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A case study of virtually delivered emotion-focused family therapy

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Abstract

Clinical psychologists and therapists are increasingly taking advantage of internet and mobile-based technologies to deliver mental health services for individuals and groups since the COVID-19 pandemic. However, there is a dearth of research evaluating the appropriateness of virtual platforms for family interventions. Further, no research has examined the effectiveness of weekly emotion-focused family therapy (EFFT). This case study presents a virtually delivered 8-week EFFT intervention, which supported caregivers to manage child symptoms of depression, anxiety, and anger, facilitate emotion processing, and strengthen relationships. Two parents from one family during a marital separation participated and completed brief measures of therapeutic alliance, family functioning, parental self-efficacy, and parental and child psychological distress at 12 time points as well as a posttreatment semistructured interview. A strong therapeutic alliance was formed, and general family functioning, parental self-efficacy, parent psychopathology, and child depression, anger, and anxiety symptoms improved over the course of therapy.

KEYWORDS
case study, emotion-focused family therapy, family teletherapy, mixed methods

INTRODUCTION

In the context of COVID-19, many families were unable to access in-person therapeutic services. Accordingly, governments and businesses increased their investments in teletherapy to improve access to clinical services (Government of Canada, 2020; Lebow, 2020b). Remote delivery of mental healthcare—through video chatting, telephone, or text messaging—can be as effective as face-to-face therapy (Bambling et al., 2008; Barnett, 2011; Berryhill et al., 2019; Centore & Milacci, 2008; Dowling & Rickwood, 2014; McAdams & Wyatt, 2010; Varker et al., 2019). While emerging evidence of the feasibility and effectiveness of teletherapies for parents with young children in high-risk context is promising (Blumer et al., 2014; Dadds et al., 2019; Flujas-Contreras et al., 2019; Harris et al., 2020; Tsami et al., 2019), prepandemic uptake had been particularly slow among family therapists (Backhaus et al., 2012; Helps & Le Coyte Grinney, 2021). Consequently, the effectiveness of various therapeutic modalities, including family therapies, has not yet been adequately established, and the supply of telehealth-ready clinicians cannot meet the growing demand (Smith et al., 2020). At the height of COVID-19, however, most child and family mental health services pivoted to virtual service delivery (Appleton et al., 2021; Racine et al., 2020) and intend to maintain their virtual practice postpandemic (McKee et al., 2022). The present study aims to address this gap in the context of student-led virtually delivered emotion-focused family therapy (EFFT; Foroughe, 2018; Lafrance et al., 2020).

EFFT is a relational therapy focused on empowering caregivers to support their loved ones with mental health and behavioral difficulties. The central goal of EFFT is to support caregivers to become agents of healing by increasing their role in providing emotional support, behavioral support, therapeutic apologies, and processing their own emotional blocks that interfere with their provision of these interventions. While the empirical basis for EFFT is emerging, existing literature has demonstrated that it is a promising therapeutic approach. EFFT was originally developed in the context of working with families of individuals recovering from eating disorders, in which the developers recognized the need for caregivers to be actively involved in their loved one's recovery, including symptom interruption and the promotion of healthy behaviors (Foroughe et al., 2018; Robinson et al., 2015). EFFT has since been extended beyond the realm of eating disorders, with manuals framing EFFT as a transdiagnostic (Lafrance et al., 2020) and trauma-informed (Foroughe, 2018) approach.

The EFFT manuals describe the modality as a flexible approach that can be implemented as a stand-alone treatment or as an over-arching framework integrated with other modalities and across varying treatment durations, including intensive 2-day workshops as well as treatments extending over 6–8 weeks (Foroughe et al., 2018; Lafrance et al., 2020). The empirical research on the effectiveness of EFFT has provided preliminary support for the transdiagnostic effectiveness of EFFT. For example, Foroughe et al. (2018) and Wilhelmsen-Langeland et al. (2020) both found improvements in parental self-efficacy, parental beliefs in their capacity to be active agents in supporting their children's recovery, and children's symptoms. However, the existing intervention effectiveness research has exclusively focused on the 2-day intensive

in-person workshops to the exclusion of weekly group or individual family sessions. Calls have been made to assess the effectiveness of virtually delivered EFFT, and guidelines have been made for adapting the 2-day intensive parent workshops (Foroughe et al., 2022); however, weekly EFFT for families has not yet been formally considered. Thus, there is a need for research examining longer-duration applications of EFFT, including in the virtual context.

The present study

In this study, we aimed to illustrate the application of weekly, virtually delivered EFFT. Specifically, we conducted a case study to address the question of whether virtually delivered EFFT can be effective for a single-family referred to an outpatient psychology clinic for difficulties related to child behavior and emotionality.

Case description

Description of the therapist

At the time of the study, the therapist for this case was a doctoral-level trainee in the Clinical Psychology program at the University of Waterloo. Prior to this case, he had completed two EFFT-specific training sessions, led by the cofounders of the modality, including the 2-day EFFT core training and a second 2-day special topics advanced clinician training. The supervisor is an expert in child and family therapy with experience in EFFT.

Description of the family

All names presented are pseudonyms. The family client consisted of Sally (mother), Terrence (father), and Damien (child). Sally is a Caucasian, Canadian-born woman who works as a first responder in a large Canadian city. Terrence is a Black, Caribbean-born man who immigrated to Canada in adulthood and works in the Trades. Sally and Terrence reported that they met in the Caribbean and that Terrence immigrated to Canada after Sally became pregnant. Damien is Sally and Terrence's 8-year-old, mixed-race son.

