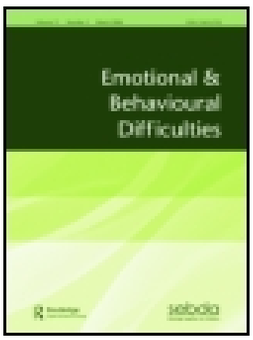

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ARTICLE

An Emotion Focused Family Therapy workshop for parents with children 6-12 years increased parental self-efficacy

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ABSTRACT

In this pilot study, we examined whether a 2-day Emotion-Focused Family Therapy workshop strengthened parental self-efficacy, satisfaction and beliefs regarding their ability to help their children regulate emotions and reduce the children's symptoms of behavioural- or psychological difficulties. Twenty-three caretakers with 17 children (9 boys) aged 6 to 12 years old completed the workshop. Pre, post and 3-month follow-up data on the Parents` Beliefs About Children`s Emotions – Guidance scale and Parenting Sense of Competence scale, as well as pre and 3-month follow-up data on the Child Behaviour Checklist parent form, were used to assess the effects of the intervention. Parental self-efficacy significantly increased, the caretakers` satisfaction in the parenting role significantly increased but faded after 3 months and the caretakers` beliefs that children can guide their emotions on their own were significantly reduced. Finally, oppositional defiant problems in the children significantly declined.

KEYWORDS

Parenting; parent training programme; parent-child relationships; emotion regulation; externalising disorders

The quality of early parent–child interaction, operationalised as attachment styles, has consistently been found to influence the child's developmental level (Main 1983). The caregiver's ability to sensitively attune to the child's needs and provide positive feedback without intruding as the child gets older, seem to have an independent contribution to the child's development, irrespective of early attachment experiences (Belsky and Fearon 2002). The parents' ability to accurately perceive and adjust to their child's developmental level is also important for their ability to support their child in developmental tasks, and thus for the child's development. It has, for example, been shown that 91% of parents in a Norwegian community sample overestimated their 4-year-old child's level of emotion understanding by 3 years on average (Kårstad et al. 2013). Parent characteristics, such as mentalisation skills and ability to accurately estimate a child's level of emotion understanding, influence a child's development and level of emotion understanding (Kårstad et al. 2013, 2015) and serve as a protective factor against depressive symptoms for children with temperamental vulnerabilities (Reinfjell et al. 2016).

How parents address the complex tasks of parenting, thus has significance for the trajectory their children take through life. Self-efficacy was introduced by Bandura in 1977, which refers to the belief a person has of mastering a task (Bandura 1977). Applied to parenting, parental self-efficacy refers to the degree in which the parent feels confident and competent in handling problems with the child (Johnston and Mash 1989), which has been found to relate to parents` well-being (Högström et al. 2016). Parental self-efficacy has been proposed as an emotional rather than a cognitive variable (Strahan et al. 2017), referring to how parents` emotional processing can

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interfere with their capacity to access and utilise their intuitive parental skills to help the child with his or her emotional problems. Parental self-efficacy is regarded to be a central factor in children's recovery from mental health problems (Byrne et al. 2015; Foroughe et al. 2018; Lafrance Robinson, Dolhanty, and Greenberg 2015; Stillar et al. 2016).

Mental health promotion and prevention of mental illness in children and youth have widespread recognition as an important, but difficult task. Worldwide it is estimated that between 10% and 20% of children and adolescents fulfil criteria for a mental illness at any given time (Kieling et al. 2011; Merikangas, Nakamura, and Kessler 2009), with the most prevalent types of mental health problems in childhood being affective, anxiety and behavioural problems. In a US national representative sample of adolescents, it was found that the lifetime prevalence of anxiety disorders among 13–18-year-old adolescents was 31.9% (19.3% had specific phobia). Over fourteen percent reported a lifetime prevalence of mood disorders, and 19.4% reported a lifetime prevalence of conduct disorders. However, 40% of the youth fulfiling criteria for one class of disorders, also fulfiled the criteria for another class of disorders (Merikangas et al. 2010).

