df = 2, p < 0,547) although their ratio decreases in time. For girls there is a significant continuous decreasing (χ^2 = 9,4, df = 2, p < 0,009). We got significant differences between age distributions of psychiatric symptoms (Figure 5: χ^2 = 23,6, df = 8, p < 0,003).

Figure 1. *The distribution of the main diagnoses in the sample*

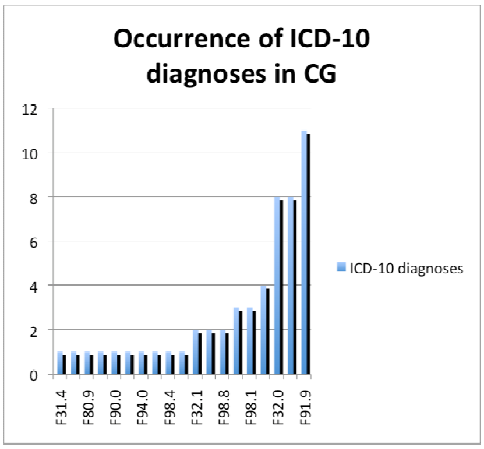


Figure 2. *The percent distribution of the syndromes*

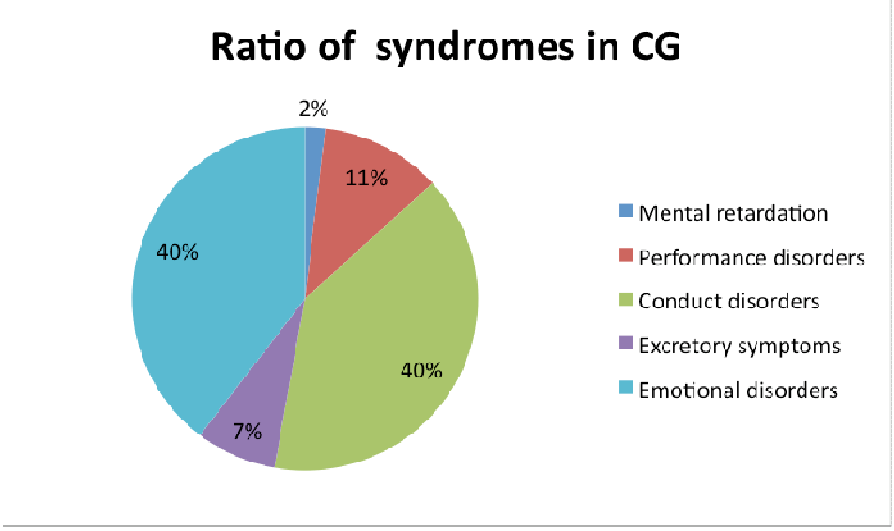


Figure 3. *The distribution of overprotection by age-groups*

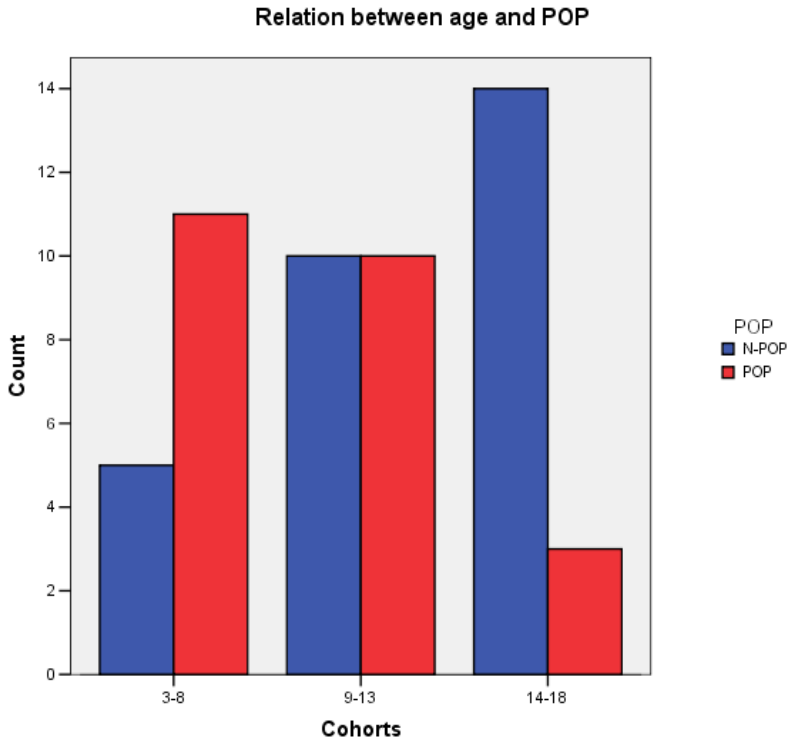
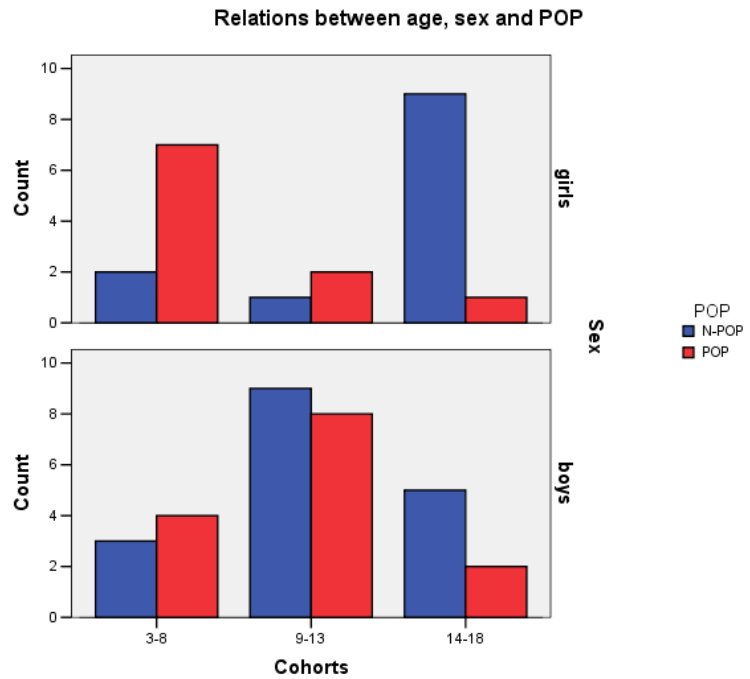


Figure 4. *The distribution of age-groups and overprotection by sexes*



In the whole sample there are no significant differences between the symptom distribution of overprotected and non-overprotected children (χ^2 = 3,464, df = 4, p < 0,483), but for girls it's significant (χ^2 = 23,6, df = 8, p < 0,003). For overprotected girls the emotional and excretional symptoms, for

overprotected boys mostly the conduct disorders prevail but the latter wasn't significant (Figure 6).

Discussion

Although the three age-group split the sample in almost equal sections, the clinical nature of the sample and the significant distribution deviation of sexes by age may put us on guard in connection with generalizability of the results. In our sample the emotional and conduct disorders were overrepresented which is typical in the child guidance population.

