

The Moderating Role of Maternal Distress Tolerance in the Relationship Between Maternal Emotional Intimacy and Parent–Child Interaction: The Mediating Role of Psychological Safety Among Mothers of Children with ADHD in Isfahan

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ABSTRACT

Mothers of children with attention-deficit/hyperactivity disorder (ADHD) are frequently exposed to persistent parenting demands that can compromise the quality of parent–child interaction. Maternal emotional intimacy may support more adaptive interaction, but its effect may depend on intrapersonal resources. This study examined a moderated mediation model in which maternal psychological safety mediated, and maternal distress tolerance moderated, the association between maternal emotional intimacy and parent–child interaction. Methods: A quantitative, cross-sectional correlational study was conducted among 350 mothers of children with ADHD attending psychological and therapeutic centers in Isfahan, Iran. Participants were selected using convenience and purposive sampling. Measures included the Emotional Intimacy subscale of the Iranian Intimacy Questionnaire, the short-form Maslow Psychological Security Questionnaire, the Distress Tolerance Scale, the Child–Parent Relationship Scale, and the SNAP-IV for ADHD symptom screening. Structural equation modeling with robust estimation and 5,000-resample bootstrapping was used. Results: The structural model showed good fit ($\chi^2/df = 1.94$, CFI = .98, TLI = .97, IFI = .94, RMSEA = .055, SRMR = .042). In the base structural model, emotional intimacy positively predicted parent–child interaction ($\beta = .299$, $p < .001$) and psychological safety ($\beta = .582$, $p < .001$), whereas its direct path to distress tolerance was not significant ($\beta = .105$, $p = .077$). Psychological safety ($\beta = .368$, $p < .001$) and distress tolerance ($\beta = .309$, $p < .001$) positively predicted parent–child interaction. Psychological safety partially mediated the emotional intimacy–interaction association (indirect $\beta = .214$, 95% CI [.192, .312]), accounting for 41.71% of the total effect. The emotional intimacy $\times$ distress tolerance interaction was significant ($B = .218$, $p < .001$), with the emotional-intimacy effect increasing from low ($\beta = .185$) to mean ($\beta = .400$) and high ($\beta = .618$) distress tolerance. Conclusion: Maternal emotional intimacy appears to be linked with better parent–child interaction both directly and through psychological safety, while distress tolerance strengthens the association. Multi-component interventions for mothers of children with ADHD may benefit from jointly targeting relational intimacy, psychological safety, and distress-tolerance skills.

Keywords: maternal emotional intimacy; parent–child interaction; distress tolerance; psychological safety; ADHD.

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Introduction

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental condition characterized by persistent patterns of inattention, hyperactivity, and impulsivity that interfere with functioning across home, educational, and social settings. Although its diagnostic features are primarily defined at the level of the child, the consequences of ADHD extend well beyond individual symptom expression and frequently reorganize everyday family life. Difficulties with sustained attention, behavioral inhibition, compliance with routines, emotional regulation, academic tasks, and interpersonal functioning can place continuous demands on caregivers, particularly mothers who often assume a substantial share of daily caregiving and treatment-related responsibilities. Recent research has therefore increasingly conceptualized childhood ADHD not only as an individual clinical condition but also as a family-level challenge involving reciprocal interactions among child characteristics, caregiver psychological resources, parenting processes, and the broader relational environment. Systematic evidence indicates that caregivers of children with ADHD experience substantial burden across emotional, social, practical, and family domains (1), while qualitative evidence suggests that mothers may additionally encounter stigma, misunderstanding, blame, and social judgment associated with their child's diagnosis and behavior (2). The uncertainty that can precede formal assessment may add further psychological strain, with parents describing the diagnostic waiting period as a prolonged state of ambiguity in which they attempt to manage difficult behaviors without adequate explanation or support (3). Consequently, understanding the psychological and relational resources that enable mothers to sustain constructive interactions with children with ADHD constitutes an important clinical and family-research priority.

The demands associated with ADHD can affect multiple domains of children's functioning and, in turn, intensify the complexity of parent–child interaction. Symptoms of inattention and hyperactivity/impulsivity may be accompanied by peer difficulties, behavioral problems, and reduced prosocial functioning, creating challenges that move between family and social contexts (4). Co-occurring difficulties may further increase impairment; for example, children with ADHD who also experience motor problems show meaningful reductions in quality of life, emphasizing the broader functional burden that families may be required to manage (5). Child and parental ADHD-related characteristics may also interact in daily academic routines, as demonstrated by evidence that parental and child ADHD symptoms jointly influence academic outcomes through processes such as homework support (6). These findings are important because parent–child interaction is one of the principal contexts through which daily behavioral demands are interpreted and managed. When interactions become dominated by repeated correction, frustration, escalating demands, or mutual negative affect, both child and parent functioning may deteriorate. Conversely, interactions characterized by emotional warmth, responsiveness, predictable boundaries, and constructive engagement may provide a relational context in which behavioral challenges can be managed without disrupting emotional connection. The importance of parenting processes is supported by evidence that structured parent-focused interventions can improve relevant outcomes in children with ADHD. Meta-analytic findings concerning Parent–Child Interaction Therapy indicate its usefulness for young people with ADHD (7), and randomized evidence suggests that internet-delivered parent–child interaction therapy can also be implemented effectively with preschool children presenting ADHD symptoms (8). Similarly, the New Forest Parenting Programme has demonstrated promising effectiveness and feasibility for children with ADHD and

their families, reinforcing the value of targeting family interaction rather than treating child symptoms in isolation (9).

