

Can transdiagnostic parent training in child psychiatry empower parents to support their children's emotional regulation? A qualitative interview study of parents' and clinicians' perspectives on Circle of Security-Parenting (COS-P).

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Abstract

Background: Many children referred to child psychiatry show insecure attachment, indicating difficulties in the parent–child relationship. Attachment-based interventions aim to strengthen this relationship by enhancing parental sensitivity and understanding of the child's needs. As the quality of the parent–child relationship has a profound influence on a child's overall well-being and psychopathology, it is important to explore whether increased focus on parents' relational capacity can positively affect children's psychiatric symptoms.

Objective: To investigate parents' experiences of participating in an attachment-based parenting intervention, Circle of Security Parenting (COS-P), within a child and adolescent mental health services setting.

Method: Qualitative semi-structured interviews were conducted with six parents participating in COS-P, alongside a focus group interview with four clinical therapists, to gain insights into their experiences with the program in a child psychiatric context. Data were analyzed using NVivo 12 and a reflexive thematic analysis approach.

Results: The analysis resulted in three main themes: (i) challenges prior to COS-P, (ii) expectations of the intervention, and (iii) perceived changes following the intervention.

Conclusion: Several parents reported positive changes in their interactions with their children after participating in COS-P. They described an improved understanding of their children's behavior and needs, as well as increased use of appropriate strategies to meet those needs. Additionally, most parents reported gaining insight into how difficulties in regulating their own emotions, rooted in their own childhood experiences, had been unintentionally transmitted to their children. Transdiagnostic parent training programs such as COS-P have the potential to empower parents to support their children before, during, and/or after psychiatric assessment, regardless of diagnosis.

Keywords: Circle of Security; Parental sensitivity; Parent-child relationship; Parenting intervention; Child psychiatry; Transdiagnostic treatment.

Introduction

For decades, research has repeatedly shown that children with a secure attachment to at least one adult perform significantly better across multiple domains, including psychological well-being, social competence, and psychopathology (1). Attachment-based interventions are designed to improve the parent–child relationship by increasing parental sensitivity to the developmental needs of the child. The aim of these interventions is to help parents improve their

recognition of the child's needs, learn how to respond appropriately, and thereby foster secure attachment in the child (2, 3). Previous meta-analytical research shows that parenting interventions characterized by a behaviorally oriented approach to improving parental sensitivity produce the most advantageous outcomes (4). Notably, interventions in clinical samples were significantly more effective than those in non-clinical groups (4).

The importance of sensitive parenting extends beyond infancy and early childhood (5). Shifts in maternal sensitivity from low levels in early childhood (age 1) to higher levels in adolescence (age 14) are associated with corresponding improved changes in the child's attachment security (5). This longitudinal evidence underscores that parental responsiveness remains relevant throughout development and suggests that parental sensitivity—and thereby attachment security—can change, even during adolescence (5).

Because the parent–child relationship is central to a child's well-being across domains, it is crucial to explore whether improving this relationship through enhanced parental skills could help reduce psychiatric symptoms in children. This is particularly relevant as attachment difficulties appear to be substantially more common among children referred to psychiatric services than among community samples, indicating underlying difficulties in the parent–child relationship (6). This finding aligns with research showing that insecure attachment is a major risk factor for psychopathology (6). Notably, secure attachment is observed in approximately 70% of children in the general population, whereas only around 20% of clinically referred children with early-onset conduct problems have secure attachment (6, 7). Even among children with ADHD, a highly prevalent neurodevelopmental disorder, the proportion of secure attachment is as low as 15% (8, 9).

Circle of Security – “Good-enough parenting” as a mandate

The Circle of Security (COS) model is a parenting intervention grounded in extensive attachment research. It combines psychoeducation with a mentalization-based approach (1, 10). COS's primary objective is to foster parental insight into their child's emotional needs while improving parental sensitivity to these needs, thereby offering a map to secure attachment.

The child is going out into the circle to explore and relies on the parent to regulate the child's various needs: watching over, helping, sharing enjoyment, and delighting in the child's experiences. As the child reaches the bottom of the circle, different needs emerge: protection, comfort, delight, and help with organizing feelings. This process effectively refills the child's 'emotional cup'.

