ENGAGING CAREGIVERS IN THE SERVICE OF THEIR CHILD'S MENTAL HEALTH: AN EXAMINATION OF EMOTION-FOCUSED FAMILY THERAPY AND THE ADULT ATTACHMENT INTERVIEW

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Abstract

This study examined the effectiveness of brief Emotion-Focused Family Therapy (EFFT), a transdiagnostic intervention that combines psycho-education and experiential exercises to empower parents to support their child's mental health and recovery. We also examined how administering the Adult Attachment Interview (AAI) prior to EFFT impacts therapeutic outcomes for caregivers and their children. It has been suggested that administering the AAI can facilitate the therapeutic process; however, previous studies have not examined the benefits of using the AAI as an adjunct to therapy. Using group randomization, 243 caregivers who attended an intensive 2-day EFFT caregiver workshop were assigned to one of two conditions: (1) AAI-enhanced EFFT, involving the completion of an AAI prior to treatment (n = 112); or (2) standard EFFT, with no AAI administration (n = 131). Caregivers completed questionnaires about child psychological symptoms and emotion regulation, as well as parental self-efficacy, parental blocks, and parental mentalization. Data were collected pre-treatment, post-treatment, and again 4-, 8-, and 12-months after treatment. Significant improvements in parent blocks, parental self-efficacy, child symptomatology and child emotion regulation were found for both groups. This confirms that EFFT is an effective intervention for a range of child mental health concerns. Additionally, parents who attended an AAI-enhanced workshop reported greater improvements, primarily during the follow-up period, compared to those who received the standard workshop. To the best of our knowledge, this is the first empirical demonstration of the clinical benefits of administering the AAI when working with parents in the service of youth mental health.

Keywords: Emotion-Focused Therapy, Adult Attachment Interview, brief intervention, treatment outcomes, child and family mental health, child emotion regulation, caregiver self-efficacy

Dedication

To my mom (and best friend), who's unconditional love and unfaltering faith in me gave me the courage to pursue my dreams.

Mom, this one's for you.

Thank you for believing in me when I did not believe in myself.

Thank you for teaching me the meaning of love, the importance of family, and the value of patience and kindness.

O amor é mais forte que a morte.

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Parenthood is perhaps the most rewarding yet physically and emotionally challenging experience in a person's life. Self-doubt and guilt are common transient experiences for many parents, but for parents caring for a child living with mental illness or disability, feelings of frustration, inadequacy, shame, and grief can be especially intense and pervasive (Burke, 2018; Foroughe & Muller, 2012; Mohr & Regan-Kubinski, 2001; Richardson, Cobham, Murray, & McDermott, 2011; Richardson, Cobham, McDermott, & Murray, 2013). These intense emotional responses to a child's diagnosis or symptomology are upsetting, negatively impacting parents' mental health and well-being. They can also interfere with parents' ability to implement the necessary strategies to support their child's treatment and recovery (Foroughe et al., 2018; Lafrance Robinson, Dolhanty, Stillar, Henderson, & Mayman, 2014; Stillar et al., 2016), consequently impeding treatment outcomes across a range of child mental health difficulties (Heath, Curtis, Fan, & McPherson, 2015; Kazdin & Whitley, 2003; Mackler et al., 2015). For example, a growing body of research within the trauma literature shows that how parents respond to their child's trauma may mediate their child's adjustment and resilience (Bambrah, Mastorakos, Cordeiro, Thornback, & Muller, 2018; Cinamon, 2017; Scheeringa & Zeanah, 2001; Williamson, Creswell, Butler, Christie, & Halligan, 2016; Wise & Delahanty, 2017). Specifically, parental warmth has been associated with fewer child post-trauma symptoms, whereas parental overprotection and the use of avoidant coping strategies have been linked to greater post-traumatic distress (Bokszczanin, 2008; Scheeringa & Zeanah, 2001; Valentino, Berkowitz, & Stover, 2010; Williamson et al., 2016).

As child and family therapists, it is helpful to acknowledge that parents' responses to their child's mental health difficulties are driven, at least in part, by their own feelings, such as fear

and helplessness. Parents may not only experience great pain seeing their child's suffering, but they may also carry with them their own histories of childhood relational trauma and/or psychopathology (Foroughe, 2018; Foroughe & Muller, 2012).

Given that parents are often the leading source of support for their children across the life-span, and considering the interplay between parental distress, parental support, and child mental health, it is clear that we need to actively engage parents as lead sources of support and agents of change in their child's mental health treatment and recovery. The question remains: how do we do so in a way that acknowledges and directly addresses parents' own feelings, which may make it difficult for parents to follow through with strategies that may meet their child's needs?

Empowering Caregivers in the Treatment of Child Mental Illness

While it is widely accepted that parents play an important role in their child's mental health, they are often ascribed a minimal role in the psychological treatment of their children, and are viewed as applying a secondary role to that of the therapist (Burke & Loeber, 2015; Foroughe et. al, 2018; Taboas, McKay, Whiteside, & Storch, 2015). Unfortunately, this focus on a therapeutic relationship that does not include parents' input undermines the importance of the parent in a child's recovery and may inadvertently reinforce parents' pre-existing feelings of guilt, inadequacy, and helplessness.

Attachment-informed and family-based approaches have been emphasized by numerous youth mental health experts who identify active parental involvement as an important ingredient for the effective treatment of child mental illness (Creswell & Cartwright-Hatton, 2007; Downs & Blow, 2013; Foroughe, 2018; Foroughe & Muller, 2012, Haine-Schlagel & Walsh, 2015; Konanur, Muller, Cinamon, Thornback, & Zorzella, 2015; Lock, 2010; Rependa, Goldstein, Watson, Lawford, & Muller, 2019; Rowe, 2012 for a review). Empirical support for the involvement of parents as primary agents of change in their child's mental health treatment is

accumulating (Konanur et al., 2015; Carr, Hartnett, Sharry, & Brosnan, 2017; Foroughe et al., 2018; Henggeler & Sheidow, 2012; Kaslow, Broth, Smith, & Collins, 2012; Wade, Treasure & Schmidt, 2011). There has been a proliferation of effective dyadic interventions for very young children and their parents, usually mothers (e.g., Cohen et al., 1999; Cohen, Lojkasek, Muir, Muir, & Parker, 2002; Juffer, Bakermans-Kranenburg, & van IZendoorn, 2017; Rusconi-Serpa, Rossignol, & McDonough, 2009; Sadler et al., 2013). Meta-analyses of child-centred play therapy with school-aged children consistently show that treatment effect sizes are significantly larger when there is full parental involvement (Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015). Generally, active parental involvement appears to improve child outcomes (Haine-Schlagel & Walsh, 2015; Coatsworth et al., 2015) and may also increase overall family functioning (Poole et al., 2017).

The largest body of evidence for direct parent involvement in therapy (outside of the infant and preschool populations) comes from work with families caring for a loved one with an eating disorder (Eisler, 2005; Eisler, Simic, Russell, & Dare, 2007; Girz, Lafrance Robinson, Foroughe, Jasper, & Boachie, 2013; Le Grange & Eisler, 2009; Treasure et al., 2008). Family-oriented therapies that work with parents directly, empowering them to become the primary source of emotional support for their children, have consistently resulted in better treatment outcomes and dramatically lowered relapse rates for youth with eating disorders relative to traditional treatment models, where the focus is on the therapeutic relationship (Eisler, 2005; Eisler et al., 2007; Girz et al., 2013; Le Grange & Eisler, 2009; Treasure et al., 2008). Much less — but needed — research examines the effectiveness of interventions that place the parent, and their feelings about their capacity to help their child, at the heart of their child's treatment for diagnoses and mental health difficulties outside the realm of eating disorders.

Emotion-Focused Family Therapy

Even when parents are called to play a lead role in their child's therapy, little work has been done with the parent to directly address the parent's feelings (i.e., fears) about their child's difficulties and treatment, which, as already stated, can greatly interfere with their ability to help their child (Foroughe et al., 2018; Lafrance Robinson et al., 2014). One notable exception is Emotion-Focused Family Therapy (EFFT; Lafrance Robinson et al., 2014), a relatively new intervention model that actively involves parents in the treatment of their child's mental illness.

EFFT is a transdiagnostic model of family therapy that empowers caregivers to be primary agents of change in the healing and recovery of their child's mental health. The intervention developed as an outgrowth of the theories, principles, and techniques of Emotion-Focused Therapy (EFT; Greenberg, 2004). It also draws from motivational enhancement and family-based therapies (Foroughe, 2018; Lock & Le Grange, 2013; Miller & Rollnick, 1991; Lafrance Robinson, Dolhanty, & Greenberg, 2015). Initially developed for caregivers supporting the treatment of a loved one with an eating disorder (Lafrance Robinson et al., 2014), EFFT has since been adapted for a broad range of mental health symptoms (e.g., anxiety, depression, oppositionality, substance abuse etc.) across the lifespan (Foroughe et al., 2018). Modes of delivery include individual or family sessions, as well as multi-caregiver group formats.

EFFT uses psycho-education and experiential exercises to equip parents with the skills they need to support their child's recovery. The intervention comprises three modules that involve helping caregivers become: (1) their child's recovery coach, helping their child interrupt symptoms, change maladaptive behaviours, and adjust to stressful life events; (2) their child's emotional coach, supporting their loved one to approach, process, and manage stress and intense and/or difficult emotions/emotional pain; and (3) facilitators of relationship repair to address any relational strain between parent and child, and to help heal old emotional wounds, self-blame and

guilt. Simultaneously, EFFT helps parents process their own difficult emotional experiences that interfere with their ability to implement the strategies learned (Foroughe, 2018; Lafrance Robinson et al., 2014).

Processing Parents' Emotion Blocks

Perhaps EFFT's most unique and defining feature is the overriding process of identifying, working through, and resolving emotion "blocks" or emotional self-interruption (e.g., feelings of fear, shame, self-blame, and resentment that block their experiences of other feelings that may be more relevant) that surface as the caregiver begins to implement the skills associated with each of the three treatment modules. These blocks diminish caregivers' self-efficacy and get in the way of strategy implementation, consequently hindering their child's recovery (Foroughe, 2018; Foroughe et al., 2018; Lafrance Robinson et al., 2014). For example, such emotional self-interruption may lead to caregiver denial, accommodation, and/or enabling behaviours that often stem from emotional avoidance (Strahan et al., 2017).

The clinician's role in EFFT is to provide psycho-education and facilitate experiential exercises that help caregivers learn the steps of the three EFFT modules, concurrently helping parents process difficult feelings that arise as they practice those steps in session. By processing and addressing these emotion blocks, caregivers are better equipped to implement the skills learned and actively support their child's recovery. Having faced and worked through some of their own difficult emotions, parents can more effectively support their child's emotion processing and promote adaptive coping skills in their child (Foroughe, 2018; Greenberg, 2008; Greenberg & Pascual-Leone, 2006; Sabey & Lafrance Robinson, 2018). Usually, the clinician works with the parent to identify the task(s) that may be most challenging for them (i.e., setting limits, emotion coaching, or relationship repair).

Emotion Dysregulation

In the EFFT model, deficits in emotion processing and regulation are believed to be at the core of all mental health difficulties — a position that is not new (Cicchetti, Ackerman, & Izard, 1995; Zeman, Shipman, & Suveg, 2002) but has been gaining further support in recent neuroscience research (see Broome, He, Iftikhar, Eyden, & Marwaha, 2015 for a review). From this perspective, mental illness can be understood as stemming from deficits in affect regulation and the development of maladaptive coping strategies (e.g., avoidance) aimed at diminishing strong negative emotions. Thus, EFFT aims to improve child clinical outcomes, regardless of the child's age or diagnosis (Lafrance Robinson et al., 2014), by increasing *caregivers'* capacity to process emotional experiences (their own and that of their child), while also cultivating caregivers' skill in symptom interruption. The idea here is that parental emotion dysregulation and emotion avoidance impact parents' capacity to effectively engage with their children and support their child's ability to regulate themselves. And so, EFFT helps parents regulate their own difficult experiences so that they can better support their child's emotion regulation. This process serves to boost feelings of self-efficacy in both the child and the parent and lends itself to increased emotional and behavioral regulation in both. With the support and increased attunement from the caregiver, the child learns to better process their strong negative emotions, eliminating the need for maladaptive coping strategies. This is in line with recent findings in the neuroscience of emotion indicating that parents play a dominant role as emotion regulators for their children (Hughes & Baylin, 2012; Siegel & Payne Bryson, 2011; Siegel, 2012). This emphasis on the role of parents as external regulators for their children is further supported by research regarding parental meta-emotion.

Parental meta-emotion has been established as a factor related to child emotion regulation in both clinical and non-clinical samples (Hurrel, Houwing, & Hudson, 2017). Gottman et al.

(1996) defines parental meta-emotion philosophy as an organized set of feelings and thoughts held by the parent about their own emotions and the emotions of others, including their child. Research suggests that parents tend to hold one of two perspectives — either an emotion coaching or an emotion dismissing philosophy (Gottman, Katz, & Hooven, 1997). Parents who hold an emotion coaching philosophy see their child's negative emotions as opportunities for learning and closeness. These parents are highly attuned to their own and their child's emotions, frequently label emotions and use validation, and tend to actively support their child through emotionally difficult situations by providing them with strategies (Gottman, 1996, 1997; Hurrel et al., 2017). In contrast, parents with an emotion dismissing philosophy view negative emotions as harmful and tend to ignore, avoid, or quickly change negative emotions (Gottman, 1996, 1997; Hurrel et al., 2017). Importantly, children of parents who provide emotion coaching do better than children whose parents are avoidant of emotions across a wide range of indicators, including better psychosocial adjustment, peer relationships and social skills (Gottman, 1997), better self-regulation abilities, fewer internalizing and externalizing difficulties, higher self-esteem, and higher levels of academic achievement (Gottman et al., 1996; Hurrel et al., 2017; Shortt, Stoolmiller, Smith-Shine, Eddy, & Sheeber, 2010).

Multi-Caregiver EFFT Workshops

The EFFT framework has been modified for delivery in an intensive and manualized 2-day multi-caregiver group format (herein referred to as the EFFT caregiver workshop; Lafrance Robinson et al., 2014). As outlined by Yalom (2005), there are several factors specific to the process of group therapy that, when present, benefit group members and predict positive outcomes following therapy. Some of these factors include universality (the normalization of experiences, which happens when group members hear others describe difficulties, emotions, or experiences that are similar to their own), the imparting of information (that is, group members

help each other by sharing information), catharis (this refers to the idea that sharing feelings and experiences with others in a safe and containing environment can help relieve pain, guilt, or stress), and group cohesiveness (which can lead to a sense of belonging). Offering EFFT in a group format also allows for vicarious learning. Additionally, as highlighted by others who have studied parent training groups (e.g., Levac, McCay, Merka, & Reddon-D' Arcy, 2008), workshops may foster social support and acceptance among parents, which may in turn lead to more positive parental self-reflection, greater self-efficacy, and lower levels of parenting stress (Levac et al., 2008). This is important because parental self-efficacy has been associated with parents' willingness and ability to implement recovery-focused strategies with their children (e.g., Jones & Prinz, 2005; Strahan et al., 2017).

A pilot study of the EFFT caregiver workshop was conducted by Lafrance Robinson et al. (2014) and included 33 parents supporting an adolescent or young adult child (ages ranged from 13 to 31 years, with a mean age of 18) in their recovery from an eating disorder. Findings demonstrated a significant increase in self-reported parental self-efficacy as well as reductions in their self-reported fears about being involved in their child's treatment, including a decrease in self-blame (Lafrance Robinson et al., 2014). A second, larger study by Strahan et al. (2017) included 124 parents of children (ages ranged from 12 to 41 years, with a mean age of 18) also recovering from an eating disorder. This group found that directly addressing parent fears and self-blame led to increased self-efficacy regarding parents' role in their child's recovery, which in turn led to an increase in parents' intentions to implement the recovery-focused behaviour learned during the EFFT workshop (Strahan et al., 2017). More recently, Foroughe et al. (2018) implemented and studied the EFFT caregiver workshop for general child mental health concerns. This study included 124 parents (child ages ranged from 2 to 19 years, with a mean age of 9) seeking support for a wide-range of child mental health problems, including anxiety, anger and

mood difficulties, attention and hyperactivity, depression, oppositional-defiance and intense anger, eating disorders, and substance abuse, among others. Results showed significant improvements in parents' self-reported fears (i.e., emotional blocks) and self-efficacy in relation to their involvement in their child's recovery. These gains were achieved immediately after the intervention and were maintained at a 4-month follow-up. Additionally, significant improvements in overall child symptomology was reported by parents on the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) and Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000, 2001) at the follow-up time-point (Foroughe et al., 2018). These initial findings suggest that when delivered in a brief group format, EFFT offers families in need an effective and cost-efficient option for the treatment of child mental illness.

