

Identifying Latent Profiles of Family-Wide Dynamics:
Associations with Child and Caregiver Mental Health
by
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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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Abstract

Family functioning and the mental health and wellbeing of individual members are intricately connected and intertwined. However, the conceptualization of mental health concerns based on relational patterns remains underutilized within clinical practice. Moreover, most family research focuses on dyadic processes, often overlooking broader family-wide phenomena and within-family differences. To address these limitations, the present study identified latent profiles of family functioning, based on indicators relating to family subsystems and contextual factors. Subsequently, latent profiles were used to predict child and caregiver mental health. Participants came from two samples with harmonized measurement: one general population cohort ($n = 549$ families) and one cohort from a family-based psychological clinic ($n = 124$ families). After identifying latent profiles, child and caregiver mental health outcomes at a later time (i.e., 18 and 12 months, respectively) were examined as a function of profile. The distribution of covariates was also examined across profiles. Results of this study support the presence of heterogeneity in family dynamics in two populations. Four profiles emerged in the general population sample: Higher Functioning, Moderate, Couple Distress, and High Conflict. Three profiles emerged in the treatment-seeking sample: Higher Functioning, Couple Distress, and Child/Sibling Tension. In both samples, profile membership predicted later child and caregiver outcomes. This study's findings demonstrate the importance of studying family processes across multiple relational subsystems. Moreover, results support the utility of person-centered approaches and their applications towards clinical conceptualizations and tailored interventions.

Keywords: family systems, family functioning, relational subsystems, relational diagnosis, precision mental health, person-centered analysis

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Table of Contents

Author’s Declaration.....	ii
Abstract.....	iii
Acknowledgements.....	iv
List of Figures.....	vii
List of Tables.....	viii
Introduction.....	1
Theoretical Models of the Family.....	1
Family Functioning.....	2
Building Blocks of the Family System.....	5
Correlates of Family Functioning: Individuals and Subsystems.....	7
Relational Subsystems Influence Individuals.....	7
Relational Subsystems Influence Each Other.....	9
Family Assessment within Children’s Mental Health.....	10
Family Functioning in Clinical and Non-Clinical Families.....	10
Integrating Families Within Interventions.....	11
Relational Health & Diagnosis.....	12
Alternative Classification Systems.....	14
Person-Centered Approaches to Family-Wide Science.....	15
Variable- and Person-Centered Research Approaches.....	16
Latent Profile Analysis.....	16
Precision Mental Health.....	18
The Present Study.....	19
Methods.....	21
Participants and Procedure.....	21
General Epidemiological Sample.....	21
Treatment-Seeking Sample.....	25
Measures.....	29
Profile Indicators.....	29
Outcome Measures.....	32
Covariates.....	33
Analytical Plan.....	33

Latent Profile Analysis.....	34
Validation Analysis with BCH & Covariates.....	35
Missing Data	35
Results.....	36
General Epidemiological Sample	36
Descriptive Statistics & Correlations of Study Variables	36
Latent Profile Analysis.....	39
Covariates	41
Mental Health Outcomes Across Profiles	44
Treatment-Seeking Sample	46
Descriptive Statistics & Correlations of Study Variables	46
Latent Profile Analysis.....	49
Covariates	51
Mental Health Outcomes Across Profiles.....	52
Discussion.....	55
Representation of Family Functioning by Relational Profiles.....	55
Predictive Validity of Profiles for Mental Health Outcomes	61
Clinical Applications.....	64
Strengths, Limitations, and Future Directions	67
Conclusion	69
References.....	70
Appendix.....	100

List of Figures

Figure 1. Bivariate Pearson Correlations of Study Variables in the CRAMPED Sample 38

Figure 2. Latent Profiles of Family Functioning in the CRAMPED Sample 41

Figure 3. Caregiver Mental Health Outcomes as a Function of Profile in the CRAMPED Sample
..... 44

Figure 4. Child Mental Health Outcomes as a Function of Profile in the CRAMPED Sample ... 46

Figure 5. Bivariate Pearson Correlations of Study Variables in the EFFT Sample 48

