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Evaluating the Impact of a Compassion Focused Therapy Group on Parent and Caregiver Psychological Flexibility

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Abstract

Compassion focused therapy (CFT) for parents and caregivers is an emerging evidence-based intervention that aims to teach caregivers how to manage their own stress and frustration, as well as co-regulate their children's emotions and self-soothing capabilities. Previous research has found that CFT interventions can improve parental self-compassion, psychological flexibility, and increase their sense of self-efficacy. The present study aimed to determine whether parental burnout and psychological inflexibility can be reduced through a novel CFT caregiver protocol. Results of the present study provide preliminary support for the utility of the intervention. Analyses of relations between constructs as well as the quantitative and qualitative results were consistent with findings from previous studies on the processes of interest. Paired samples t-tests also revealed that caregivers responded positively to the intervention and perceived the program to be helpful. Implications for future CFT parent and caregiver interventions are discussed.

Keywords: psychological flexibility, compassion focused therapy, self-compassion, self-criticism, parenting intervention, parental burnout

Summary for Lay Audience

This compassion focused therapy (CFT) caregiver program is a new intervention that was developed for caregivers who may be experiencing self-criticism and burnout, and who have children with mental health difficulties. CFT was developed for, and has been shown to be effective in, decreasing self-criticism, increasing an individual's ability to cope with difficulties, and increasing compassion with oneself and others. This research focuses on a concept called psychological flexibility, which is an ability to interact with one's thoughts and emotions, even if they are negative, while still choosing to behave in ways which align with personal values. In parenting, psychological flexibility involves being able to accept negative thoughts and emotions related to the parenting role, while still being able to perform parenting practices that align with one's parenting philosophy. CFT was chosen for this caregiver program as caregiver burnout, self-criticism, and psychological inflexibility negatively impact caregivers, their children, and the parent-child relationship.

This CFT intervention aims to help caregivers develop a greater understanding of self-compassion and self-criticism, explore how to engage in value-based action, learn about emotions and how they impact behaviour, engage in self-reflective work to understand what is impacting current parenting practices, and to develop skills to strengthen the parent-child relationship. Results of this intervention did not show a difference before and after the group in burnout and psychological inflexibility. However, results from the surveys revealed that caregivers were highly satisfied with the program, found it to be helpful, and continued to use the skills and attitudes from the program after it was complete. Results also demonstrated that caregivers believed their understanding of and relationship with their child, their ability to cope, and their confidence in their parenting skills improved. This research provides tentative support for this CFT intervention on improving the parent-child relationship, and informs future research and implementation considerations related to CFT caregiver interventions.

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Introduction

Self-criticism, self-compassion, and psychological flexibility are complexly interwoven processes that impact the experience of parenting stress and burnout. Self-criticism is found to increase parenting stress (e.g. Casalin et al., 2014), self-compassion is found to decrease it (e.g. Bögels et al., 2014), while psychological flexibility has been shown to do both (e.g. Sairanen et al., 2018; Daks et al., 2020). Studying the impact these processes have on parenting stress is important because parenting stress has been demonstrated to have a variety of negative effects on children (e.g. Beebe et al., 2007). Compassion focused therapy (CFT) is a psychotherapy that directly targets these processes of interest by striving to reduce self-criticism as well as build self-compassion and psychological flexibility (Gilbert, 2009). This study explored whether a CFT parent and caregiver group is associated with improvements on measures of psychological flexibility as well as parenting stress. This research also explored which aspect(s) of the program participants found most and least helpful, and how the provision of this CFT group can be improved for future participants.

Self-Criticism in Parents and Child Distress

Self-criticism is multi-faceted involving affective, cognitive, physiological, and intrapersonal processes (Gilbert, 2010). Regarding the affective component, self-criticism is characterized by feelings of unworthiness, inferiority, guilt, and failure. Cognitively, self-criticism involves disparaging self-judgements and rumination about flaws, and interpersonally it involves a fear of others' disapproval (Warren et al., 2016), external shame (Gilbert, 2006), and tendencies to respond with undue defensiveness or submission (Cwinn et al., in preparation). Several studies have shown that self-critical individuals are more vulnerable to psychopathology and have shown an increase in their symptom severity compared to non self-critical individuals (Besser et al., 2008; Blatt & Luyten, 2009; Casalin et al., 2014; Nolen-Hoeksema, 2000, Priel & Besser, 1999). For example, self-criticism was found to predict depression several years into the future (Dunkley et al., 2009; Murphy et. al., 2002;), and the level of self-criticism an individual experiences has been shown to negatively impact psychotherapy treatment outcomes (Cox et al., 2002; Löw et al., 2020).

In addition to serving as a predisposing and perpetuating factor in clinical syndromes, self-criticism is also associated with maladaptive parenting processes. When studied in a parent

population, it was found that self-criticism is related to a greater amount of perceived parenting stress (Casalin et al., 2014; Dunkley et al., 2003; Moreira & Canavarro, 2018). Moreira and Canavarro (2018), for instance, found self-critical rumination to be positively associated with parenting stress. Along with this, Casalin and colleagues (2014) found parental self-criticism to increase parenting stress, suggesting that highly self-critical parents may experience more stress due to negative evaluations of their relationship with their child.

In addition to being a mental health burden on parents, self-criticism relating to an increased amount of parenting stress is important because parenting stress has been shown to be associated with an increase in children's negative affectivity (Beebe et al., 2007; Bridgett et al., 2009; Casalin et al., 2014; Pesonen et al., 2008). Bridgett and colleagues (2009), for instance, found that higher levels of maternal relationship stress predicted increased levels of infant negative emotions such as distress to limitations, fear, and sadness. This rise in negative emotions was also hypothesized to constitute an increased risk for child behavioural problems (Bridgett et al., 2009). Pesonen and colleagues (2008) found that higher maternal stress contributed to negative affectivity in children, and a decrease in positive affectivity and self-regulation abilities. Pesonen and colleagues (2008) defined negative affectivity as consisting of emotions such as anger, discomfort, fear, sadness, and shyness and positive affectivity as soothability, high intensity pleasure, impulsivity, inhibitory control, and smiling. Maternal stress during infancy was significantly associated with both infant negative affectivity and later child negative affectivity (Pesonen et al., 2008). This relation indicates that maternal stress in infancy has direct negative effects on infants that can extend into the future. Cassalin and colleagues (2014) found that parenting stress partially mediated the relation between parental self-criticism and child negative affectivity, defined by externalizing behaviours such as throwing a tantrum. Importantly, Casalin and colleagues (2014) found that the parent-to-child effects were more substantial than the child-to-parent effects, as negative affectivity in children did not influence parenting stress over time, however parental self-criticism was found to be related to the development of child negative affectivity directly, as well as indirectly by increasing parenting stress. Given the substantial literature documenting parent distress and hopelessness in the context of child *physical* health difficulties (e.g., Lawoko & Soares, 2002; van Warmerdam et al., 2019), one may expect greater levels of parent burnout and self-criticism resulting from child *mental* health difficulties. This relation between parenting stress and child well-being highlights

the importance of studying interventions targeting parental self-criticism, as the direct and indirect consequences on children's well-being have been demonstrated.

Some researchers have begun to clarify what contributes to this relation between parental self-criticism and child well-being. For instance, high parental self-criticism appears to contribute to the internalization of achievement-oriented psychological control through guilt and coercion, which negatively impacts the parent-child relationship (Soenens et al., 2005, 2010; Thompson & Zuroff, 1998). Soenens and colleagues (2010) found that adolescents with parents who were controlling through guilt and coercion were more likely to be self-critical themselves when they failed to meet self-imposed standards. Tactics such as shaming, guilt induction, and appeals to pride are used by controlling parents to demonstrate conditional regard which conveys to the child that their love depends on the child behaving in a way the parent approves of (Soenens et al., 2010). Soenens and colleagues (2005) found that parental maladaptive perfectionism, which includes harsh and critical self-evaluations, predicted the use of parental psychological control, which in turn also impacted the development of child maladaptive perfectionism. Soenens and colleagues (2005) asserted that parents with high maladaptive perfectionism are preoccupied with self-imposed standards as well as a fear of failure, and are therefore unable to attune to the needs and wishes of their children, instead engaging in contingent approval and guilt induction. Thompson and Zuroff (1998) found that mothers high in self-criticism tended to be more controlling and punitive in a problem-solving coaching exercise. Thompson and Zuroff (1998) also found that that highly self-critical mothers became more depressed if they were told they would partner with their child for a problem-solving exercise, which was interpreted to reflect the tendency for highly self-critical mothers to prefer distant relationships.

Self-critical parents were also found to engage in more venting about their lives in general and chose to be secluded from their children and family more, due to their increased vulnerability to negative emotions and affect (Dunkley et al., 2003; Mongrain & Zuroff, 1995; Moreira & Canavarro, 2018). Parents preoccupied with self-critical thoughts also appear to be less capable of noticing their children's emotions, thus negatively impacting the parent-child relationship (Moreira et al., 2018). Lastly, Beebe and colleagues (2007) found that highly self-critical mothers had difficulty relating to their infant's attentional and affective signals as they

showed lower gaze and facial coordination with the infant. Self-criticism has therefore been found to negatively affect the parent-child relationship indirectly by contributing to the experience of parenting stress, as well as directly by decreasing a parent's ability to connect with their children and by increasing negative affectivity in both parents and children.

Beneficial effects of Parental Self-Compassion

Self-compassion is defined in the literature as adopting a caregiving mentality towards the self during difficult times of suffering and failure, in order to self-soothe and engage in affect regulation (Gilbert, 2009). Contrary to self-criticism, self-compassion involves exhibiting self-kindness and mindfulness, and has been shown to decrease self-judgement and feelings of isolation (Neff, 2009). Self-kindness involves being caring and understanding towards oneself rather than being harshly critical or judgemental (Neff, 2009). Mindfulness is defined as: "awareness that arises through paying attention, on purpose, in the present moment, non judgementally, in the service of self-understanding and wisdom" (Kabat-Zinn, 1994). Self-compassion supports individuals to relate to their failures using less harsh self-talk and blame and more warmth, acceptance, and belongingness (e.g., Warren et al., 2016). Self-compassion is related to greater overall life satisfaction and well-being (Allen & Leary, 2010; Bluth & Blanton, 2015; Bluth et al., 2017; Neff et al., 2007; Neff & McGehee 2010; Warren et al., 2016), less severe psychopathology symptoms (Muris et al., 2016; Neff, 2003; Neff et al., 2007; Wasylkiw et al., 2012; Wetterneck et al., 2013), and lower levels of parenting stress (Bögels et al., 2014; Gouveia et al., 2016; Potharst et al., 2017).

Parental self-compassion research has increasingly become a topic of interest, due to the beneficial effects of parental self-compassion on parental well-being and the parent-child relationship. For example, when parents are given a self-compassionate prompt before recalling a guilt- or shame-provoking parenting event, they report significantly less guilt and shame as compared to a control condition (Sirois et al., 2019). Similarly, Jefferson and colleagues (2020) revealed through a meta-analysis that parenting interventions with self-compassion prompting components significantly improved parental self-compassion and mindfulness, and decreased parental depressive, anxiety, and stress symptoms. Furthermore, self-compassion in parents was seen to benefit the parent-child relationship as Kirby and colleagues (2019) found that parents with a more self-compassionate mindset tended to engage in more facilitative parenting (i.e.,

warm and responsive) as compared to self-focused or shame-avoidant parents who tended to engage in more psychologically controlling parenting (i.e., controlling of children's thoughts and self-expression). Self-compassion in parents has been seen to have an overall positive impact on parental mental health in addition to the parent-child relationship by decreasing the amount of experienced parenting stress, and by allowing for more secure parent-child attachments to be formed.

Psychological Flexibility and the Parent-Child Relationship

Psychological flexibility is "the ability to contact the present moment more fully as a conscious human being, and to change or persist in behaviour when doing so serves valued ends" (Hayes et al., 2006, p. 7). Individuals high in psychological flexibility are able to interact with their internal experiences, thoughts, and emotions, while still responding adaptively to their environment in ways that align with their personal values (Burke & Moore, 2015; Hayes et al., 2006). Promoting psychological flexibility is a focus in Acceptance and Commitment Therapy (ACT), which views the following processes as underlying psychological flexibility: acceptance, cognitive defusion (i.e. techniques used to separate oneself from thoughts and emotions), mindfulness, the self as context, values, and committed action (Burke & Moore, 2015; Hayes et al., 2006). An inability or unwillingness to contact one's internal experiences and emotions, called experiential avoidance, leads to attempts to avoid, change or control unwanted cognitions, memories, and emotions (Blackledge & Hayes, 2001; Hayes et al., 2006). These strategies of inhibition, suppression, and avoidance often have a counterproductive effect by increasing the negative thoughts, emotions, and distress the individual wished to avoid (Krause et al., 2003). Overall, a greater amount of psychological flexibility has been associated with better quality of life (Benjamin et al., 2020; Hayes et al., 2006; Kashdan & Rottenberg, 2010; Williams et al., 2012), a lower probability of developing a psychiatric disorder (Bond & Bunce, 2000, 2003; Donaldson-Feilder & Bond, 2004), and has been shown to predict good mental health (Bond & Bunce, 2003; Gloster et al., 2011).