Introducing the Current Study: Research Aims

Because EFFT is a relatively new intervention, little research has examined its effectiveness for treating problems other than eating disorders. Moreover, many of the existent studies on EFFT have focused on changes in parental efficacy and fears but have not examined changes in child symptomology. To the best of our knowledge, only one study has reported on the effectiveness of EFFT in the treatment of a wide range of mental health difficulties and emotion dysregulation in children, examining both parent and child outcomes (Foroughe et al., 2018). Thus, one of two major aims for this study was to examine the effectiveness of EFFT in a large clinical sample of parents caring for children with a wide range of mental health problems. Expanding on previous studies, we included a range of parent and child outcome measures and followed our sample for a full year in order to explore therapeutic change following treatment and over time.

In addition to examining outcomes of EFFT for a wide range of youth mental health problems, this study also explored how adding the Adult Attachment Interview (AAI; George,

Kaplan, Main, 1985, 1996; Main & Goldwyn, 1998) to the EFFT workshop would impact the therapy process and treatment outcomes for parents and their children. Although originally developed as a research tool, the clinical applications of the AAI are now widely recognized (Steele & Steele, 2008, 2009). Further, it has been suggested that administering the AAI may facilitate responsiveness to the therapeutic process (Steele & Steele, 2008). However, no systematic reviews exploring the advantages of using the AAI within the literature presently exist, nor have researchers examined what mechanisms may be at the heart of this impact. As such, the second objective of this project was to examine if administering the AAI enhances the therapy process and outcomes when paired with EFFT.

The Adult Attachment Interview

Considered a mainstay of attachment research (Steele & Steele, 2008), the AAI is a semi-structured interview that assesses individuals' mental representations of attachment (i.e., internal working models). During the interview, individuals are asked to recall childhood memories of attachment relationships (e.g., by providing five adjectives to describe their relationship with each parent and elaborating on those adjectives by recounting specific memories, by describing what happened when they were ill or upset as a child) and to reflect on how these early experiences have impacted their current adult personality and their relationship with their own child. In doing so, the AAI activates the attachment system and elicits thoughts and feelings about early attachment experiences, uncovering traumatic experiences and important losses. The interview is transcribed and coded based on content (e.g., the extent to which the narrative is coherent and consistent, and the ease with which the interviewee recalls specific memories of their childhood relationships) in order to classify an individual’s current attachment status (i.e., Autonomous, Dismissing, Preoccupied, or Unresolved/Disorganized).

Before delving further into a discussion about the clinical usefulness of the AAI, an understanding of attachment theory as well as a review of the literature regarding the intergenerational transmission of attachment and trauma is helpful.

Attachment Theory. Attachment theory highlights the importance of early caregiver-child relationships, providing a relational perspective on early socialization and development (Laible & Thompson, 2007). The concept of attachment developed largely out of the combined work of John Bowlby and Mary Ainsworth (e.g., Ainsworth & Bowlby, 1991). Taking an ethological stance, Bowlby proposed that attachment is a universal, biologically determined behavioural system driven by the need to maintain proximity with primary caregivers, particularly during threatening and stressful situations (Bretherton, 1992). These early relationships are thought to significantly influence how people think about and relate to others in later years, forming the foundation of an individual's beliefs about self and others, referred to as his or her *internal working model* of attachment (Grossmann, Grossmann, & Waters, 2005; Main, 1983; Main & Goldwyn, 1984).

After extensively observing and studying infant-mother interactions, Ainsworth identified three principal patterns of attachment behaviour, resulting in the classification of secure, anxious, and anxious-avoidant attachments, the latter two generally representing attachment insecurity (Ainsworth, 1985a; Ainsworth, 1985b; Ainsworth, Blehar, Waters, & Wall, 1978). Later research by Mary Main and her colleagues led to the addition of a fourth category, disorganized attachment (Main & Solomon, 1990). Individual differences in attachment security are thought to stem from differences in the quality of interactions between caregivers and their children (Laible & Thompson, 2007). Specifically, caregivers who are consistently sensitive and responsive have children who are securely attached (e.g., Ainsworth et al., 1978; Belsky, Rovine, & Taylor, 1984), whereas caregivers who are inconsistently responsive in times of need, or are frightening

(in the form of role reversals, are withdrawn and intrusive; for a review see Hesse & Main, 2006), neglectful or rejecting (Crittenden, 1985), depressed (e.g., Radke-Yarrow, Cummings, Kuczynski, & Chapman, 1985), or otherwise preoccupied, are more likely to have children who are insecurely attached (Ainsworth et al., 1978).

Secure attachment relationships are critical for optimal development; they offer children a sense of safety and comfort when in frightening or stressful situations and provide them a secure base from which to explore the environment and learn. Children whose parents respond consistently and sensitively develop a dependable belief that they can obtain help from responsive others, should they need it. Attachment security influences the quality of concurrent and subsequent relationships with others, and insecurity/disorganization in infancy and early childhood negatively impacts children's cognitive, social and emotional development (e.g., Easterbrooks & Goldberg, 1990; Morrisset, Barnard, Greenberg, Booth, & Spiecker, 1990; Wartner, Grossman, Fremmer-Bombik, & Suess, 1994), as well as their health and physiological functioning (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Research shows that chronic attachment disruptions (e.g., ongoing abuse, neglect and/or emotional unavailability of caregivers) negatively impact the structure and physiological functioning of the brain, resulting in heightened adrenocortical activity (for a review see Gander & Buchheim, 2015). Children with insecure, disorganized attachments demonstrate higher levels of stress, low self-esteem, poor peer relations, more difficulties with emotion regulation, poorer academic performance, and behaviour difficulties in school (Green & Goldwyn, 2002; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). These early social and emotional difficulties not only have a tremendous impact on well-being and quality of life in childhood, but frequently continue into adulthood (Green & Goldwyn, 2002; Maunder, Hunter, & Lancee, 2011).

The Intergenerational Transmission of Attachment. Importantly, research shows that patterns of attachment are repeated from generation to generation. A child's attachment classification is strongly related to that of his or her caregiver (usually, the mother), and is consequently passed on to his or her own child(ren) in the future (Behrens, Hesse, & Main, 2007; Gloger-Tippelt, Gomille, Koenig, & Vetter, 2002; Goldwyn, Stanley, Smith, & Green, 2000; Hautamäki, Hautamäki, Neuvonen, & Maliniemi-Piispanen, 2010; Tarabulsy et al., 2005). Much of the research conducted on this intergenerational transmission of attachment has used the AAI. Indeed, the strong cross-generational association between parents' responses on the AAI and infant patterns of attachment (measured using the Strange Situation) is well established (Main et al., 1985; van Ijzendoorn, 1995; Steele & Steele, 2008) — coherent and secure parent narratives relate to infant attachment security, whereas incoherent and dismissive, preoccupied, or unresolved parent narratives relate to infant avoidance, resistance, or disorganization respectively (Bakermans-Kranenburg, van Ijzendoorn, & Juffer, 2005; Benoit Parker, & Zeanah, 1997; Crawford & Benoit, 2009; Fonagy, Steele, & Steele, 1991; Hesse & Main, 1999; Main et al., 1985; Steele & Steele, 2008; van Ijzendoorn, 1995; Ward & Carlson, 1995). Notably, this correlation remains just as strong when the AAI is administered to a pregnant mother, prior to the birth of her child (Benoit & Parker, 1994; Fonagy, Steele, & Steele, 1991; Ward & Carlson, 1995; Steele & Steele, 2008; Steele, Steele, & Fonagy, 1996).

From a family systems framework, Bowen (1978) proposed that, moving beyond the individual, family-level functioning and relational patterns may also be transmitted across generations. Bowen theory argues that children develop levels of differentiation (referring to one's ability to sustain a separate sense of self within relationships) that mirror that of their parents. Later in life, the adult child finds a partner with a similar level of differentiation as themselves, and together, the couple "passes" on this level of differentiation to their own

child(ren) (Klever, 2005), which in turn influences multigenerational family-level functioning and patterns of interaction (Bowen, 1978; Klever, 2005).

The intergenerational transmission of attachment and trauma, as well as family-level functioning, may result in part because of avoidant tendencies in parents with histories of childhood trauma. The demands for closeness, intimacy, vulnerability, and interdependence inherent within the parent-child relationship can be highly distressing for these parents, as the parent-child relationship can trigger memories of parents' own attachment traumas (Foroughe & Muller, 2012), often unconsciously. As such, approaches to family therapy must also consider the past trauma of parents in addition to current interfamilial stress and attachment difficulties within young families. As Selma Fraiberg et al. (1975) describe, only when a mother's own cries are heard will she be able to hear the cries of her child (Fraiberg, Adelson, & Shapiro, 1975).

Clinical Utility of the Adult Attachment Interview

Anecdotally, it has been observed in our clinical practice that administering the AAI with parents facilitates parental responsiveness to the therapeutic process. This is in line with the work of Steele and Steele (2008, 2009), who have published about the clinical uses of the AAI. In their book, Steele and Steele (2008) argue that the AAI helps establish a therapeutic alliance and shared goals for therapeutic work. It is also thought to provide a source of understanding and motivation to facilitate the therapeutic process and has been used to measure therapy process and outcomes, with pre-post therapy shifts in AAI narratives examined as an index of change (see Steele & Steele, 2008 for a review).

In addition to the benefits described by Steele and Steele (2008), we anticipate that, especially in our work with parents, the AAI would influence clients toward effective therapeutic work and emotional processing in several important ways. First, by asking parents to recall memories of their early relationships, the AAI communicates indirectly to the client that

speaking about emotional and relational experiences is acceptable and perhaps even an expectation of therapy. In this way, conducing an AAI prior to the EFFT workshop may serve as an implicit form of socialization to therapy. “Socialization to the model” is a concept that is often discussed within other modalities (e.g., CBT). It has been described as an understanding of the process of therapy and beliefs about its effectiveness, as well as a set of role expectancies that allow a client to understand and respond to therapist behaviour (Orne & Wender, 1968; Roos & Wearden, 2009). Second, completing the AAI also indirectly or implicitly communicates to the parent that their personal and emotional experiences are important to the therapy process in general and to their child’s recovery as well. Finally, by the very nature of its questions (personal, self-reflective, activating of attachment-related memories), the AAI might facilitate thoughtful reflection about the connections between parents’ own experiences in childhood and the experiences of their child (i.e., how their experience of their parents shaped their own parenting style).

As described by Steele and Steele (2008), one aim of the AAI is to surprise the unconscious. By taking individuals back in time to highly emotional events in early childhood that are not ordinarily discussed or reflected on, the AAI takes a “cognitive-developmental approach to the unconscious”, tapping into a “part of the mind that stores early memories and associated emotions not typically available to awareness, yet exerting an influence on mind and behaviour” (Steele & Steele, 2008, p.8). This assertion is in line with the literature on autobiographical memory, which suggests that recalling and retelling personal episodic information involves a re-experiencing of the past that typically elicits emotional responses in the individual and gives them a sense of having mentally time travelled (Holland & Kensinger, 2010).

We suggest that when parents complete an AAI prior to therapy, we are calling to the surface memories *and feelings* about a past that all too often operate just below the surface of their conscious awareness. In doing so, parents are invited to more easily make connections between their own childhood experiences and their current relationship with their child. Within the context of EFFT, we posit that this would lead to deeper processing of emotional content (i.e., parent emotion blocks) during experiential exercises. Analogous to memory priming in cognitive psychology (a well-established implicit memory effect in which the introduction of a stimulus unconsciously influences how a person responds later to another stimulus by activating associations; Weingarten et al., 2016), we expect that this activation of emotional content for parents would make parents' childhood memories and past hurt more accessible to them for processing during the EFFT workshop. By activating the attachment system and calling to mind important early memories, the AAI arouses within the parent what are often difficult or painful emotions. Importantly, emotional arousal and emotional experiencing are considered central and necessary components for effective emotional processing in experiential treatments like Emotion-Focused Therapy (Bridges, 2006; Pos, Paolone, Smith, & Warwar, 2017).

There is a great degree of overlap between the theoretical underpinnings of EFFT and the AAI. The importance of familial relations, particularly the parent-child relationship, and the primacy of the role of parents in the mental health and treatment of children, are central to the EFFT model. Additionally, EFFT acknowledges that parents' emotional responses to their child's difficulties (e.g., shame, fear, guilt, resentment and hopelessness) — which interfere with their efforts to support their child by impacting their ability to connect with, and meet the needs of, their child's powerful emotions — often stem from their own histories of intrafamilial trauma and painful attachment experiences. By helping parents process their emotional blocks *and* repair their relationship with their child, EFFT holds the potential to disrupt the intergenerational cycle

of insecurity and trauma and associated psychosocial difficulties. The AAI directly asks individuals to recall memories of early attachment experiences, trauma, and loss, and then to reflect on how those painful experiences have influenced who they are as adults and parents, tapping into emotional content that often forms the basis of parents' emotional blocks. Therefore, pairing the AAI with EFFT was a natural step insofar as it is especially well suited to the process-oriented work parents participate in as part of the EFFT workshop.

Present Study

Summary

While the AAI has been adopted for clinical use, and the notion that administering the AAI facilitates the therapy process has been put forth, no research studies to date have examined this hypothesis. Using a group randomized design, this study adds to the current literature by directly examining how conducting AAIs prior to a brief EFFT caregiver workshop impacts treatment outcomes. Additionally, because EFFT is a relatively new treatment model, there remains a paucity of research examining its implementation transdiagnostically — that is, with caregivers of children presenting with a range of mental health problems. Moreover, only one study has previously examined both parent and child outcomes following EFFT. As such, pairing the AAI with an EFFT caregiver workshop allowed our group to address these gaps in the EFFT literature. This study examined child psychological symptoms and emotion regulation, as well as parental self-efficacy, parental blocks, and parental mentalization, before and after EFFT, and throughout a 1-year follow-up period.

Questions and Hypotheses

The overall research goals for this thesis may be organized into two related lines of enquiry.

Research Question 1: EFFT Outcomes

1. How (in what domains) does EFFT impact child and parent outcomes?

   Hypothesis: Improvements in child emotion regulation, child clinical symptomology, parent self-efficacy, and parental reflective functioning, as well as a decrease in parental fears, will be observed following EFFT. Caregiver treatment gains will occur immediately following the EFFT intervention, and will be maintained at follow-up (four, eight, and twelve months following treatment). Improvements in child outcomes were expected to begin with the four-month follow-up.

Research Question 2: The AAI in relation to EFFT Outcomes

2. Does the experience of completing an AAI impact child and parent outcomes following EFFT?

   Hypothesis: Improvements in child emotion regulation, child clinical symptomology, parent self-efficacy, and parental reflective functioning, and decreases in parental fear following EFFT will be significantly greater for caregivers of the AAI-enhanced intervention group relative to the standard workshop intervention group.

Methods

The data from this thesis have been collected as part of an ongoing, collaborative study on EFFT, which took place in Toronto, Canada through the Family Psychology Centre (formerly the Kindercare Pediatrics Psychology Clinic) and the Trauma & Attachment Lab at York University. The Family Psychology Centre is a private practice that provides a range of mental health services to youth, young adults, and families. Research participants were offered a reduced fee for the EFFT caregiver workshops. The centre offers an accessible fee-structure and reduced fee and pro-bono spots were made available to families in financial need, regardless of their

participation in this study. Participant recruitment for this longitudinal study began in May 2016 and ended in September 2018; the follow-up data collection period will conclude in November 2019. The overall study comprises several sub-projects designed to address various questions around the effectiveness of EFFT for families with histories of trauma, as well as questions about the clinical use of the AAI. This thesis represents the first in a series of planned analyses.

Study Design

For this longitudinal, between-groups study, cluster randomization (also referred to as group randomization) was used to assign participants to one of two intervention groups: a standard EFFT caregiver workshop and an AAI-enhanced EFFT caregiver workshop. The AAI-enhanced workshop differed from the standard EFFT workshop only in that all AAI-enhanced EFFT workshop participants were required to complete an AAI two-to-three weeks prior to the workshop. All other aspects of the workshop and research methods were identical across the two treatment conditions. A workshop schedule was created in advance indicating which of the six workshops (i.e., January, March, May, August, September, or November) would involve the AAI and which would not. Whether a participant attended an enhanced workshop or a standard workshop depended entirely on *when* the participant was registering to attend. For example, parents who contacted the clinic in August 2018 looking to register for the next workshop were enrolled in the September 2018 workshop, a non-AAI workshop. And so, caregivers who contacted the clinic and registered for the September 2018 workshop necessarily received the standard treatment because that was the workshop being offered when they were looking to attend.