Figure 5. *The distribution of the symptoms by age*

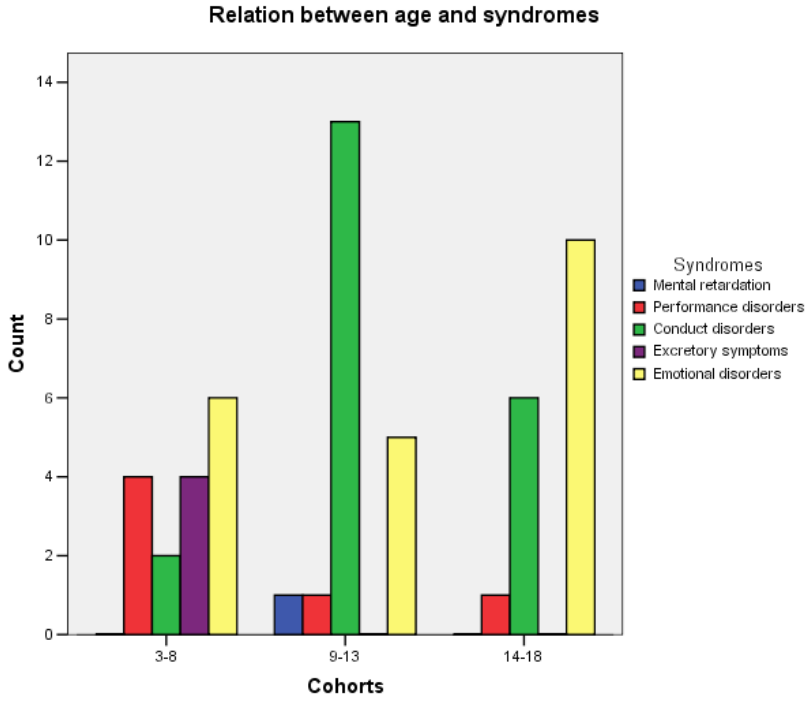
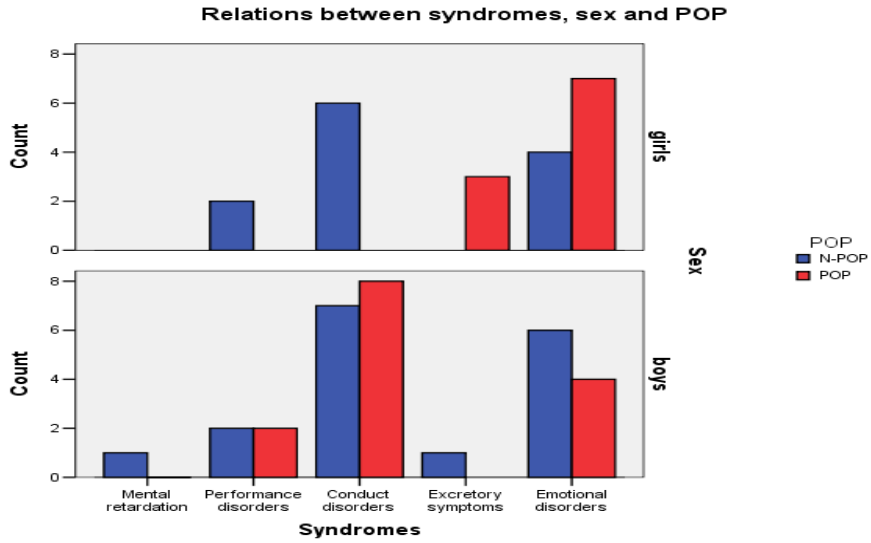


Figure 6. *The distribution of syndromes by sexes and overprotection*



For the whole sample but mostly for the girls was characteristic the significant decreasing of overprotection in time. This tendency was noticeable for boys too but in a weaker and non-significant manner.

The distribution of the psychiatric symptoms by age showed significant differences. While the 3-8 age-group has a relatively homogenous distribution, in 9-13 age-group the conduct, in 14-18 age-group the emotional symptoms prevailed.

If we divided the sample by sexes found that for girls there was a significant difference between the overprotection occurred in the different syndrome groups: the signs of overprotection occurred with emotional and excretional syndromes, but not with other syndromes (conduct and performance disorders).

Although for boys there wasn't significant difference, after all we can observe that the signs of overprotection are in higher ratio mainly related to conduct disorders, in lower degree related to emotional disorders, and there are no signs next to mental retardation or excretional syndromes.

The analysis of symptoms by sex and age showed that the conduct symptoms occur more in 9-13 years old boys, while the emotional symptoms more in 14-18 years old girls. This finding corresponds to the results of the psychiatric literature (Füredi, Németh & Tariska, 2009).

In case of 3-8 age-group we found higher overprotection degree which is correspondent to the literature data (Thomasgard & Metz, 1993), and partly could be explained with the start of school. For girls we found that the overprotection shows a linear decreasing in time, but for boys it was non-significant. The overprotection of boys was related more but non-significantly with their conduct problems, while for girls was related with depressive-anxious symptoms and the existence of the excretional disorder. It remained a further question if is it possible that the excretional and speech disorders as specific performance disorders of 3-8 years old children could be considered as the consequences of parental overprotection.