Figure 6. Latent Profiles of Family Functioning in the EFFT Sample 51

Figure 7. Caregiver Mental Health Outcomes as a Function of Profile in the EFFT Sample 53

Figure 8. Child Mental Health Outcomes as a Function of Profile in the EFFT Sample 54

List of Tables

Table 1. Sociodemographic Characteristics of Caregivers at Study Baseline in the CRAMPED Sample.....	22
Table 2. Sociodemographic Characteristics of Children at Study Baseline in the CRAMPED Sample.....	24
Table 3. Household Sociodemographic Characteristics at Study Baseline in the CRAMPED Sample.....	24
Table 4. Sociodemographic Characteristics of Caregivers at Study Baseline in the EFFT Sample	26
Table 5. Sociodemographic Characteristics of Children at Study Baseline in the EFFT Sample	28
Table 6. Household Sociodemographic Characteristics at Study Baseline in the EFFT Sample .	28
Table 7. Descriptive Statistics of Indicator Variables at Study Baseline in the CRAMPED Sample	36
Table 8. Descriptive Statistics of Outcome Variables at 18 Month Follow-Up in the CRAMPED Sample.....	37
Table 9. Fit Statistics for Models with Two to Six Latent Profiles in the CRAMPED Sample....	39
Table 10. Multinomial Logistic Regression Model Examining Covariate Predictors of Family Latent Profiles in the CRAMPED Sample.....	43
Table 11. Descriptive Statistics of Indicator Variables at Study Baseline in the EFFT Sample ...	47
Table 12. Descriptive Statistics of Outcome Variables at 18 Month Follow-Up in the EFFT Sample.....	47
Table 13. Fit Statistics for Models with Two to Six Latent Profiles in the EFFT Sample.....	49

Table 14. Multinomial Logistic Regression Model Examining Covariate Predictors of Family Latent Profiles in the EFFT Sample.....	52
Table 15. Mean Scores and Standard Deviations on Indicators Across Four Latent Profiles of Family Dynamics in the CRAMPED Sample.....	100
Table 16. Mean Scores and Standard Deviations on Caregiver Mental Health Outcomes Four Latent Profiles of Family Dynamics in the CRAMPED Sample.....	101
Table 17. Mean Scores and Standard Deviations on Child Mental Health Outcomes Four Latent Profiles of Family in the CRAMPED Sample	101
Table 18. Mean Scores and Standard Deviations on Indicators Across Three Latent Profiles of Family Dynamics in the EFFT Sample.....	102
Table 19. Mean Scores and Standard Deviations on Caregiver Mental Health Outcomes Four Latent Profiles of Family Dynamics in The EFFT Sample	103
Table 20. Mean Scores and Standard Deviations on Child Mental Health Outcomes Four Latent Profiles of Family Dynamics in the EFFT Sample.....	103

Introduction

Relational processes within families play a crucial role in child development and wellbeing (Cox & Paley, 1997; Davies & Coe, 2019). When individual family members are doing well, the overall functioning of the family system tends to improve, and vice versa (Browne et al., 2015; Pillinger et al., 2024). Despite this understanding, relational diagnosis remains underutilized within prominent classification systems, such as the Diagnostic and Statistical Manual of Mental Disorders (Wamboldt et al., 2015). Additionally, much research within family clinical science focuses on dyadic processes, often overlooking broader family-wide phenomena. This is a limitation, as difficulties in one subsystem can carry over into another subsystem through a process referred to as *spillover* (Repetti & Bai, 2025). Person-centered approaches, such as latent class/profile analysis, can offer a promising solution by identifying heterogeneous patterns of functioning across family subsystems (Lanza & Rhoades, 2013). To address this gap, the present study identified latent profiles of family functioning, based on indicators for relational subsystems and contextual factors. Profiles were derived from general population and treatment-seeking cohorts. Furthermore, these profiles were used to examine predictive validity for child and caregiver mental health outcomes at a later timepoint.

