ENGAGING CAREGIVERS IN THE SERVICE OF THEIR CHILD'S MENTAL HEALTH: AN EXAMINATION OF EMOTION FOCUSED FAMILY THERAPY IN RELATION TO PARENTAL REFLECTIVE FUNCTIONING

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Abstract

This study examined parental reflective functioning (PRF) withing the context of a brief, 2-day intensive Emotion- Focused Family Therapy (EFFT) intervention. We also examined how PRF impacts therapeutic outcomes for caregivers and their children. **Method**: Symptom change was assessed among 243 participants undergoing a brief 2-day intensive EFFT caregiver workshop. Data were collected at six timepoints: registration, pre-treatment, post-treatment, 4 months, 8 months, and 12 months following treatment. Participants completed questionnaires about child psychological symptoms and emotion regulation, as well as parental self-efficacy, parental blocks, and parental reflective functioning. **Results**: Significant improvements in levels of parent mentalization were found, confirming that EFFT is effective in improving parental mentalizing capacity. Additionally, moderate interactions were found between various components of PRF (mentalizing capacity, and parents' interest & curiosity) and level of fears surrounding parenting in reducing child symptomatology.

Keywords: emotion focused family therapy, parental reflective functioning, family and child mental health, mentalization

Dedication

To my mother and dearest friend,

whose unwavering love, strength, and wisdom have allowed me to become the person I am today.

Thank you for your countless sacrifices, words of encouragement, and your endless support.

You have moved mountains, only for me to see a brighter sunrise.

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The ways in which caregivers respond to their child's distress can work to facilitate the speed and trajectory of a child's resilience and recovery (Bambrah et al., 2018; Williamson et al., 2016; Wise & Delahanty, 2017). In the psychological treatment of youth, therapists/clinicians have historically been viewed as primary actors of intervention and therapy, with parents usually ascribed a secondary or minimal role in the treatment of their children (Burke & Loeber, 2015; Taboas, McKay, Whiteside, & Storch, 2015). These practices, in turn, undermine the importance and positive impact of a parent's involvement in their child's recovery, and may also strengthen any previous negative beliefs the parents have about their parenting abilities (Cordeiro, 2019). Such negative beliefs surrounding parenting can hinder parents from effectively applying the strategies needed to assist in their child's treatment and recovery (Stillar et al., 2016), ultimately limiting treatment effectiveness for a wide range of child mental health challenges (Mackler et al., 2015).

There has been growing empirical support for the active involvement of parents/ caregivers as key agents of change in the mental health treatment of their children, resulting in/leading to improvements in both child treatment outcomes and family functioning as a whole (Comer et al., 2019; Carr, Hartnett, Sharry, & Brosnan, 2017; Grajdan et al., 2025; Henggeler & Sheidow, 2012; Kaslow, Broth, Smith, & Collins, 2012; Lafrance Robinson et al., 2014; Wade, Treasure & Schmidt, 2011). With this, there are now several interventions that assign parents a more primary role in the therapy process. This said, many of these interventions are cognitive-behaviour-based programs (Barmish & Kendall, 2005; Haine-Schlagel et al., 2022; Thulin et al., 2014), wherein parent involvement is more centered around executing a treatment plan as

directed by the psychologist, rather than engaging in a more leading role in the process and/or strengthening their emotional connection to their child over the course of the intervention. Fewer interventions still, directly address caregivers' own feelings in relation to their parenting ability, in addition to their child's symptoms and behaviour (Cordeiro, 2019; Grajdan et al., 2025). Parental emotions such as frustration, inadequacy, shame, and grief can be particularly overwhelming, pervasive, and detrimental to both parent and child outcomes in therapy (Burke, 2018; Foroughe & Muller, 2012). An exception of note, which will comprise the focus of this study, is Emotion Focused Family Therapy (EFFT; Lafrance Robinson et al., 2013).

Emotion Focused Family Therapy

EFFT is a relatively new therapeutic intervention, using a combination of experiential exercises and psychoeducation to provide parents with the necessary skills to support their child's recovery from start to finish. Concurrently, EFFT also works to assist parents in processing their own emotional experiences and parenting obstacles (referred to as "blocks") that could interfere with their ability to engage in the strategies they learn to support their children. EFFT was initially developed for the treatment of child and adolescent eating disorders and has since been adapted to a wide array of mental health struggles (Foroughe et al., 2023; Lafrance Robinson et al., 2020) through means of emotion and behaviour coaching, relationship building, and working through parenting "blocks."

There is strong evidence showing that the involvement of parents/caregivers in the treatment of child behavioural and emotional problems results in more significant child outcomes (Brendel & Maynard, 2014; Dietz et al., 2015; Dowell & Ogles, 2010; Haine-Schlagel & Walsh, 2015) as well as improvements in overall family functioning and mental health (Poole et al., 2017). Actively prioritising caregiver involvement is one of the core principles of Emotion

Focused Family Therapy (EFFT). EFFT is a caregiver skills-based, emotion processing approach to child treatment. Described in depth by Cordeiro, 2019, Foroughe et al., 2023, and Lafrance et al., 2020, EFFT works to strengthen and highlight the parent-child relationship and supports caregivers in their efforts to become effective behaviour and emotion coaches for their children, emphasising parental involvement as a central and primary role in the therapeutic process. One of EFFT's defining features is the integrative process of pinpointing, dealing with, and resolving maladaptive parental cognitions and roadblocks, or simply "blocks." Blocks are viewed as any difficult behaviours or emotions that may interfere with the implementation of taught EFFT skills. The ways in which parents/caregivers react to their child's distress has shown to significantly affect child treatment outcomes (Bokszczanin, 2008; Lafrance Robinson et al., 2014; Scheeringa & Zeanah, 2001; Stillar et al., 2016; Valentino et al., 2010; Williamson et al., 2016; Wise & Delahanty, 2017), with strong negative emotional responses such as fear, shame, frustration, and sadness most strongly impeding caregivers' abilities to implement the appropriate skills to support their child's recovery (Foroughe, 2019; Heath et al., 2015; Lafrance Robinson et al., 2014; Stillar et al., 2016).

EFFT was developed as a flexible intervention and can be administered in various forms (parent-child dyads, individually, in a workshop format), as well as integrated into other treatment interventions, or delivered as a standalone treatment approach in and of itself. Currently, the intervention is most commonly run as a 2-day intensive caregiver workshop (Foroughe et al., 2023), evidence for the effectiveness of which is steadily accumulating. Studies have found that parents who attended the workshop showed increased perceptions of their own self-efficacy in regard to their children's mental health struggles, a decrease in parental blocks and feelings of shame/self-blame, and lower levels of anxiety or fear when it came to being

involved in their child's treatment (Lafrance Robinson et al., 2014; Strahan et al., 2017). Foroughe et al. (2019) conducted the first adapted study for general mental health outcomes for children of parents attending the workshop. The study demonstrated significant reductions in child emotional and behavioural difficulties, as well increased levels of parental self-efficacy following the workshop, as well as at 4-, 8-, and 12-month follow-up. More recently, Foroughe et al. (2023) have replicated their findings in more depth, confirming the 2-day EFFT intensive caregiver model is an effective treatment for parent as well as child outcomes.

Reflective Functioning and Parental Reflective Functioning

Reflective functioning, or mentalization, refers to an individual's ability to perceive one's own mental states, their meaning, as well as separation from those of others (Bateman & Fonagy, 2008). This capacity is crucial for our ability to navigate and integrate our understanding of ourselves, others, as well as the cognitive interplay of social motivations and interactions (Luyten et al., 2012a). Studies suggest that reflective capacities develop through early childhood attachment relationships (Fonagy, Gergely, & Target, 2007; Sharp & Fonagy, 2008), which has led to an increase in research and clinical applications of Parental Reflective Functioning (PRF) and its corresponding effects on child development and outcomes (Meins et al., 2013; Sharp & Fonagy, 2008).