The second step of the study

The second step also took place in the child guidance service. We examined a smaller subsample with more sever symptoms.

Preliminary considerations. We wish to compare the characteristics of overprotection with the mental status in 8-17 years old children. The examined clinical sample was heterogeneous from point of view of behavior problems. ($\chi^2 = 0{,}311$; df = 1; $p < 0{,}577$).

Hypotheses. In the second step of our study we examined certain sequels of parental overprotection in a smaller subsample in which children suffered from more sever clinical disorders. We supposed that in children with more sever clinical symptoms the parental overprotection would be related with the occurrence of some clinically relevant symptoms (i.e. internalization and externalization).

Methods

Participants. The second sample was aggregated from children and youth who looked up our consulting hours with more sever mental complaints (N=14, 10 boys – 71%, 4 girls – 29%, age: 8-17 years). The distribution of the internalization and externalization symptoms in the sample was 7:7 (50:50%).

Measures. The measures were composed of the assessment forms occurring in the everyday clinical usage:

- CBCL (Child Behaviour Checklist) child, parent and teacher version. Dimensions: Relationship disorders, Anxiety, Attention problems, Somatization, Aggression, Deviance, Internalization, Externalization, Total problems (Achenbach, 1991);
- SDQ (Stregths and Difficulties) parental questionnaire. Dimensions: Hyperactivity, Conduct problems, Emotional problems, Relationship problems, Prosocial behavior (the only positive dimension of the forms), Total difficulties (Goodman, 2001);
- STAI-C (State and Trait Anxiety Inventory for Children). Dimensions: State anxiety, Trait anxiety (Spielberger et al., 1973);
- CDI (Child Depression Inventory). Dimensions: Depression, Suicidal tendencies, Hopelessness (Kovács, 1992);
- JEPQ (Junior Eysenck Personality Questionnaire). Psychoticism, Extroversion, Neuroticism, Conformity (Eysenck, Kálmánchey & Kozéki, 1981; Sziszik, 2005);
- PBI (Parental Bonding Isturment) retrospective inventory for children. PBI was designed to determine the parental overprotection and over-control by Parker et al. (1979). We used the Hungarian version of the inventory (Tóth & Gervai, 1999). We also used the PBI for dividing the four parkerian quadrants ("optimal parenting", "neglecting", and the two forms of overprotection: "affectionate constraint" and "affectionless control").

Procedure. The children and youth, their parents and teachers from the selected sample filled up the assessment forms and the PBI in the diagnostic phase of their therapy. We ask for the children's and their parents' consent to investigation, assured them of entirely anonymity and informed them about the details.

Results

The mental disorders showed homogenous distribution in two sexes (χ^2 = 0,000; df = 1; p < 1,00).

The characteristics of PBI. The PBI's reliability indexes arose according to the literature (Chronbach α: 0,82-0,88). The statistical structure of PBI was examined with hierarchic cluster analysis. According to the correlations the cluster-tree showed that the overprotection and control constructs are in close relation and sharply district from the care construct.

Correlations. The PBI dimensions didn't provide significant relation with the STAI-C dimensions. The Tables 1-3. summarize the significant correlations between PBI dimensions and assessment forms values.

Table 1. *The correlations between PBI and CDI dimensions*

	CDI			
	PBI char.	**CDI dim.**	**Corr.**	
			r	**p <**
PBI	M_OP*	Dang. of suic.	0,54	0,046
	P_OP	Dang. of suic. Hopelessness	0,67 0,55	0,008 0,04

** For place saving we used some abbreviations in the tables. Here you can find these abbreviations and their meanings: OP – overprotection, CTRL – control, OC – combined overprotection and control, M – mother, F – father, P – parent, Ch – children, T – teacher*

Table 2. *The correlations between PBI and CBCL_Parent dimensions*

	CBCL_P			
	PBI char.	**CBCL_P dim.**	**Corr.**	
			r	**p <**
PBI	M_CARE	Relationship Deviance Internalization Total problem	-0,55 -0,58 -0,56 -0,69	0,039 0,028 0,037 0,005
	F_CTRL	Attention Agression Externalization	0,58 0,83 0,75	0,008 0,04 0,000
	F_OC	Agression Externalization	0,70 0,67	0,005 0,008
	P_CARE	Deviance Externalization Total problem	-0,62 -0,56 -0,69	0,017 0,037 0,006
	P_OP	Anxiety	0,52	0,05