Theoretical Models of the Family

Families play a central role in shaping healthy child development, from early infancy through later adolescence. From an ecological systems framework, the family is situated within the microsystem, one of the most immediate and influential environments in a child's life (Bronfenbrenner, 2000). As such, family dynamics directly shape children's experiences and development, through ongoing and reciprocal interactions. The familial environment acts as the first context in which children form attachments, develop close relationships, and regulate

emotions, providing a safe environment for them to explore and learn about the world (Davies & Coe, 2019). Many factors can contribute to a family's overall health and functioning, such as how individuals communicate with each other, parenting practices, and conflict management (Epstein et al., 1978; Olson, 2000).

Family Functioning

A key component of families' overall health is often described using the generic term "family functioning". This construct is often operationalized as how well a family can support the needs of its members through clear communication, appropriate roles, emotional connection, flexibility, and effective problem-solving. Three prominent frameworks of family functioning, with particular relevance to the current project, are the McMaster, Olson Circumplex, and Walsh Family Resilience models (Epstein et al., 1978; Olson, 2000; Walsh, 2003).

The McMaster Model of Family Functioning (Epstein et al., 1978) outlines six key interconnected dimensions, allowing for the assessment of complex family dynamics: problem-solving, communication, roles, affective responsiveness, affective involvement, and behaviour control. The domain of *problem solving* encompasses a family's ability to effectively resolve challenges, including identifying the problem, communicating with each other about a solution, and monitoring the outcome following action. *Communication* describes the clarity and directness in which families exchange information. *Family roles* refer to the recurring patterns through which members carry out responsibilities and contribute to the functioning of the family, including those that are necessary for healthy family functioning and others that may be less frequent, and if roles are well defined. *Affective responsiveness* represents the capacity to respond to an individual or situation with the appropriate emotional response, while *affective involvement* captures the level of interest family members show to each other and their interests.

Lastly, *behaviour control* describes the ways in which families monitor and maintain behaviours and maintain standards, within and outside the familial context.

An overlapping model of family functioning, which integrates foundations from various frameworks of family systems theory, is the Circumplex Model of Marital and Family Systems (Olson, 2000). This model's two pillars are cohesion and flexibility. Within this model, family *cohesion* represents the emotional closeness between family members, with an important balance of independence and togetherness. *Flexibility* refers to the balance between stability and changes in a family's roles, relationships, and leadership. An interesting component of this model is that moderate or average amounts of these dimensions are thought to be most adaptive. For instance, in terms of cohesion, it is possible for a family to be too cohesive (e.g., enmeshed), or for there to be too little (e.g., disengaged). The same is true for flexibility, which may run from chaotic to rigid. Thus, family processes are understood largely as combinations of the orthogonal dimensions of cohesion and flexibility (e.g., chaotically disengaged; rigidly enmeshed), where balance on both dimensions are viewed as most adaptive. The dimension of communication is also held within this framework, and viewed as facilitative of family processes, wherever they fall within the overarching circumplex.

Relatedly, Walsh (2003) presents a model of family resilience rooted in similar constructs. At its core, family resilience is defined as a family's capacity to withstand and rebound from adversity as a functional unit, supporting positive adaptation. Serious life challenges inevitably impact the entire family and family processes mediate individual members' adaptive or maladaptive responses (Walsh, 2003, 2016b). Resilience is viewed as arising from a combination of a family's *belief systems* (i.e., making meaning of adversity, positive outlook, and transcendence and spirituality), *organizational patterns* (i.e., flexibility, connectedness, and

social and economic resources), and *communication and problem-solving* (i.e., clarity, open emotional expression, and collaborative problem-solving). While these processes are foundational to family resilience, it is equally important to recognize the influence of contextual and sociocultural factors on how resilience is understood and enacted. Families vary in their structures, values, and resources, and no single model can fully capture optimal family functioning and resilience. Keeping this in mind, the Walsh model has been applied in a range of contexts. Clinically, it has informed strengths-based assessment and guided various therapeutic orientations for intervention (Walsh, 2016a). Beyond clinical practice, it has also shaped development of broader frameworks within contemporary psychology. For example, the COVID-19 Family Disruption Model draws upon Walsh's emphasis on communication, organization, and belief systems to support positive family adaptation during the pandemic (Browne et al., 2021; Shoychet et al., 2023). Overall, the Walsh model offers an adaptable approach to understanding family resilience, emphasizing internal processes while also considering external influences.