Participants

Participants included 243 caregivers (165 mothers, 74 fathers, 2 grandfathers, 1 grandmother, and 1 guardian) who attended one of a number of EFFT workshops offered

between May 2016 and September 2018 at a pediatric health centre in Toronto, Canada. Treatment condition was determined using a group randomization process (described above), and 46% of participants attended an AAI-enhanced EFFT workshop. To be included in the study, participants had to attend at least a day and a half of the 2-day EFFT caregiver workshop.

More than half of the participants (n = 140) were co-parents who attended the workshop because of concerns about the same child, providing outcome data for one child. One set of co-parents (n = 2) completed questionnaires about different children (i.e., two siblings), with each parent consistently reporting on one child throughout the study. Additionally, in two cases, a parent attended the workshop with the child's grandparent(s), completing research measures about the same child (n = 5) — in one case, a mother and maternal grandfather attended together, and in the other case, a mother and both maternal grandparents attended. The remaining 96 participants were parents who attended the workshop individually (i.e., without a co-parent). Together, parent-reported data were collected regarding 170 children.

Demographic information about caregivers and their children are presented in Table 1 by treatment condition. The two treatment groups did not significantly differ in terms of demographic characteristics, with the exception of caregiver age. The average caregiver age for the standard EFFT condition was higher than that of the AAI-enhanced condition. This was likely because two of the three grandparents who participated in the study attended a standard EFFT workshop.

Overall, caregivers ranged in age from 28 to 71 years (M = 45.01, SD = 7.65) and the children (52% female) ranged in age from 4 months to 26 years (M = 10.90, SD = 4.96). Generally, caregivers were well educated. Of the 235 caregivers who indicated their level of education, the majority had completed a college or university degree (42%) or had attended a post-graduate program (52%). In terms of income, 46% of the participants reported an annual

household income of $101,000 or greater, 12% had an annual household income between $61,000 and $100,000, 5% had an annual household income between $41,000 and $60,000, and 9% had an annual household income of $40,000 or less; 28% of the participants preferred not to provide any information about household income.

Child presenting concerns (as reported by parents at the time of registration; See Appendix A for the workshop registration form) spanned a broad range of psychiatric disorders and general mental health difficulties (see Table 2), including: anxiety, depression, inattention and/or hyperactivity, eating disorders, substance abuse, behavioural dysregulation (e.g., tantrums, oppositionality), somatic complaints, low self-esteem, trauma, and other emotional, social, or relationship difficulties warranting clinical attention (e.g., anger, general emotional dysregulation, attachment concerns, or difficulties with siblings or peers). Most caregivers described multiple presenting concerns or reasons for seeking services; 34% listed two, 21% listed 3, and 13% listed 4 concerns or more. Information regarding previous diagnoses was available for a subset of the sample (n = 199), of which half had a previous diagnosis, most commonly an anxiety disorder, ADHD, and/or depression. No significant differences with regards to presenting concerns were found between the two treatment groups.

The Clinical Intervention

EFFT was delivered in the form of an intensive 2-day caregiver workshop. A structured and manualized intervention (Lafrance Robinson et al., 2014), the workshop provided parents with psycho-education followed by opportunities to engage in highly interactive and skills-based experiential activities. Parents were invited to identify some of the most difficult situations that arise in their interactions with their child (e.g., when trying to manage behaviour at home or support their child's mental health treatment) and use role-play to practice one or more of the EFFT modules described earlier: emotion coaching, behavioural coaching, and relationship

repair. The role of the EFFT clinician was to facilitate this work by providing corrective guidance while simultaneously helping caregivers identify and process their emotional blocks, engendering confidence in their ability to carry out the techniques learned when interacting with their child following the workshop.

Experiential exercises were structured so that while one parent worked through a difficult scenario, a second caregiver (not the co-parent) participated in the process by playing the role of "blocker," giving voice to the role-playing parent's emotional blocks. Additionally, one of the workshop facilitators acted out the role of the child (following directions provided by the role-playing parent on how their child would likely respond in the situation being acted out). Having these "actors" take part in the experiential exercise is thought to optimally elevate parents' emotional arousal during role-play, facilitating effective processing of emotional experiences. As parents take turns working through these emotionally intense experiential activities, other caregivers observe, allowing for vicarious learning and peer support.

Procedure

Ethics approval was obtained for the study from York University's Ethics Review Board (Human Participants Review Sub-Committee) and the Kindercare Pediatrics Research Ethics Sub-Committee.

Because EFFT aims to empower caregivers to take the lead in their child's recovery from mental illness, regardless of the child's diagnosis or presenting issue(s), the only exclusion criterion for the study was psychosis in the caregiver or child. None of the caregivers (or children) registering for the workshop during the study met this criterion. In addition to being a transdiagnostic intervention, EFFT takes on a lifespan approach. As such, caregivers of children of all ages were eligible to participate in the treatment and research.

Information about upcoming EFFT caregiver workshops was shared with a large network of health care providers at external mental health agencies, hospitals, community centres, medical clinics, as well as various school boards in the Greater Toronto Area. In most cases, caregivers self-referred to the program after having it recommended to them by a healthcare professional or by another caregiver who attended a previous workshop, or after coming across a program flyer. Occasionally, referrals were received from clinicians within the community or from a healthcare professional practicing within the pediatric clinic hosting the workshop.

Informed consent was first obtained verbally by telephone at the time of registration. Written consent was later obtained at the start of the workshop. Demographic information was collected from caregivers at the time of registration into the program and included information about participants' age and gender, child age and gender, ethnicity, socioeconomic status, education level, marital status, child presenting concerns and existing diagnoses, previous psychological services received by the caregiver or child (e.g., assessment, therapy for child, therapy for parent) and caregivers' treatment goals. When caregivers reported concerns related to more than one child (i.e., siblings), they were asked to select the child they were most concerned about to be the subject of their questionnaire responses throughout the duration of the study. Many co-parents chose to attend a workshop conjointly, while others chose to attend separately (i.e., attended workshops held at different times, usually to accommodate individual work schedules).

For those caregivers attending an AAI-enhanced workshop, interviews were scheduled at the time of registration, following the consent process. These interviews were held 2 to 3 weeks prior to the workshop and were video-recorded. Each interview took approximately 1 to 1.5 hours to complete. Given the highly sensitive and emotional nature of the interview, caregivers could opt out of the video recording while still participating in the interview. The AAI was

administered to caregivers by one of our trained AAI administrators. Administrators included a licensed psychologist, supervised practice psychologists, psychology practicum students, social workers, psychology graduate students, or undergraduate level research assistants. An experienced clinical psychologist at the pediatric health provided training and ongoing support and supervision of AAI administrators.

Workshops were held six times a year through the Kindercare Pediatrics Psychology Clinic (now The Family Psychology Centre). Each workshop was facilitated by the same clinical psychologist (Mirisse Foroughe, Director and Clinical Psychologist at The Family Psychology Centre and Co-Investigator for the research), who was supported by a second co-facilitator, usually a psychology student (undergraduate and graduate level) trained in EFFT. The psychologist leading the workshops was trained directly by the co-founders of EFFT and is certified as an EFFT trainer. At each workshop, the same materials (e.g., audio-visual aids, supplementary materials for caregivers etc.) were used for psycho-education and group discussion, including illustrative examples from the manual. While caregiver role-plays were based on personal experiences, the instructions given to caregivers around the specific skill-based aims of each experiential activity were consistent across workshops. Caregivers were video recorded while engaging in the experiential activities during the workshop, unless they preferred to opt out of this aspect of the study.

Research questionnaires (see below and Appendices B through to F) were administered at six different time-points: at the time of registration (T0), one week prior to the workshop (T1), immediately after the workshop (i.e., at the end of day-two; T2), and again four, eight, and twelve months following the workshop (T3, T4, and T5 respectively).

A total of 270 caregivers registered for an EFFT workshop and consented to the research study; however, 6 withdrew from the study (although they still attended the workshop), 17 did

not attend the workshop and were dropped from the study, and 4 attended only one day of the workshop (i.e., due to scheduling conflicts or illness) and were dropped from the study. Figure 1 illustrates the data collection procedure and presents the number of cases with available data at each study time-point. Because data collection is ongoing, this thesis utilized the data that was available from each of the study time-points as of November 2018.

Measures

Child emotion regulation. Caregivers rated their child's ability to regulate their emotions using the Emotion Regulation Checklist (ERC; Shields & Cicchetti, 1997), which was developed for children ages 6 to 12. A 24-item questionnaire utilizing a 4-point Likert scale (1=Never; 2=Sometimes, 3=Often; 4=almost always), the ERC yields two subscales: The Negativity/Lability scale (relating to negative affect and mood lability) and the Emotion Regulation scale (relating to adaptive emotion management, includes factors like empathy and equanimity). The Negativity/Lability scale consists of 15 items (e.g., "Exhibits wide mood swings" and "Is easily frustrated"), whereas the Emotion Regulation subscale has eight items (e.g., "Can say when s/he is feeling sad, angry or mad, fearful or afraid"). Both subscales are calculated by summing relevant items, some of which are reverse scored. Negativity/Lability subscale scores range from 15 to 60 (derived from 15 items), with higher scores indicating greater emotional lability and dysregulation. Scores on the Emotion Regulation subscale range from 8 to 32 (derived from 8 items), with higher scores indicating greater emotion regulation. Reliability coefficients are high overall and for the two subscales, with coefficients of 0.96 and 0.83 for Negativity/Lability and for Emotion Regulation, respectively (Shields & Cicchetti, 1997). Both convergent and discriminant validity have been examined; the ERC is correlated to observer ratings of child emotion regulation and differentiated from other emotion-related constructs (Shields & Cicchetti, 1997). The ERC was found to have good-to-strong internal

consistency in the current sample across all study time-points; alpha coefficients ranged from α = 0.87 to α = 0.90 for the Negativity/Lability scale, and from α = 0.75 to α = 0.76 for the Emotion Regulation scale.

Child clinical symptomatology. The Strengths and Difficulties Questionnaire was used to measure child clinical symptomology (SDQ; Goodman, 1997). This 25-item screening questionnaire assesses the general mental health of children, aged 2-17 years, generating five sub-scales comprising five items each: emotional symptoms (e.g., "Often unhappy, depressed, or tearful"), conduct problems (e.g., "Steals from home, school, or elsewhere"), hyperactivity-inattention (e.g., "Easily distracted, concentration wanders"), peer problems (e.g., "Has at least one good friend"), and prosocial behaviour (e.g., "Helpful if someone is hurt, upset, or feeling ill"). Item selection was based on the DSM-IV (American Psychiatric Association, 1994) and the International Classification of Diseases 10th Revision (World Health Organization, 1994) classifications of childhood psychopathology, targeting both positive and negative child attributes. Nearly identical parent-report, teacher-report, and self-report versions are available for use in both clinical assessment and research. For this study, the SDQ was completed by caregivers, who rated each item on a 3-point Likert scale (0=Not True; 1=Somewhat True; 2=Certainly True), indicating how much each item applied to their child (Goodman, 1997; Goodman and Scott, 1999). Subscale scores range from 0 – 10. The scores on the subscales (excluding prosocial behaviours) may further be added into a total difficulties score, with a range from 0 – 40. An extended version of the SDQ was used in the current study which includes an Impact Supplement that asks caregivers about the chronicity of, as well as the degree of difficulty or distress caused by, the child's difficulties. The supplement also measures the extent to which the child's difficulties interfere with the child's daily life across several domains (e.g., home life and classroom learning) as well as the burden the child's struggles have placed on the

parent and or family as a whole. Past research has reported a Cronbach's alpha of α = 0.83 for Total Difficulties, α = 0.63 – 0.77 for the four subscales, and α = 0.46 for peer problems (Bourdon et al., 2005). Reliability analyses with the current sample indicated adequate-to-strong internal consistency across all study time-points for the emotional difficulties (α = 0.73 – 0.82), conduct problems (α = 0.69 – 0.75), hyperactivity-inattention (α = 0.79 – 0.85), prosocial behaviour (α = 0.69 – 0.81), and total (α = 0.74 – 0.85) subscales, and poor-to-adequate internal consistency for the peer problems subscale (α = 0.55 – 0.74).

Parental reflective functioning. It is argued that reflective functioning enables a parent to step back from his or her own feelings and thoughts in order to reflect on his or her child's uniquely subjective experiences and intentions. This metacognitive ability is thought to be especially important during times of stress or conflict, allowing the parent to regulate his or her child's affect by responding sensitively (Fonagy, Target, Gergely, & Jurist, 2002). As such, building the capacity for reflective functioning may be a vital contributor to the outcomes of family therapy. Given EFFTs focus on teaching parents how to validate their child's experiences and become their child's emotion coach, we anticipated that parents' reflective capacity would improve through EFFT.

Caregivers' capacity to mentalize within the parenting context was measured using the Parent Reflective Functioning Questionnaire (PRFQ; Luyten, Mayes, Nijssens, & Fonagy, 2017), a multidimensional assessment of parental reflective functioning that is based on the work of Peter Fonagy (Fonagy et al., 2016). There are two forms of the scale, one designed for children under 5 years of age, and another for children ages 12 to 18. Because this novel measure is currently the only paper-pencil measure of parental mentalization available, we expanded its use for all children in our sample. Using the PRFQ, participants were asked to rate a series of 18 statements that tap into a caregivers' curiosity about their child's internal world and the degree to

which the caregiver tries to make sense of their child's behaviour in terms of those internal experiences. The statements are rated using a 7-point Likert scale (ranging from 1=Strongly Disagree to 7=Strongly Agree) and yield three subscales (each comprising 6 items) that are obtained by calculating the average response across subscale items. The Pre-Mentalizing subscale captures non-mentalizing ways of thinking, whereby higher scores indicate a greater struggle to understand and interpret the child's mental experiences accurately. Items within this subscale include: "My child sometimes gets sick to keep me from doing what I want to do" and "When my child is fussy, he or she does that just to annoy me." The Certainty About Mental States subscale is designed to tap into a caregiver's understanding of the opaqueness of mental states. Subscale items include: "I always know why my child acts the way he or she does" and "I can always predict what my child will do." Finally, the Interest and Curiosity subscale assesses a caregivers' curiosity about their child's internal world and a desire to take their child's perspective. Items include: "I like to think about the reasons behind the way my child behaves and feels" and "I am often curious to find out how my child feels." Psychometric evaluations of the PRFQ have shown good internal consistency across the subscales, with α =.70 for Pre-Mentalizing, $\alpha = 0.82$ for Certainty about Mental States, and $\alpha = 0.74$ for Interest and Curiosity in mental states (Luyten et al., 2017; Rutherford et al., 2013). In terms of construct validity, the PRFQ has been correlated with parental attachment, emotional availability, and parenting stress and distress, as well as infant attachment status assessed by the Strange Situation (Luyten et al., under review; Rutherford et al., 2013). Reliability analyses with the current sample indicated adequate internal consistency across all study time-points for Interest and Curiosity ($\alpha = 0.74 – 0.79$) and Certainty about Mental States ($\alpha = 0.72 – 0.78$), and weak internal consistency for the Pre-Mentalizing subscale ($\alpha = 0.48 – 0.56$).

Parental self-efficacy. Using a revised version of the Parent versus Anorexia Scale (PvA; Rhodes, Baillie, Brown, & Madden, 2005) called the Parent versus General Mental Health (PvGMH), caregivers reported the degree of self-efficacy they felt within the context of supporting their child's recovery from any mental health concern. Because the scale was originally developed for use within the context of anorexia (Rhodes et al., 2005), the revised version of the questionnaire used in the present study replaces the word "anorexia" with "general mental health difficulties." The scale is made up of seven items that are rated on a five-point Likert scale (1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly Agree). A total score is derived that can range from 7 to 35, whereby higher scores indicate higher levels of self-efficacy. A sample item is "I feel equipped with specific strategies for the task of bringing about the complete recovery of my child in the home setting." The PvA scale has demonstrated adequate psychometric properties, with an internal reliability coefficient of 0.78 and significant positive correlations with conceptually similar measures of internal control (Rhodes et al., 2005). In this study, reliability coefficients ranged from $\alpha = 0.51$ to $\alpha = 0.71$ across all time-points.