This is a continuing, predictable, and iterative process. Through this interplay, the child requests and acquires experiences related to whether the parent is capable of meeting and mirroring the child's needs by being the “hands” for the child. The term “hands” in COS represents the parents' role as the secure base and safe haven for the child, which is fundamental to achieving secure attachment (11).

The program is delivered through a structured manual and uses standardized filmed interaction examples strategically designed to prompt reflection within a group of participating parents. These parents are encouraged to reflect on their own parent–child relationships and engage in discussions centered on real-life examples of interactions with their children. COS-P also provides parents with a specific language to articulate their emotions and behaviors, empowering them to become more aware of their own reactions to their child's emotional needs. In essence, it provides caregivers with the capacity to maintain mentalization and respond sensitively, even in demanding situations. This new awareness creates an opportunity to change problematic interaction patterns passed on through generations, which may compromise healthy parent–child relationships (11).

Although COS-P has been widely adopted internationally, research on its effectiveness and on parents' experiences with COS-P remains limited. The existing qualitative research suggests that parents experience improvements in their parent–child relationship. These improvements are associated with a changed understanding of the child's signals and behavior, as well as the parental role and the parent–child relationship. When parents focus on the relationship while being aware of their own developmental history, they can enhance their ability to regulate their own emotions and practice presence toward the child. This, in turn, leads to increased empathy, compassion, and confidence in the parental role among participants (12–16).

Aims of the present study

The aim of this study was to investigate parents' experiences of participating in COS-P. The study is based on a randomized controlled trial (RCT) (3), investigating how COS-P can benefit parents of children aged 3–8 years who are referred to child psychiatric services, and whether the effect of the intervention also extends to the child's symptoms. The hypothesis of the RCT is that the intervention will

TABLE 1. Characteristics of the RCT study

Time period 2018–2023	Vejle	Aabenraa	Odense
Number of randomized families	49	32	12
Number of COS-P intervention programs	11	7	2
Number of participating parents	33	21	7

Note. Numbers of randomized families, COS-P intervention programs, participating parents within the RCT study in the period from 2018–2023 at different locations.

help parents become more perceptive of the child's signals and needs, thereby improving parental sensitivity, the parent–child relationship, and reducing parenting stress. The ultimate goal is to improve affect regulation in both the parent and the child and enhance the parents' capacity to support their child's affect regulation (3).

In a Danish context, parent-training interventions are not common in child psychiatry, highlighting the need to examine how parents of referred children perceive such interventions. COS-P is a universal intervention for all parents and is not specifically tailored to a psychiatric population. Understanding how a new intervention is experienced by its users is essential for successful implementation. Therefore, we conducted a qualitative study with a subsample of the target population in the RCT (3) to examine whether aspects of the intervention require adaptation to a psychiatric target group. Through qualitative interviews, parents' and therapists' perspectives and experiences with COS-P were explored to gain insight into the program's potential impact, strengths, and limitations. This has implications for clinical practice and future research in a field with limited empirical evidence (3, 14, 17).

Research question

How do parents perceive and describe their experiences and changes after participating in the COS-P intervention in child psychiatry, and to which aspects of the intervention do they attribute these changes?

Methods

The RCT upon which this article is based was carried out in Denmark within child psychiatry from 2018 to 2023. Within the RCT, parents participated in 10 manualized COS-P sessions. Each session lasted 2 hours and was facilitated by two therapists. Treatment groups consisted of 4–5 families. The COS-P intervention program was conducted at three participating clinical sites.

The current study employs a qualitative approach, which enables access to valuable insights into parents' and therapists' experiences. This approach is particularly useful, as prior evidence on this perspective is limited, as is the case with COS-P (14). Furthermore, qualitative research has certain advantages in uncovering potential causal mechanisms underpinning intervention effectiveness (14). Qualitative methods provide an opportunity to engage with the voices and perspectives of “end users,” which is increasingly recognized as an important factor in good clinical practice and policy (14, 18).

To enhance the trustworthiness of the findings, the study was guided by Lincoln and Guba's framework (19). Credibility was supported through in-depth semi-structured interviews and the inclusion of both parent and therapist perspectives. Dependability and confirmability were addressed through a systematic and transparent analytic process, including the use of NVivo and reflexive thematic analysis. Transferability was strengthened by providing detailed descriptions of the study context, participants, and intervention setting.