PRF can be understood as a caregiver's capacity to understand and separate their child's mental states from their own, along with their interest in their child's internal world and confidence in understanding their children's cognitions and motivations (Fonagy, Gergely, & Target, 2007), allowing parents to respond to and regulate their child's uniquely subjective emotional experiences in times of distress more effectively (Fonagy & Target, 2002). In turn, PRF is argued to stimulate the child's own capacity for reflective functioning, which is thought

to play a key role in the child's development of an internal sense of self, agency, understanding and self-regulation of their emotions, as well as secure attachment to others (Ensink & Mayes, 2010). Disruptions in early attachment are considered to have the potential to disrupt the development of a coherent self-structure and capacity for reflective functioning, resulting in the loss of self-regulatory capacity in high arousal interpersonal contexts, re-emerging in times of distress throughout the individual's life (Fonagy et al., 2010). Concurrently, insecurely attached parents commonly display a lack of ability to integrate their own dysregulated emotions when primed to think of their childhood and are often unable to recognise the opacity of both their own and others' mental states (most notably in this case, their child's internal world and motivations). Both of these behaviours have been viewed as critical and necessary for the development and maintenance of healthy parental reflective functioning (Slade, 2005). In the parental context, these pre-built modes of reflective (dys)function are usually expressed as a propensity to be overly certain about their child's mental states, often attributing malevolent intentions to their behaviour and displaying an overall inability to understand the child's emotional motivation as separate from their own, features that have been shown as characteristic of parents with reflective functioning deficits in various studies (Ensink & Mayes, 2010; Leckman et al., 2007; Luyten et al., 2017; Sadler, Slade, & Mayes, 2006; Suchman et al., 2010). Disruptions in PRF, then, may be displayed as either *excessive*, characterized by undue certainty of their child's mental states, often intrusive, twisted, and sometimes paranoid; or *deficient*, usually expressed through concrete, limited, and stimulus-bound reflective functioning (Luyten et al., 2012a; Luyten et al., 2012b; Sharp et al., 2011). In this context, it is assumed that healthy modes of PRF, shown through genuine curiosity and interest in a child's mental states and the understanding of

the opacity of mental states in general, promotes healthy development and may be a vital moderator in both child and family therapeutic outcomes.

Given EFFTs strong focus on emotional validation, emotion coaching, and understanding (reflecting) on self-imposed parental blocks, we examined PRF as an outcome, predictor, and moderator in child and family treatment. We believe that parents' ability to reflect on their own motivations and experiences surrounding parenting, as well as their ability to separate those motivations and mental states from that of their child while simultaneously showing genuine interest in their child's inner emotional worlds, may foster a pathway for both parent and child recovery in EFFT.

Current Study

Summary

The current study was a continuation of previous work on the effectiveness and clinical implications of a 2-day EFFT caregiver intensive intervention, using data collected as part of a large collaborative study that took place in Toronto, Ontario. This thesis examined different aspects of parental reflective functioning (PRF) in the context of Emotion Focused Family Therapy (EFFT) and child/family outcomes.

While earlier studies demonstrated that the 2-day EFFT intervention showed significant increases in levels of parental self-efficacy and reduced child symptomatology (Foroughe et al., 2023; Foroughe et al., 2019; Cordeiro, 2019; Lafrance Robinson et al., 2016), and while PRF has been studied in relation to early childhood attachment and child developmental pathways (Ensink & Mayes, 2010; Fonagy et al., 2010), there are no studies to date examining the role of PRF in treatment response for caregivers and children or how it changes as a result of EFFT intervention.

We aim to bridge this gap and to examine the issue in depth. We believe that the ability to mentalize and apply reflective functioning skills is an integral part of adaptive parenting, to meaningfully engage with children in a way that fosters healthy intrapersonal and interpersonal development, as well as secure attachment, and good social and cognitive functioning through the lifespan.

Research Questions and Hypotheses

The aim of the current study can be organized in terms of two broader goals: (i) to evaluate the impact of a brief, intensive multi-caregiver Emotion Focused Family Therapy (EFFT) intervention on levels of PRF, and (ii) to investigate whether PRF plays a moderating role in the mechanisms of change of caregiver and child outcomes following EFFT.

Research Question 1: How does baseline PRF correlate to baseline symptoms for both children and caregivers?

Hypothesis: Higher scores on positive Parental Reflective Functioning Questionnaire (PRFQ) subscales (e.g., interest and curiosity) will correlate with lower levels of child/caregiver symptomatology. And higher scores on negative PRFQ subscales (i.e., poor mentalization) will correlate with higher levels of child/caregiver symptomatology at baseline.

Research Question 2: Do baseline levels of PRF affect EFFT caregiver treatment response?

Hypothesis: Higher baseline levels of PRF will predict better treatment response in caregivers.

Research Question 3: Will the EFFT 2-day intensive caregiver workshop significantly affect levels of caregiver PRF?

Hypothesis: Caregivers will demonstrate significantly higher levels of PRF immediately following the intervention.

Research Question 3a: Will improvements in caregiver PRF be maintained at follow-up?

Hypothesis: Gains in PRF will be maintained at all follow-up time-points (i.e., 4-, 8-, and 12-months following treatment).

Research Question 4: Will improvements in PRF predict improvements in caregiver and child outcomes?

Hypothesis: Improvements in PRF will significantly predict improvements in other outcome measures for both child and caregiver. Caregivers with higher improvements in PRF will demonstrate lower levels of parental blocks and higher levels of parental self-efficacy following the workshop. Children of caregivers with higher improvements in PRF will experience lower levels of child symptomatology and emotion dysregulation at 4-, 8-, and 12-month follow-up).

Method

This study used data from an 8-year collaborative study between the Family Psychology Centre (formerly Kindercare Psychology) in Toronto, Ontario (FPC; private youth and family mental health practice), the Emotion Transformation Institute (ETI; FPC's research lab affiliate), and the Trauma & Attachment Lab at York University (T&A Lab). Ethics approval for the study was obtained from York University's Ethics Review Board (Human Participants Review Sub-Committee), as well as the Kindercare Pediatrics Research Ethics Sub-Committee.

Procedure

All participants were recruited via physician referrals and self-referral through community circulated flyers in private practices, schools, family health navigation agencies,

hospitals, online sources. All caregivers were offered a reduced workshop fee as incentive for participation in the study at time of registration. Pro-bono spots and sliding scale options were given to all families regardless of research participation, to reduce barriers in accessing services. To test the efficacy of the 2-day intervention model in a wide variety of child and family outcomes, there were no clinical diagnosis requirements/cut-offs or age requirements for participants' children. The only exclusion criterium was child or parent psychosis. Informed consent was obtained verbally during the initial registration process, with written consent also obtained prior to the intervention (see Appendix C for informed consent form). The 2-day EFFT caregiver workshop was held on a bi-monthly basis, ranging from May 2016 to November 2022, and held by the same EFFT certified clinical psychologist, trained directly under the co-founders of EFFT. Sets of research questionnaires (see below and Appendices D through to H) were administered at six time points: at intake/ registration (T0), 1 week prior to the intervention (T1), immediately following the intervention (T2), 4 months (T3), 8 months (T4), and 12 months following the intervention (T5). The four-month interval follow up model was based on previous studies confirming changes in childhood outcomes on average at the 4-month mark post-intervention (Foroughe et al., 2023; Wilhelmsen-Langeland et al., 2020).

Participants

Participants were recruited from community settings using the abovementioned methods. Participants who reached out were registered by a team of research assistants and enrolled into the study if they chose to participate. A total of 243 caregivers participated in the study, including 165 mothers, 74 fathers, 2 grandfathers, 1 grandmother, and 1 guardian. These caregivers attended one of several EFFT workshops held between May 2016 and September 2018, with a final follow-up date for the sample in September 2019. To qualify for study

inclusion, participants needed to attend at least one and a half days of the two-day EFFT caregiver workshop.

More than half of the caregivers (n = 140) were co-parents who participated with concerns about the same child, contributing outcome data for that child (i.e., 70 children with both parents participating). In one instance, a pair of co-parents (n = 2) completed assessments on two different children (i.e., siblings), with each parent consistently reporting on the same child throughout the study. Additionally, two cases involved a parent attending with the child's grandparent(s), resulting in shared reporting for the same child (n = 5). In one case, a mother attended with the maternal grandfather, while in the other, a mother participated alongside both maternal grandparents. The remaining 96 caregivers attended the workshop alone, without a co-parent. Taken together, data were collected for 170 children based on parent reports (see Table 1 for detailed demographic information regarding caregivers and children). Caregivers ranged in age from 28 to 71 years (M = 44.93, SD = 7.59), while children (51.9% female) were between 4 months and 26 years of age (M = 10.82, SD = 4.91). The majority of caregivers had a high level of education; out of the 235 who disclosed their educational background, approximately 42% had completed a college or university degree, and 52% had pursued postgraduate (post-university) education. In terms of household income, approximately 46% of participants reported an annual income of $101,000 or more, while 12% fell within the $61,000–$100,000 range, 5% reported an income between $41,000 and $60,000, and 9% had a household income of $40,000 or less. A notable portion (approximately 28%) chose not to disclose their income.

At the time of workshop registration, caregivers identified a wide range of mental health concerns for their children (see Appendix A for the registration form), including anxiety, depression, inattention and/or hyperactivity, eating disorders, substance abuse, behavioral

challenges (e.g., tantrums, oppositional behavior), somatic symptoms, low self-esteem, trauma, and other emotional, social, or relational difficulties requiring clinical attention (e.g., anger issues, emotional dysregulation, attachment struggles, or conflicts with siblings or peers). Many caregivers reported multiple concerns, with approximately 34% identifying two, 21% listing three, and 13% noting four or more. Diagnostic history was available for a subset of children (n = 199), indicating that half of the children had a previously diagnosed mental health condition, with anxiety disorders, ADHD, and depression being the most prevalent (see Table 2 for more information on child presenting concerns).