Initial contact and assessment

With the parents' verbal consent, Damien's child psychotherapist (who was aware that the therapist and supervisor were recruiting a family for the present research) contacted the therapist via email to schedule a phone consultation to discuss the family's situation, needs, and eligibility for the present study. The therapist then phoned each parent separately to discuss the nature of the services and research involvement and to inquire about their interest in participating in the therapy and research and their technological capacity. The therapist arranged with the corporate partner, Get A-Head®, to supply Sally with a Chromebook for the duration of the therapy. The assessment phase consisted of two assessment sessions and one feedback session with the family, which included discussing research and therapy consents, reviewing privacy and limits to confidentiality, and collecting information about the family's history, details about the family system and relationship dynamics, roles, and responsibilities, and perceptions of the challenges the family hoped to address. The family also began completing a weekly battery of questionnaires before each session (described below). In the

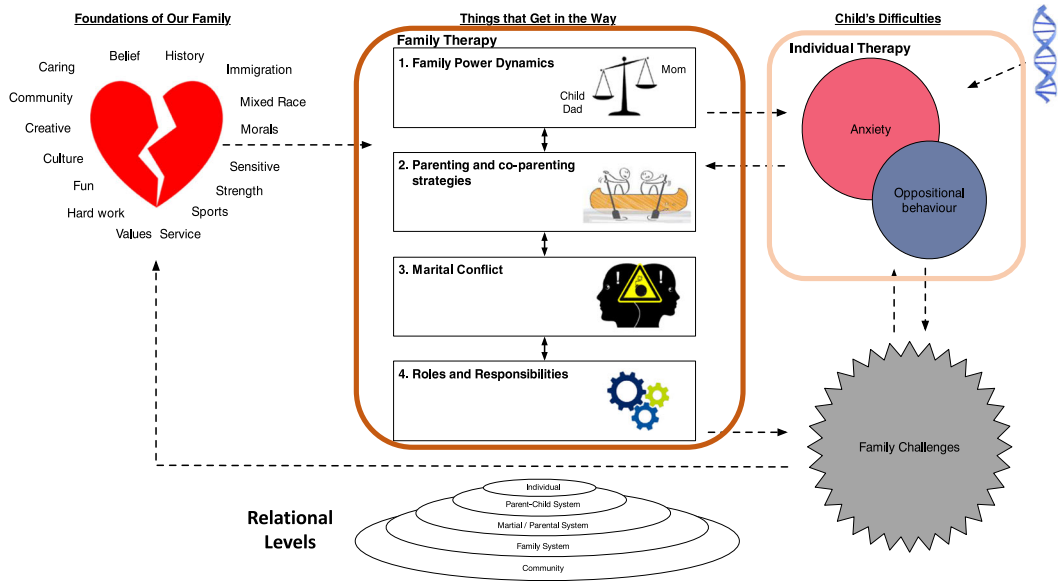

FIGURE 1 Family Case Conceptualization. The case conceptualization highlighted that the family has many strengths related to their values, beliefs, and ways of being, and contribution to the wider community, which can be protective and leveraged in a positive way. At the same time, the mutually-influencing nature of several historical experiences of adversity, ongoing relational dynamics in the family (i.e., family power dynamic in which the dad and child are allied against the mother, misalignment of parenting and co-parenting strategies, marital conflict, and uneven distribution of responsibilities in the home), and the child's mental health difficulties, contribute to and are further exacerbated by family challenges. These multidirectional influences are embedded within a positive feedback loop which threatens the foundations of the family.

final assessment session (session 3), the therapist presented the assessment findings and case formulation (see Figure 1) and discussed the treatment plan.

Presenting concerns

The assessment revealed several areas of concern for Damien and his parents. Damien was reported to exhibit high anxiety and physical symptoms, with fears of bad guys, death, and that someone would steal his puppy. Damien presented with fears about something catastrophic happening to his parents, which were exacerbated in the height of the Black Lives Matter movement, the constant portrayal of violence against young Black males in the news cycle, and the onset of the global COVID-19 pandemic. Damien was reported to engage in violent superhero play. He exhibited resistance at bedtime and, on one occasion before seeking therapy services, exhibited encopresis, whereby he placed feces on his bedside table to ward off possible intruders. Other symptoms included bed-wetting and hyperventilation when anxious. Damien was also reported to have identity concerns, wishing he were White.

Parental psychological functioning

Both parents presented with some symptomatology that influenced how they responded to Damien's needs and potentially contributed to the maintenance of his symptoms. Sally had a treatment history and was concurrently in individual therapy for anxiety, depression, and a

DSM-5 diagnosis of Bulimia Nervosa (in partial remission). Sally also reported having had postpartum depression, and it was revealed that the pregnancy with Damien was not planned. She reported having an anxious attachment style. Terrence had a history of sexual, physical, and emotional abuse in childhood and a limited relationship with his family back in the Caribbean. Damien's psychotherapist reported that Terrence struggled with understanding and knowing how to respond to Damien's symptoms and emotions and that he expressed frustration because he was trying to give Damien what he lacked as a child. Additionally, a previous assessment with the Adult Attachment Interview revealed that Terrence had an avoidant attachment style.

Family functioning

The parents reported that they had been having long-standing marital difficulties stemming from difficulties with communication, within-family power dynamics and alliances, different perspectives on parenting, marital conflict, and the distribution of roles and responsibilities. Two weeks before the first session, Sally initiated a marital separation, and Terrence moved out of the family home. However, the parents reported being on amicable terms and committed to participating in the therapy to support Damien.

Strengths

The family had several strengths that were identified during the assessment phase, which are worth noting. The most important strength for the purposes of the EFFT work is that, despite going through a marital separation, Sally and Terrence were both highly motivated and aligned in their desire to provide Damien with optimal parenting and to learn and implement strategies to support his mental well-being. Both parents have strong bonds with Damien, which is helpful for the implementation of EFFT skills. Additional strengths include the parents' professional and personal engagement in their community, as well as general creativity, resourcefulness, sense of humor, and playfulness.