Psychological flexibility within parenting is positively related to global ratings of psychological flexibility (Brassel et al., 2016). Parental psychological flexibility is a parent's ability to accept their negative thoughts and emotions while still engaging in parenting practices that align with their parenting philosophy. Negative thoughts and emotions may be related to the

parenting experience or directed towards their child, and these are acknowledged while the parent continues to act according to their values and in ways that positively impact the parent-child relationship (Brassel et al., 2016; Burke & Moore, 2015). Parent psychological flexibility impacts and is affected by the experience of parenting stress (e.g. Daks et al., 2020). Parents with lower levels of psychological flexibility are more likely to negatively evaluate their experience of parenting stress, which in turn leads to experiential avoidance (Burke & Moore, 2015) and increases in parenting stress (Sairanen et al., 2018; Weiss et al., 2012; Whittingham et al., 2012). For example, a study by Daks and colleagues (2020) found that greater levels of parent psychological inflexibility predicted greater stress related to COVID-19, greater family discord, and greater parent and child distress. Furthermore, low parent psychological flexibility adversely impacts the parent-child relationship and child well-being by decreasing a child's ability to be psychologically flexible themselves (Williams et al., 2012) which, in turn, negatively impacts the child's adjustment (Cheron et al., 2009). Parenting stress and the family environment can also contribute to the development of parental psychological inflexibility (Berryhill et al., 2018; Fonseca et al., 2020; Gottman et al., 1996). Conversely, higher levels of parent psychological flexibility were associated with greater family cohesion and lower levels of discord (Daks et al., 2020). For instance, greater maternal psychological flexibility has been associated with greater maternal responsiveness (Evans et al., 2012). Furthermore, parent psychological flexibility has been found to mediate the impact of child problem behaviour on parental mental health problems (Weiss et al., 2012). Weiss and colleagues found that when child problem behaviour increased, parent psychological flexibility decreased, which resulted in an increase in parent mental health problems such as stress, marital discord, or poor quality of life. Moyer and Sandoz (2015) also found that parental psychological flexibility moderates the relationship between parent and child distress as parental depression predicted overall adolescent distress when parental psychological inflexibility was high. Psychological flexibility was also found to moderate the relationship between parent anxiety and adolescent depression, as highly inflexible parents were more likely to have adolescents with higher depression (Moyer & Sandoz, 2015)

Parents low in psychological flexibility have also been shown to be more likely to engage in maladaptive parenting practices such as using severe, reactive, or inconsistent discipline (Brown et al., 2015; Burke & Moore, 2015; Daks et al., 2020; Sairanen et al., 2018). Fonseca and colleagues (2020) found that this relation was dependent on context, the presence of parenting

stress, and global levels of psychological flexibility. Parents with low global psychological flexibility and high parenting stress were found to more frequently engage in maladaptive parenting styles; however, this was not seen in parents with high global psychological flexibility and high parenting stress (Fonseca et al., 2020). Higher levels of parenting stress may make parent psychological flexibility more difficult, and may challenge a parent's ability to engage in value-based actions with their children. These results by Fonseca and colleagues (2020) suggest that higher levels of global psychological flexibility act as a buffer between parenting stress and the use of maladaptive parent strategies. The presence of this moderating variable highlights the importance of targeting global psychological flexibility in addition to parental psychological flexibility to promote adaptive parenting practices more comprehensively.

Self-compassion is significantly and positively correlated with psychological flexibility, in that an increased level of self-compassion is related to an increased level of psychological flexibility (Davey et al., 2020; Marshall & Brockman, 2016; McLean et al., 2018; Van Dam et al., 2011), and lower levels of self-compassion are associated with the use of more experiential avoidance strategies (Thompson & Waltz, 2008). Yadavaia and colleagues (2014) found that psychological flexibility was a significant mediator for changes in self-compassion and psychological distress after an acceptance and commitment therapy (ACT) intervention. They estimated that psychological flexibility accounted for 28.1-59.9% of all the effects of the ACT intervention (Yadavaia et al., 2014). This finding indicates that self-compassion interventions should be informed by psychological flexibility models in order to maximise increases in self-compassion and decreases in psychological distress. On the other hand, Marshall and Brockman (2016) found that while both self-compassion and psychological flexibility are related to emotional well-being, self-compassion may predict emotional well-being beyond psychological flexibility. While psychological flexibility encompasses mindful awareness of inner experiences, self-compassion is related to an individual's ability to tolerate their painful emotional experiences (Marshall & Brockman, 2016). There is a clear relation between psychological flexibility and self-compassion, but further research is required to understand the nature and direction of the relation in order to promote treatment efficacy.

A Compassion Focused Therapy Group for Parents and Caregivers

Theoretical Framework

CFT aims to develop an individual's capacity to cope with adversity and to increase their ability to act compassionately towards themselves and others (Gilbert, 2009). This approach was originally developed for highly self-critical individuals as a method for helping them take pride in their achievements and find compassion for their personal hardships (Gilbert, 2014; Neff, 2009). In a meta-analysis by Leaviss and Uttley (2015) CFT was found to be an effective treatment for individuals high in self-criticism, making this the ideal framework to apply to a parent and caregiver group, as parental stress is greatly impacted by the experience of self-criticism (e.g. Casalin et al., 2014). CFT is a biopsychosocial model of psychotherapy, which posits that individuals with high shame and self-criticism cannot properly access their self-soothing system and that they have an over-active threat detection and threat response system (Gilbert & Procter, 2006). The threat detection and response system is one of three motive-oriented states of mind that a person can enter into in response to internal and external situations and experiences. The other motive-oriented states include the drive mind which is a competitive and resource acquisition mind, and the compassionate or 'caregiving' mind. The motive-oriented states of mind organize the entire person including their cognition, arousal, emotions, behaviours, and attention (Gilbert, 2020). For instance, fear or anger may trigger movement into the threat motive-oriented state of mind, and the person will become organized towards responding to that threat by centering their thoughts around the threat, narrowing their attention, displaying increased arousal and hypervigilance, and experiencing activation in threat systems of the brain such as the amygdala and sympathetic nervous system (Gilbert, 2020). In the caregiving motive-oriented state, the parasympathetic nervous system is activated which promotes rest and acquiescence, from which we feel safe and content (Gilbert, 2009). Being in a caregiving mentality and its association with activation of the parasympathetic nervous system is related to better performance in cognitive functioning such as sustained attention, working memory, and psychological flexibility (Hansen et al., 2009; Hovland et al., 2012). Caregivers who respond to their children from the threat or drive oriented states of mind will respond with corresponding emotions and criticisms, while caregivers who are in the soothing caregiving motive will be able to respond to their children more adaptively and responsively. This is because the caregiving mentality is activated in safe relationships with others and helps an

individual to respond to others with caring emotions and an intention to reduce suffering (Gilbert, 2005). One of the central goals of CFT is to help individuals shift into a caregiving motive-oriented state of mind when in distress instead of always shifting into a threat or drive mind state.

This emphasis on shifting into the caregiving motive-oriented state of mind is important in an intervention for parents and caregivers, as they are responsible for co-regulating their children's emotions along with their own, and often experience shame and guilt in relation to parent events (Sirois et al., 2019). CFT also addresses these feelings of shame and guilt through evolutionary-focused psychoeducation in order to normalize an individuals' experiences (Kirby, 2019). Furthermore, CFT's grounding in attachment theory (Gilbert, 2009) is suited for an application to a parent and caregiver group, as a parent's own attachment history is relevant in the development of a compassionate self.

Compassion-Focused and Mindfulness Interventions: Related but Distinct Interventions for Parents

A group for parents and caregivers addressing parental self-criticism, self-compassion, and psychological flexibility is of great research interest because the direct effects these processes have on children and the parent-child relationship have been demonstrated. As noted above, parental self-criticism increases parenting stress, which in turn interferes with parents' ability to form affiliative relationships with their children (e.g. Casalin et al., 2014; Soenens et al., 2005, 2010). Conversely, self-compassion was found to decrease parenting stress, promote psychological resilience in children, and strengthen the parent-child relationship (e.g. Bögels et al., 2014; Kirby et al., 2019). Along with this, greater levels of parental psychological flexibility led to more beneficial parenting practices, an improved ability to maintain value-based action when stressed, and greater psychological flexibility in children (Brassel et al., 2016; Fonseca et al., 2020; Williams et al., 2012; see Appendix A, Figure A1).

Aside from the aforementioned self-compassion promoting interventions (e.g. Sirois et al., 2019), self-compassion in a parent population has also frequently been studied through a mindful parenting lens. Mindful parenting is a concept similar to mindfulness and compassion in CFT that involves presence, non-judgement and acceptance, emotional awareness, in addition to self-soothing in order to engage in value-based parenting (Duncan et al., 2009). What

distinguishes mindful parenting interventions from the proposed CFT intervention is that the latter provides explicit teaching and training on the caregiving and care receiving qualities of compassion, and the ways in which those are manifested in other evidence based parenting activities. The proposed CFT intervention focuses on defining and enacting the role of compassionate other for caregivers themselves, as well as for their children in explicit and structured ways.

Furthermore, many existing evidence-based parenting programs (EBPPs) are based on social learning theory and operant conditioning, which characterize parenting success by reductions of negative externalizing behaviour on part of their children (Kirby, 2019). This wave of behaviour-based parenting has largely left behind the important relationship-focused components from earlier parenting interventions. CFT is a promising framework for parenting interventions because it intentionally leverages both attachment/relationship-focused parenting practices and behaviourist approaches to parenting. Furthermore, CFT focuses on facilitating caring motivational systems and affiliative emotion processing (Kirby, 2019), and to do this, parents are given explicit instruction on how to regulate their own emotions as well as their child's. Children learn self-soothing skills through co-regulation with their caregivers by observing caregivers appropriately soothing their own and the child's feelings (Gilbert, 2014). A CFT group for parents must target the development of this skill, while at the same time providing coping skills for caregivers to manage their own stress and difficulties. Instead of investigating the impact of increasing desirable child behaviours on parenting stress and well-being, the CFT approach examines how a decrease in parenting stress and promotion of psychological skills can lead to desirable behaviours in their children.

Existing CFT Parenting Interventions

More research has been directed towards mindful parenting or compassion-promoting components in parenting interventions than towards CFT in parenting programs or interventions. However, since 2018 , research in Sweden, Australia, Iran, and the UK has begun to address this gap. Bratt and colleagues (2019) discovered through qualitative parental interviews that eight two-hour group CFT sessions improved parents' sense of agency, their ability to communicate and share their feelings with their children, and their confidence in their ability to parent. Similarly, Karlsson and Hansson (2020) analyzed the impact of eight two-hour group sessions of

CFT, finding that parents demonstrated a significant improvement in their psychological distress, and felt less alone and more connected to others and their family based on the pre and post quantitative measures and the post-intervention qualitative questionnaire. Furthermore, a study by Zamani-Mazdeh and colleagues (2019) conducted CFT sessions for mothers of autistic children and found that parental quality of life and sense of self-efficacy significantly improved between the pre and post test measures. Two other studies with similar designs also found that a CFT group for parents significantly decreased the parent's depressive and anxiety symptoms (Navab et al., 2018), and improved self-compassion in parents as well as self-esteem in their children (Shirvani et al., 2019). Furthermore, a study by Brenjestanakiet and colleagues (2020) demonstrated that after eight two-hour CFT sessions, mothers of children with a developmental disability showed statistically significant increases in psychological flexibility, and decreases in self-criticism as compared to a control condition.

One study by Mitchell and colleagues (2018) and its follow-up study (Lennard et al., 2020) differed from the eight two-hour CFT group session design by providing CFT-informed online resources and brief self-compassion and meditation videos for new and breastfeeding mothers. Participating mothers showed a significant improvement in self-compassion, a decrease in post-traumatic stress symptoms, and improved breastfeeding experience and satisfaction. In the follow-up study, participants also showed increased self-compassionate action (e.g. increased thinking and reasoning about what is likely to be helpful) and engagement in compassion (e.g. increased motivation to engage and work with other people's distress when it arises; Lennard et al., 2020). However, neither study showed significant changes in psychological flexibility levels. This research demonstrates the potential effectiveness of a short-term CFT intervention for parenting on increasing self-compassionate behaviour, and suggests that mechanisms other than increased psychological flexibility might be implicated.

Lastly, a study by Bratt and colleagues (2020) did not find significantly beneficial results from eight two-hour group CFT sessions for parents. Similar to the aforementioned studies, all participants were parents of adolescents who had complex mental health concerns and were enrolled in an outpatient youth psychiatric treatment facility. They found no significant difference between the CFT group and the treatment as usual (TAU) condition in terms of increases in self-compassion or decreases in stress. There was also no significant difference

between the pre and post tests for the CFT group independent from the TAU group. However, this study was the quantitative component of the 2019 study by Bratt and colleagues, which did reveal beneficial effects through an analysis of parent interviews. This study's results point to the importance of including both quantitative and qualitative measures to study the effectiveness of a CFT group for parents and caregivers.

Comparing the Current CFT Intervention with Existing CFT Interventions

Many interventions in the aforementioned studies began by providing psychoeducation about the concept of the 'tricky brain' through an evolutionary perspective, (Bratt et. al., 2019, 2020; & Karlsson & Hansson, 2020) as did the intervention included in the present study. These studies, as well as the current study, also focused on understanding the evolutionary purpose of the threat, drive, and caregiving regulation states (Bratt et. al., 2019, Bratt et al., 2020; Karlsson & Hansson, 2020; Navab et al., 2018; & Shirvani et al., 2019), as well as the underlying needs of emotions (Bratt et. al., 2019, Bratt et al., 2020; Karlsson & Hansson, 2020). Several studies also involved parents and adolescents completing compassion-focused homework exercises together (Bratt et al., 2019, 2020, & Karlsson & Hansson, 2020), however the compassionate exercises were not specific to the parenting context. In the present study, children of participants were not partaking in a simultaneous CFT group and did not complete exercises together, and caregiver's homework exercises were in the context of their parenting role. Several studies offered similar activities to those included in the present study such as compassionate self-imagery (Bratt et. al., 2019, 2020; Karlsson et al., 2020; Lennard et al., 2020; Mitchell et al., 2018 Navab et al., 2018), soothing breathing (Bratt et al., 2019, 2020; Karlsson & Hansson, 2020; Navab et al., 2018), offering oneself compassion and support (Bratt et. al., 2019, 2020; Karlsson & Hansson, 2020; Lennard et al., 2020; Mitchell et al., 2018; Navab et al., 2018; Zamani-Mazdeh et al., 2019) accepting compassion from others (Lennard et al., 2020; Navab et al., 2018; Mitchell et al., 2018), and understanding the role of self-criticism (Bratt et al., 2019, 2020; Karlsson & Hansson, 2020). Some of these other studies included components not included in the present study such as a focus on accepting painful feelings (Brenjestanakiet et al., 2020; Zamani-Mazdeh et al., 2019), accepting others as they are (Brenjestanakiet et al., 2020; Navab et al., 2018; Zamani-Mazdeh et al., 2019), and forgiveness (Zamani-Mazdeh et al., 2019).