Despite the recognized importance of parent–child interaction, mothers differ considerably in their ability to preserve constructive relationships under persistent parenting stress. One potentially important relational resource is maternal emotional intimacy. Emotional intimacy encompasses affective closeness, openness, trust, willingness to communicate vulnerable emotional experiences, perceived understanding, and the ability to maintain meaningful emotional connection within close relationships. For mothers facing repeated caregiving demands, emotional intimacy may create a relational foundation from which difficult experiences can be processed with less defensiveness and greater emotional availability. Evidence from relationship-focused research indicates that psychological intimacy is responsive to interpersonal processes and may be strengthened through interventions such as conflict-resolution training (10). Although this evidence originates primarily from couple relationships, the underlying processes of emotional openness, perceived acceptance, secure communication, and constructive management of relational tension may also be relevant to parenting. Family functioning more broadly has been associated with psychological adjustment through relational and intrapersonal pathways; recent evidence shows that parent–child interactions and psychological resilience can mediate associations between family functioning and depressive symptoms (11). Thus, emotional intimacy may be conceptualized not simply as a pleasant interpersonal experience but as a potentially important relational resource that shapes how mothers perceive, interpret, and respond to the emotional and behavioral demands arising in relationships with their children.

However, emotional intimacy is unlikely to influence parenting uniformly or through a single pathway. Mothers may possess strong capacities for emotional closeness while differing substantially in their internal sense of psychological security. Psychological safety, as conceptualized in the present study, refers to an internal experience of security, confidence, relative freedom from psychological threat, and an ability to engage without persistent fear of rejection, judgment, or emotional harm. Such security may be especially relevant for mothers of children with ADHD because these mothers may repeatedly encounter uncertainty regarding their parenting, concerns about social evaluation, difficult interactions with schools or treatment systems, and stigma surrounding their child’s behavioral presentation. Iranian research has demonstrated meaningful associations between psychological security and psychosocial functioning, suggesting that a stronger sense of security can operate as an important psychological resource in adaptive functioning (12). Maternal emotional intimacy may support this security by providing experiences of acceptance, understanding, and emotional connection. In turn, a psychologically safer mother may be better positioned to interpret challenging child behavior without perceiving every difficult interaction as evidence of personal failure or relational rejection. Psychological safety may therefore constitute a mechanism through which emotional intimacy becomes translated into greater emotional availability, less defensive responding, and more constructive mother–child interaction.

The importance of maternal psychological resources becomes clearer when the broader mental-health burden of caring for a child with ADHD is considered. Mothers of children with ADHD demonstrate heterogeneous psychosocial profiles, and maternal ADHD tendencies themselves may differentiate levels of mental-health difficulty and psychosocial functioning (13). Caregiver mental health is also related to coping

processes; evidence among primary caregivers of individuals with ADHD indicates meaningful relationships between mental health and strategies used to manage caregiving demands (14). Psychological distress may extend beyond subjective well-being to interfere with treatment-related behavior. Among mothers of children with ADHD, psychological distress and exposure to intimate partner violence have been associated with treatment adherence, demonstrating how maternal psychosocial circumstances can affect the management of the child's condition (15). Similarly, parent mental health is increasingly recognized as relevant to whether caregivers engage successfully in parenting interventions for childhood ADHD (16). These findings suggest that even evidence-based parenting approaches are implemented within the psychological realities of the caregiver. A mother's ability to respond sensitively and consistently may therefore depend not only on knowledge of parenting techniques but also on whether she possesses sufficient internal security and regulatory capacity to apply such strategies during emotionally difficult moments.

Emotion regulation represents another central component of this framework. Contemporary models emphasize that emotional responses emerge through interconnected cognitive, affective, social, and regulatory processes rather than through isolated emotional mechanisms. The Cognitive-Affective Social Processing and Emotion Regulation model, for example, highlights the dynamic integration of cognitive-affective processing with emotion regulation in shaping behavioral adaptation (17). Within parenting, these processes may influence how mothers appraise child behavior, regulate their own emotional activation, and select behavioral responses under stress. Longitudinal research further indicates that parental emotion regulation is associated with children's mental health through parenting stress and sensitive, challenging parenting, supporting the proposition that parental regulatory capacity has downstream implications for the parent-child relationship (18). Maternal histories of adversity may complicate these processes. Research examining maternal child maltreatment and intimate partner violence has shown that emotion regulation and responsiveness can mediate associations between maternal adverse experiences and perceptions of infant temperament (19). Related findings among kinship caregivers indicate that trauma experiences are connected with parenting stress and dispositional resilience (20). Collectively, these findings underscore the importance of examining how internal regulatory capacities determine whether relational resources remain accessible when parenting occurs under conditions of emotional strain.

Within this regulatory domain, distress tolerance may be particularly relevant. Distress tolerance refers to the perceived or actual capacity to experience, endure, and function in the presence of aversive emotional states without becoming overwhelmed or engaging immediately in maladaptive avoidance. Parenting a child with ADHD can repeatedly expose mothers to frustration, uncertainty, worry, embarrassment, interpersonal conflict, and feelings of helplessness, making the ability to tolerate distress especially consequential. Meta-analytic research indicates that lower distress tolerance is associated with greater depressive symptomatology among children and adolescents, reinforcing its significance as a transdiagnostic emotional-regulation construct (21). Developmental evidence also suggests that distress tolerance may be shaped through family emotional experiences: parental responses to children's distress have been linked with later distress, with distress tolerance functioning as a mediating mechanism (22). In addition, emotional reactivity and regulation in children are influenced by the joint contributions of attachment and environmental sensitivity (23), indicating that regulatory capacities develop within relational contexts rather than independently of them. Applied to mothers of children with ADHD, distress tolerance may thus

determine whether emotional closeness can remain behaviorally available during episodes of intense stress. A mother may value emotional intimacy and feel closely connected to her child, yet low tolerance of immediate frustration may still produce harsh, avoidant, inconsistent, or emotionally disengaged responses during challenging episodes. By contrast, higher distress tolerance may enable her to remain engaged with difficult affect long enough for intimacy, empathy, and reflective responding to guide behavior.