It is estimated that mental health problems stand for 15–30% of the loss of disability-adjusted life-years (DALYs) in childhood and early adulthood (Kieling et al. 2011), and mental health problems in childhood are related to fulfilment of diagnostic criteria for mental illness in adulthood (Patton et al. 2014). It also seems that factors such as the parents' emotion socialisation behaviours can influence a child's risk of developing mental health issues, such as conduct problems (Johnson et al. 2017). Once a family find themselves in a situation where the child has developed mental health challenges, such as conduct disorders, substantial strain is put on the parent–child interaction and relationship. Mainstream understanding of the development and treatment of conduct disorders emphasise how parents and children become interlocked in reinforcement traps, where escalating cycles of parent–child coercion functions to maintain and escalate problems (Hagen, Ogden, and Bjørnebekk 2011; Johnson et al. 2017). Efforts of mental health promotion therefore need to include a focus on how to help the parents of children who have developed symptoms of mental illness.

There is a wide range of different parenting programmes aiming to help parents develop skills, which will help them execute their role as parents more efficiently, thus reducing a child's mental health problems. For a long time, most parenting programmes targeted conduct problems, and were mainly based on social learning theory with an explicit focus on behavioural aspects of parenting and handling of conduct problems (Duncombe et al. 2016). Examples of such programmes are The Incredible Years (The IY; young children; Webster-Stratton 2006), Parent Management Training Oregon Model (PMTO; Askeland, Apeland, and Solholm 2014; Forgatch and DeGarmo 1999; Forgatch, Patterson, and DeGarmo 2005), Triple P-Positive Parenting Programme (Sanders 1999), and Multisystemic Therapy (MST, for youth; Henggeler et al. 1998). Generally, such programmes have been found to be effective in reducing child behaviour problems (Jones et al. 2008; Ogden and Hagen 2008; Salari, Ralph, and Sanders 2014; Stattin et al. 2015).

Recently some scholars and clinicians have widened their scope, turning their focus towards the role emotions might play in conduct problems. Therefore, parenting programmes have been developed that are explicitly focusing on the way parents understand and relate to emotions, and the role they can play as emotion guides (i.e. external regulation support) for their children. Examples of such programmes are The International Child Development Programme (ICDP; Sherr et al. 2014), the Tuning in to Kids (TIK) parent programme (Havighurst and Harley 2007), and Emotion-Focused Family Therapy (EFFT; Lafrance Robinson, Dolhanty, and Greenberg 2015). EFFT is theoretically and methodologically founded in Emotion-Focused Therapy (EFT; Greenberg 2010, 2015), which is a humanistic, experiential, process-oriented and transdiagnostic approach founded on the assumption that mental illness occurs when emotions no longer function adaptively (i.e. have become maladaptive). EFT has through a growing body of research proven to be an effective treatment for, i.e. depression and trauma (Greenberg 2015; Greenberg and Watson 2006; Paivio and Pascual-Leone 2010). The cornerstone of EFT is that emotions should not be downregulated, rather emotions are a key determinant of our self-organisation and when emotions are regulated in

healthy and productive ways, the client can move from a dysregulated – to a more healthy, regulated emotional organisation (Greenberg 2010; Stiegler 2015). The aim of EFFT is to improve children's emotional functioning through supporting parents, and this has the potential for prevention of mental health problems without treating the children as patients. Children's emotional needs rely to a great extent on their relations and hence their caregivers. Parents thus represent a potent way to influence children's mental health and well-being. EFFT takes this potential to a further extent by helping parents access emotional skills in order to meet the child's needs instead of a therapist working with the child. Our clinical experience with EFFT tells us that even a clumsy attempt from a parent has a greater impact than the most perfect clinical intervention. Hence, the aim of changing children's emotions through parenting programmes might have vast potential for the influence of the child's own self-regulation and the child's trajectory (Morris et al. 2007). Emotional competence means that the child internalises healthy strategies to cope with own and others` emotions and solve problems, instead of using symptoms or enter unfortunate relations as coping mechanisms (Kårstad et al. 2015).