The 6-week intervention in the present study extends beyond previous interventions because it provides training to parents on CFT-informed parenting skills. Week one focuses on building cohesion within the group, setting goals, and establishing a new perspective for caregivers in the group. This involves an overview of what will be learned in the group, as well as the completion of a 'life map' activity in which caregivers work to outline their values as caregivers, as well as how to choose to engage in actions and behaviours in pursuit of those values. Week two focuses on psychoeducation surrounding caregiver self-criticism and self-compassion. The motive-oriented states of mind outlined in compassion focused therapy are discussed and the function of self-criticism is described. Caregivers complete activities to cultivate self-compassion and learn 'compassionate reasoning' to shift away from self-attacking language to more helpful compassionate self-correction. Week three focuses on building resilience in children through a skill called emotion coaching. This week's content begins with psychoeducation about emotions through an evolutionary lens, and includes a discussion of emotion's underlying functions, action tendencies, and needs. The skill of emotion coaching is included to teach caregivers how to join with their children in their emotions and process them through experiential discussions. Week four focuses on practicing the skill of emotion coaching. This week also discusses letting compassion in from others and oneself as well as being compassionate towards others. Caregivers are given the opportunity to practice the emotion coaching skill with other members of the group. Week five focuses on discussing boundaries, authority, and secure attachment. Caregivers explore how their lived history has impacted their personal boundaries, and how boundaries can be set and maintained. Week six focuses on skills to strengthen the parent child relationship such as apologies, setting compassionate goals, and changing behaviour. Caregivers discuss what positively and negatively impacts their relationship with their child, and discuss how to repair ruptures with apologies. The concept of compassionate goal setting is discussed and a focus on creating incremental steps towards goals is described.

In addition to the unique parenting strategies and perspectives, the current intervention differs from previous interventions because the compassion training focused on their role as caregivers rather than on their overall wellbeing. It is also unique in that it uses a parallel-processes model of learning. Caregivers learn CFT-consistent parenting strategies (like meeting emotional needs, supporting behaviour change from a caregiving perspective, setting boundaries,

etc.) and *apply the skills to themselves* before learning to use them with their children. As a result, caregivers will have the opportunity to experience the ways in which these behaviours might feel to their children and will hopefully lead to greater fluency and creativity in the application of the skills.

In summary, the intervention described in this study provides psychoeducation on self-criticism, self-compassion, emotions, and behaviour change. Throughout the group, experiential practice is used to develop and practice skills such as shifting from self-criticism to compassionate self-correction and support, identifying and meeting emotional needs, working through fears, blocks and resistances to using learned skills, scaffolding behaviour change, and developing and maintaining boundaries to strengthen the parent-child relationship. This intervention utilizes a parallel process model such that caregivers learn the parenting skills to use for themselves as well as to support their children. This intervention is unique from interventions in existing studies due to its combination of both traditional CFT components to reduce caregiver stress and burnout, and training on evidence-based parenting programs (EBPPs). This combination is thought to enhance caregivers' learning experience and benefits gained through skill building and self-reflection throughout the group.

Gaps in the Literature

Current evidence suggests that CFT interventions have the potential to significantly improve parents' self-compassion (Mitchell et al., 2018; Shirvani et al., 2019) self-efficacy (Bratt, 2019; Zamani-Mazdeh, 2019) and psychological flexibility (Brenjestanakiet et al., 2020), along with decreasing self-criticism (Brenjestanakiet et al., 2020), and depressive, anxiety, (Navab et al., 2018) and post-traumatic stress symptoms (Lennard et al., 2020). However, these results come from a limited number of studies in an emerging field of research, within which several gaps can be identified. First, although past research has examined some CFT interventions for parents, no research has examined applications that target the full range of CFT components. Several of the aforementioned studies have focused on providing psychoeducation on the affect regulation system and exercises to develop a compassionate self-image, however they did not focus on meeting one's emotional needs or on using values to guide behaviour change. Along with this, these programs did not address the use of adaptive self-criticism

through self-correction and growth which CFT outlines as key components of change (Gilbert, 2014).

Second, prior research has not examined CFT parenting interventions within the family context, and there are no known studies using a CFT intervention to inform parenting practices and strategies. Existing interventions have focused on stress reduction and self-compassion development, but none have concurrently provided parenting skills. CFT for parents is promising because effectively addressing parent self-criticism may instigate an ameliorative cycle among parent well-being, child well-being, and parent-child well-being. Nonetheless, past research on evidence-based parenting-programs (EBPPs) has not examined compassion-focused parenting from this perspective.

This CFT intervention was designed as a brief online delivery model. The adaptation to an online format was made necessary by the COVID-19 pandemic. Along with this, considerations were made concerning the digital burnout caregivers were likely experiencing due to the COVID-19 pandemic, and the probable increase in caregiver burden due to stay-at-home orders. It was also believed that caregivers may be experiencing more time pressures than usual during the COVID-19 pandemic, which are factors that impacted the duration of this CFT intervention. Some of the previously discussed literature on CFT interventions for parents has demonstrated that access to online resources such as self-compassion and meditation videos significantly improved self-compassion in new and breast-feeding mothers (Lennard et al., 2020; Mitchell et al., 2018). A meta-analysis by Spencer and colleagues (2020) which evaluated the effectiveness of 28 different online parenting program studies, found the strongest effects to be on increasing positive parenting and parents' encouragement. Spencer and colleagues (2020) also found these online parenting programs to significantly reduce negative parent-child interactions, child problem behaviours, negative discipline strategies, parenting conflicts, as well as parenting stress. Similarly, a meta-analysis by Thongseiratch and colleagues (2020) found that online parent programs significantly decreased children's behavioural and emotional problems, as well as parental mental health problems. These findings provide evidence for the utility and effectiveness of online parenting interventions.

The proposed research examined the effect of an online CFT intervention for parents and caregivers on levels of global and parental psychological flexibility and parental burnout. In

addition, this study explored the relations between global and parental psychological flexibility, burnout, interpersonal processes, and motive-oriented states of mind. Furthermore, this study will examine whether parental psychological flexibility is related to improved parent-child relationship quality, as well as the impact of the CFT intervention on parent wellbeing and the parent-child relationship. These research areas will be evaluated based on the measures included in the pre, post, and one-month follow up survey. This group will be the first to combine CFT with evidence-based parenting strategies, therefore examining the efficacy will inform the improvement of future CFT interventions and aid the development and testing of new measures. Specifically this research will ask and answer:

- Does parental psychological inflexibility decrease between the pre and post-intervention measure?
- Does parental psychological inflexibility decrease between the pre-intervention and one-month follow up measure?
- Which aspects of the CFT group did parents/caregivers find the most/least helpful?

It is hypothesized that the provision of this CFT group for parents and caregivers will decrease levels of global and parental psychological inflexibility. Furthermore, it is hypothesized that parents will report an improvement in the parent-child relationship after applying skills and strategies learned throughout the group.

Methods

Participants

Participants were parents and caregivers who registered at the Mary J. Wright Child and Youth Development Clinic (CYDC) in London, Ontario for a free CFT group offered for parents and caregivers of children with mental health concerns, and for caregivers who may be experiencing self-criticism or burnout. Over the course of 2021, three groups were run through the CYDC and a total of 47 caregivers received the intervention. Because the research occurred within a service-delivery model, participants in the program could access care without participating in research. Of the 47 who received the intervention, 20 consented to have their data included in research. Of those 20, 13 individuals completed both pre and post-test measures and five completed the pre, post, and one-month follow-up measures. Of these 13 participants, two caregivers were a couple and were attending the group for the same child.

Design

This research utilized a within-subjects pretest-post-test design (Chiang et al., 2015), with the independent variables as the provision of the CFT group for parents and caregivers and time, and the dependent variables as parental burnout and psychological flexibility. There was no control condition as there was no waitlist for the program and participants in research were recruited from individuals who were already registered to participate in the group (See Appendix B). Participants filled out the survey before and after participating in the CFT group as part of the clinic's regular continuous quality improvement (CQI) process. Participants that consented to research were also invited to complete the survey one month after the end of the group.

Procedure

Participants were invited to provide consent for any of the following: using pre-intervention CQI data for research purposes, using post-intervention CQI data for research purposes, and completion of a one-month follow-up survey. Participants received a $20.00 gift certificate for participation in the one-month follow-up survey. All procedures were approved by the NMREB at Western University (see Appendix E).

Intervention

The current study describes a pilot evaluation of the CFT Caregiver Protocol, a novel CFT treatment protocol for caregivers of children with mental health difficulties. The CFT Caregiver Protocol occurs over six two-hour sessions. This is a shorter timeframe than other CFT groups for parents (e.g. Bratt et al., 2019) which tended to offer eight two-hour group CFT sessions. The CFT Caregiver Protocol was intentionally designed to be brief in an attempt to reduce digital burnout during the COVID-19 pandemic, to reduce the risk of attrition, and to reduce the risk of increasing caregiver burnout through onerous program requirements. While the CFT Caregiver Protocol can be delivered in person, it was designed to be deliverable in a virtual setting. Mitchell and colleagues (2018) demonstrated that a shorter online CFT intervention format, as compared to the typical eight two-hour sessions model, can have beneficial effects. An outline of session content can be seen in Table 1.

The CFT intervention was offered by three facilitators at a time, two main facilitators and one facilitator in training (Table A2). Facilitator A is a clinical psychologist and developed this

novel CFT intervention based on professional expertise and training in CFT. Facilitator B, the author of this report, as well as facilitators C, D, and E are student clinicians that were completing graduate education at Western University at the time of group facilitation.

Table 1.

Session content outline

Week	Purpose	Activities
Week 1: Building cohesion, setting goals, and establishing a new perspective	Create a social learning context that is open, non-judgemental, and playful to help participants develop a model of compassion	Icebreaker activities to increase playfulness and willingness to take social risks, overview of group, 'life map' activity - values outline, plan to engage in value-based action
Week 2: Caregiver self-criticism and self-compassion	Learn more deeply about self-criticism and self compassion, and how to apply it	Guided discovery and interactive psychoeducation related to self-compassion and self-criticism, CFT's motive-oriented states of mind, function of self-criticism - fears/blocks/resistances to letting compassion in, cultivating compassion, compassionate reasoning - compassionate self-correction
Week 3: Building resilience in your child through emotion coaching	Learn about emotions and how they impact behaviour	Psychoeducation on emotions - evolutionary and functional lens, emotion coaching skill
Week 4: Practicing emotion coaching with yourself and your child	Gain a deeper understanding of how emotions impact behaviour and how to let compassion in	Emotion coaching skill practice, experiential practice of letting compassion in from oneself and from others
Week 5: Boundaries, authority, secure attachment, and making it work for you	Learn more deeply about the impact of lived history on boundaries	Self-exploration and discussions about boundaries and boundary setting, authority, and secure attachment, how to set and maintain boundaries, fears/blocks/resistances to setting and maintaining boundaries

Week 6: Helping your kids grow: strengthening your relationship and shaping compassionate behaviour	Develop ways to strengthen the parent-child relationship by developing interpersonal and goal setting skills	Apologies, setting compassionate goals, incremental steps towards behaviour change

Facilitator F is a clinician observer from a local community agency interested in adopting the program. Facilitators B, C, D, E, and F received training from Facilitator A prior to facilitating the CFT intervention in group training formats. These training groups were approximately 14 hours and included a review of CFT as a theoretical orientation, specific instruction on group facilitation and content delivery, and experiential practice of the intervention components. Facilitators B, C, D, and E received weekly or biweekly supervision related to the facilitation of the CFT intervention from Facilitator A.

Table 2.

Facilitator outline

Group	Facilitators	Facilitator in Training
1	A, C	B
2	A, B	D
3	B, E	F

Ethical Considerations

The present study was approved by Western University's Research Ethics Board and the Mary J. Wright Child and Youth Development Clinic (See Appendix E). There were no complaints reported during the course of the study. There were also no participants who endorsed experiencing distress as a result of completing the questionnaire.

Measures

Sociodemographic Survey

The Sociodemographic Survey includes questions pertaining to ethnicity, gender, sexuality, guardianship, personal mental health, and age (see Appendix C).