Table 3. *The correlations between PBI and SDQ dimensions*

	SDQ			
	PBI char.	**SDQ dim.**	**Corr.**	
			r	**p <**
PBI	M_CARE	Relationship Difficulties	-0,52 -0,54	0,05 0,04
	F_CTRL	Hyperactivity Conduct disorder	0,57 0,71	0,03 0,004
	F_OC	Conduct disorder	0,54	0,04
	P_CARE	Conduct disorder	-0,57	0,03

We can observe about CDI dimensions that the paternal and maternal overprotection was in significant correlation with suicidal tendencies and feelings of hopelessness (Table 1). The parental CBCL report showed that the parental care values were negatively related with externalization symptoms, the paternal control was in strong relation with the components of externalization, the parental overprotection showed significant relation with anxiety (Table 2). From point of view of SDQ we can notice that the maternal care explain a protective effect against relationship problems and the total difficulties, the robust paternal control was in strong relation with the hyperactivity and conduct symptoms (Table 3).

The CBCL on the grounds of the children feedbacks showed positive relations between maternal overprotection and deviance, paternal and parental overprotection and internalization (anxiety) (Table 4). The teacher version of CBCL showed also a positive relation between the attention problems, externalization and robust paternal control as well as the positive effects of parental care to internalization (Table 5). At last we found weak but significant positive relation between the maternal overprotection and neuroticism and negative relation between maternal overprotection and conformity (Table 6).

Table 4. *The correlations between PBI and CBCL_Child*

	CBCL_Ch			
	PBI char.	**CBCL_Ch dim.**	**Corr.**	
			r	**p <**
PBI	M_CARE	Relationship	-0,60	0,021
	M_OP	Deviance	0,61	0,015
	F_OP	Anxiety	0,61	0,02
		Internalization	0,57	0,031
		Total problem	0,53	0,051
	P_OP	Anxiety	0,64	0,013
		Deviance	0,64	0,013
		Internalization	0,59	0,024
		Total problem	0,59	0,024
	P_OC	Deviance	0,58	0,027

Deviations of means. Two-sample t-tests: The Tables 7. and 8. shows the deviations of means in different assessing forms after we selected the most concerned subjects by PBI's maternal, paternal and parental overprotection, control and the combined variables (overprotection and control in the same time) adding to the mean the 1 standard deviation value, according to clinical research practice.

Table 5. *The correlations between PBI and CBCL_Teacher*

	CBCL_Ch			
	PBI char.	**CBCL_Ch dim.**	**Corr.**	
			r	**p <**
PBI	M_CARE	Relationship	-0,60	0,021
	M_OP	Deviance	0,61	0,015
	F_OP	Anxiety	0,61	0,02
		Internalization	0,57	0,031
		Total problem	0,53	0,051
	P_OP	Anxiety	0,64	0,013
		Deviance	0,64	0,013
		Internalization	0,59	0,024
		Total problem	0,59	0,024
	P_OC	Deviance	0,58	0,027

Table 6. *The correlations between PBI and JEPQ*

	JEPQ			
	PBI char.	**JEPQ dim.**	**Corr.**	
			r	**p <**
PBI	M_OP	Neuroticism Conformity	0,49 -0,49	0,075 0,072
	M_OC	Conformity	-0,47	0,085
	F_OP	Neuroticism	0,54	0,042
	P_OP	Neuroticism	0,62	0,017

In case of the mothers the groups divided by the maternal control dimensions differed significantly (CBCL_T_Anxiety: $t = 3,066$, $p < 0,01$; CBCL_T_Internalization: $t = -2, 281$, $p < 0,04$).

The values of the groups divided by the paternal dimensions showed the growth of internalization with the presence of paternal overprotection as well as the appearance of externalization in the presence of paternal control (Table 7).

We found the following significant differences between the groups divided by the parental aggregate dimensions (Table 8), with special attention to relation of parental overprotection and somatization.