Empirically, EFFT is understudied, but the current documentation points to a potential and underlines the importance of future research exploring the effect and efficacy of this approach. Two studies have, for example, found that parents of children with severe eating disorders or other mental health problems experienced a significant increase in parental self-efficacy and a positive shift in beliefs regarding their role as emotion coaches in their children's recovery, following a 2-day intervention with EFFT (Lafrance Robinson et al. 2014; Strahan et al. 2017). A recent study evaluated the effect of a two-day intensive modality of EFFT applied to caregivers of children with a wide array of mental health issues. One hundred and twenty-four parents completed the intervention. Results showed significantly increased parental self-efficacy in relation to involvement in their child's recovery, as well as a significant improvement in child symptomatology (Foroughe et al. 2018). In a qualitative study investigating six parents' experiences of participating in EFFT, the parents reported that they had acquired a new and increased understanding of their child, coupled with a strengthened security in their role as parents. They also experienced that the focus on emotions rather than on behaviour helped them feel closer to their children and improved communication (Bøyum and Stige 2017).

For the purpose of adding to the research on EFFT, we wanted to investigate experiences with a 2-day parent workshop based on EFFT in a Norwegian context and for children who suffer from both internalising and externalising problems. We conducted a pilot study where we measured parents' beliefs about their own ability to help their children regulate their emotions, before and after the workshop. We also investigated whether a 2-day workshop might reduce the children's symptoms of behavioural- or psychological difficulties. The main hypothesis of the study was: A 2-day EFFT-workshop will increase parental self-efficacy and beliefs about their own ability to help their children cope with their emotions. The secondary hypothesis was: A 2-day EFFT-workshop for parents will reduce the children's symptoms of behavioural- or psychological difficulties 3 months after the workshop.

Methods

Participants

The participants consisted of 17 families represented by the mother (10), the mother and father (5), the mother and stepfather (1) or the father (1) of 17 children. Caretakers were on average 39.47 (SD 4.40) years old, the children were on average 8.71 (SD 1.93) years of age, 9 boys (53%) and 8 girls. The children had 1.41 siblings (Maximum = 3, Minimum = 0, SD = .712). Five of the children had a confirmed psychiatric diagnosis (ADHD = 17.6%, anxiety = 5.9%, trauma-related = 5.9%) and 47.1% were not in any form of treatment. Over seventy percent of the children lived with both biological parents. More than two-thirds of the parents had a college or university degree. All participants lived in the Bergen area in western Norway.

Recruitment

Participants were recruited through ads on social media, contact with employees at public child health clinics, child- and adolescent psychiatry specialist clinics, and by flyers and posters in relevant locations. Participants initiated contact with Institute for Psychological Counseling (IPR) where the study was carried out. Contact was made by e-mail or telephone.

Inclusion and exclusion

Inclusion criteria were: a) being a caretaker and participate in at least 50% of the daily care for the child; b) that the caretaker experienced a need for help and had considered or decided to seek help regarding his or her child's problematic behaviour or psychological difficulties or related to conflicts in their relationship with the child; c) that the child these problems regard is between six and 12 years of age. Exclusion criteria were: a) having less than 50% of the daily care for the child, b) that the child has a confirmed or suspicion of autism-spectrum diagnosis; c) children less than 6 years of age or older than 12 years; d) that one or both caretakers suffer from moderate to severe mental illness.

Thirty-one caretakers contacted IPR enquiring to participate in the workshop during the inclusion period. One of the psychologists involved (author AWL, HA or KHF), did a systematic telephone interview based on inclusion criteria with all participating families regarding inclusion. One parent was excluded because her child had an autism-spectrum diagnosis. All others met the inclusion criteria. The group-size of the workshop was limited to 25 participants, and the first 25 to initiate contact who had the opportunity to participate was included in the study. One caretaker did not show up for the workshop and one withdrew 1 h into the 2-day workshop with no explanation. Twenty-three caretakers completed the 2-day workshop and the questionnaires before and immediately after the workshop. At approximately 3 months after the workshop, seven caretakers refrained to complete the questionnaires. Two of them withdrew before completion of the 3-month follow-up, but gave permission to use data already collected, while 5 caretakers did not respond to the enquiry to complete the 3-month questionnaire. Data already collected were used in the analyses for those who did not declare that they withdrew.