Parental Burnout

The Parental Burnout Scale (Roskam et al., 2017) is a 22-item self-report measure asking participants to rate how often they believe feelings and experiences surrounding parental burnout to occur in their lives from 0 (never) to 6 (every day; see Appendix C). This scale demonstrates good internal consistency with Cronbach's alphas ranging from 0.87-0.96, and good validity with correlations between the three identified factors ranging from 0.48-0.67

Interpersonal Processes in Parenting Scale

The Interpersonal Process in Parenting Scale (IIPS; Cwinn, in preparation) is a 27-item self-report measure designed for the current study. The IIPS asks participants to rate how often they respond to their children with authority (sample item: When I put my foot down, I don't go back on my decision), submissiveness (sample item: When my kids act up, I find that I give in), social-emotional caregiving (sample item: I meet my kid's emotional needs) and attack (sample items: I lose my temper with my kids, I jokingly tease my kids when they aren't acting up to my standards) on a scale from 0 (not at all like me) to 4 (extremely like me; see Appendix C). This scale is inspired by the interpersonal circumplex model (Moskowitz, 1994), and measures the self-to-other facet of interpersonal behaviour within the context of caregiving. Parental submission is understood as giving control, sacrificing one's needs, or acquiescing to the agenda of one's child. Parental attack is understood as expressing hostility, criticism, or demeaning humour towards the child or person being cared for.

Acceptance and Action Questionnaire - II

The Acceptance and Action Questionnaire (AAQ-II; Bond et al., 2011) is a 10-item self-report measure asking participants to rate their psychological flexibility and experiential avoidance (sample item: my painful experiences and memories make it difficult for me to live a life that I would value) on a scale from 1 (never true) to 7 (always true; see Appendix C). The scale demonstrated good internal consistency with a Cronbach's alpha ranging from .78-.88, and is strongly correlated with the original AAQ-I (r=.97).

Acceptance and Action Questionnaire - II - Caregiver

The Acceptance and Action Questionnaire for Caregivers (AAQ-II-C; Cwinn, in preparation) is a 10-item self-report measure inspired by the AAQ-II (Bond et al., 2011) which asks participants to rate their parental/caregiver psychological flexibility and experiential avoidance on a scale from 1 (never true) to 7 (always true) (Appendix C).

Compassion Focused Parenting Scale

The Compassion Focused Parenting scale is a 19-item self-report measure designed for the current study. The measure asks participants to rate their parental self-compassionate behaviour, compassionate behaviour towards children, and the self-compassionate mindset/attitude on a scale from 1 (strongly disagree) to 5 (strongly agree) see Appendix C). This scale is composed of four subscales: threat mind (sample item: I feel disrespected when my kids don't listen), drive mind (sample item: I compare myself to other parents), acceptance and non-judgement (sample item: I am able to accept myself even if I don't meet all my parenting expectations), and functional contextualistic orientation (sample item: my kid's emotional reactions make sense in their inner world).

Post-Intervention Survey

The Post-Intervention included the aforementioned scales, as well as questions regarding which skills have been used since the workshop, and which skills were found to be helpful. Participants were also be asked to evaluate changed in their child and in themselves as a result of the program (see Appendix D).

Results

The following analyses investigated the impact of the compassion-focused parent and caregiver group on caregivers' global and parental psychological inflexibility. The impact of the CFT group was analyzed through quantitative measures and short answer questions to investigate whether global and parental levels of psychological inflexibility decreased between the pre and post as well as the pre and one-month follow-up measures. Quantitative measures and short answer questions were used to determine which aspects of the CFT group parents and caregivers found the most and least helpful.

Group Attendance

Between March and November of 2021, three CFT parent and caregiver groups were facilitated. A total of 47 parents and caregivers participated in these three groups (Table A1), of which 34 (72%) participants attended 60% or more of the sessions. There were four participants who dropped out for personal reasons and six for unknown reasons, for a total of 10 participants who left the program after completing one or two weeks at the beginning of the program. A further three participants contacted the author of this report throughout their groups to report scheduling concerns were responsible for their inconsistent participation in their group. There was one participant from group one who dropped out of the program, five participants from group two, and four participants from group three. If the 10 individuals who dropped out are excluded, the average attendance rate for group one was 88%, 69% for group two, and 81% for group three. These attendance rates demonstrate that of the 37 participants who did not drop out of the program 13 individuals (35%) attended 100% of all sessions, 14 individuals (38%) missed one session, eight individuals (21%) missed two sessions, and two individuals (5%) missed two or more sessions. The majority of individuals who completed the program missed up to one session, and 26% missed two or more sessions. After the first group, the program was extended by two two-hour sessions based on feedback from participants that expressed a longer time to cover content was desired. The first group consisted of four two-hour sessions, while the second and third groups consisted of six two-hour sessions (Table 3). This increase in sessions did not remove any content, rather it added more time for discussions and practicing of experiential learning exercises.

Table 3.

Comparison of topic distribution between group one and groups two and three

Week	Group 1	Group 2 and 3
Week 1	Building cohesion, setting goals, and establishing a new perspective and caregiver self-criticism and self-compassion	Building cohesion, setting goals, and establishing a new perspective
Week 2	Building resilience in your child through emotion coaching and practicing emotion coaching with yourself and your child	Caregiver self-criticism and self-compassion

Week 3	Helping your kids grow: strengthening your relationship and shaping compassionate behaviour	Building resilience in your child through emotion coaching
Week 4	Boundaries, authority, secure attachment, and making it work for you	Practicing emotion coaching with yourself and your child
Week 5		Boundaries, authority, secure attachment, and making it work for you
Week 6		Helping your kids grow: strengthening your relationship and shaping compassionate behaviour

In total, 28 participants completed both pre and post measures, of which 13 participants consented to allow their data to be used for research. Within this sample of 13, there were six participants from group one, four participants from group two, and three participants from group three. Of these 13 participants, five completed the one-month follow-up survey measure: one participant from group one, three participants from group two, and one participant from group three (Table A2).

Demographic Information

Completed Pre and Post measures. As seen in Table A3, of the 13 participants that consented to research, nine identified as female and four as male, and all 13 participants identified as heterosexual and cisgender. Caregivers in this sample ranged in age from 35-57 years old and were attending the group for children between the ages of seven and 17. Eight participants identified as white-Caucasian, two as South Asian, one as Black Canadian/Afro Caribbean/African, one as East Asian, one as Indigenous, and one as Middle Eastern.

The majority of participants reported that they as well as their spouse/partner was caring for the child (61%). The remaining participants stated their parents (15%), their ex (15%), someone else in their extended family (7%), their spouse's parents (7%), friends of the family (7%), and the hospital (7%) was also providing care to their child. Within these 13 participants, 30% were caring for one child in total, 30% were caring for two children in total, 30% were caring for three children in total, and 7% were caring for four children in total. Along with this, 46% of the sample reported that they were currently working through a diagnosed mental health condition of their own. Of these 13 participants five participants attended all weeks, one

participant attended three out of four weeks, three participants attended five out of six weeks, three participants attended four out of six weeks, and one participant attended three out of six weeks.

Completed Pre, Post, and One-Month Follow Up Measures. As seen in Table A3, of the five participants that consented to research and completed the one-month follow-up survey, four identified as female and one as male, and all five participants identified as heterosexual. The demographic characteristics of participants who participated at all three time points is similar to those who only completed the pre and post tests and are not significantly different based on an independent sample t-test.

Table A3.

Demographic information of the caregiver participants in the CFT parent and caregiver groups

Demographic	Pre and Post measures (n=13)	1-Month Follow up (n=5)
Gender		
Cis-Female	9	4
Cis-Male	4	1
Sexual Orientation		
Straight/heterosexual	13	5
Age		
35	1	
36	1	1
37	1	
41	2	1
42	2	
47	2	2
51	1	1
52	1	
56	1	
57	1	
Age of Child		
7	1	
8	1	1
9	1	
12	3	1

13	2	1
14	1	1
15	1	
16	2	
17	1	1

Number of Children

1	4	2
2	4	1
3	4	2
4	1	

Currently working through Mental Health condition

Yes	6	3
No	7	2

Who else cares for child

Spouse/partner	8	1
My ex	2	2
My parents	2	
Someone else in extended family (e.g. aunt, cousin)	1	1
My spouse's parents	1	
Friend of family	1	1
Hospital	1	1

Ethnicity

White/Caucasian	8	3
Black Canadian/ Afro Caribbean/African	1	1
East Asian	1	1
South Asian	2	
Indigenous Canadian	1	1
Middle Eastern	1	

Attendance

100% (4 of 4)	5	1
75% (3 of 4)	1	
83% (5 of 6)	3	2
66% (4 of 6)	3	2
50% (3 of 6)	1	

Content Missed

Emotion Coaching week 3 (group 1)	1	
Emotion coaching week 3 (group 2+3)	3	3
Emotion coaching week 4 (group 2+3)	1	
Influencing behaviour week 6	3	
Introduction (caregiver matrix)	2	1
Boundaries week 5	1	1

Quantitative Analyses

Quantitative analyses were conducted to examine the effect of the CFT group on caregiver psychological inflexibility, burnout, interpersonal processes, and compassion focused parenting in order to determine whether the CFT intervention had a beneficial impact in these domains between the pre, post and one-month follow-up survey measures. Given the low n, a series of paired sample t-tests were used to evaluate potential changes. The current sample is underpowered and so the results may reflect Type 2 errors. To account for this, effect sizes are also reported to provide a metric of the pre-post change.

Change from Pre to Post Test (n=13). Analyses conducted with paired samples t-tests revealed no significant decreases in global psychological inflexibility, $t(12) = .82$, $p = .43$, however, the pre-post change does reflect a small effect size in a favorable direction ($d = .23$). Similarly, while there were also no significant decreases in parental psychological inflexibility, $t(12) = 1.96$, $p = .74$, results indicate a medium effect size in a favorable direction ($d = .54$). A non-significant trend was found for improvements in parental burnout, $t(12) = 2.09$, $p = .058$ with a medium Cohen's effect size value ($d = .58$). There were also no significant changes in any subscales of the interpersonal processes scale and effect sizes were negligible. Regarding the Compassion Focused Caregiving scale, results indicate a significant decrease and strong effect size regarding decrease in threat-minded caregiving, $t(12) = 4.15$, $p = .001$, $d = 1.15$, as well as a significant and moderate decrease in the drive mind subscale of the of the $t(12) = 2.23$, $p = .046$, $d = .62$ (Table A4)

Changes from Pre to Post Test Among Participants who Provided Data at all Three Time Points (n=5). The following section outlines the pre-post changes for participants who also

completed the one-month follow up. Due to the small sample size, these are offered as very preliminary data. These results were examined in addition to the above analyses independently from the later sample. Analyses conducted with paired samples t-tests revealed significant decreases in global, $t(4) = 5.58$, $p = .005$, $d = 2.49$, and parental, $t(4) = 3.14$, $p = .035$, $d = 1.4$, psychological inflexibility with large Cohen's effect size values. Paired samples t-tests did not reveal a significant decrease in parental burnout, $t(4) = 2.18$, $p = .094$, however, the effect size was large ($d = .98$). Along with this, there were no significant decreases in subscales of the interpersonal processes scale, aside from a significant decrease in the submissiveness,

Table A4.

Pre and post intervention scores

Outcome	Before CFT Group		After CFT Group		n	95% CI for Mean difference		t	p	d
	M	SD	M	SD						
Psychological Inflexibility	34.15	9.200	31.69	9.579	13	-4.120	0.043	.815	.431	.226
	37.80	9.884	27.60	9.864	5	5.126	15.274	5.581	**.005***	**2.496**
Parental Psych. Inflexibility	28.69	6.074	25.92	4.518	13	-.314	5.852	1.957	0.74	.543
	30.60	5.505	25.40	3.975	5	.604	9.796	3.141	**.035***	**1.405**
Parental Burnout	69.77	21.53	59.54	22.904	13	-.359	18.821	2.097	.058	.582
	67.60	30.55	51.80	28.102	5	-4.287	35.887	2.184	.094	**.977**
Inter. Processes Dominance	28.69	4.008	29.15	4.337	13	-2.217	1.294	-.573	.577	-.159
	30.40	3.050	30.40	5.079	5	-4.562	4.562	.000	1.00	.000
Inter. Processes Submission	18.38	2.785	17.31	3.497	13	-.693	2.847	1.326	.210	.368
	17.20	2.683	15.20	3.347	5	.479	3.521	3.651	**.022***	**1.633**
Inter. Processes Attack	17.23	4.781	16.15	5.014	13	-.549	2.703	1.443	.175	.400
	15.40	6.656	15.20	6.458	5	-2.764	3.164	.187	.861	.084
Inter. Processes Care	26.15	2.764	25.85	3.288	13	-1.777	2.392	.322	.753	.089
	26.60	1.517	26.80	2.588	5	-2.745	2.345	-.218	.838	-.098
Compassion FP Threat mind	15.62	2.468	13.85	2.794	13	.841	2.697	4.153	**.001***	**1.152**
	14.60	2.510	13.00	3.317	5	-.656	3.856	1.969	.120	**.881**
Compassion FP Drive Mind	17.54	3.688	16.08	4.132	13	.031	2.892	2.226	**.046***	.617
	18.20	4.087	16.40	4.930	5	-.892	4.492	1.857	.137	**.830**

Compassion FP Acc. + non-judg.	16.38	2.931	18.08	2.783	13	-4.152	.767	-1.49	.160	-.416
	14.40	1.817	17.40	4.159	5	-10.29	4.293	-1.14	.317	-.511
Compassion FP Func. Context. Or.	19.38	3.254	19.54	2.665	13	-1.750	1.442	-.210	.837	-.058
	19.20	4.025	20.60	3.286	5	4.638	1.838	-1.20	.296	-.537

$t(4) = 3.65$, $p = .022$, which also demonstrated a large effect size ($d = 1.63$). Lastly there were no significant changes on subscales of the compassion focused parenting scale between the pre and post measures of the five participants who completed the pre, post, and one-month follow-up measures (Table A4)

Changes from Pre to One-Month Follow-Up Test (n=5). Analyses with paired samples t-tests between the pre and one-month follow up survey measures indicated a significant decrease in global psychological inflexibility, $t(4) = 3.30$, $p = .030$, $d = 1.48$, as well as a significant decrease in parental psychological inflexibility, $t(4) = 4.63$, $p = .010$, $d = 2.07$. Furthermore, a significant decrease was found for parental burnout, $t(4) = 2.79$, $p = .049$, $d = 1.25$, and a significant increase in the dominance subscale of the interpersonal processes scale was also found, $t(4)= -3.67$, $p = .021$, $d = -1.64$ (Table A5).