Treatment history

Before being referred to the present study, the family participated in time-limited individual child psychotherapy at a community mental health agency in a large city in Ontario, Canada, after Sally and Terrence found Damien's feces. After several months, the child's therapist referred Sally and Terrence to Whole Family Lab at the University of Waterloo for subsidized EFFT services due to the parents' need and desire for advanced caregiving skills to better manage Damien's Separation Anxiety Disorder (diagnosed by the agency) and frustration intolerance. While not formally discharged, Damian did not continue with individual psychotherapy while Sally and Terrence were engaged in the EFFT treatment described in the present study. Sally and Terrence had attempted couple's therapy in the past, and Sally had recently completed several months of intensive virtual therapeutic services (group and individual) to address her eating disorder and was concurrently accessing less-intensive individual therapy.

Case conceptualization

A whole-family case conceptualization was developed, which considered various risk and protective factors and potential mechanisms underlying child psychopathology, parent–child, marital, and whole family (dys)functioning (Figure 1).

Treatment targets

The following treatment targets were collaboratively identified as being most poignant for the family: (1) reducing Damien's anxiety and resistance at bedtime, (2) reducing disruptive and oppositional behaviors, and (3) increasing the parents' understanding of anxiety and competency with strategies for managing child anxiety. Additional microtargets were incorporated throughout treatment, including supporting the parents' ability to prevent and respond to crises (e.g., explosive tantrums and self-harm).

Course of treatment

Due to the nature of EFFT being a caregiver-focused intervention and the fact that Sally and Terrence would be attending the sessions from separate locations, we decided not to include Damien in the therapy. The parents participated in three 60-min assessment sessions, eight weekly 60-min intervention sessions, and one 90-min feedback and termination session (see Table 1 for an overview of the treatment activities).

Intervention context

All sessions were conducted using the Get A-Head® videoconferencing platform, which the parents joined on separate devices from their respective residences (except for one session for which they were in the same location and logged on using one device). Get A-Head® is a mental health technology organization focused on facilitating the supervision of student clinicians while also providing virtual access to therapy for clients. The Get A-Head® platform was designed as a single-point solution for delivering psychotherapeutic services and training, which includes a videoconferencing interface with client- and supervisor–supervisee chat functions and a back-end system that supports case notes, video storage, messaging, and scheduling. The platform complies with the Personal Health Information Protection Act (PHIPA) of Ontario and thus conforms to regulations for protecting citizens' health information in Ontario (the case study location). The present study is the first to use the platform for family therapy.

MATERIALS AND METHODS

Procedure

Following the intake interview, parents completed weekly measures of family functioning, parent and child mental health symptoms, therapeutic alliance, and parenting self-efficacy. The mother completed measures at all time points, while the father completed three sets of questionnaires. Despite frequent reminders, Terrence attributed his failure to complete weekly measures to (1) time pressures with his job and new (much longer) commute after moving out of the family home due to the marital separation and (2) his belief that he could not provide accurate information about Damien's functioning during periods of infrequent visits. Both parents participated in the final feedback interview. This study was reviewed and approved by the University of Waterloo Research Ethics Board (ORE: #24296).

TABLE 1 Overview of activities.

Session	Phase	Activities	EFFT skills
1	Assessment	Consents and introduction to family therapy Intake interview	
2	Assessment	Focus on getting a clear description of the child's bedtime routine (primary goal for treatment), another instance where the child exhibited problem behaviors, and a time that worked well, with attention paid to mom and dad's strategies, responses, and reactions	
3	Assessment	Presentation of case conceptualization Collaborative agreement on treatment goals Overview of treatment activities and purposes	
4	Treatment	Psychoeducation about emotions and development of mental health difficulties Introduced emotion coaching framework.	EC
5	Treatment	Suicide risk assessment for child Development of a safety plan	EC, BC, PB
6	Treatment	Reviewed emotion coaching framework Practiced emotion coaching Developed emotion coaching scripts	EC
7	Treatment	Discussed parental blocks, including issues of race and racism Facilitated mom and dad practicing emotion coaching skills with each other	EC
8	Treatment	Behavior coaching presentation Discussed strategies and approaches for dealing with cooperation, procrastination at bedtime, and frustration	BC
9	Treatment	Emotion and behavior coaching review and practice We reviewed a scenario and potential responses to the scenario using an emotion coaching framework to identify and deconstruct emotionally validating responses Discussed specific praise in detail and how it differs from general praise and offering thanks/appreciation Mom practiced providing specific praise in several scenarios	EC, BC
10	Treatment	Continued to refine emotion coaching and behaviour coaching fluency Discussed the do-over and therapeutic apologies	EC, BC, TA

TABLE 1 (Continued)

Session	Phase	Activities	EFFT skills
11	Treatment	Discussed differences in values and experiences between mom and dad related to food and eating behaviors Developed emotion coaching scripts for bedtime	EC, PB
12	Treatment/ feedback	Practiced emotion coaching framework with dad Exit interview about parents' experiences with the therapy	EC

Abbreviations: BC, behavior coaching; EC, emotion coaching; PB, parenting blocks; TA, therapeutic apology.

Measures

Family functioning

Caregivers reported on the general family functioning using the 12-item version of the General Functioning Scale from the Family Assessment Device (FAD; Epstein et al., 1983), which covers aspects of family relationships, including mutual support in times of crisis, acceptance of individuality, the openness of communication and emotion, and problem-solving ability. Responses yield a global score of general family functioning, with scores of 2 or greater indicating clinically significant dysfunction. The general functioning subscale has demonstrated good psychometric properties, with Cronbach's α's in previous studies ranging from $\alpha = 0.86$ (Byles et al., 1988) to $\alpha = 0.92$ (Epstein et al., 1983), indicating good internal reliability.