Caregiver emotion blocks. The Parent Traps Scale (PTS; Lafrance Robinson, 2014) is a measure designed to assess caregivers' vulnerabilities to common emotion blocks. It captures the extent to which parents feel vulnerable to fears that interfere with their ability to support their child's recovery. Item development was based on clinical experience and feedback from parents regarding their concerns about supporting their child's recovery from anorexia. Caregivers rate the extent to which they feel vulnerable to 14 different fears when supporting their child's recovery (e.g., "Fear of being rejected by my loved one" and "Fear of breaking down or burning out throughout the process") using a seven-point Likert scale (ranging from 1=Not Likely to 7=Extremely Likely). The measure yields a total score that can range from 14 to 98, with higher scores denoting higher levels of caregiver fear. Past research has reported a Cronbach's alpha

ranging from α = 0.71 (Stillar et al., 2016) to α = 0.90 (Lafrance Robinson et al., 2014). In the current study, Cronbach's alpha ranged from α = 0.90 to α = 0.93 across all time-points, indicating strong internal consistency.

Analyses

The Type I error rate of α = 0.05 was used for all analyses, which were conducted in R (R Core Team, 2015).

Normality and Outliers. The distribution of each variable at each of the study-time points was examined (i.e., data were visualized using box-plots, histograms, and Q-Q plots) to verify normality and to identify any univariate or multivariate outliers. Univariate outliers were identified on the Emotion Regulation (at the registration and post-treatment time-points) and Negativity/Lability (at the pre-treatment and 8-month follow-up time-points) subscales of the ERC, the Certainty about Mental States (at the pre-treatment and 12-month follow-up time-points), Interest and Curiosity (all time-points), and Pre-Mentalizing (all time-points) subscales of the PRFQ, the Total (at the 4-month follow-up), Conduct (at the 8-month follow-up) and Peer Problems (at the time of registration and at the 4- and 12-month follow-ups) subscales of the SDQ, as well as on the Parent versus General Mental Health scale (at all time-points). All outliers were retained in subsequent analyses because they were deemed clinically relevant (i.e., although extreme, these scores reflected true, clinically elevated symptoms in our clinical sample). Moreover, our results were not altered upon removal of the outliers.

In terms of the distribution of variables, the Pre-Mentalizing scale of the PRFQ showed evidence of skewedness (positive) across some of the time-points. This reflects the low frequency with which parents endorsed malevolent attributions to their child's behavior — a severe form of poor mentalization. Additionally, the Interest and Curiosity subscale of the PRFQ was somewhat negatively skewed across several study time-points and the Negativity/Lability

subscale was significantly positively skewed at the 8-month follow-up. Nonetheless, the original data were retained because these distributions were not skewed for all time points and because skewness was not severe.

Missing Data. Missing data occurred because caregivers: (1) missed individual items on a questionnaire, (2) did not return a questionnaire package at a particular time-point, (3) directly withdrew from the study or became unresponsive during the follow-up period, and/or (4) had not yet reached a specific time-point when the data were examined for this thesis (November 2018; see Figure 1).

Responses for each variable were used *if* at least 75% of the questionnaire or subscale items had been completed by participants. Among those who partially competed a questionnaire, there was only one instance in which more than 25% of the items on a particular questionnaire had been missed by a participant; that participant's score on that scale was not calculated. Variables comprised both mean and total scores. When item-level responses were missing on scales comprising total scores, scores were adjusted using mean replacements (i.e., using the average response across all other items within a particular scale or subscale).

Missing data (i.e., entire scales or time-points) were evaluated using the maximum likelihood method, which yields unbiased and efficient parameter estimates with larger samples compared to data imputation and listwise deletion (Raudenbush & Bryk, 2002). Assuming that data are missing at random (that is, missingness is not depended on the missing variable), maximum likelihood estimates allow for model fit across all cases by using available data to infer probable values for missing data.

Group Equivalence: Comparison of Groups at the Time of Registration

The two intervention groups (i.e., AAI-enhanced vs. standard EFFT) were compared at baseline (T0) to confirm equivalence and to rule out any significant differences between them in

terms of demographics, presenting concerns, or baseline symptomolgy and functioning (i.e., scores on the baseline questionnaires) that would pose a threat to the study's validly. Background characteristics on continuous measures were analyzed using *t*-tests. Differences between-groups on categorical variables were analyzed with Chi-Square tests of independence.

Hypothesis Testing: Mixed Effects Modeling

Mixed effects modeling was used to examine how completing an AAI prior to EFFT impacted treatment outcome as well as the overall effectiveness of EFFT, thus answering both research questions. There are several advantages to using this method. First, it allows for the assessment of individual differences in growth trajectories (Raudenbush & Bryk, 2002). Second, it allows researchers to examine dependent (or nested) data. In longitudinal designs with repeated-measures, observations across time are often correlated (Nezlek, 2008). Furthermore, because about half of the caregivers in this study comprised co-parenting units, the parent-reported child data in this study were not independent (Kenny, Kashy, & Cook, 2006). Non-independent data increases the Type I error rate in ordinary least squares techniques. Mixed effects modeling circumvents issues related to dependency by accounting for the nested nature of grouped and repeated measures data (Raudenbush & Bryk, 2002). Third, and as already described, mixed effects modeling allows for the inclusion of cases with missing data.

First, between-group differences on each of the parent (PRFQ subscales and the PvGMH and PTS total scores) and child (ERC and SDQ subscale scores) variables were examined between the time of registration (T0) and pre-treatment (T1) in order to assess if completing an AAI had an isolated impact (i.e., a stand-alone impact) on parent-reported scores before treatment started. Then, between-group differences on all child and parent outcome variables were examined, entering all of the six study time-points into the mixed effects model. It became clear when visualizing these data (i.e., including all six study time-points in the mixed effects

model) that the assumption of linearity had been violated; however, the assumption of linearity did hold when examining change trajectories between the T0 and T2, T2 and T3, and T3 and T5 time frames. This was because the trajectory of change (for both intervention groups) varied depending on what was happening during a particular study time frame (i.e., change when waiting to start treatment looked different than change during treatment, and both of these change trajectories were different than the trajectory of change during the follow-up period). This observation lined up with our expectations around *when* change would occur, which were based on a previous study of EFFT (Foroughe et al., 2018). Therefore, we compared the change trajectories for the two intervention groups during these specified time intervals. That is, separate mixed effects models were conducted examining changes in each of the outcome variables at T0 to T2, T2 to T3, and T3 to T5. Note that in all of the models run for this thesis, only the intercepts were allowed to vary. Results are reported below.

Calculating Effect Size. The literature suggests that simple or unstandardized effect sizes (e.g. the raw difference in means or an unstandardized slope coefficient) tend to be more meaningful, robust, and versatile than standardized effect sizes (Baguley, 2009). Thus, we report unstandardized effects sizes for the mixed effects models run as part of this thesis. As such, the effect sizes reported are scaled based on the original units of analysis.

Results

Group Equivalence: Comparison of Groups at the Time of Registration

An independent samples *t*-test revealed a statistically significant difference in parent age between the AAI-Enhanced ($M = 43.84$, $SD = 7.53$) and Standard EFFT ($M = 46.02$, $SD = 7.65$) treatment groups, $t(230) = 2.18$, $p = .030$; however the effect size was small ($d = 0.29$). No other significant differences were found regarding sample demographics. See Tables 1 and 2 for a summary of parent and child demographics, respectively. In terms of baseline (T0) parent-

reported scores on child and parent outcome variables, no significant differences were found between the two treatment groups. However, group differences on parent-reported conduct problems on the SDQ approached significance, $t(198) = -1.93$, $p = .055$ (see Table 3); parents in the AAI-enhanced group reported somewhat higher levels of child behavioural difficulties ($M = 3.71$, $SD = 2.2$) than the standard care group ($M = 3.13$, $SD = 2.06$) at the time of registration (a small effect size; $d = -0.27$).

The Impact of the AAI Prior to Treatment (T0 to T1 Comparisons)

We examined if completing an AAI alone (i.e., prior to the start of treatment) resulted in changes in parents' self-reported efficacy and fears, as well as in parent-reported child emotion regulation and symptomology. To do so, we compared the treatment groups on each of the outcome variables, examining change trajectories between the time of registration (T0) and pre-treatment (T1); during which time the AAI-enhanced group completed their interviews and the standard intervention group simply waited to start the intervention. See Table 4 for these results. Across all of the variables there were no significant differences observed between the two treatment conditions with regards to change between T0 to T1. There was a main effect of time on the Interest and Curiosity scale of the PRFQ ($B = -0.22$, $p = .002$), reflecting a very small but significant decrease in parents scores for both groups.

Trajectories of Change from Pre- to Post-Treatment (T0 to T2 Comparisons)

Next, we examined the change trajectories of both intervention groups from the time of registration (T0) to immediately post-intervention (T2) across all of the parent and child outcome variables. These results are presented in Table 5. Significant between-group differences were revealed for child prosocial behaviour ($B = 0.19$, $p = .043$) and conduct problems ($B = -0.20$, $p = .013$), as well as parental self-efficacy ($B = 0.71$, $p = .011$) and parental certainty about mental states ($B = 0.10$, $p = .046$). Overall, the significant interactions were such that the AAI-enhanced

group demonstrated greater improvements compared to the standard intervention group. Effect sizes were mostly small, with a moderate effect size for parental self-efficacy. Specifically, for a one unit increase in time, parental self-efficacy increased by 0.71 points more for the AAI-Enhanced group than for the Standard EFFT group on a 5-point Likert scale with a total score ranging from 7 to 35. Between-group differences on parental pre-mentalizing states (B = -0.07, p = .053) and child emotion regulation (B = 0.31, p = .056) approached statistical significance. The visualized data revealed opposite trajectories for the two intervention groups on these two variables; the AAI-enhanced group demonstrated decreased pre-mentalizing states and increased child emotion regulation, while the opposite was true for the standard intervention group.

In terms of the overall effect of EFFT, significant improvements for both groups were observed across several outcome variables pre- and post-treatment. Significant main effects of treatment were observed on parental interest and curiosity (B = -0.06, p = .042), parental certainty about mental states (B = -0.14, p = .000), parental self-efficacy (B = 2.57, p = .000), and child emotion symptoms (B = -0.16, p = .013). In other words, both groups demonstrated increased parental self-efficacy (although the AAI group demonstrated significantly greater increases than the non-AAI group, as per the interaction described above), decreased child emotion problems, and decreased certainty about mental states (again, with the AAI demonstrating a significantly steeper slope of change). These were all in the direction expected, indicating improvements immediately following treatment. Effect sizes were mostly small; however, the overall magnitude of the effect of EFFT on parental self-efficacy was moderate.

Trajectories of Change 4-months After Treatment (T2 to T3 Comparisons)

Trajectories of change were compared for both intervention groups from post-treatment (T2) to the first follow-up time-point (i.e., 4 months after the EFFT intervention or T3). Again, these comparisons were conducted for all of the parent and child variables. Across all of these

outcome variables, there were no significant differences observed in change trajectories (i.e.,. slopes) between the two treatment conditions.

Several main effects of EFFT were revealed, indicating statistically significant treatment gains for both groups across both parent and child variables in the first 4 months following treatment. Specifically, parents reported significant improvements in their emotion blocks (i.e., fears) and certainty about their child's mental states, as well as significant improvements in their child's total difficulties, emotion symptoms, conduct problems, hyperactivity-inattention, prosocial behaviour, emotion regulation, and negativity/lability. These results are presented in Table 6. Effect sizes ranged from small to large, with a moderate overall effect of EFFT on child total difficulties, emotion regulation, and negativity lability, and a large effect of EFFT on parental emotion blocks.

Trajectories of Change 4 to 12 Months After Treatment (T3 to T5 Comparisons)

Finally, we examined the rate of change for the AAI-enhanced and standard EFFT groups between the 4-month and 12-month follow-ups, running separate mixed effects models for each parent and child outcome variable. These results are presented in Table 7. Interaction terms revealed significant differences between the two intervention groups on several outcome variables, mostly child outcomes. Specifically, statistically significant between-group differences were revealed for parents' certainty about mental states (B = -0.15, p = .024) as well as parent-reported child total difficulties (B = -1.01, p = .004), emotional symptoms (B = -0.53, p = .003), conduct problems (B = -0.31, p = .009), prosocial behaviour (B = 0.35, p = .003), and emotion regulation (B = 0.50, p = .046), with effect sizes ranging from small to moderate. Overall, the significant interactions on each of the child variables were such that the AAI-enhanced group demonstrated greater outcomes compared to the standard intervention group. More specifically, a review of the visualized data revealed that for each of the child variables where the interaction

terms were significant (i.e., total difficulties, emotional symptoms, behavioural difficulties, prosocial behaviour, and emotion regulation) the AAI-enhanced group appeared to continue to make gains from the 4-month follow-up through to the one-year follow-up, whereas the trajectories of change for the standard EFFT on these variables showed either a leveling off in change or small regressions. The visualized data also revealed opposite trajectories for the two intervention groups on certainty about mental states; the AAI-enhanced group had a decrease in scores while the standard workshop group showed an increase. For both groups, the changes in certainty about mental states were small although statistically significant.

Additionally, a main effect of EFFT on child negativity/lability was revealed, indicating significant treatment gains (i.e., decreased child negativity and lability) for both groups on this variable. The trajectories of change for each group were not significantly different from one another.

A summary of the scores (means and standard deviations) for each outcome measure at T0, T3, and T5 is presented by treatment group in Table 8.

Discussion

The objective of this study was twofold: (i) examine the effectiveness of a brief and intensive multi-caregiver Emotion-Focused Family Therapy (EFFT) intervention, and (ii) explore how administering the Adult Attachment Interview (AAI) prior to the EFFT intervention impacts therapeutic outcomes for caregivers and their children following EFFT. Using group randomization, caregivers attended either an AAI-enhanced EFFT workshop or a standard EFFT workshop (i.e., treatment as usual). To our knowledge, this is the first study to empirically assess the clinical benefits of using the AAI as an adjunct to therapy. Additionally, prior to the current study, only one other study had examined the effectiveness of EFFT in treating a wide range of child mental health concerns, examining both parent and child outcomes (Foroughe et al., 2018).

Engaging Parents in the Treatment of Their Child's Mental Illness

Parental involvement has been emphasized as an important ingredient for the effective treatment of child mental illness (Creswell & Cartwright-Hatton, 2007; Downs & Blow, 2013; Foroughe, 2018; Haine-Schlagel & Walsh, 2015; Lock, 2010; Rowe, 2012 for a review), and there is a rapidly growing body of research providing empirical support for this claim (Bratton et al., 2005; Carr et al., 2017; Cohen et al., 2002; Cinamon, 2017; Foroughe & Muller, 2012; Foroughe et al., 2018; Henggeler & Sheidow, 2012; Juffer et al., 2017; Kaslow et al., 2012; Konanur et al., 2015; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015; Rependa et al., 2019; Treasure & Schmidt, 2011; Wade et al., 2011). Generally, active parental involvement appears to improve child outcomes (Dowell & Ogles, 2010; Haine-Schlagel & Walsh, 2015; Coatsworth et al., 2015) and may also increase overall family functioning (Poole et al., 2017). Moving beyond simply involving parents in a child's treatment, recent research suggests that fundamentally shifting the focus of therapy from the role of the therapist to the role of the caregiver in a child's mental health-care leads to greater improvements and lasting outcomes for youth and families (e.g., Foroughe et al., 2018). Much of this work has been done in the area of eating disorders. Family-oriented therapies that work with parents directly, empowering them to become the primary source of support for their children, have consistently resulted in better treatment outcomes and dramatically lowered relapse rates for youth with eating disorders relative to traditional treatment models where the focus is on the therapeutic relationship (Eisler, 2005; Eisler et al., 2007; Girz et al., 2013; Le Grange & Eisler, 2009; Treasure et al., 2008).

Addressing Parental Emotional Blocks

Research shows that how parents respond to their child's distress and mental illness can greatly facilitate or impede a child's resilience and recovery (Bambrah et al., 2018; Bokszczanin, 2008; Cinamon, 2017; Foroughe et al., 2018; Lafrance Robinson et al., 2014; Scheeringa &

Zeanah, 2001; Stillar et al., 2016; Williamson et al., 2016; Wise & Delahanty, 2017; Valentino, Berkowitz, & Stover, 2010). This is also in line with recent neuroscience research indicating that parents act as chief external regulators for their child's strong emotions and behaviour (Hughes and Baylin, 2012; Siegel & Payne Bryson, 2011; Siegel, 2012). Recognizing that parents' emotional responses to their child's difficulties (e.g., shame, fear, guilt, resentment and hopelessness) — which block parents' ability to implement the necessary strategies to support their child's treatment and recovery — often stem from their own painful histories is helpful, and may engender compassion towards parents (Foroughe, 2018; Foroughe & Muller, 2012). In particular, caregiver stress and low caregiver self-efficacy have been shown to stymie treatment outcomes in children with a range of mental health problems (Heath, et al., 2015; Kazdin & Whitley, 2003; Mackler et al., 2015). It follows that directly addressing parents' emotion blocks, in addition to actively involving them in their child's treatment, would aid in a child's recovery process (Foroughe et al., 2018; Lafrance Robinson et al., 2014; Stillar, et al., 2011).