Table A5.

Pre-intervention and 1-month follow-up scores.

Outcome	Before CFT Group		After CFT Group			95% CI for Mean difference				
	M	SD	M	SD	n			t	p	d
Psychological Inflexibility	37.80	9.884	30.80	10.305	5	1.110	12.890	3.300	**.030***	**1.476**
Parental Psych. Inflexibility	30.60	5.505	22.40	4.930	5	3.280	13.120	4.628	**.010***	**2.069**
Parental Burnout	67.60	30.550	56.00	25.169	5	.065	23.135	2.792	**.049***	**1.249**
Inter. Processes Dominance	30.40	3.050	33.80	4.764	5	-5.975	-.825	-3.666	**.021***	-1.64
Inter. Processes Submission	17.20	2.683	15.60	4.669	5	-3.095	6.295	.946	.398	.423
Inter. Processes Attack	15.40	6.656	15.60	6.189	5	-5.984	5.584	-.096	.928	-.043
Inter. Processes Care	26.60	1.517	28.60	2.966	5	-5.166	1.166	-1.754	.154	-.784

Compassion FP Threat mind	14.60	2.510	13.00	3.240	5	-1.259	4.459	1.554	.195	.695
Compassion FP Drive Mind	18.20	4.087	14.60	3.715	5	-.385	7.585	2.508	.066	**1.122**
Compassion FP Acc. + non-judg.	14.40	1.817	18.60	4.393	5	-11.461	3.061	-1.606	.184	-.718
Compassion FP Func. Context. Or.	19.20	4.025	20.20	3.033	5	-3.776	1.776	-1.00	.374	-.447

Pearson Correlations. Given the small sample size, bivariate Pearson correlation coefficients were computed among the processes of interest and between the pre and post measures to explore threats to validity. The measures used in the current study correlate in the expected directions. For example, global psychological inflexibility was associated with burnout ($r = .65$, $n = 13$, $p < .05$), interpersonal submission ($r = .57$, $n = 13$, $p < .05$), interpersonal attacking ($r = .66$, $n = 13$, $p < .05$), and the functional contextualistic orientation ($r = -.65$, $n = 13$, $p < .05$) see Table A9 for more details. A similar relation was also seen between parental psychological inflexibility and burnout ($r = .59$, $n = 13$, $p < .05$) and interpersonal attacking ($r = .66$, $n = 13$, $p < .05$). These results indicate that higher levels of global and parental psychological inflexibility are related to greater levels of burnout and interpersonal attacking. These results also show that higher scores on global, but not parental, psychological inflexibility are related to higher scores on interpersonal submission. Lower levels of global psychological inflexibility are also related to higher scores on the functional contextualistic orientation subscale.

In addition, burnout correlated with other measures in expected directions. Post measures of burnout scores were associated with interpersonal attacking ($r = .79$, $n = 13$, $p < .001$), and interpersonal submission ($r = .65$, $n = 13$, $p < .05$). Along with this, pre-measures of burnout scores were associated with post levels of interpersonal attacking ($r = .64$, $n = 13$, $p < .05$), interpersonal caregiving ($r = -.78$, $n = 13$, $p < .05$), as well as the functional contextualistic orientation ($r = -.57$, $n = 13$, $p < .05$). These results indicate that higher post scores of burnout are related to higher scores on interpersonal attacking and submission. Moreover, higher pre scores of burnout are related to higher post scores on interpersonal attacking. Lower pre scores on burnout are also related to higher post scores on interpersonal caregiving as well as the functional contextualistic orientation.

Post-Hoc Analyses

In reviewing the data, it became clear that every individual included in the pre and one month follow-up sample ($n = 5$) showed decreases on measures of global as well as parental psychological inflexibility. As significant decreases in global and parental psychological inflexibility were found for this sample of five, and not between the pre and post for the entire sample of 13, further analyses were conducted. Of the 13 participants in the sample, only four participants did not demonstrate decreases in global psychological inflexibility, and only three participants did not demonstrate decreases in parental psychological inflexibility. We examined the effect of the intervention on the sample after removing non-responders. Results of paired sample t-tests show a significant decrease in global, ($t(8) = 4.19$, $p = .003$, $d = 1.39$), and parental, ($t(9) = 6.10$, $p < .001$, $d = 1.93$) psychological inflexibility both with strong effect sizes (Table A6). This may suggest that the intervention is highly effective for those who respond to it, but may be ineffective or even harmful for those who do not respond. We explored systematic differences between responders and non-responders at pre-test. While non-significant (likely due to the low n and unequal sample sizes), non-responders reported lower global psychological inflexibility ($t(11) = 1.48$, $p = .167$, $d = .89$, M (responders) = 36.56, $SD = 9.28$, M (non-responders) = 28.75, $SD = 7.27$), and higher burnout at pre-test than responders ($t(11) = -.43$, $p = .676$, $d = -.26$, M (responders) = 67, $SD = 25.16$, M (non-responders) = 72.75, $SD = 11.67$).

In combination, these results demonstrate that when responders and non-responders are compared, individuals who showed decreases in global psychological inflexibility also showed decreases in parental burnout, while individuals whose inflexibility did not decrease also did not show significant improvements in parental burnout. The directionality of the relation between decreases in inflexibility and burnout is unclear; however, it is apparent that they impact each other. Subsequently, Pearson correlations were conducted which found that relation between pre scores of burnout to post scores of global psychological inflexibility ($r = .48$, $n = 13$, $p = .095$) is stronger than the relation between pre scores of global psychological inflexibility and post scores of burnout ($r = .26$, $n = 13$, $p = .39$). Future research with a greater n is needed to further understand this relation.

Perceived Impacts and Benefits of the CFT Group

Caregivers were asked post intervention and at the one-month follow up to identify which skills they have been using since completing the workshop, and which skills were perceived to be helpful to caregivers (Table A7). The majority of parents at the post intervention stated they have been applying the emotion coaching (92%), encouraging desirable behaviour (61%), and self-compassion (76%) skills. A minority of caregivers stated they have been reminding themselves of their parenting values due to the workshop (46%). Furthermore, when caregivers were asked which skills they found helpful, the majority of parents found nearly every skill presented helpful: Emotion coaching (92%), encouraging desirable behaviour (69%), being kind and supportive to myself (84%), reminding myself of my parenting values (69%), noticing and expressing my own needs (69%), practicing breathing (69%), and changing the way I think about situations (76%). Only a minority of parents found practicing compassionate imagery to be helpful during the workshop (38%).

Table A7.

Summary of skills used from the CFT group

Skill	Post Survey (n=10)	1-Month Follow-up (n=5)
Used since the Workshop		
Emotion coaching	12	5
Encouraging desirable behaviour	8	4
Self-compassion with myself	10	4
Reminding myself of my parenting values	6	4
Perceived to be helpful		
Emotion coaching	12	5
Encouraging desirable behaviour	9	4
Being kind and supportive to myself	11	5
Reminding myself of my parenting values	9	4
Noticing and expressing my own needs	9	5
Practicing breathing	9	4

Practicing compassionate imagery	5	3
Changing the way I think about situations	10	5

Caregivers were also asked to rate the perceived impact participation in the group had on themselves in the post and one-month follow up measures (Table A8). In the post-survey, caregivers shared that their understanding of their child *got better* (38%), *got much better* (23%), or *was not applicable* (7%). Caregivers reported their relationship with their child *got better* (46%), or *got much better* (23%). No caregivers reported a deterioration in their parent-child relationship or reduced understanding of their child. Approximately half of caregivers in romantic or co-parenting relationships report that their intimate relationship *got better* (15%) or *got much better* (15%) and half reported that their relationship quality with their partner *remained unchanged* (50%). No caregivers reported a deterioration in their relationship with their partner. Within the sample of 13 caregivers, two individuals were involved in a romantic relationship and were attending the group for the same child. Both individuals in this couple reported that their relationship with their partner remained *unchanged.* Of the 11 other participants who were not attending the group with their partner, two individuals identified that their relationship with their partner remained *unchanged,* five individuals identified this as *unapplicable and unchanged,* and four individuals identified that their relationship with their partner *got better,* or *got much better.*

Table A8.

Summary of change perceived in parent

Outcome	Not applicable/Not a problem		Did not change/Applicable to me		Got better		Got much better	
	Post	1-Mo.	Post	1-Mo.	Post	1-Mo.	Post	1-Mo.
My understanding of my child	1			1	5	1	7	3
My relationship with my child		1	1		6	3	3	1
My relationship with my partner	5	4	4		2	1	2	
My burnout	3		3	1	5	3	2	1

My ability to cope		3	1	8	3	2	1
My confidence in my parenting skills	1			9	2	4	2

Note. Post survey n=13, 1-month follow up n=5

Caregivers reported their burnout *got better* (38%), *got much better* (15%), *did not change but was applicable* (23%), and *was not applicable* (23%), however no caregivers reported their burnout increased. Caregivers reported that their ability to cope *did not change but was applicable* (23%), *got better* (61%), and *got much better* (23%), and no caregivers reported a decrease in their ability to cope. Lastly, all caregivers reported that their confidence in their parenting skills improved by either *getting better* (69%), or *getting much better* (30%). Overall, parents did not report any deleterious effects of the CFT group in the post survey. Responses for the sample of five in the one-month follow up survey show similar responses (Table A8).

Suggested Changes. Participants were asked "what changes would you make to the program". In response, several participants in group one suggested extending the group from four to six weeks to allow for more time to cover content (Participant P3, group one; Participant P7, group one). The author and program developer were aware of this feedback and this feedback was used to update subsequent versions to be extended to a six-session program.

Two participants expressed a desire to be in groups with parents more similar to themselves. For example, one participant wrote:

> "Use the intake questionnaire to form groups of parents who have similar difficulties/challenges, either in breakout rooms or for the group program itself" (Participant P7, group one),

and another participant wrote

> "I wonder if there would be benefit to determining the types of behaviours that caregivers were coping with when creating the group. The parents/caregivers with children with special needs seemed to be facing a more severe set of behaviours. [...] There seemed to be two groups of parents with differing needs in the session of the program I participated in. Those parents/caregivers with children with special needs had a different set of concerns than others. It felt like it might be beneficial to have had those with children

with intensive special needs to be in a session of their own as the application of strategies is different than with neurotypical children." (Participant P4, group two).

Additionally, one participant mentioned that the group may have been better if it had been smaller (Participant P1, group three). Participant P5 from group two suggested that giving more instruction on homework and reviewing the homework assignments more thoroughly would be beneficial to the program. Participant P8 from group two encouraged facilitators to "encourage an invite to participants to a meeting 3-months post completion follow-up group," and to offer the group in person when COVID-19 restrictions lift. Participant P9 from group three requested that we "have it recorded so if you miss a session you can listen to it." Lastly, participant P7 from group one recommended that the group add a section focusing on self-worth and how the other topics of the program relate to it.

Most Helpful Parts of the Program. When caregivers were asked which parts of the program were most helpful, the role-playing in small groups, video examples, and breakout sessions to practice skills were mentioned. Participant P8 from group two also shared that the personnel who ran the group were helpful parts of the program. Other participants also mentioned that facilitators sharing anecdotes and providing examples were helpful components of the group (Participant P5, group two). Participant P5 from group two also mentioned the diagram identifying executive functions which underly particular tasks (e.g. switching from video games to a chore) was particularly helpful. Participant P3 from group one shared:

"Breakout sessions helped, personal examples shared by leaders and other parents helped me realize I was not alone and struggles are common, slides/ handouts shared were good".

Table 4.

Quotes from participants discussing the impact of the CFT intervention

Participant	Quote
Participant P2, group one	"I have learned a lot from this program. I am better now controlling my emotion[s] and dealing with my kids' emotions"

Participant P4, group two	"The self compassion and reminders of calming strategies was highly effective. The emotion coaching provided a framework, that while I can't use with the child I am a caregiver for, gave me a frame of reference when supporting families in my career […] I do find that returning to my role as a teacher I am implementing some of the emotion coaching and definitely reminders to breathe myself when feeling frustration."
Participant P5, group two	"With the return to in-person schooling, the need for emotional coaching was high. I appreciated having this tool at the ready (and even used it with some friends as well)."
Participant P7, group one	"I understand better that practicing compassion is a building block, a foundation, to healthy relationships."
Participant P8, group two	"It was a great course. As a refresher and as a component of enablement, in parenting from day-to-day care of self and children as well as supportive to see what other parents are experiencing"

Participant P7 from group one also agreed that having slides and handouts to share was necessary to be able to take in all the information. Participant P5 from group two also reflected that other parents sharing, examples provided by facilitators, and the emotion coaching examples were helpful. Several other participants commented on how the program will impact their lives going forward (Table B9). Participants reflected that the group has had an impact on caregivers' ability to respond to their own and their children's emotions, has provided them with skills that are helpful in a variety of contexts, and has encouraged caregivers to care for themselves.

Harmful or unhelpful aspects of the program

Caregivers were also asked which aspects of the program were harmful or unhelpful. All respondents indicated that there were no harmful or unhelpful aspects of the program; however, only seven of the 13 participants responded to the question.