Paired t-tests: The maternal and paternal PBI values showed significant deviations in case of overprotection and the overprotection-control combined variables (Table 9).

We didn't find any significant differences between boys and girls, internalization and externalization. There were significant differences between the younger and older children in paternal care (PBIF_CARE: $t = 2,115$, $p < 0,05$) and between the "permissive" overprotected and "controlled" overprotected in somatization reported by children (CBCL_Ch Somatization: $t = 2,852$, $p < 0,03$).

Table 7. *The differences of the discrimination groups of the paternal PBI in distinct assessment tools*

		PBI		
		F_OP	F_CTRL	F_OC
CBCL_P	Anxiety	-4,549*		
	Attention			-2,329*
	Aggression		-4,61***	-3,514**
	Deviance	-2,559*		
	Externalization		-4,039**	-3,729**
	Total problem			-2,851***
SDQ	Conduct dis.		-3,182**	-2,809*
	Hyperactivity		-2,368*	
CBCL_Ch	Attention			1,155*
	Deviance	-4,564***		
	Total problem	-6,354*		
CBCL_T	Aggression		-4,294***	
	Deviance		-3,588**	-3,048**
	Externalization		-4,209***	-2,414*

**** : p < 0,001; ** : p < 0,01; * : p < 0,05 (The table holds t values.)*

Table 8. *The differences of PBI discrimination groups in distinct assessment tools*

		PBI		
		P_OP	P_CTRL	P_OC
CBCL_GY	Attention			2,925*
	Somatization	-4,165**		-4,165**
CBCL_T	Internalization		-2,089*	
CDI	Danger of suic.	-7,416***		-2,928***
JEPQ	Conformism		2,974*	

**** - p < 0,001; ** - p < 0,01; * - p < 0,05 (The table holds t values.)*

Table 9. *The deviations of maternal and paternal PBI values*

		Mother - Father	
		t	**p <**
PBI	CARE	1,921	0,077
	OP	3,462	0,004
	CTRL	1,794	0,096
	OC	2,635	0,021

Deviations between the quadrants. Although there were no significant deviations between the PBI quadrants neither by age nor by sex however there's worthy of note some tendencies. Between the two parkerian overprotecting quadrants ("affectionate constraint" and "affectionless control") there are important tendencies from the aspects of symptoms. In the affectionate quadrant the externalizing values are stronger while in the affectionless one the internalizing values. It's an important observation that there are many children in "optimal parenting" group as clinically relevant. One explanation might be for this that behind of clinical symptoms there are not only familial and socialization factors but genetic and other environmental factors too. But we must notice that this might be also the distortion effect of a non-representative clinical sample.

Discussion

We can notice about the results that the ratio of the troubled behavior (externalization and internalization) was the same in two sexes. The PBI showed strong consistency values and the hierarchical cluster drew the expected factor tree where the overprotection and control dimensions differentiated slightly.

The correlations showed that the parental care as a general protecting factor was in negative relation with the most child symptoms. The parental overprotection related positively more to internalizing symptoms and it showed a strong relation with occurrence of suicidal thinking.

The paternal control and the externalizing symptoms (aggression and deviance) also showed a strong positive relation and the control was in significant positive correlation with hyperactivity too. In assessment forms the parents signaled more externalizing the children more internalizing symptoms so this effect could refer to children's different symptom experiencing which is distinct from the adults' around them, or the caregivers may misread the children's symptom signals.

We got positive correlations with weaker significance between the maternal overprotection and child's neuroticity and negative with child's conformity.

Henceforth we found that the strong maternal control led to internalization similar to strong paternal overprotection and paternal control

led to externalization. The combination of two paternal styles (control and overprotection) was related to attention problems.

If the two parents were overprotective in the same time the child have more somatization. If both parents were controlling we found internalization while parents combined the two styles (control and overprotection) increased the danger of suicidal thinking. The maternal overprotection and overprotection-control values were significantly higher then paternal.

In the second step we analyzed at first the psychometric data of PBI and for parents we found values also suggested by the literature (the maternal overprotection, control and care was higher than paternal, and this difference for overprotection was significant) (Parker, 1983).