Parent and Child Outcomes Following Brief EFFT: Summary of Findings

Emotion-Focused Family Therapy is a relatively new, transdiagnostic treatment that places parents at the forefront of child mental health-care. It empowers parents with the skills and techniques they need to support their child's recovery. Simultaneously, EFFT directly addresses parents' intense emotional responses to their child's diagnosis or symptomology, liberating them from their emotional blocks, which would otherwise interrupt their ability to follow-through with health-promoting behaviours.

Our findings supported the growing body of research demonstrating positive outcomes following brief group-based EFFT. As predicted, this 2-day intervention resulted in overall reductions in parental fears (i.e., emotional blocks) and improvements in parental self-efficacy. These results are in line with previous evaluations of this intervention, which have demonstrated

significant improvements in parents' feelings about their ability to meet the mental health needs of their child (e.g., Foroughe et al., 2018; Lafrance Robinson et al., 2014). In the present study, improvements in parental self-efficacy were observed immediately following the intervention and were sustained 12 months later. Improvements in parental fears or emotion blocks were observed starting at the 4-month follow-up and were maintained throughout the follow-up period. This finding is important because parental self-efficacy has been identified as a key mechanism of change in the treatment and recovery of child mental illness (Byrne, Accurso, Arnow, Lock, & Le Grange, 2015; Dimitropoulos, Freeman, Lock, & Le Grange, 2015; Foroughe et al., 2018; Lafrance Robinson, McCague, & Whissell, 2012; Lafrance Robinson et al., 2015), and poor parental self-efficacy may be common among parents with a child experiencing mental health difficulties (Foroughe et al., 2018; Lafrance Robinson et al., 2014).

The results regarding changes in parental mentalization were inconsistent across the various time-based analyses conducted. Overall, however, parents experienced increased certainty about their child's mental states from pre-treatment to the 12-month follow-up. Traditionally, a high degree of certainty about mental states is indicative of poor mentalization. While we can try to understand others' behaviours in terms of their internal experiences, strong reflective functioning entails an understanding that we cannot know with absolute certainty what another person's internal world is. A moderate level of certainty is ideal, representing a balance between a person's confidence in their ability to empathise and an understanding of the opaqueness of mental states. Although increases in parents' certainty about mental states between the pre-treatment (M = 3.18, SD = 0.98) and 12-month follow-up time points (M = 3.32, SD = 1.01) were statistically significant, they were quite small, and parents' overall scores remained within the low-to-moderate range of the PRFQ scale (i.e., an average score of 3 on a scale ranging from 1 to 7, where 1 = Strongly Disagree and 7 = Strongly Agree). Therefore, we

interpret this increase in parents' certainty about their child's mental states as a reflection of parents' increasing self-efficacy with regards to their ability to support their child's mental health following the EFFT intervention.

The brief EFFT intervention also resulted in significant improvements in child symptomology and emotion regulation overall. Most of these gains occurred within the first four months following treatment (this is true when looking at the effect of EFFT more generally; important differences between the AAI-enhanced and standard EFFT groups are discussed below). Improvements in parent-reported child emotional symptoms were observed immediately after the intervention, while improvements in child total difficulties, emotional symptoms, conduct problems, hyperactivity-impulsivity, prosocial behaviour, emotion regulation, and negativity/lability were observed beginning at the 4-month follow-up. This was in line with our hypothesis regarding *when* child treatment outcomes would be observed. Following a 2-day EFFT workshop, parents need time to implement the emotion and behaviour coaching skills they have learned, and to repair any ruptures within their relationship with their child. This was reflected in our data, which showed that improvements in child symptomolgy occurred (primarily) at the 4-month follow-up and not immediately following treatment.

There are several benefits to delivering EFFT in a multi-caregiver group format. As parents take turns working through emotionally intense experiential activities, other caregivers observe, allowing for vicarious learning. This may be especially valuable for parents who are avoidant of emotion and/or who may not volunteer to participate in the experiential exercises during the workshop, as they may still benefit from observing other parents process their own intense and difficult emotions. Additionally, the workshop setting fosters social support and acceptance among parents, which may in turn lead to more positive parental self-reflection, greater self-efficacy, and lower levels of parenting stress (Levac et al., 2008). This is important given that

parental self-efficacy has been associated with parents' willingness and ability to implement recovery-focused strategies with their children (e.g., Jones & Prinz, 2005; Strahan et al., 2017). Additionally, as suggested by Yalom (2005), hearing other parents describe and work through their difficult feelings and experiences may help parents see that they are not alone in their struggles, normalizing their experiences and giving them a sense of belonging. Yalom also suggests that sharing feelings and experiences with others in a safe and containing environment can help relieve pain, guilt, and stress (2005).

The Adult Attachment Interview as a Therapeutic Enhancer: Summary of Findings

Although the AAI was originally developed for research purposes, it has been widely adapted by clinicians, and it has been suggested that administering the AAI for clinical purposes can facilitate the therapeutic process (Steele & Steele, 2010). However, to our knowledge, no studies have directly tested the benefits of using the AAI as an adjunct to therapy. We hypothesized that administering the AAI to parents prior to EFFT would facilitate parental responsiveness to the therapeutic process, resulting in enhanced outcomes for both parents and their children. Overall, this hypothesis was supported by the data.

We examined if simply completing an AAI would have an impact on parents' self-reported efficacy and fears, as well as on parent-reported child emotion regulation and symptomology. The AAI-Enhanced and Standard EFFT treatment groups were compared across the registration and pre-treatment time-points, during which time the AAI-Enhanced group completed their interviews and the Standard intervention group simply waited to start the intervention. The data revealed that neither group changed significantly during this time-frame, nor did the two groups differ from each other. This suggests that simply activating the attachment system using the AAI, calling to mind early childhood memories and arousing parents' emotions, is not therapeutic in and of itself.

Between-group differences were observed when examining change trajectories for the AAI-enhanced and standard EFFT intervention groups from pre-treatment to post-treatment. The AAI-enhanced group experienced significantly greater improvements compared to the standard intervention group with regards to parental self-efficacy, parental certainty about mental states, child conduct problems, and child prosocial behaviour; however, the effect of the AAI was small for each of these variables during this time frame.

When comparing change trajectories from post-treatment to the first follow-up (i.e., four months following therapy), the intervention groups were not statistically different. This was the only time frame where there were no significant differences between the AAI-enhanced and standard care groups. During this time, both groups demonstrated significant gains across a range of parent and child outcomes following EFFT (described earlier), with small to moderate effect sizes. Our results showed that the greatest between-groups differences occurred later in the follow-up period (i.e., between 4 and 12 months after therapy). Most of these differences were with regards to parent-reported child outcomes, such that the AAI-enhanced group demonstrated significantly greater improvements in child total difficulties, emotional symptoms, behavioural difficulties, prosocial behaviour, and emotion regulation compared to the standard intervention group. Our data showed that while the AAI-enhanced group continued to make gains after the 4-month follow-up, through to the one-year follow-up, the rate of change for the standard EFFT group on these variables either plateaued or regressed (non-significantly).

There are a few possibilities as to why between-group differences were observed primarily during the later study follow-up periods. First, sleeper effects are not uncommon in treatment effectiveness studies, whereby the impact of a treatment is seen most clearly at follow-up compared to immediately post-intervention (Fonagy, 2003). Second, there may have been a methodological limitation at play — a ceiling effect. Because EFFT alone was so impactful,

especially within the first 4 months following the intervention, a ceiling effect may have made it difficult to detect between-group differences during that time frame, specifically.

Taken together, our findings suggest that, while the AAI is not a treatment in and of itself, conducting AAIs with clients before treatment may set the stage for effective engagement and processing during therapy. Simply activating the attachment system and arousing parents' emotions is not enough to elicit therapeutic change. However, this emotional activation may intensify parents' experiencing during therapy, which may in turn lead to deeper emotional processing and consequently better outcomes for parents and their children in the long-run. This is in line with the emphasis placed on the role of emotional arousal and emotional experiencing in experiential treatments (Bridges, 2006; Pos et al., 2017). As such, we propose that the AAI acted as a catalyst, leading to deeper engagement in the therapy process and consequently enhanced treatment outcomes for caregivers and their children following EFFT.

Steele & Steele (2008) suggest that administering the AAI helps establish a therapeutic alliance and shared goals for therapeutic work, as well as provides a source of understanding and motivation to facilitate the therapeutic process. We propose that the AAI prepares clients for effective therapeutic work and emotional processing in other important ways. For example, it indirectly communicates to clients that speaking about emotional and relational experiences is part of the therapy process and that their personal and emotional experiences are important. Additionally, by the very nature of its questions, the AAI facilitates thoughtful reflection and meaning making. It asks about past attachment experiences and the impact of those experiences on current personality and present-day relationships. By having clients complete an AAI prior to therapy, we are asking them to tap into feelings and memories that are often below the surface of their conscious awareness. Thus, especially within the context of EFFT, the AAI readies parents to more easily make connections between their own childhood experiences and their current

relationship with their child. We posit that this readiness results in deeper processing of emotional content (i.e., parent emotion blocks) during experiential exercises. In other words, conducting the AAI prior to therapy encourages clients to think critically about potential patterns within relationships and to become more cognizant of links between their own present-day parenting, and the way in which they were parented in the past.

Pairing the AAI and EFFT for this study was a natural step. Given the theoretical overlap between the AAI and the EFFT model, we felt that the AAI was especially well suited to the process-oriented work parents participate in as part of the EFFT workshop. Recall that EFFT acknowledges that parents' emotional responses to their child's difficulties (i.e., their emotion blocks) stem from their own histories of intrafamilial trauma and painful attachment experiences. By helping parents process their emotional blocks *and* repair their relationship with their child, EFFT holds the potential to disrupt the intergenerational cycle of insecurity and trauma, which has so clearly been demonstrated through cross-generational attachment studies using the AAI (Main et al., 1985; van Ijzendoorn, 1995; Steele & Steele, 2008).

Limitations and Future Directions

Notable strengths of this research include the repeated-measures long-term follow-up of a large sample of caregivers (and their clinically impaired children) and the group randomization of AAI-Enhanced and Standard EFFT. Nevertheless, the current findings should to be considered within the context of a few limitations.

First, our data were derived entirely from parental reports, which are susceptible to known biases associated with self-report data (Furnham, 1986). It is likely that the improvements in child emotion regulation and symptomology observed in this study reflect some combination of real changes in the child (resulting from parents' implementation of the relationship repair and coaching techniques learned during the intervention) as well as changes in parents' experiences

and perceptions of their child. We imagine that, as parents' own fears and self-efficacy improved, so too did their tolerance of their child's distress and maladaptive coping behaviours. This is in line with the work Kroes et al. (2003), who have studied the impact of parents' own psychopathology on their ratings of their child's difficulties. Nonetheless, given that the intervention studied was an intervention for caregivers, parent-reported data provided an important perspective on change following therapy. Still, future studies should collect data from other informants, including teacher reports of child behaviour or clinician observations. Child reported data would also greatly enhance our understanding of the shifts that happen within the parent child relationship following EFFT, giving us a sense of what parents are doing differently and how children respond from the perspective of the child. Additionally, information regarding child presenting concerns and/or diagnoses were provided by parents in this study. Confirmation of child presenting concerns from a healthcare professional familiar with the child would have been helpful.

Second, the Parental Reflective Functioning Questionnaire (PRFQ; Luyten et al., 2017) was selected for this study as it is currently the only available paper-and-pencil option for measuring parents' mentalization of their child. Because it is a newer measure, further work is needed to examine its psychometric properties. This includes examining and/or adapting the use of the PRFQ for children falling outside of the age-ranges specified for the child (i.e., 0 to 5 years) and adolescent (i.e., 12 to 18 years) versions of the questionnaire. In our study, the PRFQ was administered to all parents, regardless of their child's age (i.e., 4 months to 26 years). Further analyses should be conducted to examine if excluding those parents with children who fell outside of the specified age ranges would change our results. The low frequency with which parents endorsed pre-mentalizing states (i.e., malevolent attributions to their child's behavior) may have contributed to the weak internal consistency observed on this subscale within our

dataset. Future studies should also make use of other methods of assessing parental reflective functioning, such as the gold-standard method of coding mentalization using AAI transcripts (Reflective Functioning Scale or RFS; Fonagy, Target, Steele, & Steele, 1998).

Third, the clinical psychologist who led all of the EFFT workshops was also a primary investigator of the study. Having a certified EFFT trainer, who was directly trained and supervised by the co-founders of EFFT, lead the workshops meant better adherence to the EFFT treatment model. However, due to practical constraints (e.g., limited clinical space) the workshop facilitators were not blinded to treatment condition, which may have introduced bias. Future studies should implement a blinded randomized design.

Fourth, for the current analyses, information regarding whether or not a family (i.e., a caregiver and/or child) accessed additional mental health services during the time of the study was not available. This represents a possible confounding variable that should be considered as we continue investigating the effectiveness of the multi-caregiver EFFT intervention. It is worth noting, however, that the EFFT caregiver workshops are not necessarily meant to be stand-alone interventions. Although for some parents attending this brief multi-caregiver EFFT group may be enough to produce the change they need, for others, concurrent or additional services may be required. Additionally, with regards to our comparison of the two intervention groups, the group randomization process should have mitigated the risk of any systematic differences between the groups with regards additional services received. Nonetheless, this is an important consideration and efforts are currently underway to collect this information from the caregivers who participated in this study.

Fifth, as this study utilized the data that were available prior to the end of the study follow-up period (i.e., data were pulled early November 2018, but follow-up data collection is ongoing until September 2019), the number of cases with available data at each subsequent time-point

(i.e., T4 and T5) decreased (see Figure 1). Thus, the analyses conducted for this thesis will be re-run prior to publication, once all follow-up data has been collected. Given the strength of our findings and the consistency of the patterns observed, we anticipate similar findings at that time.

In terms of future directions, research examining the process of change in EFFT would be helpful and may identify processes of parental engagement throughout EFFT that predict better outcomes. For experiential treatments like EFT and EFFT, emotional processing is considered an important change process and therefore promoting emotional processing is a central aim of therapy (Pos & Greeberg, 2007; Pos et al., 2017). Indeed, several studies of EFT for depression have demonstrated that the depth of emotional experiencing in therapy is a robust predictor of treatment outcomes (Goldman, Greenberg & Pos, 2005; Pos, Greenberg, Goldman, & Korman, 2003; Pos, Greenberg, & Warwar, 2009). One study also showed that clients' level of emotional processing deepened following EFT (Pos et al., 2003). To the best of our knowledge, there are no reports in the literature regarding experiencing in EFFT. Our research team is currently working to code the depth of emotional experiencing observed during the EFFT workshops in the current sample.

Finally, the current findings regarding the impact of administering the AAI on treatment outcomes following EFFT need to be replicated in studies of other interventions. Although it is anticipated that the AAI would deepen clients' engagement with the therapy process and consequently enhance therapeutic outcomes across therapy modalities, care should be taken when generalizing conclusions based on this initial study. Additionally, future research should examine the mechanisms through which the AAI-enhances therapy. We hypothesize that the AAI facilitates deeper levels of emotional experiencing and processing during therapy and that it is this deeper processing that leads to enhanced treatment outcomes.

Implications and Contributions to the Literature

The results of the current study underscore the value of working with parents who are supporting a child with mental illness. The clinical importance of attending to caregiver fears in the service of reducing child psychosocial symptoms has been stressed by others (Foroughe et al., 2018; Lafrance Robinson, 2014; Stillar et al., 2016). This study showed that a 2-day intervention involving only parents and directly targeting parental self-efficacy led to significant improvements in parental self-efficacy *and* child symptoms, including child behavioural and emotional symptoms (as reported by parents). Deficits in emotion processing and regulation have been posited as the underlying thread in all mental health difficulties (Cicchetti, Ackerman, & Izard, 1995; Zeman, Shipman, & Suveg, 2002; Broome, He, Iftikhar, Eyden, & Marwaha, 2015). EFFT aims to improve child clinical outcomes, regardless of the child's age or diagnosis, by increasing *caregivers'* capacity to process emotional experiences (their own and that of their child), while also cultivating caregivers' skill in symptom interruption. The idea is that with increased attunement and emotional support from their caregiver, a child can better manage their strong negative emotions and adopt more adaptive coping strategies. Notably, we found significant increases in child emotion regulation following caregivers' participation in the EFFT intervention.