Discussion

The purpose of this study was to examine the preliminary utility of an online synchronous CFT intervention for parents and caregivers on levels of global and parental psychological inflexibility. In addition, this study explored which aspects of the CFT group parents and caregivers found the most and least helpful. For all comparisons discussed below, effect sizes ranged from Medium to Large for all variables with the exception of global psychological inflexibility which only demonstrated a small effect size. Due to the low sample size ($n = 13$),

these robust effect sizes may indicate that the non-significant results are type 2 errors rather than an absence of change in the constructs of interest. Nonetheless, the small sample size requires all of the findings to be considered preliminary.

Analysis of the quantitative data did not reveal a statistically significant decrease in levels of global or parental psychological inflexibility between the pre and post measures, although there were small to medium effect sizes in favorable directions ($n = 13$). Conversely, in the smaller sample of individuals who completed both the pre, post, and one-month follow up measures, significant decreases on both global and parental psychological flexibility measures were seen between the pre and 1-month follow up ($n = 5$). Each participant in this sample of five showed a decrease on both measures of psychological inflexibility between the pre-post as well as the pre and one-month follow-up measures. Specifically, this sample of five did not include any non-responders, which likely impacted the finding that there was a significant decrease in psychological inflexibility for this group. When non-responders are removed from the entire sample (n=13), a significant decrease in both measures of psychological inflexibility between the pre and post measures can be observed. For individuals in the sample who demonstrated decreases in psychological inflexibility (responders), this was a significant decrease, however not everyone in this sample showed decreased psychological inflexibility. Previous research found that a CFT intervention significantly increased levels of psychological flexibility (Brenjestanakiet et al., 2020), however this study compared individuals receiving the intervention to a control condition and used the cognitive flexibility inventory (Dennis & Vander Wal, 2010), rather than the AAQ-II (Bond et al., 2011).

To understand what may be contributing to these changes in psychological inflexibility scores, responders and non-responders were compared at pre-test. There was no significant difference on inflexibility scores between these groups at pre-test, however there was a large effect size indicating that non-responders showed a lower initial level of psychological inflexibility as compared to responders. Individuals with higher initial levels of psychological inflexibility may show greater decreases than individuals with lower initial levels of psychological inflexibility. In other words, a program which is intended to promote psychological flexibility may not be the right intervention for individuals who already demonstrate reasonable levels of flexibility, and may have little room left for improvement. The

results of this study may also indicate that there are diminishing returns for individuals with lower baseline scores of psychological inflexibility from interventions targeting psychological flexibility. As each individual that completed the one-month follow up survey showed decreases on both measures of psychological inflexibility, it was not possible to assess whether time impacted inflexibility scores.

It is also possible that the non-responders experienced a "response shift bias". A response shift bias is when the intervention or treatment "changes a subject's awareness or understanding of the variable being measured […] it will alter each subject's perspective in his or her self evaluation" (p. 144-145, Howard & Dailey, 1979). The items on the global psychological inflexibility scale that showed the greatest increases in inflexibility scores for non-responders included: "My painful memories prevent me from having a fulfilling life", "My painful experiences and memories make it difficult for me to live a life that I would value", and "My thoughts and feelings do not get in the way of how I want to live my life". The concept of response shift bias may apply to these items in particular as the first week of the group focused on highlighting caregiver's values, the uncomfortable thoughts and emotions that arise during parenting, and the reactionary feelings and actions that typically accompany those uncomfortable thoughts and emotions. Caregivers were asked to reflect upon what would represent value-oriented action, and the group discussed how to move away from those reactionary behaviours towards value-oriented behaviours. These items speak to this concept introduced in the first week, which may indicate these individuals gained a greater understanding of how their thoughts and feelings can make it difficult to choose value-oriented behaviours. Future research could test this hypothesis by including some retrospective pre-test questions (e.g. Howard, 1980) and addressing the issue of response shift bias in open-ended questions (i.e., Has your understanding of how your thoughts and feelings impact the way you live your life changed as a result of your participation in the CFT caregiver program?).

Parental burnout was not found to significantly decrease between the pre and post measures. These results were supported by caregiver reflections as 53% reported burnout *got better,* or *got much better,* 23% reported it *did not change,* and 23% reported burnout was *not applicable/not a problem* for them. These results show that the majority of individuals who believed burnout to be a relevant concern to them, also reported a decrease in that burnout. As

not everyone in the sample believed they were experiencing burnout, this likely impacted the findings as being non-significant with a moderate effect size in a favorable direction. A significant positive relation was found between pre as well as post scores on global psychological inflexibility and burnout, which corroborates previous findings that lower levels of psychological flexibility are related to higher levels of parenting stress (Sairanen et al., 2018; Weiss et al., 2012; Whittingham et al., 2012). Several other findings from this study also support the interrelatedness of psychological flexibility and burnout. Firstly, pre scores of burnout were found to be related more strongly to post scores of inflexibility than the inverse relation, however there was insufficient power to complete a regression analysis. In comparison, Daks and colleagues (2020) found that greater psychological inflexibility predicted greater stress related to COVID-19. Second, when comparing responders and non-responders on measures of psychological flexibility, responders also showed significant decreases in burnout between the pre and post measures, while non-responders did not. These findings give evidence for the interrelation between psychological flexibility and burnout, however the directionality of the relation remains unclear. Future analyses supported with a larger n should focus on exploring this relation to promote the development of screener questions or measures to ensure fit for the program.

Previous studies have also shown that low psychological flexibility is related to the use of maladaptive parenting practices (Brown et al., 2015; Burke & Moore, 2015; Daks et al., 2020; Sairanen et al., 2018). Strong positive correlations were found between psychological inflexibility and scores on the attack subscale of the interpersonal processes in parenting scale. Items from the attack subscale relate to previous descriptions of maladaptive parenting practices such as "severe, reactive, or inconsistent discipline" (Brown et al., 2015), as they include: losing one's temper with kids, snapping or getting angry at kids, as well as teasing and judging kids. Previous research has also investigated the relation between psychological flexibility, parenting stress, and the use of maladaptive parenting practices. Fonseca and colleagues (2020) for instance found that higher levels of global psychological flexibility act as a buffer between parenting stress and the use of maladaptive parent strategies. Although there was insufficient power in the sample to run a similar moderation analysis, bivariate Pearson correlations did reveal that higher pre levels of burnout were related to higher post levels of attacking behaviour, and that lower pre levels of burnout are related to higher post levels of caregiving. These results

speak to the relation between stress and parenting practices, as higher stress seems to be related to the use of more maladaptive parenting practices.

Similar to these findings, medium positive correlations were found between psychological inflexibility and scores on the submission subscales of the interpersonal processes in parenting scale. Submission relates to psychological flexibility as a defining characteristic is being present in the moment and engaging in behaviours which serve valued ends (Hayes et al., 2006). Several items on the submission subscale which are related to this aspect of psychological flexibility speak to parents 'giving in' to their kids, having trouble asserting themselves, and letting things such as valued goals or actions slide. An individual who scores high on the submission subscale may not be able to assert themselves towards their child to influence value-oriented behaviours. Burnout was also found to be strongly and positively related to scores on the submission subscale. These findings may indicate that individuals who are experiencing higher amounts of burnout may be less able to assert their values in the parent-child relationship and engage in discussions surrounding the completion of value-oriented behaviours.

Significant decreases on the threat mind and drive mind subscales of the compassion focused parenting scale were observed between the pre and post measures. Decreases in the threat mind subscale relate to parent psychological flexibility as this is an ability for a parent to accept their negative thoughts and emotions related or unrelated to their parenting experience, while still engaging in parenting practices which align with their parenting philosophy. The items in the threat mind subscale speak to self-criticizing statements and negative feelings parents might experience towards themselves or their children while parenting, such as not feeling good enough or feeling angry when kids do not listen. The drive mind subscale is related to global psychological flexibility, as the concepts of values and committed actions underly it. The items in the drive mind subscale speak to individuals looking for values or goals externally from themselves such as feeling it is important to keep up appearances as a parent, or feeling as if they compare themselves to other parents. The finding that threat and drive mind activation decreased between the pre and post measures gives evidence that a cognitive shift may have occurred for caregivers which allowed them to activate more caregiving motive-oriented states of mind. An increased ability to do this provides evidence for the utility of this program in supporting the

development of psychological flexibility, as being in a caregiving mentality has been associated with improved psychological flexibility (e.g. Hansen et al., 2009).

Most and Least Helpful Components

The most practiced skill after the workshop was emotion coaching, and parents and caregivers most frequently cited *emotion coaching*, *being kind and supportive to oneself*, and *changing the way they think about situations* skills as being the most helpful components of the group. Several of the skills chosen as perceived to be helpful underly aspects of psychological flexibility, such as the component *changing the way I think about situations*, as individuals high in psychological flexibility must be able to respond adaptively to their environment. Furthermore the components *reminding myself of my parenting values* and *being kind and supportive to myself* speak to the aspect of psychological flexibility which asserts that individuals must be able to interact with their internal experiences while adaptively responding to their environment in ways which align with their personal values. Lastly, the *emotion coaching* component was used most often since the workshop and was most frequently rated as being helpful by caregivers. This component underlies parental psychological flexibility as emotion coaching teaches parents to regulate themselves which may involve acknowledging negative thoughts and emotions related to parenting. Importantly, emotion coaching also teaches parents how to act in accordance with their values as well as how to positively impact the parent-child relationship as the child's needs are met through the validation skills and phase of emotion coaching, and the parent has the opportunity to "teach" after their children's emotional needs have been met.

Overall, caregivers reported a positive impact of the group on their understanding of their child, their relationship with their child, their ability to cope, and their confidence in their parenting skills. These findings are consistent with previous research which found that caregivers reported an increase in their parenting confidence as a result of the CFT intervention (e.g. Bratt et al., 2019). Four of the 13 participants reported that their relationship with their partner *got better* or *got much better* (30%) due to participating in the group. This was not an outcome being targeted in the provision of this program, however it was true for a minority of the participants. Also, about half of the sample reported a perceived improvement in their burnout due to the group. The aspect most frequently chosen as *got much better* was *understanding of my child*, and the items most frequently chosen as *got better* were *my relationship with my child*, *my confidence*

in my parenting skills, and *my ability to cope*. In summary, the majority of parents rated that their understanding of their child (92%), their relationship with their child (69%), their ability to cope (76%), and their confidence in their parenting skills (100%) *got better* or *got much better*. These results demonstrate the perceived beneficial effects this CFT parent and caregiver group had on this sample of participants.

Implementation Observations and Considerations

The writer of this thesis facilitated each of the three CFT parent and caregiver groups between March and November of 2021. As these groups were offered throughout the course of the COVID-19 pandemic, they were presented online through Zoom meetings. Based on the observations of this writer, the online format appeared to offer both advantages and challenges. The online format appeared to meet the needs of some parents who may not have been able to obtain the childcare necessary in order to attend the groups. Furthermore, it seemed as if some parents may not have been able to set the time aside to participate in the group, had they also needed to factor in commute time. For the daytime group offered October to November 2021, several parents were able to set time aside in their workday either from the office or in their home office to participate in session. This would not have been possible if parents were required to commute to a physical meeting location in the middle of the workday. In many ways, the online format seemed to offer parents easier access and may have been the deciding factor for some parents in terms of whether they were able to participate in the group at all. Although the online platform offered parents a certain level of flexibility, it may not have been removed enough from day-to-day life for some parents. The writer observed that many parents were interrupted by their children throughout the meeting time, particularly for the evening groups, which subsequently meant caregivers would turn their cameras off and leave for a period of time. Along with this, some parents were not able to access private space, and expressed that they felt they could not speak completely freely about their feelings, needs, and perceptions related to their children and their parenting role.

The author of this report also noted that the online platform made it more difficult to have discussions at times, and may have made it easier for some members of the group to avoid participating or harder to participate if desired. The technical aspect of Zoom contributed to the difficulty some members may have felt in participating due to muting and unmuting being a

necessary etiquette, and differing internet connection speeds making it easier to interrupt or misunderstand others. Active facilitation is necessary in an online format such as this one to allow for space to discuss, to moderate cross-member discussion, and to invite quieter individuals to participate. Zoom posed a particular barrier during skills practice where participants were split off into breakout rooms to practice skills such as emotion coaching with other group members. Facilitators would at times jump between rooms or wait in the general room while participants practiced, however there was no simple and accessible way to pose questions to the facilitators during such times for clarification on the task or guidance. Such activities would be simpler if completed in person, and would allow for easier facilitator support. Some participants mentioned that they preferred to practice without being watched by facilitators as this put them under less pressure, while others voiced they wished they could receive more consultation and feedback from facilitators. During the third group, the writer informally asked participants about the amount of supervision they desired during breakout rooms and was able to adjust this aspect of facilitation to meet group member needs. Future groups, if facilitated online, should coordinate needs with its members similarly to allow for an appropriate balance between independent and supervised practice.

Active facilitation involving timekeeping, summarizing of discussion topics, and facilitative control is necessary throughout the groups in order to cover all content. The group size is also a factor that may have contributed to the time pressure that was sometimes felt while facilitating a discussion or guiding participants to the next section of the presentation. A maximum of 20 participants were accepted for each group as the assumption was made that attrition and inconsistent participation would play a significant factor in each group. As expected, group one had 12-13 core participants, group two had nine core participants, and group three had eight-nine core participant, while each group started with 15-16 participants. In reality, the original group size was intended to be higher, as for each group there were several participants who completed an intake however dropped out prior to the group beginning or never attended. Group one started with 17 participants, group two started with 19 participants, and group three started with 17 participants. This means that between 5-10 participants were lost by the end of the group for each group. Future groups should work to exceed their desired group size by at least a few participants in recognition of these attrition rates, particularly if future groups are held in an online format.