This possibility suggests that distress tolerance may operate not only as an independent predictor of positive interaction but also as a moderator of the association between emotional intimacy and parent–child interaction. In other words, emotional intimacy may be more strongly translated into constructive interaction when mothers can tolerate the negative emotional states that accompany difficult parenting situations. This conditional interpretation is consistent with evidence showing that family and developmental processes often depend on interactions among regulatory capacities and contextual characteristics rather than simple direct effects. Parental control, for example, has been systematically associated with children’s aggressive behavior, but the magnitude and meaning of such associations vary across dimensions and contexts (24). Similarly, the effects of parent and child ADHD symptoms on academic functioning can depend on intermediate parenting processes and conditional relationships among variables (6). Interventions designed for mothers also support the modifiability of relevant psychological resources. Acceptance- and commitment-based group training has been shown to improve self-esteem and perceived stress among mothers of children with ADHD (25), suggesting that maternal internal resources constitute viable targets for intervention rather than fixed characteristics. An integrated model examining emotional intimacy together with psychological safety and distress tolerance may therefore provide a more realistic representation of mother–child interaction than models considering these variables separately.

The assessment of ADHD within relational research also requires attention to reliable identification of symptom patterns. Parent-report measures such as the SNAP-IV remain widely used for quantifying inattention, hyperactivity/impulsivity, and related behavioral features. Recent psychometric research has supported the structural validity and measurement properties of the SNAP-IV in populations at heightened ADHD risk (26), while research using the parent form in a population-based birth cohort has further demonstrated acceptable psychometric characteristics across childhood assessment contexts (27). Such evidence is important because reliable characterization of the child’s ADHD-related symptoms provides the clinical context within which maternal relational and psychological processes are interpreted. Nevertheless, symptom measurement alone cannot explain why mothers confronting relatively similar behavioral demands may experience very different qualities of parent–child interaction. The heterogeneity of caregiver responses points toward the need for models that combine relational characteristics, internal security, and emotion-regulation capacities rather than treating parenting difficulties as straightforward consequences of ADHD symptom severity.

A further gap concerns the integration of these variables within a single conditional-process framework. Existing studies have documented caregiver burden (1), stigma and maternal subjective experiences (2), caregiver mental health and coping (14), maternal psychological distress (15), parental emotion regulation (18), distress tolerance (21, 22), and the effectiveness of parent-focused ADHD interventions (7, 9). However, these lines of evidence have largely developed separately, leaving less clarity regarding how relational closeness, psychological security, and distress-regulation capacity operate simultaneously in mothers of

children with ADHD. From a methodological perspective, research questions involving interconnected direct, indirect, and conditional effects require designs capable of evaluating multivariable relationships systematically (28). Structural equation modeling is particularly useful when theoretical propositions concern networks of associations rather than isolated bivariate relationships, while careful assessment of model fit remains necessary for determining whether a proposed structural representation adequately corresponds to observed data (29). Examining mediation and moderation together may therefore clarify not only whether maternal emotional intimacy is associated with parent–child interaction, but also the psychological mechanism through which this relationship operates and the circumstances under which it becomes stronger or weaker.

The need for such an integrated approach is especially salient in the Iranian context, where family relationships, maternal caregiving expectations, access to psychological services, and sociocultural interpretations of childhood behavioral problems may shape mothers' experiences in ways that are not fully captured by findings from other populations. Mothers managing childhood ADHD may simultaneously encounter behavioral demands within the home, concerns about school functioning, social judgment, treatment responsibilities, and pressures within intimate and family relationships. These overlapping demands make it theoretically plausible that emotional intimacy provides relational support, psychological safety provides an internal foundation for nondefensive engagement, and distress tolerance determines the degree to which relational resources can be maintained when negative affect becomes intense. Such a framework also has practical value because each component suggests a potentially distinct intervention target. Relational work may strengthen emotional closeness and communication, interventions focused on security may reduce threat-based responding and improve confidence, and acceptance- or regulation-based approaches may increase mothers' capacity to remain engaged during distress. Understanding the interplay among these factors may therefore contribute to more individualized interventions for families of children with ADHD rather than relying exclusively on symptom management or generic parenting instruction.

Accordingly, the aim of the present study was to examine the moderating role of maternal distress tolerance in the relationship between maternal emotional intimacy and parent–child interaction, while testing maternal psychological safety as a mediating mechanism, among mothers of children with ADHD in Isfahan, Iran.

Methods and Materials

Study Design and Participants

This was a quantitative, cross-sectional, descriptive-correlational study analyzed within a structural equation modeling framework. The target population consisted of mothers of children with a formal ADHD diagnosis who attended selected psychological and therapeutic clinics in Isfahan, Iran, during the study period. The sample comprised 350 mothers selected by convenience and purposive sampling. The sample size was chosen to provide adequate statistical stability for the structural model and sufficient power for mediation and moderation analyses.

Eligibility criteria included having a child in the study age range with ADHD symptoms/diagnosis established through the study screening and clinical-entry criteria, maternal willingness to participate and provide informed consent, and sufficient literacy to complete the questionnaires. Exclusion criteria were a

severe diagnosed psychiatric disorder in the mother, major child comorbidity likely to obscure the ADHD clinical picture, and incomplete study questionnaires.

Data Collection Tools

Maternal Emotional Intimacy: Maternal emotional intimacy was assessed using the Emotional Intimacy subscale of the Iranian Intimacy Questionnaire developed by Oliya and colleagues (2006). The complete instrument contains 87 items across nine domains of intimacy; the present study used only the emotional-intimacy subscale because it directly corresponded to the independent construct in the proposed model. Items are rated on a four-point Likert scale from 1 (not at all/never) to 4 (always), with selected items reverse-scored. Higher scores represent greater intimacy. Iranian studies have reported supportive evidence for face, content, criterion, convergent, and discriminant validity. Internal consistency of the full instrument was reported as $\alpha = .92$, and an Iranian study reported $\alpha = .87$ for the emotional-intimacy subscale. Because only the emotional subscale was used in the current study, whole-instrument score ranges were not used to interpret the focal construct.