While EFFT is a transdiagnostic intervention, there remains a paucity of research assessing its effectiveness in treating a wide range of child mental health concerns. Furthermore, few studies have examined both changes in parental self-efficacy and child symptomology following therapy. Thus, this study contributed meaningfully to the current literature by examining both parent and outcomes in a large clinical sample which was followed for a full-year after treatment.

This is the first study to provide empirical support for the claim that administering the AAI enhances the therapy process and has clinical benefits for clients. On its own, EFFT is a powerful

intervention. The current findings showed that administering the AAI prior to EFFT resulted in even greater gains immediately following treatment. Perhaps more notably, parents who received AAI-enhanced EFFT reported continued improvements in their child's symptoms throughout the follow-up period. This was not the case for the standard EFFT group, whose gains often tapered off. We hypothesize that completing the AAI led to several process level changes, such as deeper levels of emotional processing during experiential work. We also wonder if perhaps these parents (i.e., the AAI-enhanced group) internalized the EFFT techniques differently or more effectively quieted their emotion blocks. Whatever the mechanism (which, would be a target of future research), something unique happens within the parent and between the parent and their child when the AAI is combined with EFFT, resulting in continued gains after treatment.

Conclusion

Fee-for-service policies and long waitlists at many Canadian mental health agencies pose significant barriers for children, adolescents, and families in need of psychological support. In Ontario, approximately 36% of parents have sought mental health services for a child, but four in ten did not receive the help they needed (MHASEF Research Team, 2015; Ipsos Public Affairs, 2017). One way to improve access to mental health services in Canada is to develop and deliver brief and effective psychotherapy.

Based on the current findings, multi-caregiver EFFT groups appear to be an effective and cost-efficient option for families in need. Parents of children of all ages, presenting with a variety of mental health concerns, may benefit from this brief intervention, regardless of whether their child is on a waitlist for treatment, actively receiving treatment, or refusing treatment. Even when children are not directly involved in treatment, working directly with parents may lead to improved child emotion regulation and overall symptom relief.

On its own, EFFT is powerful. When coupled with the AAI, parents and their children may experience continued and lasting improvements well after the workshop is over. If the pattern of results demonstrated here holds true when combining the AAI with other interventions, as we expect that it will, then the clinical implications for effective and efficient treatment are clear. Taking the time to conduct an AAI at the start of therapy may facilitate the process and outcomes for clients.

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Table 1
Baseline Demographics by Treatment Condition

	Treatment Condition	
Demographic	AAI-Enhanced EFFT	Standard EFFT
Mean Parent Age (SD)*	43.84 (7.53)	46.02 (7.65)
Parent Gender		
Female (%)	68.2%	69.5%
Male (%)	31.8%	30.5%
Household Income[a]		
$0 – $20,000	2.8%	3.8%
$21,000 – $40,000	8.3%	3.1%
$41,000 – $60,000	6.4%	4.7%
$61,000 – $80,000	5.5%	3.8%
$81,000 – $100,000	8.3%	6.2%
$101,000+	45.9%	46.9%
Preferred not to respond	22.8%	31.5%
Highest Education Obtained		
Postgraduate Degree (%)	47.2%	47.3%
Some Postgraduate Training (%)	4.7%	4.7%
Undergraduate/College Degree (%)	45.3%	38.8%
Trade/Technical/Vocational Training (%)	0.0%	1.6%
Some Undergraduate/College Training (%)	1.9%	4.5%
High School Graduate (%)	0.9%	2.3%
Some High School (%)	0.0%	0.8%
Marital Status		
Never married (%)	1.8%	4.6%
Married/Common Law (%)	76.8%	73.3%
Widowed (%)	0.9%	0%
Parents Separated (%)	7.1%	5.3%
Parents Divorced (%)	8.0%	12.2%
Preferred not to respond	5.4%	4.6%
Attended with a Co-parent (%)	64.3%	58%
Relationship to Child		
Biological Mother	63.6%	63.0%
Biological Father	29.1%	29.1%
Adoptive Mother	2.7%	3.1%
Adoptive Father	1.8%	0.0%
Step Mother	0.0%	0.8%
Step Father	0.9%	0.8%
Foster Mother	0.0%	1.6%

Table 1 *(Cont'd)*

	Treatment Condition	
Demographic	AAI-Enhanced EFFT	Standard EFFT
Grandparent	0.9%	1.6%
Other	0.9%	1.6%
Ethnicity		
Caucasian	89.9%	85.2%
Black	1.8%	3.1%
Hispanic	2.8%	2.3%
Pacific Islander	0.0%	3.1%
European	15.6%	14.8%
West Indian	2.8%	3.9%
Middle Eastern	4.6%	7.0%
East Asian	7.3%	10.9%
South Asian	5.5%	3.1%
First Nations	2.8%	0.8%
Other	0.9%	3.1%
Mean Child Age	10.91 (4.85)	10.74 (4.97)
Child Gender		
Female	53.8%	50.0%
Male	46.2%	50.0%

***** Mean caregiver age significantly differed for the two treatment groups ($t(230) = 2.18$, $p = 0.030$). No other significant differences on demographic characteristics were found between the two groups.

[a]Household income was calculated based on the number of individual households within the sample (n =) and not based on individual participants in order account for cohabiting co-parents.

Table 2
Child Presenting Concerns by Treatment Condition

	Treatment Condition	
	AAI-Enhanced EFFT	Standard EFFT
Mean Number of Concerns (SD)	2.32 (1.06)	2.07 (1.05)
Number of Concerns		
1 (%)	25.2%	36.3%
2 (%)	35.5%	33.1%
3 (%)	23.4%	19.4%
4 or more (%)	15.9%	11.2%
Most Common Presenting Concerns		
Anxiety (%)	41.7%	33.1%
Social/Emotional Difficulties (%)	65.7%	64.5%
Behavioural Dysregulation (%)	39.8%	46.8%
Depression (%)	15.7%	16.1%
Eating Disorder (%)	5.6%	8.9%
Self-esteem (%)	8.3%	4.0%
Trauma (%)	3.7%	4.0%
Previous Diagnosis		
Yes	48.6%	53.9%
No	51.4%	46.1%

Note: The clinical profiles of the children were reported by their caregiver(s) at the time of registration. No formal assessment of the parent or child was completed at the time of registration. There were no significant differences between the groups with regards to child presenting concerns.

Table 3
Comparison of Group Characteristics at Baseline

	t	χ^2	*df*	*p*
Demographics				
Parent Age	2.18		230	.030
Parent Gender		1.07	1	.301
Household Income		5.82	6	.444
Highest Education Obtained		5.02	6	.541
Marital Status		4.04	4	.401
Attended with a Co-parent (%)		0.75	1	.386
Child Age	-0.37		241	.709
Child Gender		0.12	1	.725
Child Presenting Concerns (#)		0.85	1	.358
Parent Outcome Measures				
Pre-Mentalizing (PRFQ)	-0.66		217	.512
Interest and Curiosity (PRFQ)	0.00		217	.998
Certainty About Mental States (PRFQ)	0.12		217	.908
Parental Self-Efficacy (PvGMH)	1.40		218	.161
Parent Emotion Blocks (Parent Traps)	0.04		218	.967
Child Outcome Measures				
Total Difficulties (SDQ)	-0.77		198	.444
Emotional Symptoms (SDQ)	0.36		198	.716
Conduct Problems (SDQ)	-1.93		198	.055
Hyperactivity-Inattention (SDQ)	-1.05		198	.297
Prosocial Behavior (SDQ)	1.63		198	.106
Peer Problems (SDQ)	0.93		198	.352
Emotion Regulation (ERC)	1.65		218	.100
Negativity/Lability (ERC)	-1.52		218	.129

Table 4
T0 to T1 AAI Effects and Group Comparisons

		B	*SE*	*t*	*p*
Parent Outcome Measures					
Pre-Mentalizing (PRFQ)	Time	0.05	0.06	0.88	.378
	Time X Group	-0.05	0.08	-0.57	.567
Interest and Curiosity (PRFQ)	Time	-0.22	0.07	-3.11	.002
	Time X Group	-0.01	0.10	-0.10	.922
Certainty About Mental States (PRFQ)	Time	-0.02	0.07	-0.26	.793
	Time X Group	-0.03	0.10	-0.33	.743
Parental Self-Efficacy (PvGMH)	Time	0.05	0.28	0.17	.862
	Time X Group	0.37	0.40	0.94	.350
Parent Emotion Blocks (Parent Traps)	Time	0.15	1.24	0.12	.907
	Time X Group	-0.73	1.74	-0.42	.674
Child Outcome Measures					
Total Difficulties (SDQ)	Time	-0.50	0.34	-1.48	.142
	Time X Group	0.43	0.46	0.92	.359
Emotional Symptoms (SDQ)	Time	-0.28	0.15	-1.94	.055
	Time X Group	0.26	0.20	1.31	.193
Conduct Problems (SDQ)	Time	-0.12	0.13	-0.98	.328
	Time X Group	-0.13	0.17	-0.72	.474
Hyperactivity-Inattention (SDQ)	Time	-0.11	0.17	-0.67	.504
	Time X Group	-0.03	0.24	-0.11	.910
Prosocial Behavior (SDQ)	Time	0.08	0.14	0.57	.568
	Time X Group	0.06	0.19	0.30	.767
Peer Problems (SDQ)	Time	0.05	0.14	0.36	.721
	Time X Group	0.30	0.19	1.56	.121
Emotion Regulation (ERC)	Time	-0.06	0.24	-0.24	.811
	Time X Group	0.56	0.33	1.70	.091
Negativity/Lability (ERC)	Time	-0.40	0.40	-0.99	.325
	Time X Group	-0.34	0.56	-0.60	.547

Note: Results of the Mixed Effect Model comparing treatment groups on each of the outcome variables, examining change trajectories between the time of registration (T0) and pre-treatment (T1); during which time the AAI-enhanced group completed their interviews and the standard intervention group simply waited to start the intervention.

Table 5
T0 to T2 EFFT Effects and Group Comparisons

		B	*SE*	*t*	*p*
Parent Outcome Measures					
Pre-Mentalizing (PRFQ)	Time	0.01	0.03	0.39	.695
	Time X Group	-0.07	0.04	-1.94	.053
Interest and Curiosity (PRFQ)	Time	-0.06	0.03	-2.04	.042
	Time X Group	0.02	0.05	0.47	.637
Certainty About Mental States (PRFQ)	Time	-0.14	0.03	-4.20	.000
	Time X Group	0.10	0.05	2.00	.046
Parental Self-Efficacy (PvGMH)	Time	2.57	0.19	13.79	.000
	Time X Group	0.71	0.27	2.57	.011
Parent Emotion Blocks (Parent Traps)	Time	-0.40	0.61	-0.65	.516
	Time X Group	0.60	0.90	0.67	.504
Child Outcome Measures					
Total Difficulties (SDQ)	Time	-0.17	0.15	-1.14	.257
	Time X Group	-0.12	0.21	-0.58	.564
Emotional Symptoms (SDQ)	Time	-0.16	0.07	-2.50	.013
	Time X Group	0.14	0.10	1.46	.144
Conduct Problems (SDQ)	Time	-0.04	0.05	-0.83	.408
	Time X Group	-0.20	0.08	-2.49	.013
Hyperactivity-Inattention (SDQ)	Time	0.01	0.07	0.15	.879
	Time X Group	-0.17	0.11	-1.54	.124
Prosocial Behavior (SDQ)	Time	0.01	0.06	0.21	.832
	Time X Group	0.19	0.09	2.03	.043
Peer Problems (SDQ)	Time	0.03	0.06	0.58	.560
	Time X Group	0.10	0.09	1.14	.254
Emotion Regulation (ERC)	Time	-0.13	0.11	-1.22	.222
	Time X Group	0.31	0.16	1.92	.056
Negativity/Lability (ERC)	Time	0.01	0.17	0.03	.975
	Time X Group	-0.42	0.26	-1.61	.107

Table 6
T2 to T3 EFFT Effects and Group Comparisons

		B	*SE*	*t*	*p*
Parent Outcome Measures					
Pre-Mentalizing (PRFQ)	Time	-0.09	0.06	-1.56	.121
	Time X Group	0.07	0.08	0.87	.386
Interest and Curiosity (PRFQ)	Time	0.09	0.07	1.18	.239
	Time X Group	-0.14	0.10	-1.40	.164
Certainty About Mental States (PRFQ)	Time	0.34	0.08	4.15	.0001
	Time X Group	-0.08	0.12	-0.66	.511
Parental Self-Efficacy (PvGMH)	Time	-2.21	0.36	-6.09	.0000
	Time X Group	0.36	0.52	0.70	.484
Parent Emotion Blocks (Parent Traps)	Time	-5.70	1.46	-3.91	.0001
	Time X Group	-2.05	2.08	-0.98	.326
Child Outcome Measures					
Total Difficulties (SDQ)	Time	-1.71	0.41	-4.16	.0001
	Time X Group	0.10	0.59	0.17	.868
Emotional Symptoms (SDQ)	Time	-0.66	0.20	-3.33	.001
	Time X Group	0.01	0.28	0.05	.964
Conduct Problems (SDQ)	Time	-0.44	0.14	-3.19	.002
	Time X Group	0.02	0.20	0.09	.927
Hyperactivity-Inattention (SDQ)	Time	-0.37	0.19	-1.97	.050
	Time X Group	0.02	0.27	0.09	.927
Prosocial Behavior (SDQ)	Time	0.34	0.15	2.34	.021
	Time X Group	-0.34	0.21	-1.67	.098
Peer Problems (SDQ)	Time	-0.25	0.15	-1.71	.089
	Time X Group	0.05	0.21	0.23	.819
Emotion Regulation (ERC)	Time	1.22	0.30	4.08	.0001
	Time X Group	-0.36	0.43	-0.83	.406
Negativity/Lability (ERC)	Time	-1.82	0.50	-3.62	.0004
	Time X Group	0.06	0.71	0.08	.936

Table 7
T3 to T5 EFFT Effects and Group Comparisons

		B	*SE*	*t*	*p*
Parent Outcome Measures					
Pre-Mentalizing (PRFQ	Time	-0.03	0.04	-0.76	.447
	Time X Group	0.03	0.05	0.48	.630
Interest and Curiosity (PRFQ)	Time	-0.03	0.03	-0.90	.371
	Time X Group	0.05	0.05	1.00	.320
Certainty About Mental States (PRFQ)	Time	0.09	0.04	2.20	.029
	Time X Group	-0.15	0.07	-2.28	.024
Parental Self-Efficacy (PvGMH)	Time	-0.09	0.19	-0.44	.657
	Time X Group	0.01	0.30	0.05	.961
Parent Emotion Blocks (Parent Traps)	Time	0.27	0.75	0.36	.718
	Time X Group	-1.27	1.17	-1.08	.279
Child Outcome Measures					
Total Difficulties (SDQ)	Time	0.09	0.23	0.41	.679
	Time X Group	-1.01	0.35	-2.85	.004
Emotional Symptoms (SDQ)	Time	0.13	0.11	1.10	.271
	Time X Group	-0.53	0.18	-2.93	.003
Conduct Problems (SDQ)	Time	0.06	0.08	0.74	.457
	Time X Group	-0.31	0.12	-2.63	.009
Hyperactivity-Inattention (SDQ)	Time	-0.09	0.09	-0.96	.340
	Time X Group	-0.13	0.15	-0.88	.382
Prosocial Behavior (SDQ)	Time	-0.01	0.08	-0.13	.895
	Time X Group	0.35	0.12	2.92	.003
Peer Problems (SDQ)	Time	0.00	0.09	0.01	.989
	Time X Group	-0.02	0.14	-0.14	.885
Emotion Regulation (ERC)	Time	-0.06	0.16	-0.35	.730
	Time X Group	0.50	0.25	2.00	.046
Negativity/Lability (ERC)	Time	-0.59	0.26	-2.25	.025
	Time X Group	-0.34	0.41	-0.82	.413

Table 8

Outcome Variables Across Time by Treatment Condition: Means and Standard Deviations