Intervention

For this study, EFFT was delivered as an intensive 2-day caregiver group intervention. The structured intervention was comprised of four components to assist parents/caregivers in (1) processing their own emotional blocks and self-interrupting emotional experiences in order to be able to meaningfully and wholeheartedly engage with their children's struggles; (2) becoming their children's emotion coach through guidance on emotion regulation; (3) becoming their children's behaviour and recovery coach through symptom interruption and intervention; (4) building and maintaining the parent-child relationship and addressing aspects of relationship strain that could worsen symptomatology. The clinician leading the workshop works to provide psychoeducation, assist caregivers in working through any difficult emotions or blocks while engaging with the material, as well as facilitates experiential exercises to engage and lead caregivers in mastering the skills associated with the four EFFT components (Foroughe et al., 2023; Foroughe et al., 2019; Henderson, & Mayman, 2020; Lafrance Robinson). The same supplementary materials were used and distributed at each intervention, including audio-visual aids, presentation slides, and skill illustrative examples, to ensure consistency across workshops.

Measures

Child symptomatology. General child clinical symptomatology was measured through the Strengths and Difficulties Questionnaire - SDQ (Goodman, 1997; Appendix D). This 25-item measure evaluates the overall mental health of children aged 2 to 17 years. It consists of five subscales, each containing five items: emotional symptoms (e.g., "Frequently unhappy, depressed, or tearful"), conduct issues (e.g., "Takes things that don't belong to them from home, school, or other places"), hyperactivity/inattention (e.g., "Easily distracted, has trouble maintaining focus"), peer relationships (e.g., "Has at least one close friend"), and prosocial behavior (e.g., "Offers help when someone is hurt, upset, or unwell"). The questionnaire was designed based on diagnostic criteria from the DSM-IV (American Psychiatric Association, 1994) and the ICD-10 (World Health Organization, 1992), capturing both strengths and difficulties in child behavior. There are nearly identical versions of the questionnaire for parents, teachers, and children themselves, making it useful for both clinical and research purposes. In this study, caregivers completed the SDQ, rating each item on a three-point Likert scale (0 = Not True, 1 = Somewhat True, 2 = Certainly True) to indicate how well each statement applied to their child (Goodman, 1997; Goodman & Scott, 1999). Each subscale produces a score between 0 and 10, and except for the prosocial behavior subscale, these can be combined into an overall difficulties score ranging from 0 to 40. An extended version of the SDQ was used in this study, incorporating the Impact Supplement. This additional section asked caregivers about the duration, severity, and distress caused by the child's difficulties. It also assessed how these challenges affected different areas of daily life, such as home and school, as well as the burden placed on the family as a whole. Previous research has reported a Cronbach's alpha of $\alpha = 0.83$ for total difficulties, with reliability scores for the four core subscales ranging from $\alpha = 0.63$ to

0.77, and a lower reliability of $\alpha = 0.46$ for the peer problems subscale (Bourdon et al., 2005). In the present study, internal consistency was found to be adequate to strong across various time points for emotional difficulties ($\alpha = 0.73 – 0.82$), conduct problems ($\alpha = 0.69 – 0.75$), hyperactivity/inattention ($\alpha = 0.79 – 0.85$), prosocial behavior ($\alpha = 0.69 – 0.81$), and total difficulties ($\alpha = 0.74 – 0.85$). The peer problems subscale, however, showed lower reliability, ranging from $\alpha = 0.55$ to 0.74.

Child emotion regulation. Caregivers assessed their child's emotional regulation abilities using the Emotion Regulation Checklist - ERC (Shields & Cicchetti, 1997; Appendix E), a tool designed for children aged 6 to 12. This 24-item questionnaire employs a 4-point Likert scale (1 = Never, 2 = Sometimes, 3 = Often, 4 = Almost Always) and consists of two subscales: Negativity/Lability, which measures emotional instability and negative affect, and Emotion Regulation, which evaluates adaptive emotion management, including traits like empathy and composure. The Negativity/Lability subscale comprises 15 items (e.g., “Displays extreme mood swings” and “Becomes frustrated easily”), while the Emotion Regulation subscale includes eight items (e.g., “Can express when they feel sad, angry, afraid, or mad”). Subscale scores are calculated by summing the relevant items, with some requiring reverse scoring. The Negativity/Lability scale ranges from 15 to 60, with higher scores indicating greater emotional dysregulation, whereas the Emotion Regulation scale ranges from 8 to 32, with higher scores reflecting stronger emotional regulation skills. The ERC demonstrates strong reliability, with reliability coefficients of 0.96 for the Negativity/Lability subscale and 0.83 for the Emotion Regulation subscale, respectively (Shields & Cicchetti, 1997). Its convergent and discriminant validity have been established, showing strong correlations with observer ratings of child emotion regulation while distinguishing it from other emotional constructs (Shields & Cicchetti,

1997). In the present study, internal consistency for the ERC was found to be good to strong across all time points, with alpha coefficients ranging from $\alpha = 0.87$ to $\alpha = 0.90$ for the Negativity/Lability subscale and $\alpha = 0.75$ to $\alpha = 0.76$ for the Emotion Regulation subscale.

Parental self-efficacy. Caregivers assessed their sense of self-efficacy in supporting their child's recovery from mental health challenges using a modified version of the Parent versus Anorexia Scale (Rhodes, Baillie, Brown, & Madden, 2005), referred to as the Parent versus General Mental Health scale – PvGMH (Appendix H). Originally designed for parents of children with anorexia (Rhodes et al., 2005), this adapted version replaced the term "anorexia" with "general mental health difficulties" to broaden its applicability. The scale consists of seven items, each rated on a five-point Likert scale (1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree). The total score ranges from 7 to 35, with higher scores reflecting greater self-efficacy. An example statement from the scale is, "I feel equipped with specific strategies for the task of bringing about the complete recovery of my child in the home setting." The original Parents versus Anorexia (PvA) scale has shown good psychometric properties, including an internal reliability coefficient of 0.78 and strong positive correlations with other measures of internal control (Rhodes et al., 2005). In the current study, reliability coefficients for the PvGMH scale ranged from $\alpha = 0.51$ to $\alpha = 0.71$ across different time points.

Parental emotion blocks. The Parent Traps Scale - PTS (Lafrance Robinson, 2014; Appendix G) is a tool designed to evaluate caregivers' susceptibility to emotional barriers that may hinder their ability to support their child's recovery. It measures the extent to which parents experience fears that interfere with their caregiving role. The scale was developed based on clinical insights and parental feedback regarding concerns about helping a child recover from anorexia. Caregivers assess their vulnerability to 14 specific fears (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 total score ranges from 14 to 98, with higher scores indicating greater caregiver fear. Previous studies have reported Cronbach's alpha values between $\alpha = 0.71$ (Stillar et al., 2016) and $\alpha = 0.90$ (Lafrance Robinson et al., 2014), demonstrating good reliability. In the present study, internal consistency remained strong across all time points, with Cronbach's alpha values ranging from $\alpha = 0.90$ to $\alpha = 0.93$.

Parental reflective functioning. Until recently, reflective functioning measures have been dependent on interview data, narrative coding, or observation and coding of parent-infant dyad interactions (Cooke et al., 2017). These ways of assessment have since proven to be difficult to administer on a larger scale and present with considerable expense as well (both financially and in terms of training/ administration/ coding time), proving impractical for more widespread research (Cordeiro, 2019; Pajulo et al., 2015). In the interest of providing a more convenient assessment tool, researchers have since developed various paper-pencil self-report alternatives, one of which was the Parental Reflective Functioning Questionnaire – PRFQ (Luyten et al., 2017; Appendix F). The PRFQ is a multidimensional self-report questionnaire of parental reflective capacity, which was created based on Peter Fonagy's previous work on behaviour coding systems (Fonagy et al., 2016). The measure is designed to capture the three integral theoretical components of PRF through a series of 18 statements, yielding three subscales with 6 items each. Measured components include: (1) Pre-Mentalizing modes (PM); (2) Interest and Curiosity in Mental States (IC); (3) Certainty about Mental States (CMS). All responses are on a 7-point Likert-type scale (ranging from 1 = Strongly Disagree to 7 = Strongly Agree). The PM scale evaluates maladaptive aspects of reflective functioning, often reflected in significant

impairment of parents' ability to understand their child's mental states as separate from their own (e.g., "My son always cries when I have to do something important just to stop me from getting it done"). Higher scores on the PM scale indicate lower reflective capacity. The IC scale works to assess a parent's or caregiver's mental curiosity about their child's behaviour and emotional motivation (e.g., "I often try to consider why my child behaves the way they do"). The CMS scale measures caregiver's ability to understand the opaqueness of mental states, both their and their child's, as well as their openness to different perspectives (e.g., "I know exactly why my child does what they do"). In this case, both too little and too high levels of certainty indicate lower levels of reflective capacity. The PRFQ has shown high levels of internal consistency in all 3 subscales (α =.70 for PM; α =.74 for IC; α =.82 for CMS), as well as construct validity through a strong correlation with emotional capacity, parental/ infant attachment, and parenting stress/distress (Luyten et al., 2017, Rutherford et al., 2013). The majority of existing research on PRF focuses solely on the PM scale. We will be analyzing outcomes of both the PM and IC scales for the purposes of this study. The CMS scale was excluded from analyses due to its lack of straightforward directionality (i.e., the "ideal" score for the scale falls in the middle of its score range, as opposed to a straightforward decrease or increase) and subsequent complications in interpretation of moderating relationships for other PRFQ scales and parent measures.