The maternal overprotection increased the chance of suicidal thinking and internalization, the paternal control was a risk factor for externalizing behavior (aggression and deviance) of children, while the parental overprotection was a risk factor for internalizing behavior and suicidal thinking of the children. The "affectionate constraint" group showed more externalizing, while the "affectionless control" group more internalizing symptoms, but this outcome wasn't significant. From these results the relation between the suicidal thinking and the overprotection has the biggest clinical relevance, so this needs further considerations and investigations.

Summary

The two investigations detailed above could be considered as the first phase of our overprotection research. Despite of the initial difficulties as the weaker representatives of the samples we earned encouraging data both for general personality characteristics (IQ, social status), and for clinically relevant dimensions (internalization, externalization, suicidal thinking etc.). Learning from the results of the first research steps it's necessary the usage of bigger, more representative, non-clinical samples for the detailed analysis of overprotection.

Secondly for the clarifying of the research results it's indispensable to design a more accurate measure. Among our long-term plans there is the prospective, longitudinal exploration of the outcomes of the overprotection but we'll be able to realize this just after the assurance of psychometric quality of our new measures.

References

ACHENBACH, T. M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 profile.* Burlington, VT: University of Vermont Department of Psychiatry.

AVAGIANOU, P-A., & ZAFIROPOULOU, M. (2008). Parental bonding and depression: Personality as a mediating factor. *International Journal of Adolescent Medicine and Health*, *20* (3), 261-269.

BOGELS, S. M., & VAN MELICK, M. (2004). The relationship between child-report, parent self-report, and partner report of perceived parental rearing behaviors and anxiety in children and parents. *Personality and Individual Differences, 37* (8), 1583-1596.

CARR, S. N., & FRANCIS, A. J. P. (2010). Do early maladaptive schemas mediate the relationship between childhood experiences and avoidant personality disorder features? A preliminary investigation in a non-clinical sample. *Cognitive Therapy and Research, 34* (4), 343-358.

COPLAN, R.J., REICHEL, M., & ROWAN, K. (2009). Exploring the associations between maternal personality, child temperament, and parenting: A focus on emotions. *Personality and Individual Differences, 46* (2), 241-246.