Psychological Safety: Maternal psychological safety was measured with the short form of Maslow's Psychological Security Questionnaire as used in Iranian research. The form contains 18 dichotomous items organized into four components: self-confidence (7 items), dissatisfaction (3 items), environmental maladjustment (5 items), and perceived views of others (3 items). Responses are scored against the instrument key, with one point assigned to a keyed response and zero otherwise. Previous Iranian studies supported the instrument's content and factorial validity and described its internal consistency as acceptable. The measure was used as the mediator in the structural model.

Distress Tolerance Scale: Distress tolerance was assessed with the 15-item Distress Tolerance Scale (DTS; Simons & Gaher, 2005). The DTS comprises four dimensions: Tolerance (items 1, 3, and 5), Absorption (items 2, 4, and 15), Appraisal (items 6, 7, 9, 10, 11, and 12), and Regulation (items 8, 13, and 14). Items are rated on a five-point scale from 1 (strongly agree) to 5 (strongly disagree); item 6 is reverse-scored. Higher scores indicate greater perceived distress tolerance. In the original validation study, subscale Cronbach's alpha coefficients ranged from .70 to .82 and the total-scale alpha was .82. An Iranian study reported $\alpha = .71$ for the total scale, with subscale coefficients of .54, .42, .56, and .58 for Tolerance, Absorption, Appraisal, and Regulation, respectively.

Child-Parent Relationship Scale: Parent-child interaction was assessed using Pianta's 33-item Child-Parent Relationship Scale (CPRS). The instrument evaluates conflict, closeness, dependency, and an overall positive-relationship score. Items are rated from 1 (definitely does not apply) to 5 (definitely applies). Higher scores on a domain indicate greater presence of that relationship feature; the positive-relationship score is derived by combining closeness with reverse-scored conflict and dependency components. Iranian adaptation studies supported content and construct validity. In the Iranian validation, Cronbach's alpha coefficients were .84 for conflict, .69 for closeness, .46 for dependency, and .80 for the overall positive relationship. Driscoll and Pianta (2011) reported corresponding coefficients of .75, .74, .69, and .80.

ADHD Symptom Screening: The Swanson, Nolan, and Pelham Rating Scale-Fourth Revision (SNAP-IV) was used to screen ADHD-related symptoms. The parent-report form assesses inattention, hyperactivity/impulsivity, and oppositional-defiant symptoms on a four-point scale ranging from 0 (not at

all) to 3 (very much). Ratings of 2 or 3 are treated as symptomatic responses. Conventional symptom-count thresholds were applied to the inattention and hyperactivity/impulsivity domains. The SNAP-IV was used as a screening instrument rather than as a stand-alone diagnostic test. The Persian version has reported content and construct validity, while international work has supported the scale's structural validity and reliability.

Procedure and Ethical Considerations: After administrative coordination with selected psychological and treatment centers in Isfahan, eligible mothers were approached and the purpose and procedures of the study were explained. Mothers who agreed to participate provided informed consent and completed the questionnaires under standardized instructions. Participation was voluntary; confidentiality and privacy of responses were maintained; participants could withdraw at any time; and collected data were used solely for research purposes.

Data Analysis

Descriptive analyses included frequencies, percentages, means, standard deviations, skewness, and kurtosis. Distributional assumptions were examined using skewness, kurtosis, Kolmogorov–Smirnov, and Shapiro–Wilk tests. Pearson correlations were inspected for bivariate associations, and tolerance and variance inflation factor (VIF) statistics were used to assess multicollinearity. The final structural model was estimated using structural equation modeling with maximum-likelihood estimation and robust standard errors. Model adequacy was evaluated with χ^2/df , CFI, TLI, IFI, RMSEA, and SRMR. Direct effects were tested from path coefficients and robust test statistics. Indirect effects and interaction effects were evaluated using nonparametric bootstrapping with 5,000 resamples and 95% confidence intervals. Statistical analyses were conducted using SPSS version 27 and AMOS version 24. Statistical significance was set at $p < .05$.

Findings and Results

The final sample included 350 mothers. Most mothers were between 30 and 40 years of age (40%), 69% held a bachelor's degree, and 55% were homemakers. Boys accounted for 55% of the children. The largest child-age group was 6–8 years (58%), and 44% of families had received the child's diagnosis less than one year before participation.

Table 1. Participant characteristics (N = 350)

Characteristic	Category	n	%
Maternal age	<30 years	122	35
	30–40 years	140	40
	>40 years	88	25
Maternal education	Below diploma	31	9
	Diploma	43	12
	Bachelor's degree	242	69
	Master's or higher	34	10
Employment	Homemaker	193	55
	Employed	157	45
Number of children	One	188	54
	Two	126	36
	Three or more	36	10
Child age	6–8 years	203	58
	9–11 years	89	25
	12 years or older	58	17

Child sex	Boy	192	55
	Girl	158	45
Time since diagnosis	<1 year	153	44
	1–3 years	102	29
	>3 years	95	27

Descriptive statistics are shown in Table 2. Skewness and kurtosis values for all study variables were within ± 2 . Formal Kolmogorov–Smirnov and Shapiro–Wilk tests were statistically significant for all variables, as is common in large samples; therefore, interpretation emphasized skewness and kurtosis when judging approximate univariate normality. Multicollinearity was not considered problematic: tolerance values were .805, .677, and .243 and corresponding VIF values were 1.24, 1.47, and 4.12 for emotional intimacy, psychological safety, and distress tolerance, respectively.