Analyses

All analyses were conducted with R statistical software (R Core Team, 2023). A nominal Type I error rate of $\alpha = 0.05$ was applied to all hypotheses.

Normality and Outliers

The distribution of each variable at different study time points was analyzed using the Shapiro-Wilk test for normality (Shapiro & Wilk, 1965), with the addition of visual tools such as

boxplots, histograms, and Q-Q plots, to detect any potential univariate or multivariate outliers. Outliers were identified in several subscales, including the Emotion Regulation subscale (at registration and post-treatment) and the Negativity/Lability subscale (at pre-treatment and the 8-month follow-up) of the ERC. Additionally, outliers were observed in the IC (all time points), and PM (all time points) subscales of the PRFQ, as well as in the Total (4-month follow-up), Conduct (8-month follow-up), and Peer Problems (registration, 4-month, and 12-month follow-ups) subscales of the SDQ. The PvGMH scale also showed outliers across all time points.

Despite the presence of extreme values, these outliers were retained in the analysis because they were considered clinically meaningful, as they reflected actual elevated symptoms within the clinical sample. Separate analyses were run without outliers and indicated no significant changes in outcomes.

The PM subscale of the PRFQ exhibited positive skewness at certain time points, suggesting that parents rarely attributed malevolent intent to their child's behavior. Additionally, the IC subscale of the PRFQ displayed mild negative skewness across multiple time points. However, the original data were preserved, as skewness was not consistent across all time points and was not severe enough to warrant transformation.

Missing data

Missing data arose due to several reasons: (1) caregivers skipped individual questionnaire items, (2) they failed to return an entire questionnaire package at a given time point, and (3) they withdrew from the study or stopped responding during the follow-up period. Responses for each variable were included in the analysis if participants had completed at least 75% of the questionnaire or subscale items. In cases where a participant partially completed a questionnaire, only one instance was found in which more than 25% of the items were missing; as a result, that

participant's score for the scale was not calculated. When missing responses occurred in scales that required total scores, missing values were replaced with the mean of the participant's responses across the remaining items within the same scale or subscale (i.e., were averaged to a total score).

To address missing data—whether entire scales or specific time points—the maximum likelihood estimation method was applied. This approach is preferred over data imputation or listwise deletion as it provides unbiased and efficient parameter estimates, especially in large samples (Cordeiro, 2019; Raudenbush & Bryk, 2002). Under the assumption that data were missing at random (meaning that the likelihood of missing data was unrelated to the missing variable itself), the maximum likelihood method ensured that all available data contributed to model estimations, enhancing overall model fit.

Hypothesis Testing

Mixed effects modelling was selected for the majority of the outcome analyses due to several key advantages. First, it facilitates the analysis of individual differences in patterns of change over time (Raudenbush & Bryk, 2002). Second, it accounts for the structure of dependent (or nested) data, which is particularly useful in longitudinal studies with repeated measurements, where data points collected over time tend to be correlated (Nezlek, 2008). Furthermore, since nearly half of the caregivers in this study were part of co-parenting units, the child-related data reported by parents were not independent, which can increase the risk of Type I error when using ordinary least squares regression (Kenny, Kashy, & Cook, 2006). Mixed effects modeling overcomes this challenge by adjusting for the nested nature of grouped and repeated measures data (Raudenbush & Bryk, 2002). Additionally, this approach accommodates missing data without excluding cases from the analysis, as noted above.

Correlation analyses of individual differences in parent PRFQ subscale scores and other child/parent measures were assessed at time of registration (T0) to determine whether baseline PRF levels were correlated with parent and child symptomatology prior to treatment (i.e., if parents with higher reflective functioning report lower child and parent concerns on average, regardless of treatment).

Mixed effects modelling was then used to examine if any significant differences in parent reported PRFQ scores occurred because of the waiting period between the registration phase (T0) and the pre-treatment phase (T1). This same model was then fitted across all 6 timepoints to examine the impact of the EFFT workshop on changes in PRF immediately post-intervention (T2), as well as 4- (T3), 8- (T4), and 12-months (T5) following.

Next, mixed effects models were used to explore the impact of baseline PRFQ subscale scores on treatment responsiveness for parents (i.e., if parents who showed greater/ lesser reflective capacity at baseline also showed more/less significant improvements in other measures following the workshop).

Finally, comparisons of individual changes in scores across all parent and child-related measures were conducted, incorporating all six study time points into the model to determine if there were any moderating effects between changes in parental PRF and other parent outcomes (PTS, PvGMH) on child outcomes (SDQ, ERC) over the 12 months following treatment. All data was nested by child ID to account for grouped data between co-parents. Effect sizes were examined and presented as unstandardized, as the average change in measurements across phases, in accordance with Wilkinson's (1999) recommendations for mixed-effects model analysis.

Given that workshop and study registration was open to participants up to a week prior to the intervention (which is when the pre-intervention T1 questionnaires were typically completed), some participants did not complete both sets of pre-intervention questionnaires (T0 and T1) due to closeness of timepoints. As no waitlist effects were observed in parent or child measures in previous studies (Cordeiro, 2019), this data was recorded under the T0 timepoint (rather than T1) for further analyses to remain consistent with the remaining baseline registration data.

Results

Research Question 1:

We examined if parental reflective functioning had a significant correlation to child and parental difficulties prior to engaging in EFFT. Pearson's correlation testing revealed multiple significant correlations between PRFQ subscales and parent/child outcome measures at time of registration (T0). Poor mentalization (PM-PRFQ) was significantly positively correlated with both increased child difficulties (SDQ; $r = 0.46$) and increased levels of parent fears/traps (PTS; $r = 0.30$), as well as significantly negatively correlated with lower levels of child emotion regulation capabilities (ERC; $r = -0.42$) and lower levels of parental self-efficacy (PvGMH; $r = -0.18$). Higher levels of interest and curiosity (IC-PRFQ) were only significantly positively correlated with higher levels of parental self-efficacy (PvGMH; $r = 0.22$). See Table 3 for a full correlation matrix.

Research Question 2:

Mixed effects modelling was used to examine if baseline parental reflective functioning was predictive of immediate treatment response for parents (T0-T2). Baseline level of mentalization was not significantly predictive of changes in levels of parent fears/traps (B = -

2.16, $p = 0.13$) nor parent self-efficacy ($B = 0.19$, $p = 0.62$). Baseline levels of interest and curiosity also were not significantly predictive of changes in parent traps ($B = -0.18$, $p = 0.89$) nor parent self-efficacy ($B = 0.09$, $p = 0.79$), indicating that baseline reflective functioning is not predictive of how treatment is received by parents in the short-term. Full results are outlined in Table 4.

Research Questions 3/3a:

Mixed effects modelling examining the trajectory of PRF changes pre- and post-intervention demonstrated no significant changes in mentalization between registration and the intervention (PM: PRFQ, $p = 0.45$), indicating that levels of parental mentalization remained relatively stable before treatment. Statistically significant changes from baseline (T0) to final follow-up (T5) were observed in the PM subscale at $p < 0.01$, with the initial significant decrease occurring at 4-months post-intervention (T3; $p = 0.03$) and maintaining at 8- and 12-months ($p < 0.01$; see Table 5, Figure 1), demonstrating the maintenance of treatment gains over time. A small but significant decrease in interest and curiosity (IC-PRFQ; $p = 0.002$) was observed during the waiting period (T0-T1), indicating a decrease in average parental interest and curiosity about their children's mental states as the workshop approached. However, the results are inconsistent as there were no significant changes observed in the IC scale in the 12 months following the intervention (see Table 5, Figure 2).

Research Question 4:

Mixed effects modelling was used to test if improvements in PRF predict improvements in other outcomes for parents and children.

Parent outcomes. Improvements in mentalization (PM-PRFQ) were predictive of a decrease in levels of parent fears/traps (PTS; $p < 0.01$) and an increase in parental self-efficacy

(PvGMH; $p < 0.01$) at 4 months following the intervention (T3). However, while improvements in parent fears/traps remained significantly predicted by PRF changes at 8 months following the intervention (T4; $p < 0.01$), they were not maintained at 12 months (T5; $p = 0.06$). Similarly, improvements in parental self-efficacy as predicted by improvements in mentalization were initially not maintained at 8 months (T4; $p = 0.06$) but were significant at 12 months (T5; $p = 0.04$) following the intervention. Additionally, improvements in parental interest and curiosity (IC-PRFQ) were only significantly predictive of improvements in parental self-efficacy at 4 months (T3; $p = 0.03$), indicating a relatively inconsistent maintenance of gains on parental measures with PRF as a predictive factor. See Table 6 for parent outcome analyses.