The domains encapsulated by the Walsh, Olson, and McMaster models have demonstrated associations with improved family functioning and family members' wellbeing. Effective communication within a family has been linked to greater family satisfaction, improved wellbeing of children and caregivers, and stronger peer relationships for children (Akhlaq et al., 2013; Koerner & Fitzpatrick, 2002; Schrodtt, 2009; Theiss, 2018). Additionally, a balanced level of family cohesion has been associated with positive child outcomes, such as fewer internalizing and behavioural concerns and improved self-esteem (Cooper et al., 1983; Lucia & Breslau, 2006). Similarly, responsive and warm parenting has been positively linked with children's cognitive, social, and emotional development (Davidov & Grusec, 2006; Eshel et al., 2006; Landry et al., 2006). While these frameworks highlight the importance of specific family

processes, a more comprehensive understanding of family functioning also requires a broader, systemic perspective that considers the complex interactions among family members and subsystems.

Building Blocks of the Family System

A family-wide approach to research is crucial, as it recognizes families as dynamic, interconnected entities, including individuals, subsystems, and the whole family (Browne et al., 2015). Bowen's (1978) Family Systems Theory emphasizes the importance of considering the family as a whole and its interconnected nature. Similar to Olson's (2000) view, Bowen emphasizes the importance of wholeness and order, suggesting that the whole family unit is *greater than the sum of its parts* (Fiese et al., 2019). The family is thought of as an open system, interacting with its members and environment. Each family member is embedded within the larger system and cannot be fully understood outside that context (Cox & Paley, 1997). It is therefore important to consider the various hierarchical levels within the family system—namely, the individual, subsystem, and whole-family levels (Browne et al., 2015). By examining both shared (i.e., family-wide) and nonshared (i.e., individual-specific) environments and processes, researchers can begin to untangle dynamics that may be unique to a specific family member from those that apply to the entire family (Jenkins & Bisceglia, 2010). For example, siblings in the same family may experience parenting differently, reflecting variability in the caregiver-child interactions. Further distinctions can also be made between individual-specific, dyadic, and family-wide processes and influences on the family (Browne et al., 2015). Taking a multilevel perspective not only enhances our understanding of complex family systems but also strengthens our ability to detect meaningful between- and within-family differences. The study of differences

within families—beyond between-family comparisons alone—is essential to forming a holistic understanding of risk and resilience factors, and their cascading influences on family members.

The family systems perspective emphasizes the bidirectional and transactional nature of relationships within the family, underscoring the influence of family members on each other. Changes in one relational domain—such as the caregiver-child, marital, or sibling relationship—can affect other relational domains, but also the entire family unit (Bowen, 1978; Fiese et al., 2019). As such, it is crucial to consider the entire family within children’s mental health research. Family systems theories have been applied within the context of clinical work for decades (P. Minuchin, 1985). For example, Minuchin’s (1974) Structural Family Therapy (SFT) emphasizes the importance of healthy boundaries, supporting a balance between cohesion and individuality, within and across subsystems. This therapeutic orientation works by strengthening overly diffuse or loosening overly rigid boundaries within the family system and can be applied to a diverse range of presenting concerns. Drawing from SFT, the Biobehavioural Family Model (BBFM) suggests that relational family patterns reinforce the structure of relationships and individual family members’ wellbeing (Wood, 2023). Based on the idea that relational processes can either exacerbate or buffer against challenges, the BBFM proposes that intervening on any given dysfunctional relational process will lead to improvements across other dimensions and within the entire family. Accompanied by a related assessment tool, this model provides a guiding structure to family assessment, including understanding areas of relational challenges within a family and how they contribute to the presenting concerns (Wood, 2023). Altogether, these frameworks reinforce the importance of conceptualizing child and caregiver wellbeing within the context of the family system.