Ethical considerations

In Denmark, qualitative research does not require ethical approval from the National Committee on Health Research Ethics (www.nvk.dk). However, the study was reported to the Data Security Department in the Region of Southern Denmark.

All participants received both written and oral information about the study prior to inclusion, including information that participation was voluntary and that consent could be withdrawn at any time. Informed consent was obtained prior to all interviews.

Recruitment and participants

Parents

We recruited parents from the target population of the RCT (3). These were parents of children, who were referred to child and adolescent mental health services. Some children already received a diagnosis and some were still under clinical assessment and did

TABLE 2. Participant characteristics (parents)

Parent pseudo-nym	Age	Gender	Number of children	Referred child gender	Child age	Referred child diagnosis	Months since COS-P	Completed COS-P with partner
Ann	43	F	4	M	5	+	< 12	+
Ben	42	M	2	M	7	–	> 1	÷
Charlotte	33	F	2	M	8	+	> 1	+
David	36	M	2	F	8	+	> 1	+
Emma	39	F	3	F	5	–	< 12	÷
Frederik	37	M	2	M	4	+	> 1	÷

Note. Table 2 presents participant characteristics (parents), including gender, age, number of children, and characteristics of the referred child (gender, age, and diagnosis). Diagnosis is coded as present (+) or absent (–) and refers to if the child has received a diagnosis (yet). Time since participation in COS-P is reported in months, and partner participation is indicated (+ = yes, ÷ = no). COS-P: Circle of Security–Parenting.

not receive a diagnosis (yet). All included children exhibited some amount of emotional and behavioral issues and disruptive behaviors. Inclusion criteria for children in the RCT were: age 3 - 8 years old; a score at or above the 93rd percentile on the CBCL total score and the ODD or conduct disorder subscale. Children were excluded if they had autism spectrum disorder, severe psychopathology, neurological conditions or head injury, IQ < 80 and medical conditions requiring treatment. Parents were excluded if they suffered from schizophrenia, substance abuse, or severe intellectual impairment.

Parents in this qualitative study had all recently completed the COS-P intervention program and were invited to participate in qualitative in-depth interviews. One group of parents was approached towards the end of their COS-P intervention program and was asked whether they were interested in participating in an interview about their experiences with COS-P. All four parents in this group accepted the invitation and were subsequently contacted by author 1, who provided more detailed information about the

study. Upon receiving verbal consent, interviews were arranged. Before the interviews, written consent was obtained.

The four parents were interviewed across three interviews, as two of the parents were married and therefore participated together. Furthermore, we contacted five parents from the most recently completed COS-P group by phone. They also agreed to participate in the study, and interviews were arranged. However, three parents later canceled the interviews due to busy schedules, so we were only able to conduct two interviews with this group.

Consequently, we interviewed a total of six parents in five interviews. The interviewees included three women and three men between 33 and 43 years of age. See Table 2 for further characteristics of the parents.

Therapists

We recruited all therapists who had facilitated the COS-P intervention program in the RCT to participate in a focus group interview. The purpose of this