	Baseline (T0)		Post Treatment (T2)		4-Months Follow-Up (T3)		12-Months Follow-Up (T5)	
	AAI-Enhanced	Standard	AAI-Enhanced	Standard	AAI-Enhanced	Standard	AAI-Enhanced	Standard
Parent Outcome Measures								
Pre-Mentalizing	1.99 (0.71)	1.92 (0.73)	1.91 (0.78)	1.98 (0.75)	1.85 (0.68)	1.93 (0.77)	1.89 (0.84)	1.82 (0.65)
Interest and Curiosity	5.83 (0.77)	5.83 (0.78)	5.73 (0.85)	5.69 (0.96)	5.71 (0.82)	5.82 (0.85)	5.72 (0.78)	5.79 (0.84)
Certainty About Mental States	3.22 (0.99)	3.23 (1.03)	3.17 (0.96)	2.95 (1.06)	3.36 (1.07)	3.25 (1.00)	3.24 (0.93)	3.37 (1.06)
Parental Self-Efficacy	19.71 (3.40)	20.4 (3.74)	26.05 (3.53)	25.35 (3.93)	24.28 (3.82)	23.04 (3.94)	24.35 (4.33)	22.9 (4.34)
Parent Emotion Blocks	50.29 (16.47)	50.39 (18.99)	50.60 (17.48)	49.90 (17.69)	42.84 (17.02)	44.98 (18.24)	43.12 (19.35)	45.06 (17.76)
Child Outcome Measures								
Total Difficulties	16.18 (5.65)	15.57 (5.47)	15.52 (5.82)	15.24 (5.53)	13.96 (6.42)	13.68 (6.18)	12.56 (6.6)	14.06 (5.86)
Emotional Symptoms	4.67 (2.69)	4.81 (2.80)	4.61 (2.96)	4.61 (2.70)	4.06 (2.83)	4.15 (2.80)	2.97 (2.83)	4.59 (2.72)
Conduct Problems	3.71 (2.20)	3.13 (2.06)	3.23 (2.04)	3.00 (2.01)	2.76 (2.05)	2.49 (1.91)	2.72 (2.24)	2.62 (1.97)
Hyperactivity-Inattention	5.61 (2.74)	5.20 (2.79)	5.30 (2.72)	5.05 (2.98)	4.85 (2.61)	4.75 (2.66)	4.59 (2.41)	4.51 (2.48)
Prosocial Behavior	6.71 (2.17)	7.23 (2.28)	7.19 (2.07)	7.17 (2.04)	7.13 (2.16)	7.60 (2.02)	7.79 (1.84)	7.54 (1.81)
Peer Problems	2.19 (1.66)	2.44 (2.02)	2.38 (1.75)	2.58 (2.03)	2.30 (1.71)	2.29 (1.92)	2.28 (1.93)	2.35 (2.22)
Emotion Regulation	23.45 (4.39)	24.39 (4.06)	23.79 (4.4)	23.89 (4.03)	24.68 (4.19)	24.96 (3.8)	25.53 (3.99)	24.70 (4.03)
Negativity/Lability	35.51 (7.86)	33.81 (8.53)	34.77 (7.72)	33.71 (8.51)	32.54 (8.08)	31.86 (7.86)	31.65 (8.95)	30.62 (7.74)

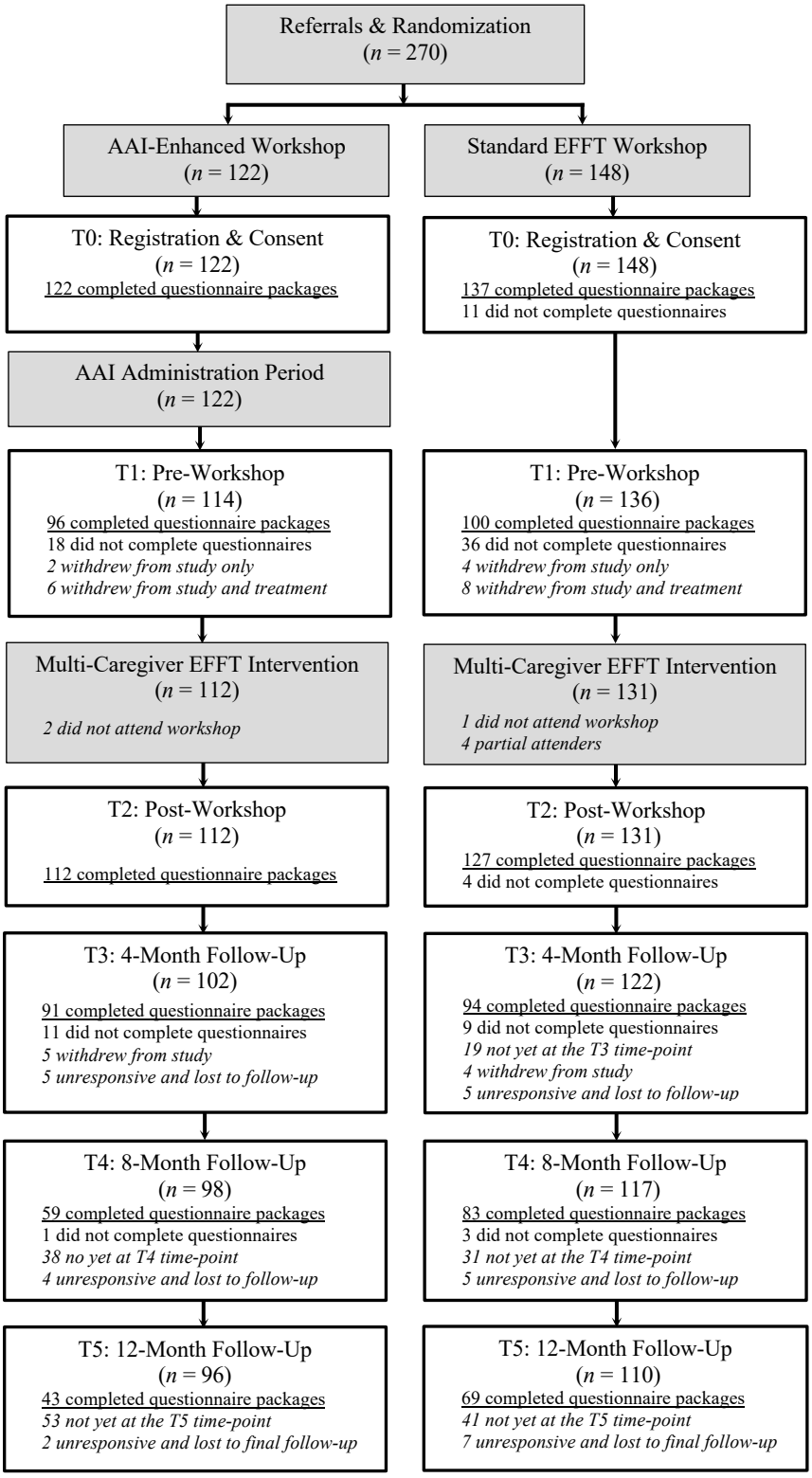

Figure 1. Data collection procedure and sample sizes at each data collection time-point. Also see above for the number of participants who completed questionnaires at each time-point. As the follow-up data collection period is ongoing, this thesis utilized the data that was available from each of the study time-points as of November 2018; represented here.

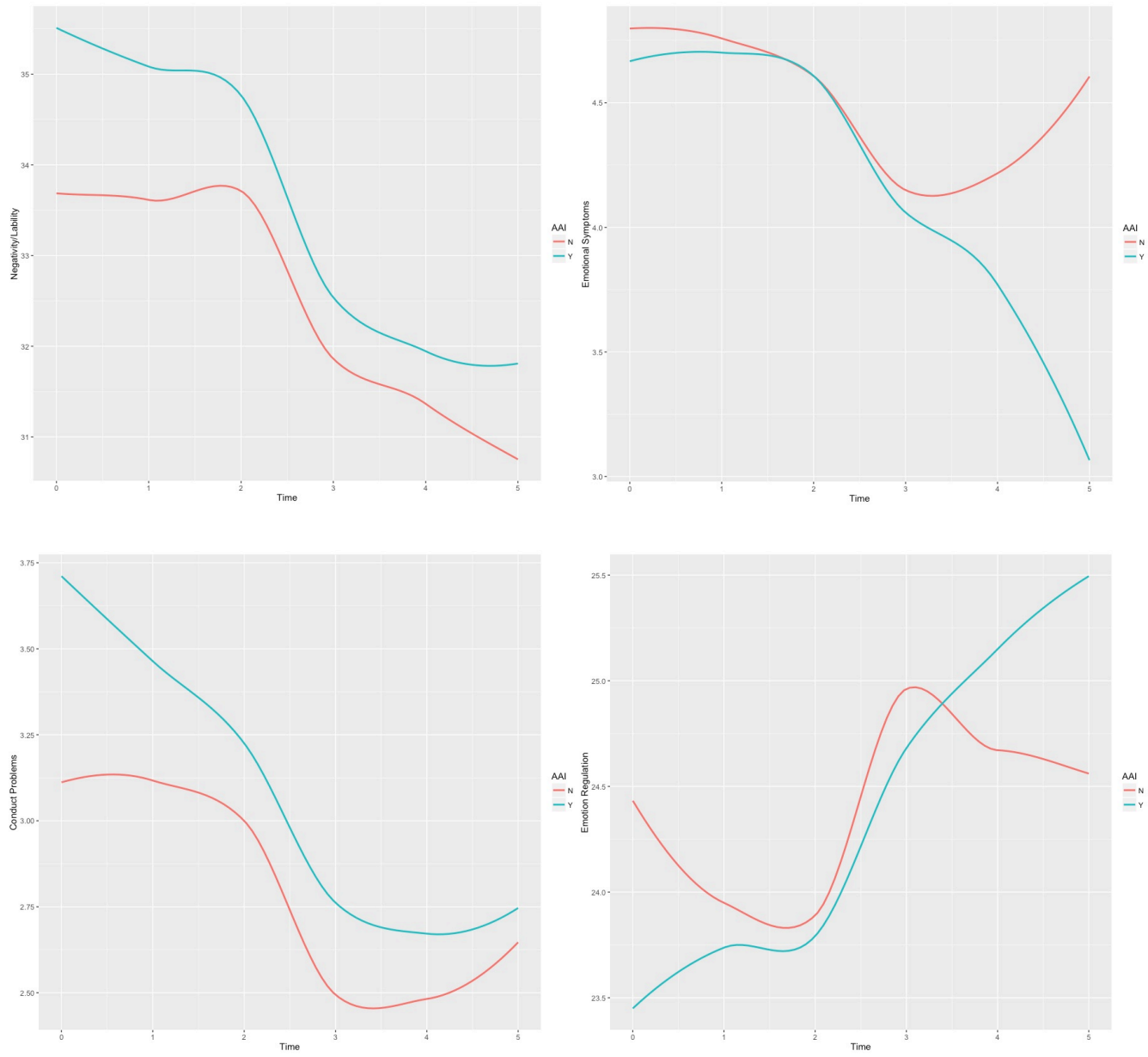

Figure 2. Examples of Change Trajectories in Child Outcome Variables Overtime. The red line represents the Standard EFFT group whereas the blue line represents the AAI-Enhanced group. Variable names are listed along the Y axes, and the X axes represent time (i.e., the various study time-points). Top left: negativity/lability; top right: emotional symptoms; bottom left: conduct problems; bottom right: emotion regulation.

Appendix A

Workshop Registration Form

Emotion-Focused Family Therapy — Parents Workshop

<table>
<tr><td>Child's Name:
Date of Birth:
School Grade:</td><td>Today's Date:
Home Address:</td></tr>
<tr><td>Caregiver/Parent's Name:
Occupation:
Age (years):
Home Telephone:
Work Telephone:
Cellphone:
*Emai
l:

Relationship to Child:
☐ Biological parent
☐ Step parent
☐ Adoptive parent
☐ Foster parent
☐ Other, please specify:
Address:

OR Same as above ☐
Will this parent be attending? Yes ☐ No☐</td><td>Caregiver/Parent's Name:
Occupation:
Age (years):
Home Telephone:
Work Telephone:
Cellphone:
*Emai

Relationship to Child:
☐ Biological parent
☐ Step parent
☐ Adoptive parent
☐ Foster parent
☐ Other, please specify:
Address:

OR Same as above ☐
Will this parent be attending? Yes ☐ No☐</td></tr>
<tr><td>Presenting Concerns (reasons for attending workshop, child behaviours or symptoms of concern etc.)</td><td>Goals for this workshop:</td></tr>
<tr><td colspan="2">List any medications your child is taking:</td></tr>
<tr><td rowspan="3">Have you and/or your child received mental health services before (psychology, psychiatry, social work, other)?
☐ Yes
☐ No
IF YES:
When (start and end dates)?
How many sessions have you had?

Who were/are the services for?
☐ You
☐ Your child
☐ Both you and your child

Please describe the service (e.g., assessment for child, one-on-one therapy for parent, family therapy, couples therapy etc.):</td><td>Brothers and Sisters: (names and ages)</td></tr>
<tr><td>Previous Diagnoses?</td></tr>
<tr><td>Family Physician/Paediatrician:

Referral Source:</td></tr>
</table>

<table>
<tr>
<td>Household Income:
☐ $0-20,000
☐ $21,000 - $40,000
☐ $41,000 - $60,000
☐ $61,000 - $80,000
☐ $81,000 - $100,000
☐ $101,000+
☐ Prefer not to answer</td>
<td>☐ Parents never married
☐ Parents married/common law
☐ Widowed
☐ Parents separated
☐ Parents divorced

Custody: JOINT ☐ SOLE ☐
If Sole Custody, which parent?</td>
</tr>
<tr>
<td>What is the highest level of education you have completed?
☐ Some high school
☐ High school graduate
☐ Some college or University
☐ Trade/technical/vocational training
☐ College or University graduate
☐ Some postgraduate work
☐ Post graduate degree</td>
<td>What is the highest level of education the other parent/caregiver has completed?
☐ Some high school
☐ High school graduate
☐ Some college or University
☐ Trade/technical/vocational training
☐ College or University graduate
☐ Some postgraduate work
☐ Post graduate degree</td>
</tr>
<tr>
<td colspan="2">Which of the following would you identify as your child’s ethnic background (you may pick more than one option):
☐ Caucasian
☐ Black
☐ Hispanic
☐ Pacific Islander
☐ European
☐ West Indian
☐ Middle Eastern
☐ East Asian
☐ South Asian
☐ First Nation
☐ Other, Please specify:</td>
</tr>
</table>

Appendix B

Verbal Consent Scripts

Verbal Script for AAI-Enhanced Workshops

Hello [Parent Name],

My name is [your name], and I am calling from Kindercare Psychology, how are you? Thank you for taking the time to discuss the Emotion-Focused Family Therapy research project over the phone. The purpose of this phone call is to review what the study involves and to obtain your verbal consent to participate in this research project over the phone. Is this still a good time to talk?

Before we get started, have you had any training in Emotion Focused Family Therapy?

As you know, this project is being conducted to investigate the long-term effectiveness of Emotion-Focused Family Therapy (EFFT). Your willingness to participate is completely voluntary, and I want to emphasize that there will be **no** change to the treatment you will receive should you choose not to participate.

As a participant in this study, you will be asked to fill out questionnaires at six separate time points: at the time of registration, before and after the workshop, and again 4, 8, and 12 months after the workshop. You will also take part in a parent background interview one to two weeks before the workshop. The interview will be about you, and your relationships with family members and other important people from childhood onwards. We also talk about your child and what you hope to gain from this workshop. It takes about 1 and a half hours and is videotaped. The video recording of the interview will be kept confidential and will be accessed only by Dr. Mirisse Foroughe and our trained research team. Do you have any questions about the interview or about the video recording?

EFFT will provide all parents with an opportunity to learn about and practice emotional coaching, behavioural coaching, and relationship repair. This is knowledge that we believe will be of benefit to the child, participating caregivers, and the family as a whole. There are no risks associated with this research.

If you decide to participate, I will be sending you the first set of forms to be filled out over the next 3 days. They will take about 10 minutes to fill out; this means they would be due on [date]. All questionnaires you fill out will remain anonymous and will be entered into a secure database without any identifying personal information.

If you have any questions or concerns, please feel free to contact Dr. Mirisse Foroughe at XXX-XXX-XXXX or by email at XXXX.

This research has been reviewed by the York University Research Ethics Committee and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact Dr. Daniel Flanders, Director, Kindercare Pediatrics, by email at XXXX.

I wonder if you have any thoughts or concerns about the research or interview…and if this is something you're interested in participating in…

Do you agree to the following statement?