Child outcomes. Trajectories of change in child outcomes were examined to determine if there was a moderating relationship between PRF and other parental outcomes in predicting changes in child symptomatology. We found that improvements in mentalization alone (PM-PRFQ) were significantly predictive of improvements in child emotion regulation capacity (ERC; $B = -2.4$, $p < 0.01$). Additionally, we observed an interaction between improvements in mentalization (PM-PRFQ) and interest and curiosity (IC-PRFQ) in predicting changes in levels of child difficulties (SDQ; $B = 1.3$, $p = 0.02$), wherein improvements in mentalization resulted in an increase of the effect of parental interest and curiosity on reducing total child difficulties (see Figure 3; Table 7).

The only significant interaction between PRF and other parent measures on child outcomes was between interest and curiosity (IC-PRFQ) and parent traps (PTS) on child emotion regulation (ERC; $B = -0.09$, $p < 0.01$), with increases in parental interest and curiosity significantly reducing the effect of parent traps/fears surrounding parenting on child emotion regulation capacity over the follow-up period (see Figure 4; Table 7).

Discussion

We conducted this study with two primary goals in mind: (i) to evaluate the impact of a brief, intensive multi-caregiver Emotion Focused Family Therapy (EFFT) intervention on levels parental reflective functioning (PRF), and (ii) to investigate whether PRF moderates mechanisms of change in caregiver and child outcomes following EFFT. Research to date has examined the effectiveness of EFFT on a wide range of parent and child mental health outcomes (Cordeiro, 2019; Foroughe et al., 2019; Foroughe et al., 2023). To our knowledge, this is the first study to empirically assess the effects of PRF in its possible connection to other family outcomes in EFFT.

Parental Reflective Functioning as an Outcome of EFFT: Summary and Findings

It has been proposed that healthy parental reflective functioning —characterized by a genuine interest in understanding a child's mental states and recognizing the inherent complexity, and separation of these states from that of the parents' —supports positive development and may significantly influence therapeutic outcomes for both the child and caregiver (Fonagy, Gergely, & Target, 2007). In line with this, we initially analyzed correlations between levels of reflective functioning and general parent and child mental health before engaging in EFFT. Lower levels of mentalization were revealed to be directly correlated with increased difficulties for both parents and children, with parents that had more difficulty mentalizing or reflecting on their children's mental states reporting significantly more fears and less confidence around parenting. This is in concert with previous research that posits that levels of parental reflective capacity directly influence the extent to which parents are able to effectively support and manage their child's individual emotional experiences during times of distress (Fonagy & Target, 2002), arguably leaving parents that are unable to reflect and

mentalize on their children's states with less ability to regulate their children's emotions, which may result in or contribute to a sense of parental inefficacy and emotional blocks surrounding parenting. Moreover, PRF is believed to foster the child's own reflective functioning, which plays an important role in the development of a coherent sense of self, emotional regulation, personal agency, and secure attachment to others, all believed to be crucial psychological processes in healthy development both in childhood and adulthood (Ensink & Mayes, 2010). Concurrently, our initial findings indicated that children of parents with poorer reflective functioning demonstrated significantly higher levels of overall behavioural, emotional, and regulatory challenges. This was the strongest between-parent-and-child correlation in the baseline analyses, further stressing the importance of PRF in both parent and child outcomes.

As PRF has been established as an important factor in family and child mental health, we examined PRF as an outcome of EFFT, to determine if this intervention, which has shown promising results in addressing a variety of family mental health difficulties (Foroughe et al., 2023; Cordeiro, 2019) also affects parents' ability to meaningfully reflect on their child's mental states and motivations. We hypothesized that caregivers would show immediate gains in reflective functioning following the intervention, as other caregiver outcomes have been observed to significantly improve in this pattern in previous research (Foroughe et al., 2023). Overall, caregivers demonstrated significant improvements in mentalization at 12 months following EFFT, however significant gains were not initially observed until the 4-month mark (T3). Previous research examining general child outcomes in this sample (Cordeiro, 2019, Foroughe et al., 2023) reported that significant changes in child difficulties were not observed until the 4-months (T3) following the workshop, noting that parents most likely need time to implement learned EFFT skills and repair any ruptures in their relationship with their children

before certain treatment gains were observed. It may follow that parents do not experience significant improvements in their ability to mentalize until they are able to engage with their children and practice separating their children's mental states from their own through EFFT skills. That said, there is also a possibility that improvements in mentalization are themselves mediated by improvements in other parent outcomes over the course of the follow-up period. There is a possibility that, as parents start to implement EFFT skills successfully and their children begin to improve, the reduction in fears and increase in confidence surrounding parenting concurrently facilitates parents' general ability to mentalize more successfully and attribute less maladaptive motivations to their children's mental states through trial and exposure. It is possible that parental fear inhibits mentalization in subtle ways, wherein parents that are anxious or uncertain about their parenting may become more reactive or self-focused, reducing their capacity to separate their child's emotional world from their own. Conversely, parents who feel more confident in their understanding of their child motivations and are more emotionally steady, may not only be better understanding their child but also more effective in translating that understanding into helpful, emotionally attuned responses. Regardless of process, however, gains in PRF were demonstrated to be present and maintained within this study, indicating that brief intensive EFFT may be an effective intervention in working with caregivers with difficulties in reflective functioning, which have proven to be linked to a variety of positive child outcomes.

Influence of PRF on Caregiver and Child Mental Health Outcomes in EFFT: Summary and Findings

Research has reliably demonstrated that involving parents or caregivers in the treatment of children's behavioral and emotional issues leads to better child outcomes (Brendel &

Maynard, 2014; Dietz et al., 2015; Dowell & Ogles, 2010; Haine-Schlagel & Walsh, 2015) and enhances overall family functioning and mental well-being (Poole et al., 2017). The way parents or caregivers respond to a child's distress can significantly impact the effectiveness of treatment (Bokszczanin, 2008; Lafrance Robinson et al., 2014; Scheeringa & Zeanah, 2001; Stillar et al., 2016; Valentino et al., 2010; Williamson et al., 2016; Wise & Delahanty, 2017), with negative emotional reactions, such as fear, shame, frustration, and sadness, are particularly likely to obstruct caregivers' ability to use the appropriate skills needed to support their child's recovery (Foroughe, 2019; Heath et al., 2015; Lafrance Robinson et al., 2014; Stillar et al., 2016). There has been evidence that parents with lower levels of reflective functioning often exhibit these emotions in relation to their understanding of their child's mental states, which directly affect their ability to respond to their child's distress and regulate their emotions (Ensink & Mayes, 2010). Considering EFFT's emphasis on parental involvement in child therapy and work with parental blocks, we hypothesized that PRF might play an important moderating role in the mechanisms of change in family and child outcomes following EFFT.

We found that parental ability to mentalize was significantly predictive of better child emotion regulation capacity, which is in concert with previous research indicating that parental mentalization allows for the development of child mentalization and general regulatory skills, as noted above. In addition to this, parental mentalizing ability and genuine interest and curiosity in their child's thoughts, feelings, and intentions were found to be significant predictors of reduced emotional and behavioural difficulties in children. This suggests that when parents are both attuned to and actively engaged with their child's mental states, they may be better equipped to respond to their child's needs in a thoughtful and supportive way. By understanding not just what their child is doing, but why they might be doing it, and what they might be feeling or thinking,

parents could be more likely respond with greater sensitivity and appropriateness. This combination of cognitive empathy and emotional engagement may help foster a deeper parent-child connection, which may act as a protective factor against a range of psychological challenges in child development in both the short- and long-term.

Last, parents' genuine interest in their children's mental states, along with decreased fears about parenting showed to be significantly predictive of better emotion regulation capacity in children. This was a somewhat surprising outcome considering child emotion regulation ability has generally been more directly linked to parental mentalization. One possible explanation is that parental interest and reduced anxiety around parenting contribute to a more emotionally safe and responsive environment for the child. More specifically, that when a parent shows genuine curiosity without judgment and is not overly burdened by fear or self-doubt in their role, they may be more attuned, more emotionally present, and more consistent in their interactions with their children, which may in turn help children feel more secure, more understood, and more emotionally supported, contributing to their own capacity to explore, manage, and regulate their emotions in a safe emotional environment.

These findings invite a broader perspective on how different factors of parental functioning interact to support child development. It may be that, while mentalization provides the framework for understanding a child, it is the parent's emotional openness and security in the parenting role that bring that framework to life in meaningful, emotionally impactful ways. However, we do not want to overemphasize this, as it is not consistent across the sample and requires further research to be stated with more certainty.

No other significant changes in child symptomatology as a result of PRF and other parent outcomes were found. Given this, it does not seem that PRF contributes additional benefits when

numerous improvements are already occurring, but is rather another part of a broader array of positive changes brought about by the therapy as a whole. That said, while there is no definitive evidence that improvements in parent and child outcomes are a direct function of PRF, it is clear that improvements are present, consistent, and clinically relevant.