Measurements

Parents` Beliefs About Children`s Emotions – Guidance scale (PBCE-parent and PBCE-child). As a measure of caretaker's beliefs about their own ability to help their children cope with their emotions, we used the PBCE. This is a questionnaire consisting of phrases regarding values, attitudes and feelings regarding emotions (Dunsmore et al. 2009). The parents` answers range from 'strongly agree' to 'strongly disagree' on a 6-point Likert scale. The subscales refer to (1) parents' beliefs about their ability to guide their children's emotions (PBCE Parent scale, 9 questions, i.e. It`s the parents' job to teach children how to handle negative feelings) and (2) parents' beliefs about their children's ability to guide their own emotions (PBCE Child scale, 8 questions, i.e. Children generally learn how to deal with their angry feelings, without parents telling them how). Higher score on the parent subscale (range 9–54) means a stronger belief in the importance of their role in helping their child deal with its emotions. Higher score on the child subscale (range 8–48) means that the parent has a stronger belief that their child can deal with its emotions on its own. We translated the questionnaire to Norwegian.

Parenting Sense of Competence (PSOC)

As a measure of parental self-efficacy, we used the PSOC. This questionnaire contains 16 items which are answered on a scale from 'Completely disagree' to 'Completely agree' (Johnston and Mash 1989). The scoring of some items is reversed, hence higher scores indicate higher perceived parental efficacy (an instrumental dimension reflecting competence, problem-solving ability and capability in the parenting role; 7 items) and parental satisfaction (an affective dimension reflecting

parenting frustration, anxiety and motivation; 9 items) combined (PSOC Total). Two subscales measures effectiveness (PSOC Efficacy) and satisfaction (PSOC Satisfaction) regarding the parents' role in raising their children. The form has been translated to Norwegian with permission from the developers (translated by Charlotte Reedtz, associate professor, RKBU Nord, UiT). A total score of 70–96 is considered 'high', scores from 51 to 69 is considered 'moderate' and scores ranging from 16 to 50 is considered 'low' as regards to parental confidence (Johnston and Mash 1989).

Child Behaviour Checklist (CBCL)

To measure the children's symptoms we used the CBCL. The CBCL gives a comprehensive assessment of adaptive and maladaptive behaviour in children and provides a total problem score, which creates the base for subscales for different clusters of symptoms' (Achenbach 1991). We used the validated Norwegian version of the questionnaire (Nøvik 1999). We used a computerised scoring programme, part of the Achenbach System of Empirically Based Assessment (ASEBA), to score the CBCL forms. The measures used for the analysis in this study were the norm T-scores for a Norwegian population for Internalising problems, Externalising problems, Total problems, Competence Scale scores (Activities, Social, School, Total competence), DSM-oriented scales (Depressive problems, Anxiety problems, Somatic problems, Attention deficit problems, Oppositional defiant problems, Conduct problems) and Scale scores (Sluggish Cognitive Tempo, Obsessive-Compulsive Problems, Stress Problems).

The PBCE, PSOC and CBCL were completed by the caretakers before the 2-day workshop (T1), the PBCE and PSOC immediately after (T2) and all three again approximately 3 months after the workshop (T3).

Demographics

For caregivers, we collected data regarding age, relation to the child, level of education, vocation, yearly household income and mental health. All caregivers also completed a course evaluation form after the 2-day workshop where some questions had open answers. For the children, we collected data regarding age and diagnosis status (before and between the 2-day workshop and 3-month follow-up).