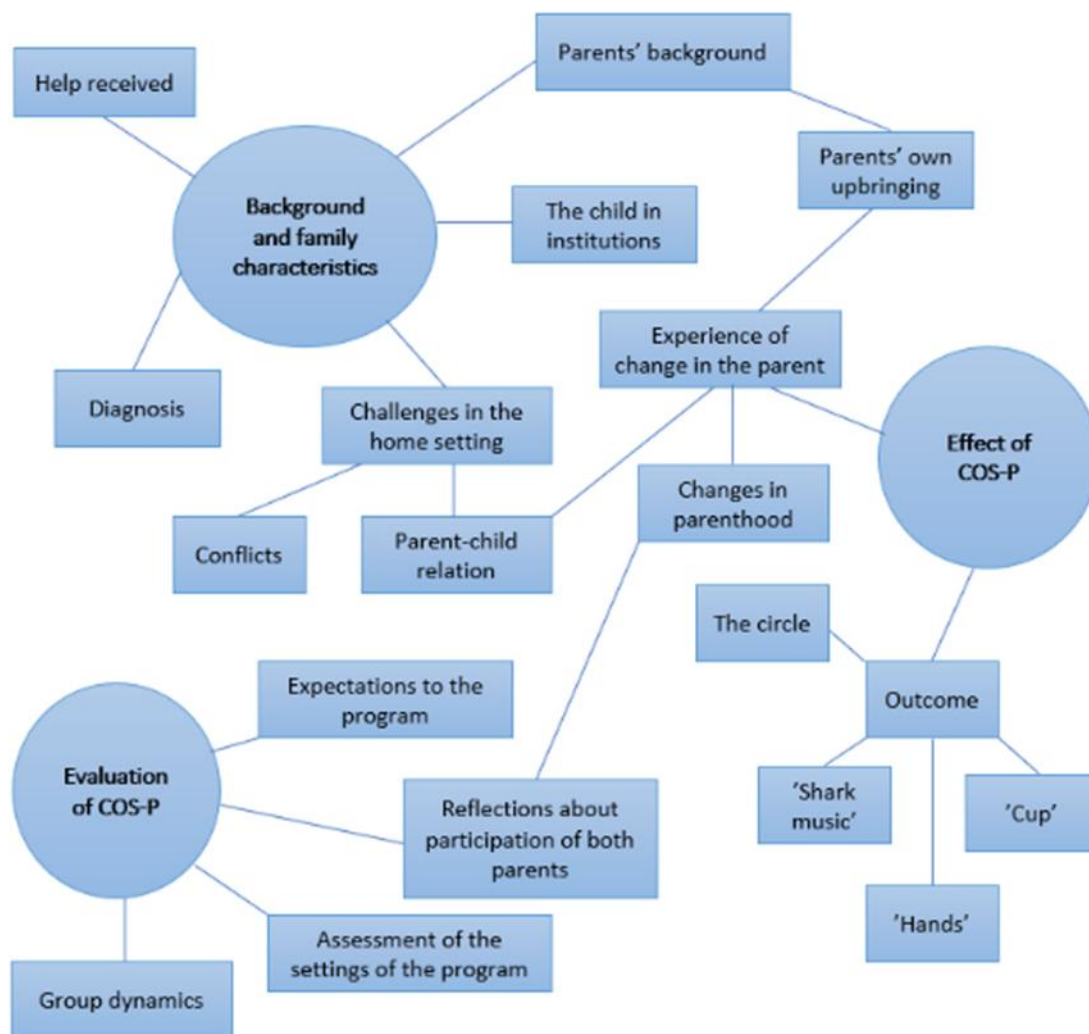


FIGURE 1. Thematic map of the coding process

interview was to provide insight into the therapists' observations and perspectives on the parents' outcomes of the intervention, as well as their views on the COS program in general. All four therapists accepted the invitation to participate in the study.

Two of the therapists were no longer engaged in the RCT study, one had been involved in the study for almost a year and was currently facilitating COS-P, and the final practitioner had been involved in the facilitation of COS-P from the beginning.

Data collection

Parents

The qualitative interviews and the focus group interview were conducted between May and June 2023 and were carried out by author 1 and author 2. The parent interviews took place at a location of the parents' choice. Three interviews were conducted in the parents' homes, and two interviews were conducted at the clinic. The duration of the interviews ranged between 1 and 1½ hours.

The interviews were guided by a semi-structured interview guide. The interview guide began with a few background questions covering demographic data and was then followed by open-ended questions on the following themes:

- a) the parents' motivation for participating in the COS-P intervention;
- b) expectations and experiences of change (if any) during and following COS-P, both personally and in relation to their child;
- c) challenges experienced in relation to COS-P and perspectives on how to improve the COS-P intervention.

In all interviews, parents were encouraged to speak freely about their experiences and to introduce topics they considered important that were not covered in the interview guide.

Therapists

The focus group interview with therapists followed a semi-structured interview guide with open-ended questions with a duration of 1½ hours and was conducted at the clinic. The interview themes covered in the interview guideline were:

- a) Focus and strategies in COS-P
- b) Experiences of outcomes for parents
- c) Challenges in COS-P facilitation
- d) Perspectives on how to improve COS-P
- e) Comparison of COS-P with Treatment As Usual (TAU).

Data analysis

All interviews were recorded and transcribed. An inductive thematic analysis was applied to identify and analyze themes and patterns in the transcribed data. Thematic analysis is a theoretically flexible tool for

analyzing qualitative data using a six-phase analytical process (20).