Limitations and Future Directions

This study has several limitations that should be considered. First, the data utilized in this study were exclusively based on parental self-reports, which are known to carry certain biases (Rosenman, Tennekoon, & Hill, 2011). It is likely that observed improvements in children's behavioural and emotional functioning reflect both genuine behavioral changes in the children due to parents applying skills taught in the intervention, as well as shifts in how parents perceive and interpret their child's behavior as a result of improvements in their own mental health surrounding parenting. Despite the limitations of self-reported data, the use of caregiver perspectives remains valuable, especially considering the intervention was designed for them. However, future research would benefit from incorporating additional viewpoints, such as teacher assessments or clinician observations of the child's behaviour. Including reports directly from children would also offer meaningful insights into the parent-child dynamic post-intervention, revealing how parental behavior may have changed and how those changes are perceived by the child, with age-appropriate considerations.

Second, this study used the Parental Reflective Functioning Questionnaire (PRFQ; Luyten et al., 2017), which is still a relatively under-researched measure in assessing reflective capacity in parents and additional research is necessary to fully evaluate its reliability and validity. Our lab is currently conducting an in-depth psychometric analysis of the measure for this reason. In the current study, the PRFQ was used with all parents, regardless of their child's

age, which ranged from 4 months to 26 years. However, it is currently unclear how well the PRFQ performs with children outside the intended age brackets (i.e., 0 to 5 years for the child version and 12 to 18 years for the adolescent version). Future analyses should investigate whether removing data from participants whose children fall outside the designated age ranges would impact the overall findings.

Last, the EFFT intervention workshops were facilitated by a clinical psychologist, with direct training and supervision from the model's co-founders. It is possible that some variation in participant outcomes was, in part, influenced by the extent of expertise of the facilitator. This factor warrants due consideration when interpreting the study's findings, given that a clinician's confidence and proficiency in a specific therapeutic approach can have a meaningful impact on a treatment's effectiveness in itself.

Future research should work to investigate additional possible mechanisms of change in EFFT, as it may help identify specific aspects of parental processing that are linked to better outcomes. Our research team is currently working on assessing the depth of emotional processing during the EFFT workshops in the present study sample, which has been shown to be a key element of the change process in experiential therapies such as EFT and EFFT in previous research (Pos & Greenberg, 2007; Pos et al., 2017).

Conclusion

This study has demonstrated that parental reflective functioning is an important contributing factor in child and family mental health. Additionally, we have demonstrated that there is consistency in improvements in PRF as a result of an intensive 2-day EFFT intervention, which has already shown to be effective in treating a variety of other parent and child mental health challenges. We were unable to confidently isolate the specific interplay of variables

driving the improvements observed following EFFT, however, while it may not be that the mechanism of change is a function of PRF, improvements in PRF are significant and stable and in themselves important for parent and child outcomes both in the short- and long-term. Additional research is needed to further disentangle the mechanisms of change in family outcomes following EFFT.

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TABLES

Table 1. *Baseline Sample Demographics*

Demographic	**Sample Amount (%)**
Mean Parent Age (SD)	44.93 (7.59)
Parent Gender	
Female	68.8%
Male	31.2%
Household Income[a]	
$0 - $20,000	3.3%
$21,000 - $40,000	5.7%
$41,000 - $60,000	5.6%
$61,000 - $80,000	4.7%
$81,000 - $100,000	7.3%
$101,000 +	46.4%
Preferred not to respond	27.2%
Highest Education Obtained	
Postgraduate Degree	47.3%
Some Postgraduate Training	4.7%
Undergraduate/ College Degree	42.1%
Trade/ Technical/ Vocational Training	0.8%
Some Undergraduate/ College Training	3.2%
High School Graduate	1.6%
Some High School	0.4%
Marital Status	
Never Married	3.2%
Married/ Common Law	75.1%
Widowed	0.5%
Parents Separated	6.2%
Parents Divorced	10.1%
Preferred not to respond	5.0%
Attended with Co-parent	61.2%
Relationship to Child	
Biological Mother	63.3%
Biological Father	29.9%
Adoptive Mother	2.9%
Adoptive Father	0.9%
Stepmother	0.4%
Stepfather	0.9%
Foster Mother	0.8%
Grandparent	1.3%
Other	1.3%
Ethnicity	
Caucasian	87.6%
Black	2.5%

Hispanic	2.6%
Pacific Islander	1.6%
European	15.2%
West Indian	3.4%
Middle Eastern	5.8%
East Asian	9.1%
South Asian	4.3%
First Nations	1.8
Other	2%
Mean Child Age (SD)	10.82 (4.91)
Child Gender	
Female	51.9%
Male	48.1%

[a]Household income was calculated using the number of distinct households in the sample (n =), rather than individual participants, to account for cohabiting co-parents.

Table 2. *Child Presenting Concerns at Baseline*

Child Presenting Concern Data	**Sample Amount (%)**
Mean Number of Concerns (SD)	2.20 (1.06)
Number of Concerns	
1	30.8%
2	34.3%
3	21.4%
4	13.6%
Most Common Presenting Concerns	
Anxiety	37.4%
Social/Emotional Difficulties	65.1%
Behavioural Dysregulation	43.3%
Depression	15.9%
Eating Disorder	7.3%
Self-esteem	6.2%
Trauma	3.9%
Previous Diagnosis	
Yes	51.3%
No	48.7%

Note. Child clinical profiles were provided by their caregiver(s) during registration. No official evaluation of either the parent or child was conducted at that time.

Table 3. *Between-measure Correlation Matrix at time of registration (T0)*.

Variable	M	SD	1	2	3	4	5
1. Pre-Mentalizing (PRFQ)	1.95	0.72					
2. Interest & Curiosity (PRFQ)	5.84	0.78	-0.20** [-.33, -.08]				
3. Child Total Difficulties (SDQ)	15.85	5.55	0.46** [.34, .56]	-0.04 [-.17, .10]			
4. Child Emotion Regulation (ERC)	64.43	10.67	-0.42** [-.53, -.31]	0.04 [-.09, .18]	-0.72** [-.78, -.65]		
5. Parent Fears/Traps (PTS)	50.32	17.91	0.30** [.17, .41]	-0.08 [-.05, .22]	0.25** [.12, .38]	-0.30** [-.42, -.17]	
6. Parent Self-efficacy (PvGMH)	20.08	3.59	-0.18** [-.34, -.05]	0.22** [.10, .35]	-0.24** [-.37, -.11]	0.19** [.05, .31]	-0.20** [-.33, -.07]

Note. Values with * indicate a significant correlation at the $\alpha = .05$ level. Values with ** indicate a significant correlation at the $\alpha = .01$ level.

Table 4. *Immediate changes in caregiver outcomes as predicted by baseline PRF levels.*

		T0 – T2				
Predictor	**Outcome**	***B***	***t***	***df***	***p***	**95% CI**
PRF-PM	PTS	-2.16	1.33	63	0.13	-4.93, 0.63
PRF-PM	PvGMH	0.20	0.50	63	0.62	-0.57, 0.95
PRF-IC	PTS	-0.18	-0.14	63	0.89	-2.78, 2.42
PRF-IC	PvGMH	0.09	0.27	63	0.80	-0.61, 0.76

Note. PRF-PM represents the Pre-Mentalizing Scale of the Parental Reflective Functioning Questionnaire. PRF-IC represents the Interest & Curiosity Scale of the Parental Reflective Functioning Questionnaire. PvGMH represents the Parents vs. General Mental Health Measure. PTS represents the Parent Traps Scale Measure.

Table 5. *Changes in PRFQ subscales from baseline (T0) to final follow up (T5).*

	Pre-Mentalizing (PM)				**Interest & Curiosity (IC)**			
Timepoints	***M(SD)***	***t***	***df***	***p***	***M(SD)***	***t***	***df***	***p***
T0	1.95 (0.7)				5.84 (0.9)			
T1	2.04 (0.8)	0.75	1033	0.45	5.58 (0.8)	-3.40	1034	0.00**
T2	1.95 (0.8)	-0.68	1033	0.15	5.71 (0.9)	1.82	1034	0.10
T3	1.89 (0.7)	-2.07	1033	0.03*	5.73 (0.9)	1.43	1034	0.10
T4	1.79 (0.6)	-3.66	1033	0.00**	5.75 (0.8)	1.63	1034	0.15
T5	1.83 (0.7)	-2.80	1033	0.00**	5.73 (0.9)	1.43	1034	0.10

Note. Values with * indicate a significant change at the $\alpha = .05$ level. Values with ** indicate a significant change at the $\alpha = .01$ level.