Table 2. Descriptive statistics for the study variables

Variable	Min	Max	M	SD	Skewness	Kurtosis
Maternal emotional intimacy	89	347	214.03	71.423	.130	.261
Psychological safety	26	88	67.70	4.760	.624	.375
Distress tolerance	18	40	29.98	2.965	1.037	-.875
Parent–child interaction	28	125	95.11	11.426	.129	-.485

Bivariate correlations showed that emotional intimacy was not significantly associated with parent–child interaction ($r = .057$, $p = .288$), psychological safety ($r = -.028$, ns), or distress tolerance ($r = .007$, ns) at the zero-order level. Psychological safety correlated positively with distress tolerance ($r = .306$, $p < .001$) but negatively with parent–child interaction ($r = -.122$, $p = .023$), whereas distress tolerance correlated positively with parent–child interaction ($r = .263$, $p < .001$). The divergence between several zero-order associations and the multivariable path estimates underscores the importance of interpreting the structural paths conditionally, within the specified model rather than as simple bivariate relationships. The proposed structural model demonstrated good overall fit. All reported indices met the prespecified acceptance criteria: $\chi^2/df = 1.94$, CFI = .98, TLI = .97, IFI = .94, RMSEA = .055, and SRMR = .042 (Table 3). These indices supported proceeding to interpretation of the structural paths.

Table 3. Fit indices for the structural model

Fit index	Observed value	Acceptance criterion	Interpretation
χ^2/df	1.94	< 3	Good
CFI	.98	> .90	Good
TLI	.97	> .90	Good
IFI	.94	> .90	Good
RMSEA	.055	< .08	Good
SRMR	.042	< .05	Good

Table 4 summarizes the bootstrap estimates for the direct effects. Maternal emotional intimacy had a positive direct effect on psychological safety ($\beta = .582$, $t = 16.681$, $p < .001$) and on parent–child interaction ($\beta = .299$, $t = 5.255$, $p < .001$). In contrast, the direct path from emotional intimacy to distress tolerance was not statistically significant ($\beta = .105$, $t = 1.769$, $p = .077$). Both psychological safety ($\beta = .368$, $t = 6.997$, $p < .001$) and distress tolerance ($\beta = .309$, $t = 7.495$, $p < .001$) positively predicted parent–child interaction. The model accounted for approximately 33.7% of the variance in psychological safety and 47.8% of the variance in parent–child interaction.

Table 4. Direct structural effects in the base model

Structural path	β	t	p	95% CI	Result
Emotional intimacy → Psychological safety	.582	16.681	<.001	[.514, .653]	Significant
Emotional intimacy → Distress tolerance	.105	1.769	.077	[-.009, .223]	Not significant
Emotional intimacy → Parent–child interaction	.299	5.255	<.001	[.185, .408]	Significant
Psychological safety → Parent–child interaction	.368	6.997	<.001	[.266, .472]	Significant
Distress tolerance → Parent–child interaction	.309	7.495	<.001	[.229, .392]	Significant

Bootstrapping supported a significant indirect effect of maternal emotional intimacy on parent–child interaction through psychological safety ($\beta = .214$, $SE = .024$, $t = 8.916$, $p < .001$, 95% CI [.192, .312]). The direct effect of emotional intimacy on interaction remained significant ($\beta = .299$), indicating partial rather than complete mediation. The total effect was $\beta = .513$ ($SE = .037$, $t = 13.861$, $p < .001$, 95% CI [.380, .622]). The indirect pathway represented 41.71% of the total effect.

Table 5. Mediation analysis for psychological safety

Effect	Estimate	SE	t	p	95% CI	Interpretation
Direct effect	.299	—	5.255	<.001	[.185, .408]	Significant
Indirect effect via psychological safety	.214	.024	8.916	<.001	[.192, .312]	Significant
Total effect	.513	.037	13.861	<.001	[.380, .622]	Significant

The moderation model included the interaction between maternal emotional intimacy and distress tolerance. The focal interaction significantly predicted parent–child interaction ($B = .218$, $t = 5.601$, $p < .001$, 95% CI [.142, .295]). Thus, distress tolerance strengthened the positive association between maternal emotional intimacy and parent–child interaction. By contrast, the additional interaction between distress tolerance and psychological safety was not significant ($B = -.003$, $t = .056$, $p = .955$, 95% CI [-.098, .089]).

Simple-slope analysis clarified the significant focal interaction. At low distress tolerance (one standard deviation below the mean), the conditional effect of emotional intimacy on parent–child interaction was $\beta = .185$ ($p < .001$). At the mean level of distress tolerance, the effect increased to $\beta = .400$ ($p < .001$), and at high distress tolerance (one standard deviation above the mean), it increased further to $\beta = .618$ ($p < .001$). The confidence interval at each level excluded zero (Table 6).

Table 6. Conditional effects of emotional intimacy on parent–child interaction across levels of distress tolerance

Distress tolerance	Conditional β	SE	t	p	95% CI
Low (-1 SD)	.185	.061	3.033	<.001	[.065, .305]
Mean	.400	.050	8.000	<.001	[.302, .498]
High (+1 SD)	.618	.062	9.973	<.001	[.496, .740]

Conditional indirect effects were also evaluated with 5,000 bootstrap resamples. The indirect effect through the mediating process was significant at low, mean, and high levels of distress tolerance and increased from .192 to .218 and .246, respectively. The corresponding 95% confidence intervals were [.098, .286], [.142, .295], and [.164, .328], all excluding zero. These results were consistent with a conditional-process interpretation in which the indirect association becomes stronger as maternal distress tolerance increases. In contrast, the alternative conditional indirect sequence associated with the nonsignificant psychological-safety $\times$ distress-tolerance interaction was not statistically supported.