To organize the data systematically, the analysis tool NVivo 12 was used to code all interviews. Coding was data-driven rather than theory-driven, to emphasize the experiences of the parents and therapists as the primary focus of this study. Thus, we applied an inductive approach to the coding process.

Initially, all interview transcripts were thoroughly reread by the two authors who had collected the data and transcribed the interviews. The two authors then coded the first interview together to identify and discuss codes. A codebook was developed, consisting of a complete list of codes, a definition of each code, instructions on how to identify each code, and examples of each code (20). Throughout the coding process, the two authors discussed discrepancies in the coding, and codes were refined when necessary. Finally, the coded material was organized into a thematic map, which was then discussed by all three authors.

Results

There were three interrelated main themes identified in the data from both parents and therapists:

- (i) experienced challenges
- (ii) expectations to the intervention
- (iii) changes achieved through the intervention.

Experienced challenges

Parents

All parents described the distress and frustration they experienced prior to their participation in COS-P, as they had been seeking help for years. Some parents did not feel heard or taken seriously, while others were referred to various municipal and healthcare services across different parts of the country. Parents had typically tried all available options that might help their distressed child, often leaving them feeling frustrated and powerless:

"We have asked for all the help we could get. I (...) notified the municipality because no one would listen. He [the son] is having a hard time." (Ann)

"(...) there were 3000 different theories, and it got worse and worse, and we were sent from one doctor to another in several cities." (Ben)

"He [the son] has been challenged for many years, he is delayed in many developmental areas related to his hearing, speaking and social skills." (Frederik)

The children's challenges varied across contexts and were often observed in childcare or school settings. Some children overcompensated when they were

away from home, trying to maintain “nice and presentable” behavior at school, only to completely collapse once they returned home:

“If the school says it is like that, then it probably is. We just experienced something different at home (...) we have many conflicts and emotional challenges with her, where she shouts and screams, and it escalates and goes completely crazy.”

(Charlotte)

“Everything she does, she does because children do the best they can, and they do what they can, when they can. However, the teachers could not see it. Our challenges are so massive.”

(Emma)

Although the challenges had been present for years, none of the families experienced having received the help they thought they needed.

Expectations of the intervention

The sense of abandonment and powerlessness that the parents had previously experienced across different systems affected their expectations of the parent training COS-P. Compared to Ben’s statement about the many theories concerning his son, COS-P became another attempt to support his son’s well-being. Nevertheless, Ben’s low expectations of the process might be an expression of a way to protect himself from further disappointment. In contrast, Ann finally found something she could cling to:

“We were desperate; (...) we were completely worn out. Therefore, we will do it [the COS-P research project]. We’ll take what you offer!” (Ann)

“As I said, I signed up without thinking it would make a difference. I don’t care, let’s just do it.” (Ben)

However, most parents indicated certain expectations of COS-P, as they expressed in the interviews that they hoped to achieve:

“...some tools and understanding.” (Frederik)

“...an understanding. My experience is that she [the daughter] was not being understood or met. I need tools.” (Emma)

Experiences of change

Parents

Ann, a mother in a blended family of six, believes that regardless of whether the challenges have arisen from a diagnosis or not, participation in COS-P has been beneficial for all members of the family. She described the impact of COS-P on her and her husband, who also participated in the program, as a new “way of being together”:

“It is a way of being together - we see the effect! It’s the best thing we’ve ever given ourselves (...) there isn’t a single one of our children at home who didn’t have challenges.” (Ann)

Furthermore, the level of conflict in their home prior to participating in COS-P had gradually become so intense that:

“(...) it wasn’t particularly pleasant at home – in fact I don’t know if we would have ended up moving apart, [COS-P] has made a huge difference. We do not have all these challenges anymore. Now we do things the way we have learned it in COS-P.” (Ann)

The couple, Charlotte and David, who both participated in the intervention, also experienced change. David was not sure whether this was due to the ADHD medication that his daughter had started taking two months before the parents began COS-P. However, he had no doubt that he could apply what he had learned:

“We do have conflicts, but no longer the escalating ones. But whether it’s because of the medication, I don’t know – anyway I’m using something I learned [from COS-P] and we can actually move on without ending up in (a meltdown) – well I can’t remember the last time we [he and his daughter] had such an outburst.” (David)