Participants noted several areas for possible improvements for future groups. Two participants noted there was an apparent divide within each of the offered groups determined by perceived severity of difficulties parents were experiencing as well as the level of support their child required. This divide was mentioned by two separate participants who suggested offering separate groups to account for this. The writer of this report noted this divide in each of the three groups, with parents that seemed to be faced with more extreme behaviours at home often requiring the most support throughout the sessions. In informal discussions with participants throughout the groups it became clear that this difference may have made some parents feel as if their concerns were inconsequential in comparison to others'. It was also clear to the author of this report that several parents were more interested in some skills over others, which may have contributed to the attrition rate and inconsistent participation after the first few sessions in each of the groups. Despite an elaborate intake process describing the content of the group to each participant, it appeared as if some participants were surprised by the focus on values, self-compassion, and self-criticism which is covered in the beginning weeks of the program. Perhaps participants who were more distressed entering the groups would have preferred more concrete skills and strategies or action-oriented solutions rather than self-exploration throughout the entire program. Future facilitators should take care to ensure participants are aware of the types of activities the group will be completing, as well as the topics that will be covered and in which order they will be covered.

The writer of this report would like to note that the amount of peer support that was offered between caregivers was substantial. Although peer support was not focused on in this group, parents naturally gravitated towards providing support towards others when stories and struggles were shared, which highlights a benefit of participating in a group such as this one. Participants reflected how encouraging it felt to be supported in such a way by other caregivers, and remarked that they enjoyed connecting with individuals experiencing similar difficulties and self-criticisms as themselves. This was most noticeable in the emotion coaching weeks (week three for group one, and weeks three and four for group two and three) where caregivers practiced tackling real-life situations and provided compassionate support to one another. The nature of the skill encouraged this type of support from caregivers while practicing this skill, however it was already present before and continued to be present throughout the groups.

Overall, participants were actively engaged in the content, practice, and discussions, and required minimal encouragement to contribute after the first few weeks.

Limitations

Firstly, this study was significantly under-powered, which increases the risk of type-2 errors. There was also a high rate of inconsistent participation in this CFT group, particularly in the second and third groups. In the first group there was an average of 85% attendance, 57% in group two, and 67% in group three (Table A1). When the 13 individuals who dropped out of the program are removed these attendance rates improve, and it becomes clear that the majority of individuals who completed the program missed up to one session. This attrition and inconsistent participation seen in this program impacts the research findings as individuals who persisted in the groups and consented to research are more likely to be favorable candidates for the intervention. The individuals who persisted in completion of the group are more likely to have perceived the group to be helpful and positive, and are more likely to demonstrate positive impacts on the variables measured. For these reasons, the results of this study do not fully represent the impact this CFT intervention had on the 47 participants who completed the program.

Along with the small sample size, there was also no control group with which to compare the results of the study. Other studies such as Bratt and colleagues (2020) were able to draw comparisons to treatment as usual groups. It is possible that some effects seen in this group are due to factors other than the material focused on improving psychological flexibility, such as the general benefit of joining with other caregivers. Participants were also gathered through the CYDC's mailing list, which could lead to an overrepresentation of a particular group, such as group of caregivers who have participated in other parenting groups in the past. These participants were also self-referred, and may have certain similar characteristics due to this self-referral, for instance a greater motivation to learn and apply new strategies. During the intake, participants were asked what brought them to the group and what they hoped to gain from it. Participants were also asked if they were able to attend every session, whether they could access the technology required to participate in the group, and whether they would be able to participate in this program in English. In addition, several of the utilized scales were newly developed and require further studies to validate them. There was also insufficient power to test for differences

between facilitators. Finally, the groups and research were all taking place within the context of the COVID-19 pandemic. Although the impacts of the pandemic on parenting and parenting stress are still being studied, it is not unreasonable to assume that parents experienced increasing stress at different times during this unprecedented period of disruption. Thus, it is difficult to disentangle the potential impacts of the intervention from the ongoing effects of the global pandemic.

Future Directions

Future groups. Based on feedback from participants of group one, the groups were extended from four to six weeks. Participants from groups two and three within this sample did not report a desire for the group to be extended past six weeks, however this should be re-evaluated when more data and feedback is available. Attendance rates indicated that six weeks is still a large commitment for caregivers, so future research may investigate various ways of maintaining attendance in a longer group. Along with this, several caregivers suggested for future groups to screen participants for more similar difficulties and challenges. While the CFT Caregiver Protocol is intended to serve as a transdiagnostic intervention, heterogeneity in youth mental health difficulties appears to adversely impact group cohesion. Indeed, some caregivers mentioned that there seemed to be a divide within the group, with some individuals facing more severe behaviours due to their children's special needs or diagnoses. It may be beneficial in the future to screen participants to allow for more targeted groups. These targeted groups may also require small changes to best fit the needs of the population they are serving, which would require more data for analysis. Due to the findings in this study, it may also be beneficial to apply additional pre-intervention measures to ensure caregiver fit for this program, specifically related to levels of psychological flexibility and burnout. As the results suggest, this intervention may be most beneficial for individuals with higher initial levels of psychological inflexibility. Lastly, many participants mentioned that the role-playing, breakout rooms, and time to practice skills were some of the most beneficial aspects of the group. Future group provision should evaluate whether more time should be dedicated towards these experiential components.

Future research. Due to the small sample size and low power, moderation analyses and comparisons between groups were not possible. However, future analyses should work to address the following. Due to the challenges in complete attendance and attrition observed

throughout the three groups, it would have been beneficial to analyze whether there is a dosage effect on outcome variables. Such an analysis would reveal whether there are certain components or content areas critical to beneficially affecting psychological flexibility. Furthermore, this type of analysis will inform the amount of exposure to CFT content that is needed to affect positive change on participating caregivers. Of the 13 participants, nine showed decreases in global psychological inflexibility, and 10 showed decreases in parental psychological inflexibility. Individuals who showed decreases on measures of global psychological inflexibility had an average attendance of 85% while those who did not improve had an average attendance of 74%. For parental psychological inflexibility, individuals who showed a decrease had an average attendance of 83% while those who did not improve had an average attendance of 80%. Not every participant who had 100% attendance showed a decrease on both measures of psychological inflexibility, and not every participant who attended 50-66% of the time showed decreases in both measures of psychological inflexibility. However, once more data is gathered further analyses should be conducted to test whether a significant difference exists between responders and non-responders.

Along with this, previous research on CFT groups for caregivers have typically involved eight two-hour group sessions (16 hours total), whereas fewer have offered shorter groups. As this current study involved four two-hour group sessions (eight hours total) as well as six two-hour group sessions (12 hours total), and demonstrated beneficial preliminary evidence, future analyses may give further evidence for the validity of this shorter group offering model. Future research should also work to test a moderation model between parental burnout, psychological inflexibility, and the attacking subscale of the interpersonal processes scale. Such an analysis would work to determine if parenting stress is a moderator between parental psychological inflexibility and maladaptive parenting practices, as was reported by Fonseca and colleagues (2020). In addition, future analyses should focus on revealing whether individuals that have dropped out of the program or failed to show decreases in psychological inflexibility share common traits, for instance higher levels of parental burnout on the pre-group measure. It would be beneficial to understand whether higher levels of parental burnout are related to increased chance of drop-out and diminished benefits in terms of decreased psychological inflexibility. Such an analysis would speak to whether there are diminishing returns after a certain level of

parental burnout, which may indicate that a higher dose of intervention, or additional supports, are required for more burned-out parents.

Conclusion

Parental burnout and psychological inflexibility are characteristics with known deleterious effects for caregivers, their children, and the parent-child relationship. Past research on these topics has demonstrated that various interventions such as mindfulness, ACT, and compassion-based interventions can decrease psychological inflexibility and decrease parenting stress. The current CFT program differs from existing CFT interventions as it combines traditional CFT components with training on evidence-based parenting programs (EBPPs), and it applies a parallel-processes model as well as experiential learning to allow caregiver to learn skills for themselves before learning to use them with their children. Statistical analyses were limited due to the low sample sizes, however the results indicate that this novel CFT caregiver protocol may be effective in reducing parenting burnout, decreasing inflexibility, and decreasing maladaptive parenting processes. Overall, the majority of caregivers also reported that their understanding of and relationship with their child was positively impacted after participating in the CFT caregiver protocol. Qualitative results also indicated that caregivers were highly satisfied with the program, found it to be helpful, and continued to use the learned skills and attitudes after program completion. Future research should capitalize on the suggestions outline in the above sections and test the CFT caregiver protocol in a more controlled setting where participant characteristics are randomized between a CFT group and a comparison group. The results of this project speak to the beneficial impact that a combination of parenting 'hard skills' and 'soft skills' can have on the parent-child relationship, with hard skills being specific parenting techniques learned and soft skills being components of effective interpersonal relationships. Both types of skills appear to be necessary, but not sufficient, in promoting the most successful outcomes. The preliminary results of this novel CFT caregiver protocol indicate that it is a promising intervention for caregivers as it promotes an improvement of the parent-child relationship.

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Appendix A

Data Analysis

Figure A1

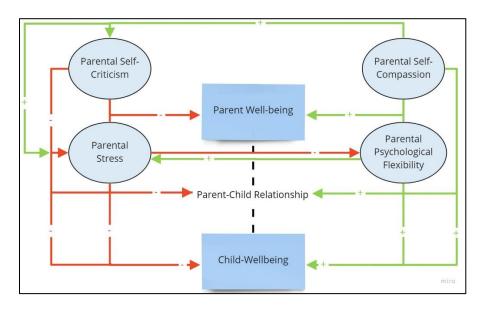*Summary of Relations between Constructs of Interest*

Table A1.

Summary of attendance in the CFT parent and caregiver groups

Group	N	M Attendance						Total M	Excluding Drop-Outs
		W1	W2	W3	W4	W5	W6		
Group 1 (Mar. 24 - Apr. 14, Wed 7:00-9:00pm)	16	100% (16)	87% (14)	81% (13)	75% (12)	N/A	N/A	86%	88%
Group 2 (Jul. 12 - Aug. 16, Tues 6:30-8:30pm)	16	87% (14)	56% (9)	56% (9)	62% (10)	56% (9)	25% (4)	57%	69%
Group 3 (Oct. 26 - Nov 30, Tues 9:30-11:30am)	15	93% (14)	86% (13)	60% (9)	53% (8)	60% (9)	53% (8)	67%	81%

Table A2.

Summary of survey completion and research consent

Group	N	Pre-Survey	Post-Survey	Survey Consent	Survey consent + completed	1-month survey	Focus-Group Consent
Group 1	16	16	10	7	6	1	4
Group 2	16	16	7	8	4	3	4
Goup 3	15	15	11	5	3	1	6
Total	47	47	28	20	13	5	14

Table A6.

Pre and Post scores of psychological flexibility with non-responders removed

Outcome	Before CFT Group		After CFT Group			95% CI for Mean difference		t	p	d
	M	SD	M	SD	n					
Psychological Inflexibility	36.56	9.275	28.78	9.494	9	3.502	12.054	4.195	**.003***	**1.398**
Parental Psych. Inflexibility	30.40	5.797	25.30	4.762	10	3.209	6.991	6.101	**<.001***	**1.929**

Note. Individuals who did not show decreases in psychological inflexibility were excluded from the analysis.

Table A9.

Pearson Correlations (n=13)

Variables	R Value	Strength	Significance	Direction
Pre to Pre				
Pre global psychological flexibility and Pre burnout	.625	Strong	$p < .05$	Positive
Post to Post				
Post global psychological flexibility and Post burnout	.832	Very Strong	$p < .001$	Positive
Post parental psychological flexibility and Post burnout	.586	Moderate	$p < .05$	Positive
Post submission subscale and Post global psychological flexibility	.565	Moderate	$p < .05$	Positive
Post attack subscale and Post global psychological flexibility	.655	Strong	$p < .05$	Positive
Post Func. Contex. Subscale and Post global psychological flexibility	-.646	Strong	$p < .05$	Negative
Post attack subscale And Post parental psychological flexibility	.659	Strong	$p < .05$	Positive
Post submission subscale and Post burnout	.649	Strong	$p < .05$	Positive
Post attack subscale and post burnout	.789	Strong	$p < .001$	Positive
Pre to Post				
Pre global psychological flexibility and Post burnout	.260	Weak	$p = .391$	Positive
Pre burnout to Post global psychological flexibility	.482	Moderate	$p = .095$	Positive
Pre burnout And post attack subscale	.641	Strong	$p < .05$	Positive
Pre burnout And post caregiving subscale	-.776	Strong	$p < .05$	Negative
Pre burnout And post Func. Contex. Subscale	-.568	Moderate	$p < .05$	Negative

Pre to 1-month				
Pre burnout and 1-month follow up global psychological flexibility	.976	Very Strong	$p < .005$	Positive
Pre global psychological flexibility and 1-month follow up burnout	.989	Very strong	$p < .005$	Positive
Pre burnout and 1-month follow up Parental psychological flexibility	.933	Very strong	$p < .05$	Positive

Appendix B

Recruitment

Verbal Recruitment Script – CFT for caregivers

Thanks for having this chat with me about the CFT group. You are all registered and ready to go. The clinic will send you a zoom link for the dates and times of the group. Do you have any questions about the group before we finish for today?

< questions are answered>

Before we end our meeting, there is one more thing I would like to ask you. The CFT Research Group is doing research to find out whether it is helpful for caregivers and their children.

Your enrollment in the group is completely separate from the research. Many participants do not want to participate and that is totally fine. Can I take a moment to send you information about the study and talk about it with you?