Table 7. Bootstrap conditional indirect effects across levels of distress tolerance

Distress tolerance	Indirect effect	SE	p	95% CI
Low (−1 SD)	.192	.048	<.001	[.098, .286]
Mean	.218	.039	<.001	[.142, .295]
High (+1 SD)	.246	.042	<.001	[.164, .328]

Taken together, the findings supported the central moderated-mediation framework. Maternal emotional intimacy had a significant direct association with parent–child interaction ($\beta = .299$), a significant indirect association through psychological safety ($\beta = .214$), and a significant interaction with distress tolerance ($B = .218$). The final model explained approximately 47.8% of the variance in parent–child interaction. Thus, psychological safety served as a partial mediator and distress tolerance functioned as a positive moderator of the emotional intimacy–parent–child interaction relationship. The only prespecified direct path not supported in the base structural model was the path from emotional intimacy to distress tolerance ($\beta = .105$, $p = .077$).

Discussion and Conclusion

The present study investigated an integrated conditional-process model of parent–child interaction among mothers of children with ADHD, focusing on maternal emotional intimacy as the principal relational predictor, psychological safety as a mediating mechanism, and distress tolerance as a moderating psychological resource. Overall, the findings supported the proposed conceptual model. Maternal emotional intimacy had a significant positive direct effect on parent–child interaction and strongly predicted psychological safety, while psychological safety also positively predicted parent–child interaction. The indirect effect of emotional intimacy on parent–child interaction through psychological safety was significant, indicating partial mediation. Distress tolerance independently predicted more positive parent–child interaction and significantly moderated the relationship between emotional intimacy and parent–child interaction, such that the positive association became progressively stronger at higher levels of distress tolerance. At the same time, the direct path from maternal emotional intimacy to distress tolerance was not statistically significant, and the interaction between psychological safety and distress tolerance was also nonsignificant. The final model explained approximately 47.8% of the variance in parent–child interaction and demonstrated satisfactory overall structural fit, indicating that the combined consideration of relational closeness, psychological security, and affective regulatory capacity provides a meaningful framework for understanding maternal interaction with children with ADHD.

The first major finding was that maternal emotional intimacy positively predicted parent–child interaction. This result suggests that mothers who experience greater emotional closeness, openness, mutual understanding, and capacity for affective engagement are more likely to establish constructive and responsive interactions with their children. This association is particularly meaningful in families of children with ADHD because everyday parenting frequently involves repeated exposure to impulsivity, distractibility, difficulties following instructions, academic problems, emotional dysregulation, and behavioral conflict. These demands can place substantial strain on maternal responsiveness and increase the likelihood of coercive or emotionally disengaged interaction patterns. Evidence concerning caregiver burden similarly shows that caring for children with ADHD imposes considerable emotional, social, and practical demands

on parents (1). Mothers may also encounter stigmatizing responses from others, including blame for the child's behavior or negative judgments regarding parenting competence (2). Under such conditions, emotional intimacy may provide an important relational resource that helps mothers preserve warmth and responsiveness instead of interpreting difficult behavior exclusively through frustration or interpersonal rejection.

The positive relationship between emotional intimacy and parent–child interaction is also consistent with evidence demonstrating the importance of relational processes in interventions for ADHD. Parent–Child Interaction Therapy has shown beneficial effects for children and adolescents with ADHD, supporting the principle that improvement in parent–child relational patterns can constitute an important component of treatment (7). Likewise, internet-delivered Parent–Child Interaction Therapy has demonstrated efficacy among preschool children with ADHD, emphasizing that strengthening parent–child exchanges can improve outcomes even when treatment is delivered remotely (8). The effectiveness and feasibility of the New Forest Parenting Programme similarly indicate that interventions targeting everyday parenting relationships can contribute to improved family functioning in ADHD (9). These studies do not assess emotional intimacy in exactly the same manner as the present investigation, but collectively they support the broader interpretation that relational warmth, sensitive engagement, and adaptive parent–child exchanges are clinically meaningful in families managing ADHD. The present findings extend this literature by suggesting that maternal emotional intimacy itself may represent a foundational relational resource contributing to better interaction.

The second major finding was the strong positive association between maternal emotional intimacy and psychological safety. Mothers reporting greater emotional intimacy also demonstrated higher levels of psychological safety, suggesting that emotionally supportive relational experiences may contribute to an internal sense of security, confidence, and reduced psychological threat. Psychological safety may be particularly important for mothers of children with ADHD because caregiving takes place within a context in which mothers may repeatedly question their parenting competence, face criticism from others, or experience uncertainty regarding their child's diagnosis and future. Parents awaiting an ADHD assessment have described prolonged uncertainty and a sense of being in “limbo,” emphasizing the psychological strain generated when families lack diagnostic clarity and adequate professional support (3). Psychological security has also been associated with healthier psychosocial functioning in Iranian samples (12). Thus, emotional intimacy may facilitate psychological safety by providing mothers with greater perceived acceptance and relational stability, thereby reducing threat-based appraisals and creating greater capacity for constructive engagement with the child.

Importantly, psychological safety positively predicted parent–child interaction and significantly mediated the relationship between emotional intimacy and interaction. The indirect effect was $\beta = .214$, and approximately 41.71% of the total effect of maternal emotional intimacy on parent–child interaction operated through psychological safety. This finding indicates that emotional intimacy does not influence maternal interaction only through a direct relational pathway; rather, a substantial proportion of its association may be explained by the degree to which intimacy is accompanied by an enhanced internal sense of security. Mothers who feel emotionally understood and relationally connected may experience less fear of judgment, reduced defensiveness, and greater confidence in managing difficult parenting encounters. This

interpretation is compatible with studies showing that parental psychological functioning has implications for parenting behavior and child adjustment. For example, maternal mental health and psychosocial status differ meaningfully among mothers of children with ADHD according to their own ADHD tendencies (13), while caregiver coping strategies have been associated with mental-health outcomes among primary caregivers of individuals with ADHD (14). Parent mental health has also been shown to affect engagement with parenting interventions for childhood ADHD (16). These findings support the proposition that maternal internal psychological functioning is not peripheral to parenting but can shape whether relational capacities are effectively expressed in everyday interactions.