Correlates of Family Functioning: Individuals and Subsystems

The quality of relationships within families, or relational health, is a foundational component of child development, shaping attachment security, social functioning, and long-term wellbeing (Davies & Coe, 2019). High quality relationships are essential to fostering healthy development, with the caregiver-child relationship being especially formative in early years. The quality of this relationship is shaped by both caregiver and child characteristics. At the caregiver level, these include psychosocial resources, personality traits, and mental health concerns (Belsky, 1984; McCabe, 2014; Möller et al., 2015; Prinzie et al., 2009). At the child level, contributing factors include temperament, age, and special health care needs, including physical and mental health (Cousino & Hazen, 2013; Gallitto, 2015; Hayes & Watson, 2013; Morawska et al., 2019). Additionally, non-parental caregivers (e.g., grandparents, extended family members, friends) can also play an important role in a child's development, providing additional resources of social support and stability, though there are variations across cultural groups (Dressler, 1985; Ensor & Hughes, 2010; Hayslip & Kaminski, 2005; Jæger, 2012; Kang & Cohen, 2017).

Relational Subsystems Influence Individuals

The quality of relational systems within the family (e.g., caregiver-child, marital, sibling) has well-established associations with individual family members' wellbeing. Secure attachment in the caregiver-child relationship is linked to a range of positive socioemotional and health outcomes for children, including greater empathy, social competence with peers, school readiness, and fewer physical health conditions (Cassidy et al., 2013; Groh et al., 2014; Ranson & Urichuk, 2008). Caregivers also benefit from positive relationships with their children, reporting higher levels of wellbeing and life satisfaction (Nelson et al., 2014; von Kraemer et al., 2024). In contrast, difficulties in the caregiver-child relationship, including insecure attachment,

high conflict, and low warmth, were associated with increased child depression, anxiety, and delays in cognitive development (Cuevas et al., 2014; Lei et al., 2023; J. Li et al., 2025; Zhou et al., 2023). These challenges can also negatively impact caregivers, with conflict in the caregiver-child relationship linked to increased parenting stress, anxiety, and psychological distress (Du et al., 2024; Nelson et al., 2014).

Similarly, marital relationship quality plays a crucial role in shaping both caregiver and child outcomes. Positive marital relationships were associated with increased caregiver wellbeing and satisfaction (Iwasa et al., 2024; Proulx et al., 2007), while marital conflict was linked to elevated parenting stress, depressive symptoms, and physical health problems (Choi & Marks, 2008; Lin et al., 2017). For children, higher marital relationship quality was linked with better adjustment, stronger social skills, and improved memory performance (Hosokawa & Katsura, 2017; McCoy et al., 2013; Zemp et al., 2021). Conversely, marital conflict was associated with increased depressive and anxious symptoms, weaker cognitive performance, and sleep disturbances for children (Adare et al., 2021; Buehler et al., 2007; Rhoades et al., 2012).

The sibling relationship also contributes meaningfully to child development, offering both protective and harmful effects on children's wellbeing. Warm and supportive sibling relationships were linked with better emotion regulation, self-esteem, and social skills, while also buffering against negative impacts of parental conflict (Buist & Vermande, 2014; Morgan et al., 2012; Turgeon & Bureau, 2022). However, sibling relationships marked by low warmth and high aggression were linked with increased internalizing and externalizing concerns, loneliness, lower self-esteem, and intensified the impact of parental conflict (Buist & Vermande, 2014; Turgeon & Bureau, 2022). These findings emphasize the interdependence of family subsystems and

highlight how relational quality within and across subsystems can shape the socioemotional and physical wellbeing of both children and caregivers.

Relational Subsystems Influence Each Other

The relational health perspective, grounded in family systems theory, emphasizes the interconnectedness of family members and the bidirectional, transactional nature of family relationships (Frosch et al., 2021). Within this framework, caregivers influence children, children influence caregivers, and caregiving adults influence each other. Given this mutual influence, it is essential to consider not only the caregiver-child relationship but also the relationships between caregiving adults (i.e., subsystems beyond the parent-child dyad). Moreover, the quality of one relationship within the family system may influence the quality of other relationships, highlighting the dynamic interplay among subsystems.