Parental self-efficacy

To assess parents' self-efficacy regarding their capacity to support their child's recovery from psycho-emotional and behavioral symptoms, we used the Parent versus General Mental Health (PvGMH; Foroughe et al., 2019) scale—a revised version of the Parent versus Anorexia Scale (PvA; Rhodes et al., 2005) in which the word "anorexia" was replaced with "general mental health difficulties." The PvGMH is a 7-item scale with higher total scores, ranging from 7 to 35, indicating higher levels of self-efficacy. The scale has demonstrated acceptable internal reliability, with a Cronbach's α's of $\alpha = 0.72$ (Foroughe et al., 2019).

Caregiver psychological distress

The Kessler Psychological Distress Scale (K10; Kessler et al., 2002) is a widely utilized, 10-item scale assessing the frequency of feelings related to depression and anxiety experienced in the past 30 days. Summed responses yield a global score of distress, with a range of 10–50 and several bands of severity of distress: ≤19 indicates an absence of clinically significant distress, 20–24 indicates mild distress, 25–29 indicates moderate distress, and 30–50 indicates severe distress (Kessler et al., 2002). The scale has demonstrated excellent internal reliability, with a Cronbach's α's of $\alpha = 0.92$ (Kessler et al., 2002).

Child mental health problems

Caregivers reported on children's mental health problems using the Patient-Reported Outcomes Measurement Information System (PROMIS®). The following domains were administered: anger (v2.0, 5-items), anxiety (v2.0, 8-items), and depressive symptoms (v2.0, 6-items). Each scale was summed and converted to a *t*-score to determine the severity of symptoms. Item response theory analysis of the PROMIS® scales yielded excellent psychometric properties, with minimum reliabilities > 0.80 (Varni et al., 2012).

Therapeutic alliance

The Family Therapy Alliance Scale Revised–Short Form (FTASr-SF; Pinsof et al., 2008) includes 12 items relating to the client's perception of the therapeutic bond, the degree of agreement on the goals, and the degree of agreement on specific tasks. Six items focused on the alliance between the therapist and the client and the therapist and the client's key group/family (i.e., self/group; six items), three items focused on the alliance between the therapist and the client and the client's relevant others (i.e., other; three items), and three items focused on the alliance between the client and the people who are important to them in the therapeutic context (i.e., within system; three items). The scales have demonstrated good psychometric properties, with Cronbach's α's of 0.89, 0.88, 0.78, and 0.63 for the total score, self/group, other, and within-system scales, respectively (Pinsof et al., 2008).

Semistructured interview

The parents participated in a posttreatment semistructured interview, which occurred during the final feedback session. The interview focused on soliciting qualitative feedback about the parents' experiences and reflections with the virtual EFFT.

Analysis

Quantitative analyses

Individual family member change was measured for all measures. Scale scores (average or total, depending on the scale manuals) were calculated for all measures at each time point, and then three quantitative metrics were computed to assess change between the baseline and treatment phases: (1) percent change, (2) nonoverlap of all pairs (NAP), and (3) slope and level change (SLC). First, percent change was calculated using the first and last measures each parent completed. Second, NAP, which represents the proportion of nonoverlapping data relative to all possible comparisons between the baseline and treatment phases (Parker & Vannest, 2009), was computed using the *SingleCaseES* package (Pustejovsky & Vannest, 2022) in R version 4.2.2 (R Core Team, 2022). NAP of 0–0.65 (weak), 0.66–0.92 (medium), and 0.93–1.0 (large/strong) were used based on Parker and Vannest's (2009) analysis. Third, trajectories of scores over the course of treatment were estimated, correcting for any linear trend present during the baseline phase (Manolov et al., 2016) using Manolov's (2010) R syntax.

Qualitative analysis

The semistructured interview was transcribed verbatim. The purpose of the qualitative interview was to add descriptive insight into the quantitative measures; thus, responses were organized accordingly and representative quotes were selected for each domain of functioning.

RESULTS

Results for all measures are described below. Additionally, quantitative results for clinical measures are presented in Table 2 and visualized in Figure 2.

Therapeutic alliance

The therapeutic alliance scales were consistently high for both parents over the course of treatment (see Figure 2A). Sally's ratings neared the ceiling (out of 5) for all sessions, with slightly lower scores on the first and last measurement occasions. Terrence's scores were approximately onepoint lower than Sally's for the weeks he completed measures.

The qualitative feedback during the final feedback session reveals that the parents felt a strong therapeutic bond. For example, Sally indicated that she felt strong emotional support and that the therapy was aligned with and consistent with their goals:

> SALLY: Personally, I think, you know, a big factor of why I think this was so successful was because we had you, [THERAPIST]. I do think that you have been fantastic at connecting—at least I have felt this way, I can't speak on [TERRENCE]'s behalf—at connecting with us about what our needs are and keeping us focused on the goal, and even just how we were able to manage time on some really heavy emotional stuff at times. I felt like you were very supportive. I felt that. So, I think that's what made me feel like I enjoyed coming back each week was because I knew I was sitting down with somebody who was actually invested in our family.

Terrence also indicated a strong bond with the therapist, which both he and Sally reported to be unlike their previous experiences of conjoint therapy:

> TERRENCE: Yeah, [THERAPIST], you always made it feel comfortable for the both of us. Never really excluded us. In some therapy that we've been in, I've felt excluded. [...]
>
> SALLY: Yeah, I was going to say, that's big words coming from [TERRENCE], because I know we've had our fair share of counseling in the past, and he felt it was one-sided.

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TABLE 2 Quantitative results.