Intervention

The intervention was a 2-day manualised EFFT workshop (Foroughe et al. 2018; Lafrance Robinson et al. 2014; Strahan et al. 2017). The main goal is to increase parental self-efficacy and to empower parents to become primary agents of change while supporting their children to recover from mental health problems (Foroughe et al. 2018). Through psychoeducation and experiential tasks, parents learn how to support and be involved in their children's recovery. The first part of the workshop focuses on empowering the parents in their role in their child's recovery. The main part of the workshop focuses on teaching parents how to pay attention to, label, and validate feelings, meeting their child's emotional need, and help them move through the emotional experience including problem-solving if necessary, hence becoming their child's 'emotion coach'. This means that the parents learn how to help their children deal with difficult emotions through helping their children to process emotions, access adaptive emotions and thus increase their children's emotional competence, coping, self-compassion and promote psychological health (Lafrance Robinson et al. 2014). The workshop also focuses on helping parents regain access to their healthy parenting instincts by identifying and processing their own 'emotional blocks': fear or self-blame that interfere with parents support or involvement in the child's recovery process. Furthermore, the workshop aims at helping the parents repair emotional wounds in the parent–child relation, and in this way strengthen the relationship (Lafrance Robinson et al. 2014). When children experience that parents can help them deal with their painful emotions, the symptoms developed to deal with pain on their own will decrease. Through experiencing that their parents can handle their own difficult emotions and meet the emotional need of the children, the children will also acquire self-compassion and increased trust in their parents. The

workshop also focusses on how to set appropriate boundaries and stop harmful behaviours or symptoms if necessary, hence helping parents becoming their child's 'recovery coach' (Foroughe et al. 2018; Lafrance Robinson et al. 2014).

Statistics

IBM SPSS Statistics 25 were used to perform the analyses. For demographics, the descriptive function was used to obtain data. Repeated measures t-tests were performed for the PBCE, PCOS and the CBCL to test for differences from immediately before the 2-day workshop (T1) and approximately 3 months after the workshop (T3). Repeated measures t-tests were also performed for the PBCE and PCOS comparing scores immediately before the 2-day workshop (T1) to those obtained immediately after (T2). For the evaluation of the 2-day workshop, the answers to the open-ended questions were analysed using NVivo 11, software that supports qualitative and mixed methods research (QSR International). Effect sizes were calculated using the formula: $d = t/(\sqrt{n})$. Effect sizes of d = .20 are considered small, d = .50 medium and d = .80 large (Cohen 1988).

Ethics

Participation in the 2-day workshop was free of charge for the parents. The children did not participate in any of the data collection. All data were obtained through the parents. Participants got information about the study in written and oral form, and all signed informed consent regarding themselves and their child. For the children who lived in separate households, both legal guardians signed the consent form. The study was approved by the Regional Committee for Medical and Health Research Ethics in Western Norway (REK-Vest) (reference number 2016/1379/REK Vest).

Results

Results for the PBCE child and parent scale

The caretakers` score on the PBCE Child scale significantly decreased from before the workshop to immediately after (p = <.00005) with a large effect size (.898). Their score after approximately 3 months was still significantly decreased (p = .015) with a medium effect size (.553). The caretakers score on the PBCE parent scale did not change from before the workshop to immediately after (p = .958) or from before to approximately 3 months after (p = .216).

Results for the PCOS satisfaction, efficacy and total scale

The caretakers score on the PCOS Satisfaction scale increased significantly from before the workshop to immediately after (p = .008) with a medium effect size (−.607). Their score went back to the same level as before the workshop after approximately 3 months, showing no significant change between before the workshop and 3 months after (p = .233). The caretakers score on the PCOS Efficacy scale significantly increased from before the workshop to immediately after (p = <.00005) with a large effect size (−1.131). The score was significantly higher approximately 3 months after the workshop compared to before the workshop (p = .018) with a medium effect size (−.533). The PCOS Total scale score significantly increased from before to immediately after the workshop (<p = .00005) with a large effect size (−.979), then dropped closer to the before workshop measure 3 months after and the difference was no longer significant (p = .052) (but did show a trend) (Table 1).

Table 1. Parents beliefs about children's emotions (PBCE) and Parent sense of competence scale (PSOC) before, immediately after and about 3 months after the 2-day workshop.