Two key concepts within the family systems literature—spillover and compensatory processes—capture how stressors can shift across relational subsystems (Engfer, 1988; Erel & Burman, 1995). *Spillover* refers to the transfer of tension from one relationship to another, such as when marital conflict leads to reduced parenting quality. Conversely, *compensatory* processes occur when individuals increase their investment in one relationship to offset difficulties in another. Both processes often arise in the context of the marital and caregiver-child subsystems. For example, Gao and Cummings (2019) found that daily marital challenges were linked to lower parenting quality on the same day via spillover, but resulted in higher parenting quality the next day, as a compensatory response. Similarly, Ramos and colleagues (2022) observed transactional effects between child behaviour, the parenting relationship, and the marital relationship, wherein child anger resulted in increased interparental conflict and decreased interparental warmth.

The sibling relationship also interacts bidirectionally with other subsystems in the family (Bucsea et al., 2025). For instance, greater parental warmth and involvement were associated with positive sibling relationships (Feinberg et al., 2012; McHale et al., 2000). Similarly, caregiver involvement in teaching their children effective conflict resolution strategies fostered healthier sibling interactions (Perlman & Ross, 1997). In contrast, when children felt less accepted by their caregivers, experienced greater parental differential treatment, and spent less time with their fathers, the frequency of sibling relational aggression increased (Updegraff et al., 2005). Conflict in the caregiver-child relationship was also linked to increased sibling conflict (Volling & Belsky, 1992). Moreover, caregivers were found to utilize different conflict resolution strategies based on the frequency of sibling conflict (Updegraff et al., 2005).

The quality of these interconnected family relationships contributes to the broader family functioning and can shape the emotional climate in which a child develops. Many elements contributing to family functioning like communication, problem-solving, and affective response also play important roles within individual subsystems (Cox & Paley, 1997; Farrell & Barnes, 1993). These patterns highlight the importance of viewing family relationships as part of a dynamic and interdependent system, where change in one subsystem ripples across others.

Family Assessment within Children's Mental Health

Family Functioning in Clinical and Non-Clinical Families

Family functioning often differs across clinical and non-clinical populations (Friedmann et al., 1997; Sawyer et al., 1988; Trangkasombat, 2006; J. Wang et al., 2013). For instance, having a family member with a psychiatric diagnosis increased the chances of worse family functioning across domains, compared to non-clinical families (Friedmann et al., 1997). This included challenges in areas of communication, problem solving, affective responsiveness and

expression, among others. These difficulties may reflect emotional or logistical demands placed on families navigating mental health concerns, which can put a strain on daily family functioning and relational dynamics. Moreover, the quality of caregiver-child relationships was found to be lower in a clinical sample, compared to non-clinical families (Dollberg et al., 2010; Noller et al., 1992; Willemen et al., 2008). Relationships in the clinical samples were generally characterized by lower intimacy and warmth, higher conflict, and challenges in affect regulation. This suggests that children's mental health challenges may influence attachment processes and responsiveness. Taken together, these findings emphasize the importance of attending to family-level processes in clinical contexts, as difficulties in family functioning may contribute to the maintenance or exacerbation of mental health challenges.

Integrating Families Within Interventions

A strong understanding of family dynamics is essential when conceptualizing child mental health concerns. As previously discussed, family dynamics play a foundational role in shaping children's mental health and wellbeing. While family-related factors can contribute to the development or maintenance of mental health concerns and psychopathology, they also offer beneficial points of intervention. In fact, many effective interventions for child mental health actively involve the family, across various therapeutic orientations. Innovative interventions including family members have demonstrated success across a range of child concerns—including conduct and externalizing disorders, internalizing disorders, eating disorders, and even early-onset psychosis (Carr, 2019). These systemic approaches can be delivered by individual clinicians, interdisciplinary teams, or through structured psychoeducation (Hoagwood et al., 2010). These models are both feasible and generalizable, as interventions are often brief and the skills taught can be applied across multiple presenting concerns. Despite the growing use of

family-wide interventions, it remains less common for relational challenges to be explicitly included in the formulation or diagnosis of children's mental health concerns.