Variables	Pretreatment range	Posttreatment range/ final measure range[†]	% Change	Nonoverlap of all pairs (NAP) Est (95% confidence interval)	Slope and level change (SLC) Baseline slope	Slope and level change (SLC) Detrended treatment slope
Mother report						
Family functioning[a]	Clinical	Normal	−43.00	0.94 (0.58–0.99)	0.03	−0.17
Selfefficacy[b]	N/A	N/A	15.00	0.86 (0.50–0.97)	−0.33	0.33
Psychological distress[a]	Severe	None/well	−58.84	0.89 (0.53–0.98)	−2.00	–
Child depression[a]	Clinical (moderate)	Normal	−26.89	0.81 (0.42–0.96)	0.00	−1.29
Child anxiety[a]	Clinical (moderate)	Normal	−46.11	1.00 (1.00–1.00)	−1.50	−0.07
Child anger[a]	Clinical (severe)	Normal	−30.80	0.85 (0.46–0.97)	0.50	−2.07
Father report						
Family functioning[a]	Borderline	Normal	−8.50	-	-	-
Selfefficacy[b]	N/A	N/A	9.09	-	-	-
Psychological distress[a]	Mild	None/well	−29.17	-	-	-
Child depression[a]	Clinical (moderate)	Clinical (moderate)	−12.50	-	-	-
Child anxiety[a]	Clinical (severe)	Clinical (moderate)	−27.60	-	-	-
Child anger[a]	Normal	Normal	0.00	-	-	-

[†]The father's final measure range and % change were calculated with the final measurement occasion he completed (session 7).

[a]Higher scores reflect worse functioning.

[b]Higher scores reflect better functioning. NAP and SLC values not calculated for the father's responses due to lack of responses during the treatment phase.

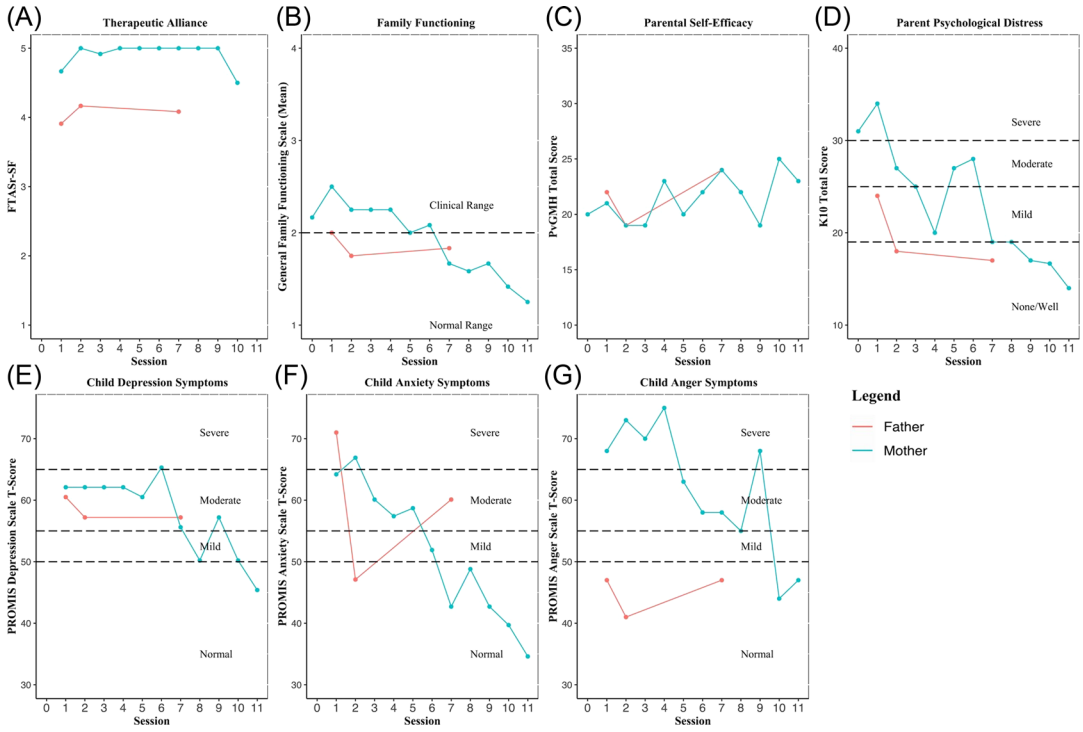

FIGURE 2 Weekly mother and father report measures. (A) Therapeutic alliance scores. (B) general family functioning scores. (C) parental self–efficacy scores. (D) parent psychological distress scores. (E) child depression symptoms. (F) child anxiety symptoms. (G) child anger symptoms.

Family functioning

Prior to the start of therapy, both the mother and father reported clinically significant difficulties regarding the general functioning of their family, with the mother reporting poorer overall family functioning. As illustrated in Figure 2B, during the course of the therapy, Sally and Terrence's reports of the general family functioning improved, falling below the clinical cut-off of 2.00 by the seventh session and remaining in the range of positive family functioning for the rest of the treatment. Between baseline and the feedback session, Sally's score decreased by 42.31%, and between sessions 1 and 8, Terrence's score decreased by 8.33%. Improvements were also found in Sally's reports of family functioning according to the NAP and SLC metrics. With regard to the NAP, 94% of treatment measurements are below (better) the baseline measures, which is indicative of a large effect size. As for the SLC, after controlling for the baseline linear trend, Sally showed improvements across the treatment phase ($b = -0.17$).

In the posttherapy interview, both Terrence and Sally discussed improvements in the functioning of their family, particularly with regard to improvements in the quality of communication and support in their relationship as co-parents—despite their marital separation.

> TERRENCE: Going through this therapy I actually developed a new relationship with [SALLY]. And we are always there for the best interest of our son. You know. And I know it's going to continue that way.