"I have understood the information provided to me and have discussed any question that I have. I understand the possible risks and benefits of participating in this project, and I have had enough time to consider my decision."

Do you agree to provide verbal consent to participate in the Emotion-Focused Family Therapy research study?

Thank you!

I have a few more questions in order to start the registration process:

1. Child's age:
2. Child's name:
3. Presenting concerns (reasons for wanting to participate in the workshop):
4. Does your child have any previous diagnoses?
5. Is the other parent participating?
6. If yes, make sure to ask for that parent's name and contact information:
7. For demographic purposes, would you be willing to share with me your age? What is the age of the other parent?

Fantastic, thank you for answering these questions. This information is very helpful.

We are holding the parent interviews one to two weeks prior to the workshop, and I am wondering if we can schedule this in now, or if you'd like us to call you back?

Verbal Script for non-AAI Workshop Participants

Hello [Parent Name],

My name is [your name], and I am calling from Kindercare Psychology, how are you? Thank you for taking the time to discuss the Emotion-Focused Family Therapy research project over the phone. The purpose of this phone call is to review what the study involves and to obtain your verbal consent to participate in this research project over the phone. Is this still a good time to talk?

Before we get started, have you had any training in Emotion Focused Family Therapy?

As you know, this project is being conducted to investigate the long-term effectiveness of Emotion-Focused Family Therapy (EFFT). Your willingness to participate is completely voluntary, and I want to emphasize that there will be **no** change to the treatment you will receive should you choose not to participate.

As a participant in this study, you will be asked to fill out questionnaires at six separate time points: at the time of registration, before and after the workshop, and again 4, 8, and 12 months after the workshop.

If you decide to participate, I will be sending you the first set of forms to be filled out over the next 3 days. They will take about 10 minutes to fill out; this means they would be due on [date]. All questionnaires you fill out will remain anonymous and will be entered into a secure database without any identifying personal information.

EFFT will provide all parents with an opportunity to learn about and practice emotional coaching, behavioural coaching, and relationship repair. This is knowledge that we believe will be of benefit to the child, participating caregivers, and the family as a whole. There are no risks associated with this research.

If you have any questions or concerns, please feel free to contact Dr. Mirisse Foroughe at XXX-XXX-XXXX or by email at XXXX.

This research has been reviewed by the York University Research Ethics Committee and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact Dr. Daniel Flanders, Director, Kindercare Pediatrics, by email at XXXX.

Do you have any questions for me at this time about the workshop or research?

Do you agree to the following statement?

“I have understood the information provided to me and have discussed any question that I have. I understand the possible risks and benefits of participating in this project, and I have had enough time to consider my decision”

Do you agree to provide verbal consent to participate in the Emotion-Focused Therapy research study?

Thank you!

I have a few more questions in order to start the registration process:

1. Child's age:
2. Child's name:
3. Presenting concerns (reasons for wanting to participate in the workshop):
4. Does your child have any previous diagnoses?:
5. Is the other parent participating?:
6. If yes, make sure to ask for that parent's name and contact information:
7. For demographic purposes, would you be willing to share with me your age? What is the age of the other parent?

Fantastic, thank you for answering these questions. This information is very helpful.

Appendix C

Informed Consent Form

Study Name: EFFT Caregiver Study
REB Certificate #: 2016-093
Researchers:

Dr. Robert Muller,Ph.D, Department of Psychology, York University
120 Behavioural Sciences Building
XXXX@XXXX

Dr. Mirisse Foroughe, Ph.D., Kindercare Pediatrics
491 Eglinton Avenue West, Suite 301
XXXX@XXXX

Kristina Cordeiro, Department of Psychology, York University
143 Behavioural Sciences Building
XXXX@XXXX

Purpose of this Study:
You are invited to participate in a psychotherapy research project. The purpose of this study is to investigate the process of change for caregivers receiving Emotion-Focused Family Therapy (EFFT). We are interested in learning more about caregiver background and therapy outcomes for both caregivers and children. Please read this information carefully and feel free to ask any questions that you may have.

What the Study Involves:
Should you decide to participate, you will be asked to complete this consent form indicating your willingness to participate on a voluntary basis. There will be no change to the treatment that you will receive in either case, should you choose to participate or not.

As a participant in this research study, you may be interviewed about your family background and life experiences. With your consent, this background interview is video-recorded and coded by our research team. You will also be asked to fill out some questionnaires at six different time points:

1. Once you've consented to participate in this study;
2. One week before treatment;
3. At the end of the final day of treatment;
4. Four months after treatment; and
5. Eight months after treatment
6. Twelve months after treatment

The questionnaires that you will be answering are related to your child's abilities to regulate his/her emotions, his/her strengths and difficulties, as well normal parental difficulties that caregivers have. You will also be asked about your own emotion regulation, current physical or emotional difficulties, and childhood experiences.

Risks and Discomforts:
Given that some interview questions or research questionnaires may be personal in nature, they may cause mild discomfort for some research participants. You are encouraged to ask for clarification about any of the items and may choose not to complete a specific question(s) or questionnaire(s) without consequence.

Benefits of the Research and Benefits to You:
EFFT will provide all parents with an opportunity to learn about and practice emotional coaching, behavioural coaching, and relationship repair. This is knowledge that we believe will be of benefit to the

child, participating caregivers, and the family as a whole. The completion of research measures may present an opportunity for you to enhance awareness of your own wellbeing (e.g. emotion regulation abilities, parental stress) and caregiving styles, as well as to learn strategies to help you support your child through mental health difficulties.

Participation in the current study will also be an opportunity for you to become more knowledgeable about important issues related to childhood relationships and later behaviours, mental health, and personality functioning. Participants will receive services at a discounted rate. Details about this have already been given to you by our research team by telephone. If desired, you will have the opportunity to contact the investigator for further information.

Voluntary Participation:
Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the nature of the ongoing relationship you may have with the researchers or study staff, and the nature of your relationship with York University either now, or in the future.

Withdrawal from the Study:
You can stop participating in the study at any time and for any reason, if you so decide, without prejudice or consequence. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. If you wish to continue with individual EFFT sessions following withdrawal from the research, you will be required to pay the full-cost for these sessions, unless otherwise agreed upon with Kindercare Pediatrics.

Confidentiality:
Participant names and identifying data will never be disclosed during the dissemination of results. During data collection, care will be taken to de-link data from identifying information. Upon consent, you will be assigned a research identification number. Video-recordings of background interviews and questionnaires will be labeled with the research identification number only and stored in a locked file cabinet.

All data gathered from participants online will be stored on a password-protected computer that will be stored in a locked file cabinet within a locked office. This data will also be printed as hard copies and stored within locked file cabinets in a locked office. Access to this office will be restricted only to the principal investigator and research assistants. Any individuals engaged to code digital recordings will be required to sign a confidentiality agreement prior to viewing any digitally recorded sessions/interviews. Anonymized research data will be kept for three years after data collection, to allow for data entry, analysis, and publication of results. After this time, all hard copies of data will be shredded.
Confidentiality will be provided to the fullest extent possible by law.

Results:
The results of this study may be published in a peer-reviewed scientific outlet, and disseminated in the mental health professional community. For those interested, a copy of the results of the study will be available once the information has been analyzed. If you wish to have a summary of the results sent to you, please contact one of the researchers.

Questions About the Research?
If you have questions about the research in general or about your role in the study, please feel free to contact Dr. Robert Muller either by telephone at (XXX-XXX-XXXX, extension XXXX) or by e-mail (XXXX@XXXX).

This research has received ethics review and approval by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone XXX-XXX-XXXX or e-mail XXXX@XXXX).

Thank you very much for taking the time to consider participating in this study!

Agreement:

Your signatures below indicate that you have read the information in this agreement. Your signatures also indicate that you agree to be in the study and have been told that you can change your mind and withdraw consent to participate at any time.

By signing this consent agreement you are not giving up any of your legal rights

I agree, or consent, to participate in this study and am willing to (check those that apply):

- ☐ Have demographic information about me and my child collected and used in this study.
- ☐ Complete some questionnaires and have them used in this study.
- ☐ Have the video-recording of my **parent background interview**, which took place before the workshop, used for research purposes. I understand that neither I nor my child will be identified in these video-recordings.
- ☐ Have **any activities or exercises that I participate in during the workshop** video-recorded and viewed by the research team.
- ☐ Have my video-recordings from the workshop viewed by the Kindercare clinical team.
- ☐ Have my video-recordings from the workshop viewed by clinicians and researchers outside of Kindercare, for eduational purposes.
- ☐ Be contacted in the futre about related studies. I understand that if I am contacted in the future, I will be given more information about the study at that time and will be free to decide if I would like to particpate or not.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Investigator Date

Appendix D

Emotion Regulation Checklist (ERC)

Please respond to the statements below about your child by selecting a number from 1 to 4.

1 = Rarely/Never 2 = Sometimes 3 = Often 4 = Almost Always

1	2	3	4	1) Is a cheerful child.
1	2	3	4	2) Exhibits wide mood swings (child's emotional state is difficult to anticipate because s/he moves quickly from a positive to a negative mood).
1	2	3	4	3) Responds positively to neutral or friendly overtures by adults.
1	2	3	4	4) Transitions well from one activity to another; doesn't become angry, anxious, distressed or overly excited when moving from one activity to another.
1	2	3	4	5) Can recover quickly from upset or distress (for example, doesn't pout or remain sullen, anxious or sad after emotionally distressing events).
1	2	3	4	6) Is easily frustrated.
1	2	3	4	7) Responds positively to neutral or friendly overtures by peers.
1	2	3	4	8) Is prone to angry outbursts/tantrums easily.
1	2	3	4	9) Is able to delay gratification.
1	2	3	4	10) Takes pleasure in the distress of others (for example, laughs when another person gets hurt or punished; seems to enjoy teasing others).
1	2	3	4	11) Can modulate excitement (for example, doesn't get "carried away" in high energy play situations or overly excited in inappropriate contexts).
1	2	3	4	12) Is whiny or clingy with adults.
1	2	3	4	13) Is prone to disruptive outburst of energy and exuberance.
1	2	3	4	14) Responds angrily to limit---setting by adults.
1	2	3	4	15) Can say when s/he is feeling sad, angry or mad, fearful or afraid.
1	2	3	4	16) Seems sad or listless.
1	2	3	4	17) Is overly exuberant when attempting to engage others in play.
1	2	3	4	18) Displays flat affect (expression is vacant or inexpressive; child seems emotionally absent).
1	2	3	4	19) Responds negatively to neutral or friendly overtures by peers (for example, may speak in an angry tone of voice or respond fearfully).
1	2	3	4	20) Is impulsive.

1	2	3	4	21) Is empathic towards others; shows concern when others are upset or distressed.
1	2	3	4	22) Displays exuberance that others find intrusive or disruptive.
1	2	3	4	23) Displays appropriate negative emotions (anger, fear, frustration, distress) in response to hostile, aggressive or intrusive acts by peers.
1	2	3	4	24) Displays negative emotions when attempting to engage others in play.

Appendix E

Strengths and Difficulties Questionnaire for ages 2 – 4

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your Name: Child's Name:
Child's Date of Birth: Child's Gender:

	Not True	**Somewhat True**	**Certainly True**
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children, for example, toys, treats, pencils	☐	☐	☐
Often loses temper	☐	☐	☐
Rather solitary, prefers to play alone	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset, or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, depressed, or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often argumentative with adults	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, or other children)	☐	☐	☐
Can stop and think about things before acting	☐	☐	☐
Can be spiteful to others	☐	☐	☐
Gets along better with adults than with older children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐
Do you have any other comments or concerns?	☐	☐	☐

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes – minor difficulties	Yes – definite difficulties	Yes – severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

How long have these difficulties been present?

Less than a month	1 – 5 months	6 – 12 months	Over a year
☐	☐	☐	☐

Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Mother/Father/Other – (Please specify):

Thank you very much for your help

No	Yes – minor difficulties	Yes – definite difficulties	Yes – severe difficulties
☐	☐	☐	☐

Appendix F

Parental Reflective Functioning Questionnaire

Listed below are a number of statements concerning you and your child. Read each item and decide whether you agree or disagree and to what extent.

Use the following rating scale, with 7 if you strongly agree; and 1 if you strongly disagree. The midpoint, if you are neutral or undecided, is 4.

1	2	3	4	5	6	7
Strongly Disagree						Strongly Agree

1. The only time I'm certain my child loves me is when he or she is smiling at me.
2. I always know what my child wants.
3. I like to think about the reasons behind the way my child behaves and feels.
4. My child cries around strangers to embarrass me.
5. I can completely read my child's mind.
6. I wonder a lot about what my child is thinking and feeling.
7. I find it hard to actively participate in make believe play with my child.
8. I can always predict what my child will do.
9. I am often curious to find out how my child feels.
10. My child sometimes gets sick to keep me from doing what I want to do.
11. I can sometimes misunderstand the reactions of my child.
12. I try to see situations through the eyes of my child.
13. When my child is fussy he or she does that just to annoy me.
14. I always know why I do what I do to my child.
15. I try to understand the reasons why my child misbehaves.
16. Often, my child's behaviour is too confusing to bother figuring out.
17. I always know why my child acts the way he or she does.
18. I believe there is no point in trying to guess what my child feels.

Appendix G

Parent versus General Mental Health (PvGMH)

Please rate the following statements on the 5-point scale by placing a checkmark beside the answer corresponding to the way you are thinking/feeling at the moment.

1. I don't have the knowledge to take a leadership role when it comes to achieving a total victory over my loved one's mental health issues.

   Strongly Disagree Disagree Neutral Agree Strongly Agree

2. Caregivers cannot be seen as the solution in the treatment of mental health issues until ways in which they have caused it have been properly explored.

   Strongly Disagree Disagree Neutral Agree Strongly Agree

3. I feel equipped with specific practical strategies for the task of bringing about the complete recovery of my loved one in the home setting.

   Strongly Disagree Disagree Neutral Agree Strongly Agree

4. It is not always advisable for caregivers to be firm with a loved one with mental health issues because he/she will experience too much trauma and distress.

   Strongly Disagree Disagree Neutral Agree Strongly Agree

5. My own caregiving instincts can be a more reliable guide for the task of achieving the recovery from my loved one's mental health issues than any treatment received from an expert.

   Strongly Disagree Disagree Neutral Agree Strongly Agree

6. While caregivers are important, loved ones with mental health issues will never get better until they receive some sort of individual therapy themselves.

   Strongly Disagree Disagree Neutral Agree Strongly Agree

7. It is more my responsibility than anyone else's to take charge of, and help heal my loved one's mental health issues.

   Strongly Disagree Disagree Neutral Agree Strongly Agree

Appendix H

The Parent Traps Scale (Part A)

We have found it is a very normal process for caregivers to struggle with concerns that surface while engaging in the tasks of recovery. How likely are you to feel vulnerable to the following concerns when supporting your loved one's behavioral recovery?

1. Fear of being rejected by my loved one.

1	2	3	4	5	6	7
Not likely						Extremely Likely

2. Fear of putting strain on my couple relationship.

1	2	3	4	5	6	7
Not likely						Extremely Likely

3. Fear of alienating other significant relationships.

1	2	3	4	5	6	7
Not likely						Extremely Likely

4. Fear that my loved one will be seen as abnormal or mentally ill.

1	2	3	4	5	6	7
Not likely						Extremely Likely

5. Fear that I will do/say something I will regret out of frustration or desperation.

1	2	3	4	5	6	7
Not likely						Extremely Likely

6. Fear that my loved one will miss out on normal activities or special occasions.

1	2	3	4	5	6	7
Not likely						Extremely Likely

7. Fear of causing suffering to my loved one.

1	2	3	4	5	6	7
Not likely						Extremely Likely

8. Fear of causing suffering to my family.

1	2	3	4	5	6	7
Not likely						Extremely Likely

9. Fear of breaking down or burning out throughout the process.

1	2	3	4	5	6	7
Not likely						Extremely Likely

10. Fear of pushing my loved one "too far" with symptom interruption (leading to symptom---shifting/depression/running away/suicide).

1	2	3	4	5	6	7
Not likely						Extremely Likely

11. Fear of coddling my loved one and preventing her/him from becoming independent.

1	2	3	4	5	6	7

Not likely Extremely Likely

12. Fear of having to face my own past along the way.

1 2 3 4 5 6 7
Not likely Extremely Likely

13. Fear that my loved one's symptoms will shift (e.g. go from restricting to purging).

1 2 3 4 5 6 7
Not likely Extremely Likely

14. Fear of being blamed or being to blame.

1 2 3 4 5 6 7
Not likely Extremely Likely