	T1: Before 2-day workshop (N = 23)	T2: Immediately after 2-day workshop (N = 23)	T3: 3 months after 2-day workshop (N = 23*)	Before (T1) - After (T2)		Before (T1) - 3 months after (T3)	
	Mean (SD)	Mean (SD)	Mean (SD)	# *p*-value	+ Effect size	# *p*-value	+ Effect size
PBCE							
Child scale	19,22 (7,13)	12,96 (4,93)	16,22 (5,26)	**<.00005**	.898	**.015**	.553
Parent scale	49,96 (3,82)	50,00 (4,74)	48,91 (4,82)	.958	−.011	.216	.266
PSOC							
Satisfaction	37,09 (7,66)	40,26 (8,00)	38,48 (7,54)	**.008**	−.607	.233	−.256
Efficacy	29,74 (5,27)	33,96 (4,70)	31,78 (6,11)	**<.00005**	−1.131	**.018**	−.533
Total	66,83 (11,39)	74,22 (12,10)	70,26 (12,69)	**<.00005**	−.979	.052	−.428

Paired samples t-tests.
* 7 were missing at T3, we replaced missing values with the values from the T1 (before 2-day workshop) scores (intent to treat).
+ Effect size based on Cohens` *d.*

Results for the CBCL

There was a significant difference in the DSM-oriented scale Oppositional defiant problems from before the 2-day workshop (Mean (SD) 66,36 ± 7,92) compared to approximately 3 months after (Mean (SD) 63,55 ± 10,07; p = .040) with a medium effect size (.466). There were no significant differences on any of the other CBCL-scales before the 2-day workshop compared to approximately 3 months after. However, we did detect a trend towards reduction in Externalising problems (p = .060) with a medium effect size (.423) and on Stress Problems (p = .089) showing a small effect size (.028).

Results from the evaluation of the 2-day workshop

Quantitative

When asked immediately after completion of the 2-day workshop, caretakers reported that their attitudes as parents had changed to a large degree because of the workshop (mean 4.8 on a 6-point scale, SD = 1.3). They also reported that they had gained high levels of new practical skills as parents (mean 5.3 on a 6-point scale, SD = 0.77).

Qualitative

The caretakers were given the opportunity to answer two open-ended questions regarding what they found especially useful about the workshop and what they found were missing. Analyses of these 22 answers resulted in six categories of useful aspects of the workshop: Hope ('It is never too late to change'); Knowledge ('Learning that anger in me and my child often has underlying reasons'); Tools ('Simple tools that everyone can use'); Time and repetition ('The pace was slow'); Expanded room as a parent ('Ok to make mistakes'); Being with others ('Experience that my challenges are not unique – I am not alone'). Only six caretakers responded to the question about what they were missing in the workshop. Their answers reflected uncertainty about how to handle the different aspects of parenting, i.e. the balance between validating their child's emotions and at the same time influencing the child`s behaviour in a preferable direction. One caretaker expressed uncertainty about how to respond when the newly acquired skills learned during the workshop was not sufficient and another caretaker missed an extended focus on how to relate to the school when the school environment is a part of the problem.

Discussion

A 2-day EFFT workshop for parents that struggled with problematic behaviour, psychological difficulties in their child and/or problems related to conflicts in the relationship with their child, lead to an increase in parental self-efficacy, indicated by an increase in PSOC scores following the intervention. The increase in the efficacy scale of PSOC remained after 3 months. The parents' belief in their children's ability to cope with their emotions on their own (i.e. PBCE child-scale) also decreased following the intervention, indicating an increased room for the parent to execute their role as emotion coaches. This change was stable approximately 3 months after the intervention. These findings are in line with our main hypothesis that a 2-day EFFT-workshop will increase parents` self-efficacy and beliefs about their own role in helping their children handling their emotions. The 2-day workshop also led to a decrease in Oppositional defiant problems, measured by CBCL parent scale. Our secondary hypothesis thus gained some support.