<if no>

No problemo! In that case just look out for an email from the clinic with the link to the zoom

meeting. Do you have any questions before we finish up?

<if yes>

Alrighty, I am sending it now <send email template>. There are four things you can choose to consent to if you want. The first is whether we can use that questionnaire you just filled out for research purposes. At the end of the group there is a follow-up questionnaire the clinic uses and we are also asking for permission to use that for research purposes. Outside of that you can choose to participate in a 1-month follow-up questionnaire and a 1-month follow-up focus group if you choose to do so. Consent is completely voluntary and does not impact your participation in the group.

So take some time and read through the consent form and letter of information I just sent you. If you choose to participate you can click the link in that email and fill out the consent form. If you want to meet and talk about the research I am always open to connecting so just let me know. Do you have any questions about anything we spoke about today? Thanks for talking and have a good day.

Email Recruitment Script

<u>Subject:</u> Invitation to Participate in Study on the Compassion Focused Parenting and Caregiving Program

<u>Attachment:</u> Letter of Information and Consent Form

Hello <u>[insert caregiver name]</u>,

As a participant in the Compassion Focused Parenting and Caregiving (CFC) Program, you are being invited by Western University researchers to participate in a study to learn more about the benefits of the program for parents, caregivers, and their children. You are being invited to participate in one survey, one focus group and to give permission for your program facilitator to share information about your participation in the program. Please read the Letter of Information on the link below. The letter outlines the research activities, purpose of the research, procedures, and your rights as a participant. If you are interested in participating , please complete the consent form on the same link below by clicking the right bottom arrow. Please note that participating in the study is voluntary and in no way affects your participation in the CFC Program or any other services you receive. A copy of the letter is attached for your records.

<u>LINK to Letter of Information and Consent Form:</u> [insert individualized link]

If you have any questions about this study, please contact X at Western University by email at (X).

Thank you,

[Insert name]

Appendix C

Measures

Sociodemographic Survey

1. What is your age in years?

2. How old is the child for whom you are attending the group?

3. How many children are you currently raising or helping to raise?

4. Have you every been diagnosed with a mental health condition from a medical professional (e.g. psychologist, family doctor, psychiatrist, etc.)?

5. Are you currently working through a diagnosed mental health condition?

6. Who else in acts as a significant caretaker of the child that brought you to this group? (My spouse/partner, my ex, my ex's current partner, my parents, my spouse's parents, my ex's parents, the parents of my ex's spouse Someone else in my extended family, foster parents, a group home, other).

7. Who else is in charge of taking care of your child/acting as their guardian?

8. What best describes your sexual and romantic orientation? (Straight/heterosexual, gay, lesbian, queer, still figuring it out, pansexual, asexual, grey sexual, homoromantic, panromantic, aromatic, demiromantic, other).

9. What other label do you identify with?

10. What gender identity do you identify with? (Cis-male, cis-female, gender fluid, transgender, gender queer, tans, two-spirit, agender, FtM, MtF, gender non-conforming, I am still figuring it out).

11. What other gender identity label do you identify with?

12. What is your ethnicity? (White/Caucasian, Latina/Latino/Latinx, Black Canadian/Afro-Caribbean/African, East Asian Chinese/Japanese/Korean/Taiwanese, South East Asian Indian/Pakistani/Nepalese, Indigenous Canadian First Nation/Metis/Inuit, other).

13. What other ethnicity/ethnicities do you identify with?

Parental Burnout

Please read each statement and rate how often you believe it to be true from (0) never to (6) every day (Roskam et al., 2017).

1. I can no longer show my children how much I love them.

2. I am less attentive to my children's emotions.

3. I do the bare minimum for my children but no more.

4. I have the impression that outside the routines, I can no longer get involved with my children.

5. I am less and less involved in the relationship with my children.

6. I am less and less involved in the upbringing of my children.

7. I sometimes feel as though I am taking care of my children on autopilot.

8. I do not really listen to what my children tell me.

9. I feel emotionally drained by my parental role.

10. I am at the end of my patience at the end of a day with my children.

11. I feel tired when I get up in the morning and have to face another day with my children.

12. Being a parent every day requires a great deal of effort.

13. It stresses me too much to take care of my children.

14. When I think about my parental role, I feel like I'm at the end of my rope.

15. I feel that being a parent requires too much involvement.

16. I feel my parental role is breaking me down.

17. I am easily able to understand what my children feel.

18. I look after my children's problems very effectively.

19. Through my parental role, I feel that I have a positive influence on my children.

20. I am easily able to create a relaxed atmosphere with my children.

21. I accomplish many worthwhile things as a parent.

22. As a parent, I handle emotional problems very calmly.

Interpersonal Processes in Parenting Scale

Please read each statement and choose your answer between (1) strongly disagree and (5) strongly agree (Cwinn, in preparation).

1. I make changes or accommodations to help my kids meet their obligations.

2. I meet my child's emotional needs.

3. I am wiser then my kids.

4. I jokingly tease my kids when they aren't acting up to my standards.

5. I need to get angry to make my kids to listen.

6. I find it hard to stand my ground when my kids dig their heels in.

7. My kids respect me.

8. I find I nit-pick or micromanage my kids.

9. If my kids don't do their chores I usually let it slide.

10. I go out of my comfort zone to help my kids when the situation calls for it.

11. Even if I don't want to, when my kids ask for something I get it for them.

12. When I put my foot down my kids know that is the final answer.

13. I snap at my kids.

14. I stand my ground even when my kids have a tantrum.

15. Its easy for me to be firm with my kids.

16. I help and support my kids with their problems.

17. My kids look up to me.

18. I will pick up the slack around the house because it isn't worth the hassle to get my kids to do their chores.

19. I lose my temper with my kids.

20. I am more powerful than my kids.

21. I let my kids find their own solutions to problems.

22. Sometimes I feel like my kids are in charge.

23. I let my kids "just be".

24. When I put my foot down I don't go back on my decision.

25. I am warm and gentle with my kids.

26. When my kids act up, I find that I give in.

27. I judge my kids.

Acceptance and Action Questionnaire - II

Please read each statement and rate how often you believe each to be true from (1) never true to (7) always true (Bond et al., 2011).

1. It's OK if I remember something unpleasant.

2. My painful experiences and memories make it difficult for me to live a life that I would value.

3. I'm afraid of my feelings.

4. I worry about not being able to control my worries and feelings.

5. My painful memories prevent me from having a fulfilling life.

6. I am in control of my life.

7. Emotions cause problems in my life.

8. It seems like most people are handling their lives better than I am.

9. Worries get in the way of my success.

10. My thoughts and feelings do not get in the way of how I want to live my life.

Acceptance and Action Questionnaire - II - Caregiver

These questions ask about how your emotions and worries impact your parenting practices. Please read each statement and choose between (1) strongly disagree and (5) strongly agree based on what is generally true for you (Cwinn, in preparation).

1. Painful emotions and memories get in the way of me parenting the way I want to.

2. I am afraid of some feelings that come up during parenting.

3. I worry about being able to control my feelings.

4. I avoid certain parenting tasks because they make me feel uncomfortable.

5. I avoid certain parenting tasks because I know my child will have a big emotional reaction.

6. It seems like most parents are handling their lives better than I am.

7. I am afraid of my child's emotional reactions.

8. I am afraid of my child's behaviour.

9. I am in control of my parenting.

10. I parent the way I want to even when my feelings make it hard to do so.

Compassion Focused Parenting Scale

Please read each statement and choose between (1) strongly disagree and (5) strongly agree (Cwinn, in preparation).

1. I feel disrespected when my kids don't listen.

2. I feel angry when my kids don't listen.

3. I worry that I am not good enough as a parent.

4. I worry that my kids will have problems when they grow up.

5. It is important that my kids succeed in the competition of life.

6. People judge parents by how well their kids do.

7. I compare myself to other parents.

8. If you don't keep up with parenting expectations, other parents will look down on you.

9. It is important to keep up appearances as a parent.

10. Others will accept me even if I fail.

11. I am able to accept myself even if I don't meet all my parenting expectations.

12. People value me as a person regardless of how my kids behave or perform.

13. I am worthy of love and belonging regardless of whether or not I meet my parenting goals.

14. I can accept myself even if my kids don't succeed in life.

15. I experience my child's big emotions as a chance to deepen our relationship.

16. I experience my child's misbehaviour as a time to teach them skills or help them grow.

17. My kid's emotional reactions make sense in their inner world.

18. My child's behaviours serve a function.

19. When my kids don't listen I believe I need to do something differently or change something in their environment

Appendix D
Post-Intervention Survey

Participation and Skills

1. Did your partner or another of your child's caregivers participate in the Compassion Focused Parenting workshop?

2. What is your partner's first and last name? (if either of you agreed to participate in research this question will be removed).

3. Which of the following skills have you been using since the workshop? (Emotion coaching, encouraging desirable behaviour, self-compassion with myself, reminding myself of my parenting values, I haven't been using any skills from the workshop).

4. Why have you not been using the skills? (I forgot to use them, I didn't understand them, I tried but they weren't helpful so I stopped, they are too distressing for me to try, they are too hard to use).

5. Which of the following skills from the workshop did you find helpful? (Emotion coaching, encouraging desirable behaviour, being kind and supportive to myself, reminding myself of my parenting values, noticing and expressing my own needs, practicing breathing, practicing compassionate imager, changing the way I think about situations).

Changes in Parent/Caregiver

The next questions ask about you reflect on changes in you or your you as a parent or caregiver, as a result of the Compassion Focused Parenting and Caregiving Program. Please answer the following questions. Please answer the questions on the following scale: Got much worse, got worse, did not change, got better, got much better, not applicable.

1. As a result of the program, my understanding of my child
2. As a result of the program, my relationship with my child
3. As a result of the program, my relationship with my partner
4. As a result of the program, my self-criticism
5. As a result of the program, my burnout
6. As a result of the program, my ability to cope
7. As a result of the program, my confidence in my parenting skills
8. As a result of the program, my depressed mood

9. As a result of the program, my anxiety

10. As a result of the program, my anger/irritability

11. As a result of the program, my ability to control my temper

Follow-up Questions

1. Did you child complete the I Have My Back Program?

2. Before registering in Compassion Focused Parenting and Caregiving program, which formal mental health services have you tried? (Individual counselling/therapy, other counselling groups, medication, religious or spiritual counselling, family therapy, other).

3. Was your child engaged in other mental health services since you participated in the parenting/ caregiving workshop? (Individual counselling/therapy, other counselling groups, medication, religious or spiritual counselling, family therapy, other).

Open-Ended Questions

1. As a parent or caregiver, what changes would make to the Compassion Focused Parenting / Caregiving Program?

2. Was there anything in the program you found harmful or offensive? If so please let us know about it here.

3. What do you think were the helpful parts of the program?

Appendix E

Ethics Approval

Date: 11 February 2021

To: Dr. Claire Crooks

Project ID: 116866

Study Title: Evaluating a Compassion Focused Therapy group for parents and caregivers

Short Title: Evaluating CFT for Parents and Caregivers

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 18/Dec/2020

Date Approval Issued: 11/Feb/2021 19:42

REB Approval Expiry Date: 11/Feb/2022

_____

Dear Dr. Claire Crooks

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. **All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study.**

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Email recruitment script CFT parents 2020-11-16	Recruitment Materials	16/Nov/2020	1
Pre- Caregiver QI survey from CYDC	Online Survey	17/Nov/2020	1
Post -Caregiver QI survey from CYDC	Online Survey	17/Nov/2020	1
One Month Follow Up Caregiver 2020-11-17	Online Survey	17/Nov/2020	1
Focus Group Guide CFT caregivers 2020-11-11 cc	Focus Group(s) Guide	17/Nov/2020	1
Online participant consent and LOI Track Change - CLEAN - CFT caregiver v2 2021-01-15	Written Consent/Assent	20/Jan/2021	2
CFT Caregiver Verbal Recruitment Script - CYDC 2020-11-10	Oral Script	10/Nov/2020	1

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Kelly Patterson , Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Western Research

To: Dr. Claire Crooks

Project ID: 116866

Study Title: Evaluating a Compassion Focused Therapy group for parents and caregivers

Application Type: NMREB Amendment Form

Review Type: Delegated

Full Board Reporting Date: July 9 2021

Date Approval Issued: 28/May/2021 18:26

REB Approval Expiry Date: 11/Feb/2022

Dear Dr. Claire Crooks,

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the amendment, as of the date noted above.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
CFT Caregiver Verbal Recruitment Script - 2021-05-13 - CLEAN	Recruitment Materials	13/May/2021	3

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Kelly Patterson , Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Curriculum Vitae

Name: Katarina Guillen

Post-secondary Education and Degrees:

Western University
London, Ontario, Canada
2020-2022, M.A.

University of Waterloo
Waterloo, Ontario, Canada
2015-2020, B.A.

Honours and Awards:

Canada Graduate Scholarship - Masters (CGS-M)
SSHRC - Joseph Armand Bombardier
2021-2022

University of Waterloo Admission Scholarship
President's Scholarship
2015

Related Work Experience

Focused Family Therapy Intern
Vanier Children's Services
2021-2022

Dialectical Behaviour Therapy Group Student Counsellor
Canadian Mental Health Association (CMHA)
2021-2022

Compassion Focused Therapy Group Student Clinician
Mary J. Wright Child and Youth Development Clinic (CYDC)
2021-2022

Instructor Therapist
Breaking Barriers Behaviour Consulting Inc., Best Behaviour Inc.
2016-2017, 2019-2020

Community Testing Coordinator
University of Waterloo, Developmental Learning Lab
2019

Research Assistant
University of Waterloo
2016-2019