COYNE, J. C., & DELONGIS, A. (1986). Going beyond social support: The role of social relationships in adaptation. *Journal of Consulting & Clinical Psychology, 54* (4), 454-460.
EGGERT, J. W. (2008). Separation-individuation and disordered eating in adolescence. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 69* (1-B), 673.
EYSENCK, S. B. G., KÁLMÁNCHEY M. G., & KOZÉKI B. (1981). Magyar és angol iskoláskorú gyermekek összehasonlító vizsgálata: a Junior Eysenck Personality Inventory magyar változata. *Pszichológia, 1* (2), 213-240.
FISHER, L., & CHALDER, T. (2003). Childhood experiences of illness and parenting in adults with chronic fatigue syndrome. *Journal of Psychosomatic Research, 54* (5), 439-443.
FÜREDI J., NÉMETH A., & TARISKA P. (Eds) (2009). *A pszichiátria magyar kézikönyve*. Budapest: Medicina.
GOODMAN, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry, 40* (11), 1337-1345.
HORÁNYI A., & HOFFMANN G. (1999). *Pszichológiai és pedagógiai szolgálat a Nevelési Tanácsadóban*. Budapest: Okker Kiadó.
JANSSENS, K. A. M., OLDEHINKEL, A. J., & ROSMALEN, J. G. M. (2009). Parental overprotection predicts the development of functional somatic symptoms in young adolescents. *The Journal of Pediatrics, 154* (6), 918-923.
JEFFERIS, P. G., & OLIVER, C. (2006). Associations Between Maternal Childrearing Cognitions and Conduct Problems in Young Children. *Clinical Child Psychology and Psychiatry, 11* (1), 83-102.
JOHNSTONE, J. M., LUTY, S. E., CARTER, J. D., MULDER, R. T., FRAMPTON, C. M. A., & JOYCE, P. R. (2009). Childhood neglect and abuse as predictors of antidepressant response in adult depression. *Depression and Anxiety, 26* (8), 711-717.
KOVÁCS M. (1992). *Children's Depression Inventory. Manual*. New York: Multi-Health Systems.
LEVY, D. M. (1966). *Maternal Overprotection*. New York: W. W. Norton & Company, Inc.
LIVIANOS-ALDANA, L., & ROJO-MORENO, L. (1999). On the convergent validity of two Parental Rearing Behaviour Scales: EMBU and PBI. *Acta Psychiatrica Scandinavica*. *100* (4), 263-269.
LŐKE J. (2005). Bizonyítékokon alapuló módszerek a pszichoterápiában. In Mórocz K., & Perczel Forintos D. (Eds), *Kognitív viselkedésterápia*. Budapest: Medicina.
MARTIN, G., BERGEN, H. A., ROEGER, L., & ALLISON, S. (2004). Depression in young adolescents: Investigations using 2 and 3 factor versions of the Parental Bonding Instrument. *Journal of Nervous and Mental Disease, 192* (10), 650-657.
MÉREI F. (2006). *Közösségek rejtett hálózata*. Budapest: Osiris.
MULLINS, L. L., FUEMMELER, B. F., HOFF, A., CHANEY, J. M., PELT, J. V., & EWING, C. A. (2004). The relationship of parental overprotection and perceived child vulnerability to depressive symptomatology in children with Type 1 diabetes Mellitus: The moderating influence of parenting stress. *Children's Health Care, 33* (1), 21-34.
MURIS, P., MEESTERS, C., & VON BRAKEL, A. (2003). Assessment of anxious rearing behaviors with a modified version of „Egna Minnen Betraffande Uppfostran" questionnaire for children. *Journal of Psychopathology and Behavioral Assessment, 25* (4), 229-237.
PARKER, G. (1983). *Parental overprotection: a risk factor in psychosocial developement.* New York: Grune & Stratton.
PARKER, G., TUPLING, H., & BROWN, L. B. A. (1979). Parental bonding instrument. *British Journal of Medical Psychology, 52* (1), 1-10.
RÓZSA S. (2006). *Raven-féle progresszív mátrixok. Kézikönyv*. Budapest: OS Hungary Tesztfejlesztő.
SANDERS, K. Y. (2006). Overprotection and lowered expectations of persons with disabilities: The unforeseen consequences. *Work: Journal of Prevention, Assessment & Rehabilitation*, *27* (2), 181-188.

SPIELBERGER, C. D., EDWARDS, C. D., MONTUORI, J., & LUSHENE, R. (1973). *State-Trait Anxiety Inventory for Children*. Palo Alto, CA: Consulting Psschologist Press.
SZISZIK E. (2005). *A JEPQ személyiségkérdőív ismertetése*. Budapest: ELTE PPK.
THOMASGARD, M. (1998). Parental perceptions of child vulnerability, overprotection, and parental psychological characteristics. *Child Psychiatry & Human Development, 28* (4), 223-240.
THOMASGARD, M., & METZ, W. P. (1993). Parental overprotection revisited. *Child Psychiatry & Human Development, 24* (2), 67-80.
THOMASGARD, M., & METZ, W. P. (1999). Parent-child relationship disorders: What do the Child Vulnerability Scale and the Parent Protection Scale measure? *Clinical Pediatrics, 38* (6), 347-356.
THOMPSON, S. C., & SOBOLEW-SHUBIN, A. (1993). Overprotective relationships: A nonsupportive side of social networks. *Basic and Applied Social Psychology, 14* (3), 363-383.
TÓTH, I., & GERVAI, J. (1999). Perceived parental styles: The Hungarian version of the Parental Bonding Instrument (PBI). *Magyar Pszichológiai Szemle, 54* (4), 551-566.
VIKÁR Gy. (1999). *Az ifjúkor válságai*. Budapest: Animula.
WILLINGER, U., HEIDEN, A. M., MESZAROS, K., FORMANN, A. K., & ASCHAUER, H. N. (2002). Maternal bonding behaviour in schizophrenia and schizoaffective disorder, considering premorbid personality traits. *Australian and New Zealand Journal of Psychiatry, 36* (5), 663-668.