SALLY: I feel like we're showing up as our best selves, individually, right now. We're communicating better now. [TERRENCE] being supportive even for me has been huge. Has certainly eased a lot of the anxiety for me. He's a lot easier to talk to and communicate things with now than when we were living in the same household. So, that has made things much more like ... I guess I don't feel—oddly enough I may be physically alone, but I don't actually feel as alone with all of it, which I think makes things easier. I know I can call or text him anytime to address something with [DAMIEN], or if I need his backup or whatever, or like him to step in, like "you talk to [DAMIEN] I need to take a moment" he would.

Parental self-efficacy

Regarding the parents' capacity and confidence related to supporting Damien with his mental health symptoms, the results indicate slight improvements overall, with scores fluctuating between 19 and 24 out of 35 over the course of the treatment (Figure 2C). Weeks in which parental self-efficacy decreased tended to correspond with higher expressions of symptoms. For example, on the day before session 5, Damien became highly emotionally dysregulated and expressed suicidal intent. Overall, Sally's score increased by 15% from baseline to termination, and Terrence's score increased by 9.09% from sessions 1–8. Improvements were also found in Sally's reports of parenting self-efficacy according to the NAP and SLC metrics. The NAP showed a medium effect size, in which 86% of treatment measurements were above (better) the baseline measures. After controlling for a baseline linear trend, Sally's trajectory showed improvement across the treatment phase ($b = 0.33$).

Despite the variability in the parents' responses on this scale, both parents expressed that they feel more competent and confident in their ability to support their son's mental health.

SALLY: I feel like I've gained space. I feel like I've gained more tolerance and abilities to not be reactive and more so see it from a bigger picture and then like, okay, how are some of these steps that I can—you know, what's my best way of dealing with this. It's kind of helped me slow down my quick-thinking process to being a little bit more structured, which I like, I like structure in general. And then because things have gotten a little easier, in many ways, that all of this work has led to increasing my capacity in general. ... nothing's perfect yet, but it's manageable now. It feels manageable.

TERRENCE: Me, likewise. There's definitely clarity. You know, observation of our growth. And I, I think moving forward I think we're better equipped to manage [DAMIEN's] anxiety and his emotions, you know, so we can support him.

Parent psychological distress

Both parents started the therapy with elevated levels of psychological distress (Figure 2D), with Sally's and Terrence's levels of distress being in the severe and mild ranges, respectively. Sally's

level of distress was not surprising, given her pre-existing eating disorder diagnosis and her role as Damien's primary caregiver. Regardless of baseline symptomatology, both parents' levels of distress reduced into the healthy range over the course of therapy. Overall, Sally's score decreased by 58.84% from baseline to termination, and Terrence's score decreased by 29.17% from sessions 1 to 8. With regard to the NAP, 89% of Sally's treatment measurements fell below (better) the baseline measures, indicative of a medium effect size. Sally's rate of improvement across the treatment phase was found to be slow ($b = 1.14$), though this was accounted for by Sally's increased distress during Weeks 2 and 3 of treatment, and she still generally improved over time.

During the feedback session, Sally and Terrence both reported that, consistent with the questionnaire data, their mental health had improved.

> SALLY: This is 100% right.
>
> TERRENCE: Yeah, mentally, it has been better.

Additionally, as an example of the increased capacity to deal with stressful situations that her reduced distress has afforded her, Sally described a situation in which she provided a life-saving intervention to a young child in the playground near her residence:

> SALLY: My own anxiousness has come down significantly. The most, in fact. So, again I don't know if that's just, you know with the separation there's obviously other emotions but, you know, I think it was really eye opening for me last weekend. [Shares story of responding to a child who stopped breathing at a playground]. I thought that was really going to up my anxiety after the fact, and it didn't. I actually felt overall like really confident. I was like, I am very, reasonably calm. I still debriefed with some friends and neighbors, but I remember being like "Wow, a year ago or even like a few months ago, I would have never been this stable."

Child's mental health symptoms

Regarding Damien's depressive symptoms, both parents reported initial scores in the clinical range (moderate severity; Figure 2E). While Terrence's reports remained in the moderate severity range for sessions 1 and 7, Sally reported improvements in Damien's depressive symptoms in the second half of the treatment, with Damien's symptoms falling in the subclinical (normal) range at termination. The parents' reports of Damien's anxiety symptoms initially fell in the clinical range and improved over treatment, with marked improvements reported by the mother (Figure 2F). Terrence reported his son to have severe symptoms of anxiety, and Sally reported her son to have moderate symptoms of anxiety at the outset of therapy. Sally's reports of Damien's anxiety remained stable and elevated until session 6, at which time the reported symptoms fell into the normal range for the remainder of the treatment. Terrence's reports of Damien's anxiety were more varied, falling in the normal range in the second session and then up to the moderate range at session 7. Regarding anger, Sally's and Terrence's reports substantially differed (Figure 2G). While Terrence did not report or

experience anger from Damien, Sally reported observing severe outbursts of anger throughout the therapy. Sally's responses indicated that Damien experienced elevated anger symptoms until the final session, though the symptoms were the most marked in the first 5 weeks. Given Sally's experiences of her son's difficulties with regulating his emotions and tolerating frustration, much of our emotion coaching work focused on developing the parents' capacity to be emotion and behavior coaches related to anger and oppositionality. During the second half of the sessions, Sally reported that Damien still had elevated anger symptoms but that the symptoms were generally mild and more manageable.

Change from first measure to termination based on Sally's reports indicates clinically significant improvement for all three domains of symptoms: depression = −26.89%; anxiety = −46.11%; and anger = −30.8%. Percent change based on Terrence's reports also showed improvements for depression and anxiety (−12.50% and −27.60%, respectively) and showed no change in anger (though Terrence did not report Damien expressing anger symptoms at baseline). Improvements were also found in Sally's reports of Damien's depression, anxiety, and anger symptoms. With regard to the NAP, Damien's depression, anxiety, and anger symptoms were lower (better) than the baseline period during 81% (medium effect), 100% (large effect), and 85% (medium effect) of treatment measurements, respectively. After controlling for the baseline linear trend, Sally's reports of Damien's depression, anxiety, and anger symptoms improved over time ($b = -1.29$, -0.07, and -2.07, respectively).