Table 6. *Parent outcome changes as predicted by changes in PRFQ subscales.*

		B (p)			
Predictor	**Outcome**	***T2***	***T3***	***T4***	***T5***
PRF-PM	PTS	3.01 (0.06)	4.61 (0.01**)	6.65 (0.00**)	0.32 (0.86)
PRF-PM	PvGMH	-0.35 (0.43)	-1.26 (0.01**)	-0.46 (0.31)	-0.98 (0.04*)
PRF-IC	PTS	1.70 (0.23)	0.91 (0.56)	3.04 (0.09)	-0.11 (0.95)
PRF-IC	PvGMH	0.49 (0.21)	0.89 (0.03*)	0.26 (0.56)	0.94 (0.06)

Note. PRF-PM represents the Pre-Mentalizing Scale of the Parental Reflective Functioning Questionnaire. PRF-IC represents the Interest & Curiosity Scale of the Parental Reflective Functioning Questionnaire. PvGMH represents the Parents vs. General Mental Health Measure. PTS represents the Parent Traps Scale Measure. Values with * indicate a significant interaction at the $\alpha = .05$ level. Values with ** indicate a significant interaction at the $\alpha = .01$ level.

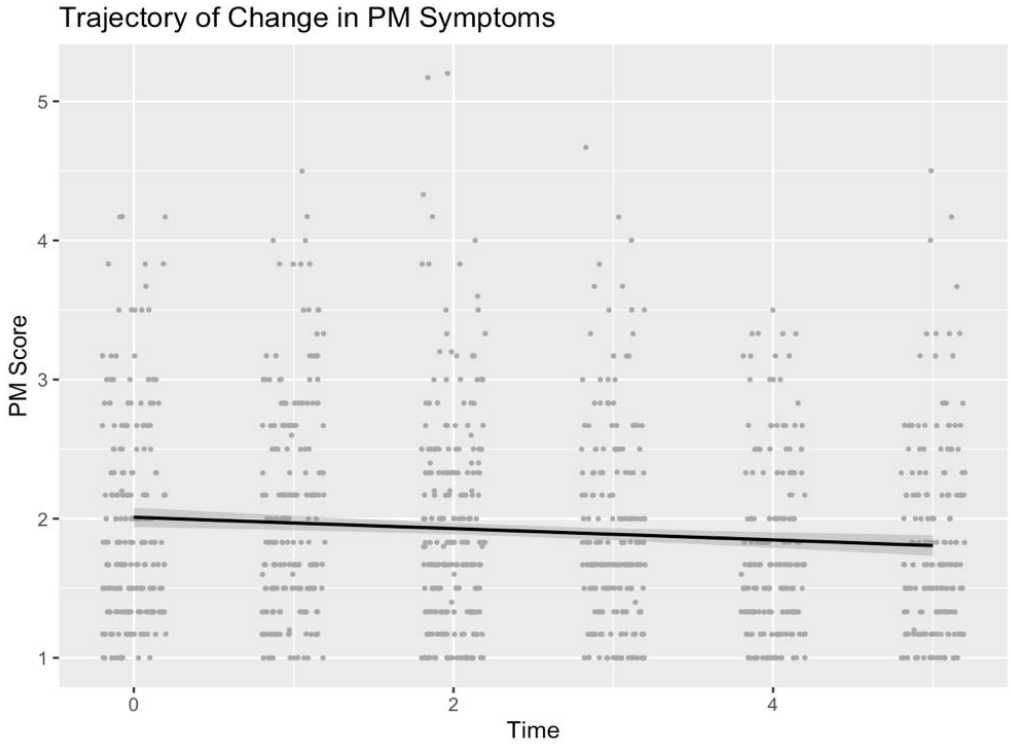
Table 7. *Child outcome changes as predicted by changes in PRFQ and other parent outcomes.*

	Total Difficulties (SDQ)			Emotion Regulation (ERC)		
Moderating Variables	***B***	***df***	***p***	***B***	***df***	***p***
PRF-PM	0.61	545	0.12	-2.40	601	0.000**
PRF-IC	0.17	545	0.60	-1.28	601	0.42
PRF-PM:PRF-IC	1.30	545	0.02*	-0.43	601	0.56
PRF-PM:PvGMH	0.05	545	0.48	-0.10	601	0.33
PRF-IC:PvGMH	-0.05	545	0.34	0.07	601	0.42
PRF-PM:PTS	-0.03	545	0.19	0.002	601	0.94
PRF-IC:PTS	0.01	545	0.52	-0.09	601	0.008**
PRF-PM:PRF-IC:PvGMH	-0.11	545	0.28	0.14	601	0.31
PRF-PM:PRF-IC:PTS	0.06	545	0.09	-0.02	601	0.61
PRF-PM:PvGMH:PTS	-0.002	545	0.41	-0.01	601	0.70
PRF-IC:PvGMH:PTS	-0.003	545	0.39	0.007	601	0.17
PRF-PM:PRF-IC:PvGMH:PTS	-0.007	545	0.08	0.006	601	0.41

Note. PRF-PM represents the Pre-Mentalizing Scale of the Parental Reflective Functioning Questionnaire. PRF-IC represents the Interest & Curiosity Scale of the Parental Reflective Functioning Questionnaire. PvGMH represents the Parents vs. General Mental Health Measure. PTS represents the Parent Traps Scale Measure. X:Y indicates an interaction relationship between variables. Values with * indicate a significant interaction at the $\alpha = .05$ level. Values with ** indicate a significant interaction at the $\alpha = .01$ level.

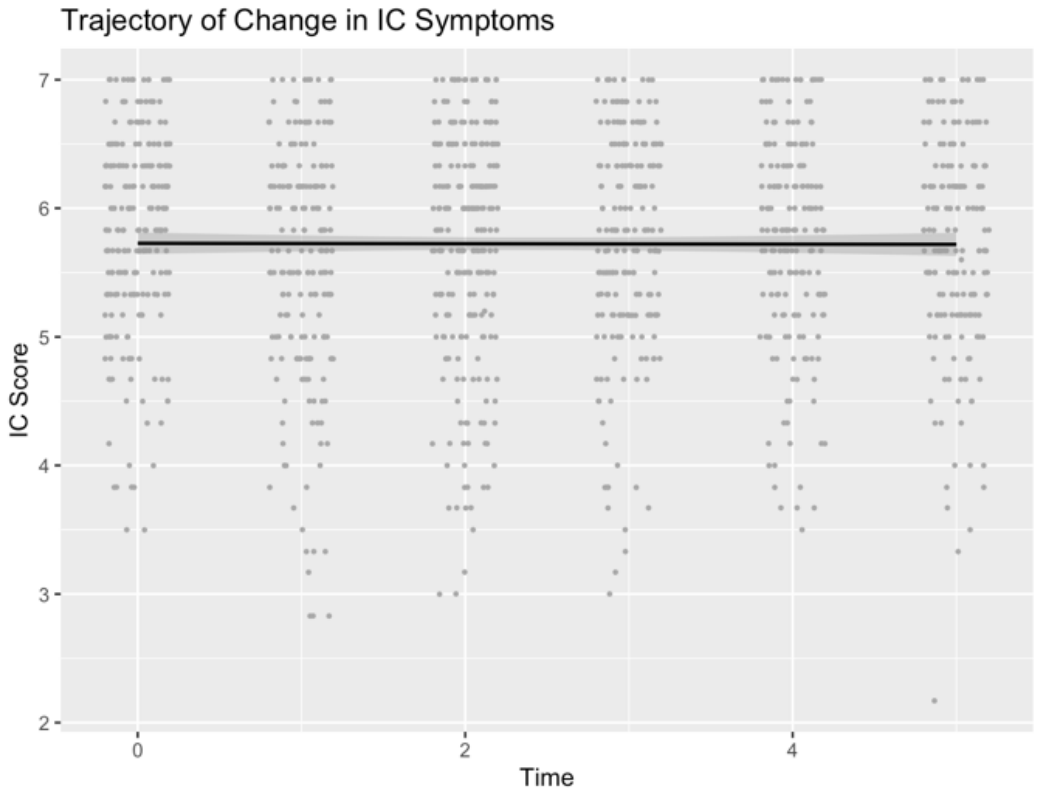
FIGURES

Figure 1. *Trajectory of change in caregiver mentalization from baseline (T0) to final follow-up (T5).*