The mediating role of psychological safety is also consistent with broader family-process research. Yan and colleagues demonstrated that parent–child interaction and psychological resilience play important mediating roles in the relationship between family functioning and depressive symptoms (11). Although the direction and variables in that study differ from those examined here, the findings similarly indicate that family relationships influence psychological adjustment through intervening psychological processes rather than only through simple direct associations. The present study extends this perspective by positioning psychological safety as a mechanism through which maternal emotional intimacy may become translated into more adaptive interaction. In practical terms, relational closeness may create the psychological conditions necessary for mothers to remain emotionally available, tolerate vulnerability, and respond less defensively during stressful parent–child exchanges.

A third important finding concerned distress tolerance. Distress tolerance had a significant positive direct effect on parent–child interaction, indicating that mothers who were better able to endure aversive emotional states were more likely to report positive interactions with their children. This finding is theoretically plausible given the emotional demands associated with parenting a child with ADHD. Mothers may frequently experience frustration, worry, helplessness, embarrassment, or exhaustion when responding to impulsive behavior, academic difficulties, social problems, or repeated noncompliance. The capacity to remain psychologically engaged in the presence of such affect may help prevent immediate reactive responses and facilitate more deliberate, supportive parenting behavior. Meta-analytic evidence has demonstrated that distress tolerance is closely related to emotional adjustment, with lower distress tolerance associated with greater depressive symptoms among children and adolescents (21). Developmental evidence further indicates that parental responses to distress during childhood may affect later psychological distress through the development of distress tolerance (22). Together, these findings support the interpretation of distress tolerance as a meaningful regulatory capacity with implications for interpersonal functioning.

The importance of distress tolerance can also be situated within the broader literature on emotion regulation. The Cognitive-Affective Social Processing and Emotion Regulation framework conceptualizes emotional functioning as the product of interconnected cognitive, affective, and social-regulatory systems rather than isolated emotional reactions (17). Parenting requires precisely this form of integrated regulation because mothers must interpret child behavior, regulate their own emotional responses, anticipate consequences, and choose relationally appropriate actions under conditions of stress. Longitudinal evidence has further shown that parental emotion regulation is associated with children's mental health through parenting stress and sensitive challenging parenting (18). Similarly, environmental sensitivity and attachment have been linked with physiological emotional reactivity and regulation in children (23).

Although these studies examine different populations and pathways, they reinforce the broader principle that regulatory capacities shape interpersonal behavior and adjustment. The positive association observed in the current study suggests that distress tolerance may be one specific regulatory capacity enabling mothers to maintain constructive interaction despite the aversive emotional experiences that accompany ADHD-related caregiving.

More importantly, distress tolerance significantly moderated the relationship between emotional intimacy and parent–child interaction. The interaction coefficient was positive, and simple-slope analysis demonstrated that the association between emotional intimacy and interaction strengthened systematically as distress tolerance increased. At low distress tolerance, the conditional effect of emotional intimacy was $\beta = .185$; at the mean level it increased to $\beta = .400$; and at high distress tolerance it reached $\beta = .618$. Thus, emotional intimacy was beneficial across all examined levels of distress tolerance, but its association with positive parent–child interaction was substantially stronger when mothers possessed greater capacity to withstand emotional discomfort. This finding provides one of the most important contributions of the present study because it indicates that relational resources do not necessarily operate with equal strength across mothers. Emotional closeness may provide a basis for constructive interaction, but its translation into actual parenting behavior appears to depend partly on the ability to remain emotionally engaged during stressful circumstances.

This moderation finding may be understood through the interaction between relational motivation and regulatory capacity. A mother may feel deep emotional closeness toward her child but still become overwhelmed during episodes of impulsivity, emotional outbursts, refusal to complete tasks, or repeated behavioral correction. When distress tolerance is low, immediate emotional discomfort may interfere with the behavioral expression of emotional intimacy. In contrast, mothers with greater distress tolerance may be better able to remain present during difficult interactions, thereby allowing affection, empathy, and relational commitment to guide their responses. Evidence that psychological distress can undermine treatment adherence among mothers of children with ADHD further illustrates how emotional strain can interfere with adaptive caregiving behavior (15). Conversely, acceptance- and commitment-based training has been shown to reduce perceived stress and improve self-esteem in mothers of children with ADHD (25), supporting the possibility that psychological flexibility and tolerance of difficult internal experiences can enhance maternal adaptation.

The conditional indirect effects were also significant at low, average, and high levels of distress tolerance and increased as distress tolerance became greater. This pattern reinforces the interpretation that the psychological pathway linking emotional intimacy, psychological safety, and parent–child interaction operates within a broader regulatory context. Mothers may derive psychological security from emotionally intimate relationships, but the benefits of this security for parenting may be more readily sustained when difficult affect can be tolerated rather than immediately escaped or discharged. Contemporary family research increasingly indicates that parenting outcomes emerge from interactions among parent characteristics, child characteristics, and regulatory processes. For example, Goulet and colleagues demonstrated that child and parental ADHD symptoms jointly contribute to academic outcomes through homework support within a moderated mediation framework (6). Similarly, research on parental control and child aggression demonstrates that parenting behavior is embedded in complex contextual relationships

rather than operating as an isolated predictor (24). The present study complements this literature by demonstrating that maternal distress tolerance conditions the extent to which emotional intimacy is translated into positive parent–child interaction.