During the feedback session, Sally and Terrence both indicated that the results of the weekly measures of Damien's symptoms are consistent with their subjective experience:

> SALLY: We dealt with some racial concerns, we dealt with some suicidal concerns, there was a lot of heavy things that happened in this period of time. So, I'm not surprised to see a little bit of fluctuation. [...] I think back to what our future goals were, and I feel like we've accomplished them. You know, that was probably the thing that got me right off the bat, at first, was seeing what I said in the first session of what I wanted and thinking about where we are today, like, total, total change.

> TERRENCE: We definitely benefitted from these sessions. And you can tell by the actions of our son.

DISCUSSION

We aimed to present the application of weekly, virtually delivered EFFT. Overall, the results from this study supported the use of virtually delivered EFFT in that parents' responses indicated that there was a strong therapeutic alliance formed and maintained throughout the treatment and that the general family functioning and the parents' and child's symptoms substantially improved.

The quantitative assessment of the therapeutic alliance was consistently at or near the ceiling of the scale from the outset. While this does not provide a nuanced understanding of the alliance, the qualitative feedback indicated that the parents both felt supported by the therapist and that the work was aligned with their goals. This finding adds support to the general use of teletherapy for relational and family modalities, demonstrating that a strong therapeutic relationship can be forged in the virtual context—a concern that has contributed to the slow

uptake of teletherapy by couple and family therapists (Hertlein & Earl, 2019). Importantly, early therapeutic alliance has been found to moderately predict treatment outcomes (Friedlander et al., 2018), which was consistent with the improvements in family functioning and parental and child symptoms.

This is the first study to measure general family functioning in the context of an EFFT intervention. The findings from the present study illustrate that the EFFT intervention can positively affect the whole family system. This study showed an improvement from clinically significant family dysfunction at baseline to healthy family functioning by termination. This is likely due to several factors, including the improvements in the parents' and child's mental health, as well as the development of different ways of communicating with each other and an increased sensitivity and responsiveness to emotions. In these sessions, the therapist facilitated the parents' use of the emotion coaching framework with each other, with the intent of providing the parents with the opportunity to practice the skills in an emotionally charged situation and to learn to communicate with one another in a new way. Future research should assess general family functioning as an outcome of EFFT, given that this is an important predictor of young children's biopsychosocial functioning (Browne et al., 2015; Sokolovic et al., 2021). Additionally, this research contributes to the evidence that the responsivity of fathers is related to the responsivity of other family members (Sokolovic et al., 2021), as Sally felt better equipped to respond to Damien's emotions and behaviors given that she now felt supported—emotionally and practically—by Terrence.

The present study found promising results regarding the parents' self-efficacy, which is a key target and purported mechanism of change in the EFFT model (Foroughe et al., 2019; Strahan et al., 2017). While the survey responses showed a variation of scores on a session-by-session basis, the trajectories showed an overall increase in self-efficacy. This finding is consistent with previous research on the effectiveness of 2-day EFFT workshops (Foroughe et al., 2019; Hertlein & Earl, 2019; Lafrance Robinson et al., 2016; Strahan et al., 2017; Wilhelmsen-Langeland et al., 2020). The qualitative responses during the final feedback session suggested that the parents felt better equipped to handle their child's ongoing mental health concerns and challenges that may arise in the future. As the mother pointed out, this increased confidence in her capacities may be owing to several changes, including (1) improvements in the relationship between her and the father via an increased sense of trust, supportiveness, and communication, (2) improvements in her well-being, and (3) her increased understanding of how to communicate with her son in a way that validates his emotions before providing practical solutions. The father, on the other hand, had less confidence in his immediate capacity to implement the therapeutic techniques due to the relatively limited time he spends with his son; however, he indicated a high degree of motivation and confidence that he will become more adept at the skills with practice. While this study did not include a follow-up measurement, previous studies of EFFT interventions have found parental self-efficacy to be sustained above baseline levels several months after the intervention (Foroughe et al., 2019; Lafrance Robinson et al., 2016; Wilhelmsen-Langeland et al., 2020).

Maternal reports of her child's anger, anxiety, and depressive symptoms showed substantial improvements in the present study, from clinically significant (moderate to severe) at baseline to within the normative range at termination. This finding is also consistent with the findings of previous research. For example, Foroughe et al. (2019) found significant improvements in children's behavioral symptomatology from preintervention to the 4-month follow-up, and Wilhelmsen-Langeland et al. (2020) found significant reductions in children's oppositional defiant behaviors at the 3-month follow-up following a 2-day EFFT workshop. It is worth

noting that, in contrast to Wilhelmsen-Langeland et al.'s results, the present study also showed improvements in the child's internalizing problems (i.e., anxiety and depression). Overall, this study supports the preliminary evidence of EFFT's applicability as a transdiagnostic intervention.

While previous research examining change processes in EFFT has focused on changes to parental fears and self-blame (Strahan et al., 2017), this is the first study to examine parents' psychological distress. In the present study, parents' self-reported psychological distress started in the clinical range during the initial assessment and improved over treatment, with final self-reported scores in the normative range. Given that parental (especially maternal) psychopathology is an important predictor of parents' coregulation of their children's emotions via socialization practices (Breaux et al., 2016), assessing parent psychological distress is an important factor to include in future EFFT outcome intervention studies.