Parental self-efficacy and satisfaction

Self-efficacy is important for how one approaches a challenging task (i.e. tries several times or gives up) (Bandura 1977), but also for the experience of being in a challenging situation. Low expectation of being able to handle problems as a parent concurs with symptoms of depression, and a reduction of depression in parents has been found in combination with increases in parents' sense of competence (Högström et al. 2016). Even though measured on the parental level, the degree of parental self-efficacy is believed to be directly relevant for a child's well-being due to the way parental efficacy will influence the parents' behaviour and way of approaching challenging situations in the parent–child relationship (Bloomfield and Kendall 2012; Bode et al. 2016). Being one of the key target areas in EFFT (Foroughe et al. 2018; Lafrance Robinson et al. 2014), our main hypothesis was linked to a movement in parental self-efficacy following the intervention.

The parents in this study reported increased parental self-efficacy after the intervention, a result that was maintained after 3 months of being back into their daily routines. This is consistent with results found by Lafrance Robinson et al. (2014) and Foroughe et al. (2018), where they found an increase in parental self-efficacy immediately after a 2-day EFFT workshop, Foroughe et al. (2018) also found similar to our study that self-efficacy declined at 4 month follow-up but was still significantly higher than before the intervention. Moreover, Högström et al. (2016), looking at effects across four different parenting programmes (Comet, The IY, Cope, and Connect), found that parents' sense of competence was increased even 2 years after completion of the interventions. A study by Reedtz, Handegard et al. (2011) found that both satisfaction and efficacy increased more after The IY parent programme than in the waitlist control group. Hence, parental self-efficacy seems to be changeable by different types of parenting programmes, including a 2-day EFFT workshop.

Parents` beliefs about their role in helping their children cope with emotions

Part of being a parent is to deal with the child`s emotional development through cries for breastmilk, comfort or dry diapers in infancy to toddler cries for chocolate in the store or to the teenagers' rejection because the parent doesn`t understand, and so on. All parents will most likely yearn for a solution to these age-specific situations and challenges, but for families where problems have escalated, a sense of having a map to follow in guiding the child`s emotions can have great importance not only in the here and now, but also for their development.

After two days of EFFT training, the parents in this study had adjusted their beliefs about their children's ability to cope with their emotions on their own. Their belief in the children's ability to handle emotions on their own was weakened, thus creating a need and opportunity for them to take a more active role in guiding their children through their emotions. This

change was stable across the next 3 months, after going back to their regular life at home. Previous findings from Norway show that most parents overestimated their 4-year-old's emotional comprehension (Kårstad et al. 2013), and we assume that the parents had become empowered by the workshop to become their child's emotion coach. This finding contrasts with, for example, one study where TIK was used for children with emerging conduct problems where they found no increase in emotion coaching beliefs (Havighurst et al. 2015). Our result is however consistent with findings from studies on parent programmes such as The IY for promoting positive parenting practices in primary care, TIK for improving emotion socialisation practices in parents of preschool children and EFFT for eating disorders across the life-span (Havighurst et al. 2010; Lafrance Robinson et al. 2014; Reedtz, Handegard, and Mørch 2011; Strahan et al. 2017).

Despite movement in the PBCE child-scale, we did not find any significant movement in the PBCE parent-scale. Observational measures as opposed to self-report might have been a better measure and reduce bias (Havighurst et al. 2010; Lafrance Robinson et al. 2014). This could include observation ratings and/or video recordings of parent–child interaction and systematic observation and scoring of attachment styles for example. Both the focus in the intervention and the recruitment procedure might have played a role in selecting parents who are conscious about their role in helping their children guide their own emotions, thus scoring moderate on the PBCE parent-scale initially (a score between 57 and 69). Although the PBCE parent- and child scale might appear similar, they tap on different emotion capacities. The intervention itself focuses on the role parents play in guiding their children through their emotions, possibly opening up space parents were not aware they could enter and take part in. Parents who self-recruited were thus both motivated and interested in learning more about how to execute their role as emotion coaches.