An additional finding was that maternal emotional intimacy did not significantly predict distress tolerance directly. This result is theoretically informative because it suggests that distress tolerance should not be interpreted simply as a consequence of current emotional closeness. Distress tolerance is likely influenced by multiple developmental and psychological factors, including temperament, prior adversity, learning history, emotion-regulation strategies, and previous experiences of stress. Evidence among kinship caregivers demonstrates that trauma histories are meaningfully related to parenting stress and dispositional resilience (20), while Fairchild and colleagues found that maternal experiences of maltreatment and intimate partner violence can influence relational perceptions through emotion regulation and responsiveness (19). These studies suggest that regulatory capacities may reflect accumulated developmental experiences extending beyond current relational intimacy. Thus, mothers may demonstrate high levels of emotional intimacy but remain vulnerable to becoming overwhelmed by negative emotional states, whereas others may tolerate distress effectively despite more limited relational closeness. The nonsignificant path in the present study therefore supports treating emotional intimacy and distress tolerance as distinct but complementary psychological resources.

The nonsignificant interaction between psychological safety and distress tolerance also deserves consideration. Although both psychological safety and distress tolerance positively predicted parent–child interaction, distress tolerance did not significantly alter the specific relationship between psychological safety and interaction. This suggests that psychological safety may exert a comparatively stable positive association with parent–child interaction across varying levels of distress tolerance, whereas distress tolerance appears particularly important in determining whether emotional intimacy is translated into adaptive interaction. Conceptually, psychological safety and distress tolerance may therefore contribute through partially different processes: psychological safety may reduce perceptions of interpersonal or internal threat, while distress tolerance may determine the extent to which a mother can remain behaviorally engaged when unpleasant affect nevertheless arises. Their independent positive effects support the usefulness of retaining both constructs within models of maternal functioning rather than assuming that one substitutes for the other.

Taken together, the results support a multidimensional understanding of parenting in the context of childhood ADHD. Parenting difficulties cannot be explained solely by the severity of the child's symptoms, nor can positive parent–child interaction be reduced to the presence of affection or parenting knowledge. ADHD symptoms frequently interact with broader peer, behavioral, and functional difficulties (4), and co-occurring problems can further impair the child's quality of life (5). Reliable assessment tools such as the SNAP-IV remain important for identifying ADHD-related symptom patterns, with recent studies supporting its structural validity and measurement properties across different child populations (26, 27). Nevertheless, the present results suggest that understanding family adaptation also requires attention to maternal relational and intrapersonal resources. The satisfactory structural fit of the model and the substantial proportion of explained variance in parent–child interaction support this integrated perspective. From a methodological standpoint, this is consistent with the value of structural models for examining

interconnected pathways and conditional relationships among psychosocial variables (29), while the quantitative correlational design employed here is appropriate for examining theoretically specified multivariable relationships, provided causal interpretations remain appropriately constrained (28).

Several limitations should be considered when interpreting the findings. First, the cross-sectional and correlational nature of the study prevents definitive conclusions regarding temporal ordering or causality among emotional intimacy, psychological safety, distress tolerance, and parent–child interaction. Although the structural model was theoretically specified, alternative directional relationships remain possible. Second, all principal variables were assessed using self-report questionnaires completed by mothers, increasing the possibility of common-method variance, social-desirability effects, recall bias, and shared response tendencies. Third, participants were recruited through convenience and purposive sampling from psychological and therapeutic centers in Isfahan, which may limit the representativeness of the sample and restrict generalization to mothers who do not seek clinical services, families in other regions of Iran, or populations with different cultural and socioeconomic characteristics. Fourth, fathers and other caregivers were not included, preventing examination of whether the proposed pathways operate similarly across different caregivers. Finally, potentially relevant variables such as child ADHD severity, medication status, psychiatric comorbidity, maternal psychopathology, marital relationship quality, socioeconomic status, social support, duration of treatment, and family structure were not comprehensively controlled and may account for additional variation in parent–child interaction.

Future investigations should employ longitudinal designs to clarify temporal relationships and determine whether emotional intimacy prospectively predicts psychological safety and later parent–child interaction. Experimental and intervention studies would be especially useful for establishing whether deliberate increases in emotional intimacy, psychological safety, or distress tolerance result in measurable improvements in parent–child interaction. Future research should also recruit larger probability-based and multicenter samples from different Iranian provinces and include fathers, grandparents, and other primary caregivers to improve generalizability and permit comparisons across caregiving roles. Incorporating observational assessments of parent–child interaction, clinician ratings, teacher reports, and ecological momentary assessment would reduce reliance on a single informant and strengthen measurement validity. Researchers should additionally examine child ADHD symptom severity, presentation, comorbid behavioral or emotional disorders, maternal ADHD symptoms, parental stress, social support, marital functioning, socioeconomic conditions, and treatment history as covariates, mediators, or additional moderators. Testing competing structural models and conducting longitudinal conditional-process analyses could further determine whether distress tolerance moderates other stages of the proposed mechanism and whether psychological safety functions differently under varying levels of family stress.

The findings suggest that psychological and family interventions for mothers of children with ADHD may benefit from moving beyond behavioral parenting instruction alone and incorporating relational and emotion-regulation components. Clinicians could assess maternal emotional intimacy, psychological safety, and distress tolerance during initial evaluation to identify the psychological resources and vulnerabilities most relevant to each family. Interventions may include exercises designed to strengthen emotional expression, empathic communication, relational closeness, and the mother's ability to recognize the child's behavior without interpreting it exclusively as intentional opposition. Mothers reporting low psychological

safety may benefit from interventions focused on reducing self-blame, increasing confidence, strengthening supportive relationships, and creating psychologically secure environments for emotional expression. Mothers with low distress tolerance may benefit from structured training in acceptance, mindfulness, emotion regulation, delayed responding, and remaining engaged during intense negative affect. Integrating these components with evidence-based parent-management strategies may allow mothers not only to learn effective parenting behaviors but also to maintain access to those behaviors during stressful interactions, thereby promoting more stable and constructive mother–child relationships.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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