In addition, Charlotte thinks COS-P is a:

“...new way of being parents and acting and reacting!”
(Charlotte)

Ben, who was initially skeptical of the intervention, concludes that the effect of COS-P is manifesting in his son. He believes that his own changed behavior is influencing his son’s behavior and states:

“...at least it works to a certain extent. I think it was worth it. I think things are better now in our relationship.” (Ben)

Therapists

The parents experienced changes in their children’s symptoms and behavior after the intervention and reported that it had become easier to engage with their child within the parent–child relationship. The therapists emphasized in the focus group interview the essence of what is really at stake in the parent–child interaction:

“In a parent-child relationship, there will always be an interaction regardless of whether there is a diagnosis or not, so there can be a more or less well-functioning interaction and how much [the parents] acknowledge the premise of their own role.” (Therapist 1)

Reaching this realization is not an easy task for the parents, as the therapists also emphasize, as it requires a certain level of mentalization capacity and a willingness to reflect on oneself:

“There is a big processing task for [the parents] in this [program]. It’s a question of being present in what happens in me [as a parent] and what happens in [the child], so it’s about the ability to mentalize and the readiness to work with oneself and one’s own realization in that – that’s a determining factor” (Therapist 1)

This process can be extremely uncomfortable and even painful to go through, especially when recognizing one’s own role in the interaction with the child. Therefore, some parents may develop a form of “tunnel vision” when their child receives a diagnosis:

“...as if it absolves them [the parents] of any responsibility, 'because it is [the child's] ADHD that does it'. As if it requires nothing from the parents. But ADHD research in children shows that 85% of children are insecurely attached – as opposed to 30% in the general population, i.e., that with most children with ADHD there is also something relational at stake.” (Therapist 4)

This suggests that parents of children in psychiatric care can benefit from an intervention such as COS-P. Parents gain knowledge of concepts that provide them with both a language and an understanding of what their child is trying to communicate through their behavior, and how they can respond appropriately. Even if Emma did not remember the exact COS-P wording, “bigger, stronger, wiser, and kind,” she is, more importantly, well aware of how she applies it in her interactions with her daughter and thus demonstrates parental responsibility:

“I am aware of (...) where she gets her 'cup filled' and I clearly feel that it is what is happening. I wasn't aware of that before (...) and the 'hands' are one of the things I focus on the most, and the one with the “seesaw” - not getting cold/hard.” (Emma)

Emma refers to the concept of “filling the (child’s) cup,” symbolizing that the child’s emotional needs are met and that the child is seen by the parents at the bottom of the circle, where the child has a need for emotional regulation. Parents are the “hands” at the top and bottom of the circle represent a secure base and safe haven.

The influence of the parents’ own childhood experiences

Most parents expressed that, through the COS-P

program, they became aware of the patterns they carried from their own childhood and how these patterns affect their parenting abilities in the present.

The term “Shark music” in COS-P refers to the parent’s negative emotional and physiological arousal in response to their child’s expressed needs, e.g., becoming angry or withdrawn when the child expresses anger. These are typically feelings that parents did not learn to regulate in their own childhood and for which they did not receive adequate support. With this increased awareness, most parents came to accept and reflect on the understanding that their emotional reactions to their child (“shark music”) were shaped by their own childhood experiences of unregulated emotions and limited co-regulation, even if they initially found it absurd:

“...at first, hearing about that shark music, I was like... bullshit. But that’s what ultimately makes the most sense to me.” (Ben)

It can be painful and challenging to experience one’s old defense mechanisms crumbling while simultaneously working to change deeply ingrained patterns and communicate something new to one’s children:

“I have become very aware of 'shark music' (...) It brings insight, also in one's own way [of parenting] and it makes us ask ourselves: do I want to continue and pass on this pattern, or do I want to change something? And [COS-P] is a good reason and opportunity to change” (Charlotte)

“How these parenting patterns are passed (...) down through generations, seeing what I have inherited myself, that’s where the ‘shark music’ occurs. We gained a lot from that part, especially in understanding what it is like for oneself and how difficult it can be.” (Ann)

When asked directly whether David had gained insight into his own patterns and whether he could use what he had learned, he replied:

“Yes, I actually think so, there is some of it that (...) has given a new perspective on my upbringing, (...) my parents weren't really there (emotionally).” (David)

Therapist 1 supports the parents' statements by adding slightly different wording on how they experience the effective change:

“They (the parents) gain an understanding of the child’s behavior and needs and move away from the idea of a tool that would remedy the problems. When they come to realize that ‘there is something I have to understand, there is something I have to deal with [my own shark music],’ this process of self-awareness begins to emerge, and something starts to change. Where we got stuck (...) was with those [parents] who were

preoccupied with: 'So what is it that we have to do?' 'Tell me, what is the solution?'" (Therapist 1)

Only when parents are willing to examine their own behavior and act differently from how they used to, change in the parent–child interaction takes place:

"It's not about technical knowledge (...) but if [parents] are able to look at themselves and look at 'what am I doing in this situation', transfer it and extend it [this understanding] to [the child's] behavior - THEN a change happens." (Therapist 2)

The concepts and awareness generate reflection, whereby the parents can actively decide whether they want to act differently in challenging situations and help the children processing all their emotions:

" (...) what do I bring with me from my upbringing and am I aware of which signals I'm sending [to my child with my behavior]? Because it has to be okay [for my daughter] to reach out to me for help, regardless of what kind of feelings she experiences." (Emma)

Changes achieved through the intervention

As Emma so well expressed: "Children do the best they can, when they can!" Children communicate through their behavior on a frequency that adults sometimes find incomprehensible. However, children do not adopt behaviors to annoy adults or demand attention; rather, they communicate their needs in the relationship and a sincere desire to connect with their parents (11).

The components of change in parents in this study share some common features: "Shark music," awareness of dysfunctional patterns from one's upbringing, and reflections on one's parenting approach. This self-awareness is crucial in creating the opportunity to take different actions toward the child, resulting in positive changes in the parent–child interaction. Thus, previous challenges and conflicts with the child are no longer experienced as overwhelming or disruptive to the parent–child interaction, but as situations that parents can manage without the communication escalating or breaking down. After the intervention, parents are better able to remain present in interactions with their child and communicate through their own behavior that they take adult responsibility and act as "bigger, stronger, wiser, and kind." In this role, parents take responsibility for the interaction, which fosters a sense of security in the child and contributes to changes in the parent–child relationship as experienced by the parents.

Components that can get in the way of change

The therapists are univocal about the barriers preventing some parents from experiencing changes after participating in COS-P. The ability to mentalize is a prerequisite for understanding one's own and others' behavior based on psychological states. Therefore, if parents are not able to reflect on the thoughts, feelings, and needs that may underlie their children's behavior, it makes communication and interaction difficult (11, 22) and thus becomes an inhibiting factor. Some parents have great difficulty looking at themselves and their role in the parent–child relationship because of their own defense mechanisms and may experience this process as threatening. In the following discussion, we emphasize the findings of our study and discuss them in relation to existing research within the field.

Discussion

In our analysis, we identified three key components that parents experience as contributing to change and improvement in the parent–child relationship. First, increased awareness and visualization of the child's behavioral communication within the circle. This finding aligns with other qualitative studies (14, 17), suggesting that such awareness shifts parents' focus from perceiving behavior as attention-seeking to recognizing the child's valid needs for connection—needs that must be met consistently by caregivers.

This "new way of being parents," as expressed by Charlotte and Ann, involves interpreting the child's behavior as an emotional pattern reflecting unmet relational needs. Several parents described this shift. In line with previous studies, this insight appears to be both surprising and empowering for parents (13, 16), and supports the hypothesis that the intervention enhances parental sensitivity to children's signals and needs (3).

Secondly, parents described how this new way of parenting could be disrupted. When their own "shark music" and unconscious discomfort take over, it interferes with their responsiveness toward the child. This understanding, together with the recognition of how their own childhood experiences shape current parenting, is also described by Kim et al. (2018), who found a 75% correspondence between parent and child attachment styles. This suggests that parents may unconsciously transmit internalized attachment representations across generations. In our study, this realization led to increased awareness among several parents, who actively sought to change inherited patterns and respond as "bigger, stronger, wiser, and kind" caregivers (13, 15, 22). When children are able to express emotions safely without eliciting negative parental responses, they are more likely to use caregivers as a secure base and experience greater relational comfort (23).