The amount of research examining family teletherapy is relatively scarce compared with the extant literature on individual therapy, as this area of research has lagged (Backhaus et al., 2012; Helps & Le Coyte Grinney, 2021). The present study is the first to illustrate the application of weekly delivered EFFT in a virtual context. While this is a case study with a single family, the present research provides proof of concept for the compatibility of EFFT across online and offline environments. Thus, in the context of an increasing reliance on virtual service provision (Lebow, 2020a, 2020b), this study provides important preliminary data to support the appropriateness of offering virtually delivered EFFT for caregivers who wish to increase their capacities to become active agents in the resolution of their child's mental health challenges.

Clinical implications

Several practical implications are worth noting for clinicians considering the use of EFFT. First, the extension of EFFT to weekly sessions provides the opportunity to take a developmental approach to support parents' skill development. Specifically, therapists can use emergent issues in the family's life to scaffold the parents' learning through in-session practice. For example, in the case described above, the therapist gradually supported the parents' learning of emotion coaching by beginning with psycho-education, then using one-on-one role-plays with the therapist (the second parent observing), and eventually facilitating the parents' use of emotional validation, provision of emotional support, and problem-solving (practical support) with each other in session during moments when the parents were emotionally activated. During the latter process, the therapist provided prompts and redirections as needed to shape the skills and verbal and nonverbal cues of affirmation to deepen the parents' emotional engagement throughout. Afterward, the therapist provided descriptive praise to underscore the parents' effective use of the components of emotion coaching. This was particularly effective in two sessions—one that centered on an incident of Damien threatening self-harm and another that dealt with Terrence's lived experience of racial discrimination and his and Sally's fears of Damien's risk of experiencing racial violence—in that it served to both increase the parents' facility with the skills and initiate a shift to a more validating communication style between Terrence and Sally when expressing their experiences and emotions.

A second related implication of the weekly extension of EFFT pertains to the ability to support parents to apply the skills to various situations that give rise to different emotions and behavioral responses. We found that the parents' self-efficacy with using the EFFT skills varied depending on the types of emotions and behaviors that their son displayed. The weekly sessions

provided the opportunity to apply the skills to different emotions (e.g., sadness, anger, and anxiety). Doing so also provided an important opportunity to integrate and refine the use of a range of behavioral interventions when discussing behavior coaching and practical support (e.g., use of descriptive praise, limit setting, logical consequences, exposure, etc.).

Third, the acceptability of EFFT in the virtual context, along with the weekly implementation, has implications for the provision of EFFT for families who have difficulties otherwise accessing services. Research shows that many people and families face substantial barriers to accessing psychological services (Moroz et al., 2020). It is conceivable that for many families who are under-resourced, are geographically isolated, or comprise members living in separate homes (or geographic locations), attending a 2-day intensive workshop to learn the EFFT modules may not be feasible, whereas meeting regularly for a shorter duration from a device may be within their means. This is important for improving the accessibility of clinical services for families—an increasingly important issue as the demand for psychological services continues to rise (Ontario Psychological Association, 2023).

Limitations and future directions

The current study included several limitations, including threats to external and internal validity due to limited data, potential social desirability bias, and an inability to disentangle the nature of the maternal and child symptom change due to the consistency between the mother's self- and parent-report measures. As a case study, the generalizability of the results is limited—particularly related to the effectiveness of the EFFT intervention. Additionally, most of the survey data included in the present study were based solely on the mother's responses, as the father only completed three of the 12 surveys that we administered. Future research should expand on this work by increasing the sample of families accessing services and the number of supervisors and clinicians involved in delivering services. There is also a risk for some of the results to reflect social desirability bias regarding the parents' interview responses, as the clinician was also responsible for leading the research. For example, during the feedback interview, it is possible that the parents presented their experiences with the EFFT intervention more favorably than would have been the case had they shared their feedback with a third party or if they were providing the feedback anonymously. That said, the interview was conducted like a typical termination session, and the clinician and clients had developed a trust and an openness that supported honest (including critical) feedback throughout therapy, so this sentiment likely extended to the feedback. Additionally, the qualitative feedback is generally consistent with the quantitative results. Nevertheless, the parents' feedback should be interpreted with caution, and interviews should be conducted by a third party in future qualitative studies of EFFT.

It is also worth noting that the change in Sally's symptoms cannot be solely attributed to the EFFT treatment due to her concurrent participation in weekly individual therapy sessions. Sally saw a dramatic improvement in her psychological well-being, starting the treatment with clinically severe distress and ending it with levels of distress indicative of normal functioning. While Sally indicated that the EFFT sessions and strategies that she learned directly contributed to her increased psychological well-being, it is likely that pairing the individual therapy with the relational- and child-focused EFFT intervention yielded an additive effect, which led to rapid and significant gains that improved her functioning in multiple life domains and roles. The relationship between concurrent versus sequential participation in individual

and family therapy would be worth examining in future controlled trials of EFFT. Finally, changes in Damien's symptoms tended to correspond with changes in Sally's symptoms. Given previous research, which has found that mothers over-report children's anxiety symptoms when they themselves are anxious (Frick et al., 1994), it is possible that Damien's parent-reported symptoms could be more illustrative of Sally's psychological functioning at each time point than his. On the other hand, the conflation of Sally's and Damien's symptoms could also be a function of mutuality given the close nature of their relationship as well as their constant proximity in their small apartment due to Sally and Damien both being home from work/school due to COVID-19 protectionist policies. Future research examining the effectiveness of EFFT interventions should control for parental psychological distress when examining children's symptoms.

Despite these limitations, the study provides the first insight into the application of weekly, virtually delivered EFFT, which is important for advancing the evidence base for virtual family therapies and addressing the systemic shift toward virtual service provision. The results are promising and provide important impetus for a larger-scale randomized controlled study examining virtual and in-person delivery of weekly EFFT, which has commenced since concluding the research described above.

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