Children's symptoms

Behavioural problems, more specifically Oppositional-defiant problems from the DSM-oriented scales in the CBCL decreased after a 2-day EFFT intervention with medium effect size. This corresponds with previous findings from other parent programmes (Reedtz, Handegard, and Mørch 2011; Stattin et al. 2015; Wilson, Havighurst, and Harley 2012). This finding indicates that in line with studies on TIK, not only programmes that target mainly behaviour, have the capabilities of reducing behavioural problems in children by working with the parents (Havighurst et al. 2015). Overall Externalising problems and Stress Problems (Scale score) were not significantly reduced, but a trend was found with medium and small effect sizes. These findings open for different types of parenting programmes to be utilised for the same types of unwanted behaviour in children and show that a negative direction and development in childhood can be redirected by supporting parents in groups to become their children's emotion- and recovery coaches.

EFFT aims to help the parents repair emotional wounds in the parent-child-relation, and in this way strengthen the relationship between the parent and child. This intervention also has the potential to change unfavourable parent–child interplay. Parents reported that the 2-day EFFT workshop gave them hope, increased knowledge about emotions and the underlying reasons for their child's emotions, simple tools to use in guiding their children's emotions, a feeling of expanded room as a parent and a feeling of togetherness (not being alone facing their problems). A qualitative study from Norway found similarly that some parents felt that they understood their child better after participating in a 2-day EFFT workshop (Bøyum and Stige 2017). This study hence shows promising results and open up for an alternative way of helping parents become their children's emotion coaches (as opposed to, i.e. supervision sessions weekly over a certain number of weeks) and to redirect a negative and potentially

pathological trajectory (Patton et al. 2014; Reedtz, Martinussen et al. 2011) without burdening the children by directly involving them in the treatment.

Strengths and limitations

This study provided data on a specific, time-limited intervention that can target wide groups of parents. Results are comparable to interventions given over a longer time stretch, typically 6–8 weeks or longer which provide numerous situations to test what they have learned and learn from mistakes. After the intervention in this study, parents increase their self-efficacy with limited opportunity to test what they learned at home. Attrition rate was very low for the 2-day workshop, thus avoiding biased results due to high drop-out rates. The major limitation of this study is the design. Most significantly, there was no control group, and the sample was self-recruited, resulting in a sample of parents with moderate to high socio-economic status (SES). It has previously been found in a Norwegian context that parents with risk factors related to lower SES may not sign up to participate in face-to-face mental health promotion interventions (Reedtz, Martinussen et al. 2011). Hence, the generalisability of these results towards a group of parents with lower SES is uncertain. Moreover, the sample was heterogeneous and small, thus limiting generalisability. Also, all data were based on the parents' self-report; hence, biased outcomes might be an issue as opposed to observational data or video recordings. Teacher reports on the children's symptoms, for example, would give a different perspective and strengthen the study. Also, a measure of the parent's mental health such as symptoms of depression, anxiety and stress would provide important information. Longer follow-up than 3 months would also provide useful information regarding the robustness of the findings.

This study calls for larger trials investigating the 2-day EFFT workshop on a larger scale. Preferably in a controlled design either comparing EFFT to a different parenting programme or to a waitlist control group. In our study, we used t-tests without controls. Future studies should aim at using more sophisticated statistics with control conditions in order to further explore the relationship between EFFT and different outcomes. Future research should also look more closely at the change mechanisms involved in different parenting programmes, including EFFT, to help guide decisions about what kind of parenting programme will be most efficient for particular groups of parents. Investigating the efficacy of a 2-day EFFT workshop for different groups of parents and for different and more specific symptoms in children might also bring about valuable information.

Conclusions

A 2-day EFFT workshop for parents who struggle with problematic behaviour or psychological difficulties in their child or problems related to conflicts in the relationship they have with their child leads to increased parental self-efficacy and satisfaction in the parent role, a positive change in the parent's beliefs about children's ability to guide their own emotions, and a reduction in oppositional defiant problems in the children. The results and effect sizes are similar to other parent programmes given over a longer stretch of time. A 2-day EFFT workshop seems to be a promising option among different parent programmes. More research on EFFT is warranted.

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IPR teaches the method this study is based on. Author VH and HA receive honoraria to teach the method as part of their daily job as self-employed working at IPR.

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