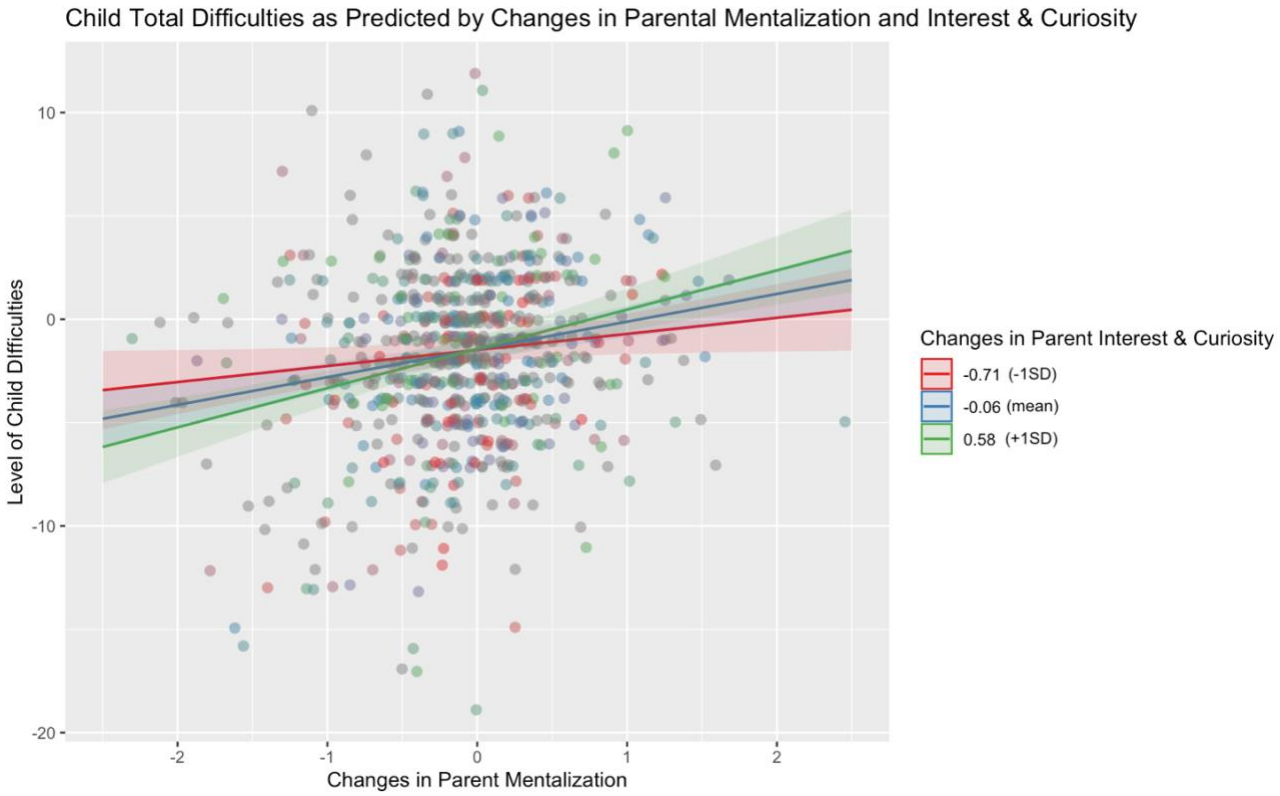
Note F1. The *x*-axis indicates data collection time points (0 = registration (baseline); 1= pre-intervention; 2 = post-intervention; 3 = four months post-intervention; 4 = eight months post-intervention; 5 = twelve months post-intervention). The *y*-axis indicates the Pre-Mentalizing subscale scores. The black line represents the average trajectory of change, with the grey area surrounding the line representing the 95% confidence interval. The grey dots represent individual participant data points at each timepoint.

Figure 2. *Trajectory of change in caregiver interest and curiosity from baseline (T0) to final follow-up (T5).*



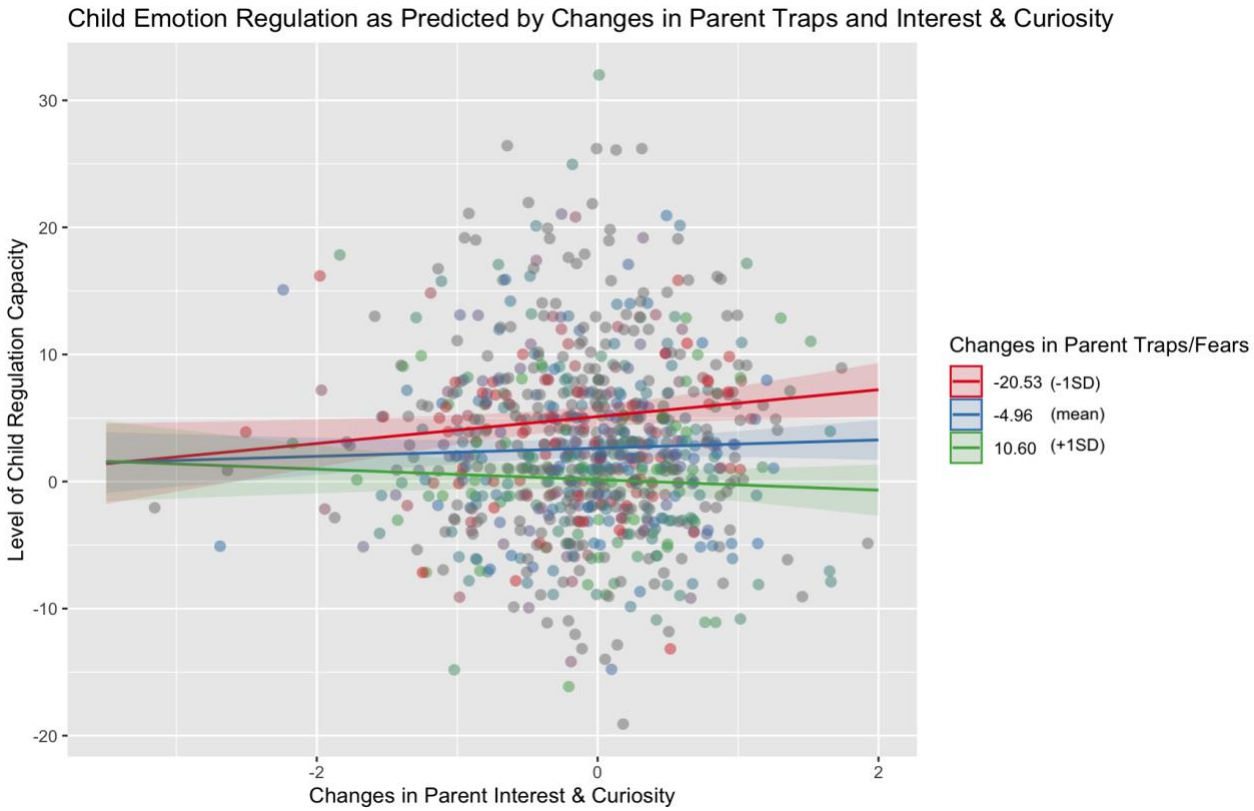
Note F2. The *x*-axis indicates data collection time points (0 = registration (baseline); 1= pre-intervention; 2 = post-intervention; 3 = four months post-intervention; 4 = eight months post-intervention; 5 = twelve months post-intervention). The *y*-axis indicates the Interest & Curiosity subscale scores. The black line represents the average trajectory of change, with the grey area surrounding the line representing the 95% confidence interval. The grey dots represent individual participant data points at each timepoint.

Figure 3. *Child Total Difficulties as predicted by changes in parental mentalization and interest & curiosity.*



Note F3. The *x*-axis represents raw changes in parent mentalization during the follow-up period. The *y*-axis represents raw changes in reported child difficulties during the follow-up period. The red, blue, and green lines show raw changes in parent interest & curiosity one standard deviation below the mean, at the mean, and one standard deviation above the mean, with the shaded areas representing the 95% confidence intervals for each respective line. The coloured dots represent individual participant data points in their respective categories.

Figure 4. *Child Emotion Regulation Capacity as predicted by changes in parental interest & curiosity and parent traps/ fears.*



Note F4. The *x*-axis represents raw changes in parent interest & curiosity during the follow-up period. The *y*-axis represents raw changes in reported levels of child emotion regulation capacity during the follow-up period. The red, blue, and green lines show raw changes in parent levels of parent traps/fears one standard deviation below the mean, at the mean, and one standard deviation above the mean, with the shaded areas representing the 95% confidence intervals for each respective line. The coloured dots represent individual participant data points in their respective categories.

APPENDICES

Appendix A
Workshop Registration Form

Workshop Registration Form

Emotion-Focused Family Therapy — Parents Workshop

Child's Name: Date of Birth: School Grade:	**Today's Date:** **Home Address:**
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☐	**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☐
Presenting Concerns (reasons for attending workshop, child behaviours or symptoms of concern etc.)	**Goals for this workshop:**
List any medications your child is taking:	
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.):	**Brothers and Sisters: (names and ages)** **Previous Diagnoses?** **Family Physician/Paediatrician:** **Referral Source:**

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	☐ Parents never married ☐ Parents married/common law ☐ Widowed ☐ Parents separated ☐ Parents divorced Custody: JOINT ☐ SOLE ☐ If Sole Custody, which parent?
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	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
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:	

Appendix B
Verbal Script

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
8. age of the other parent?

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

Appendix C
Informed Consent

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

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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):

- o Have demographic information about me and my child collected and used in this study.
- o Complete some questionnaires and have them used in this study.
- o 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.
- o 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 educational purposes.
- Be contacted in the future 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 participate or not.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Investigator Date

Appendix D
Strengths & Difficulties Questionnaire

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 E
Emotion Regulation Checklist

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 F
Parental Reflective Functioning Questionnaire

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
The Parent Traps Scale

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

Appendix H
Parent versus General Mental Health

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