Thirdly, the ability to mentalize emerged as a key prerequisite for change. Parents need to reflect on their own behavior from an external perspective and understand the child as an intentional agent. Observable behavior must be interpreted in light of underlying mental states, rather than reduced to symptoms alone. This requires attention to the dyadic nature of the parent–child interaction (17, 24).

In its basic form, COS-P is presented as relevant for parents, regardless of gender, child age, or cultural background (14). However, two parents in our study found the intervention insufficient, either due to the severity of their challenges or because the child received a diagnosis during the process. This contrasts with other participants whose children also had diagnoses, most commonly ADHD, suggesting that the presence of a diagnosis alone does not explain variability in perceived benefit. Gilhooly (2018) and Muddle et al. (2021) highlight that COS-P may be particularly beneficial for parents of children with ASD, ADHD, or other developmental difficulties.

A central mechanism of change in the parent–child interaction appears to be the shift in parental perspective: separating the child from the unwanted behavior and reframing behavior as an expression of relational needs. However, recognizing one's own role in this process requires emotional vulnerability and sustained self-reflection, which may be demanding for some parents. For families with more complex or entrenched relational difficulties, this process may exceed what can be achieved within COS-P's relatively brief format—typically delivered in 8 sessions (10 sessions in the RCT)—compared to the more intensive 20-session Circle of Security intervention.

Future research should examine which parent groups benefit most from COS-P and whether assessing parental mentalizing capacity prior to intervention may be useful. In addition, it would be relevant to investigate whether adaptations such as extended formats or follow-up sessions improve outcomes for families with more complex needs. Several studies emphasize that COS-P “is not for all” parents, highlighting the need to better understand “what works for whom” (12, 14, 17, 23, 25). This was also reflected in our findings, where therapists noted that parents with greater introspective capacity, awareness of psychological defenses, and emotional regulation skills tended to benefit more.

Overall, our findings indicate that COS-P contributes to meaningful change in the majority of the interviewed parents, particularly by reshaping their understanding of their child's behavior and strengthening relational responsiveness. However, outcomes vary depending on parental capacities and contextual complexity. Importantly, this study is part of a larger RCT (3), and the present analysis focuses specifically

on parent–child interaction dynamics. The interviews did not include data on SES, attachment styles, or parental psychopathology. Across narratives, parents described high levels of conflict and frustration prior to referral. Similar patterns of relational chaos are reported by Reay et al. (2019) (25). COS-P's non-pathologizing, attachment-based psychoeducational approach may therefore be particularly valuable, as it builds on parental strengths and has demonstrated benefits across diverse socio-economic contexts (26).

Clinical Significance

This study is the first of its kind within a Danish child psychiatric context (3), where the parent–child relationship is rarely a central treatment focus. Children referred to child psychiatry show higher rates of insecure attachment than the general population (6–9), underscoring the need for relational interventions.

Parents in our study consistently reported a longstanding search for effective tools, often spanning several years before receiving support. During this period, parents frequently lack structured guidance despite experiencing significant daily challenges.

In this context, COS-P represents a clinically meaningful and pragmatic intervention. As a brief and cost-effective program, it can be implemented in municipal settings and offered at the first signs of emotional, relational or behavioral difficulties, rather than delayed until diagnostic clarification.

As a transdiagnostic parent training, COS-P equips parents with fundamental skills in understanding behavior as communication and in regulating both their own and their child's emotions. These competencies are essential across diagnostic categories and are particularly critical for families experiencing frequent conflict. While receiving a diagnosis can offer psychoeducation, it does not in itself provide parents with the practical strategies needed to manage everyday emotional regulation challenges.

Early access to COS-P may therefore help families manage everyday life, reduce conflict, and strengthen the parent–child relationship. As such, COS-P holds potential as a supportive intervention before, during, and after psychiatric assessment, and may function as an accessible early intervention that helps prevent the escalation of difficulties over time (16).

Limitations

This study has several limitations. The sample was self-selected, and information on non-participants is lacking. Additionally, most participants expressed high enthusiasm for COS-P, which may have influenced their responses.

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Conflicts of Interest

The authors report no conflicts of interest.

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