Relational Health & Diagnosis

From a public health perspective, early relational health emphasizes the importance of responsive and reciprocal interactions between children and caregivers that are culturally grounded and foster optimal development and wellbeing (Opie et al., 2023). Like any behaviours, relational health and dynamics can range from healthy to dysfunctional. Relational diagnosis refers to the conceptualization of mental health concerns based on relationship patterns, rather than individual factors alone (Kaslow, 1996; Mudry & Gosnell, 2021). Challenges in relational domains contribute to individuals' wellbeing and their own mental health challenges. While widely utilized classification systems like the Diagnostic and Statistical Manual of Mental Disorders (DSM) include predetermined criteria for disorders, it is also essential to consider the level of impairment experienced by relational entities (i.e., families).

Although the conceptualization of families as systems and the importance of relational health are well established, the classification of problematic relational patterns within the family has remained a longstanding issue (Denton, 2007; Kaslow, 1996). Family therapists have long argued that only including classifications for disorders at the individual level excludes concerns relating to dysfunctional relational patterns (Kaslow & Patterson, 2006). Moreover, it fails to consider contextual relational information that may also contribute to individual challenges. Over the last few revisions of the DSM, the classification of relational patterns has often been overlooked. The DSM-IV was organized in a multi-axial system with five axes. Axis I was the primary axis and described mental health and substance use disorders, while Axis IV classified "Psychosocial and Environmental Problems" which included relational problems (Beach et al.,

2006). To provide further details to an Axis I diagnosis, a clinician had the option to include a V Code, some of which specified relational concerns (e.g., parent-child relational problem, partner relational problem, and sibling relational problem). However, these were rarely a primary focus within conceptualization and diagnosis and were often underutilized in clinical practice. Moreover, the DSM-IV first introduced the Global Assessment of Relational Functioning (GARF) scale in its appendix (Wamboldt et al., 2015). Included as a measure needing further testing, the GARF may have been underutilized due to its inclusion in the appendix, rather than within a more prominent section of the DSM. Despite numerous efforts from working groups composed of family psychologists, relational concerns remained a peripheral inclusion in the DSM-5. Following its revision, the DSM-5 eliminated the multi-axial system and integrated all disorders into a unified classification system. Relational concerns are now categorized as Z Codes—similar to V Codes—under the section for “Other Conditions That May Be a Focus of Clinical Attention” (American Psychiatric Association, 2013).

The current classification of relational problems remains a key concern for family therapists, particularly in how it shapes communication and intervention. Clinicians depend on clear, shared language to describe relational dynamics to the families they work with, fostering a sense of mutual understanding and collaboration (Beach et al., 2006; Strong, 2015). While there are some concerns around diagnoses—such as the potential for stigma or misplaced blame—diagnostic frameworks are often viewed as helpful tools for articulating complex patterns. Perhaps most importantly, diagnoses are often accompanied by various treatment options, which can provide families with a sense of direction and hope. However, despite potential benefits, the language used to formulate relational problems remains inconsistent across settings and

providers. This lack of standardization can lead to variation in how relational problems are conceptualized and ultimately addressed in treatment.

Alternative Classification Systems

While relational diagnosis has not been fully recognized and integrated by major classification systems like the DSM, alternative frameworks have been developed to address this gap. One such model is Karl Tomm's "IPscope," an assessment tool designed to classify interpersonal patterns (Tomm, 2014). These patterns are defined as recurrent interactions between two or more individuals, marked by mutually reinforcing patterns of behaviours, attitudes, feelings, ideas, or beliefs. The IPscope identifies six major types of interpersonal patterns—pathologizing, wellness, healing, deteriorating, transforming, and socio-cultural—which capture both constructive and problematic relational dynamics. A key strength of this framework is its emphasis on challenges lying within the interpersonal patterns, rather than the families themselves, thereby reducing stigma and shifting the blame away from individual family members (Tomm, 2014).

Another important classification system is the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3), which has since been updated to include children up to five years old (DC:0-5). Developed by the National Center for Clinical Infant Programs, this system provides a developmentally sensitive framework for classifying mental health concerns in very young children (Zero to Three, 2005, 2016). Notably, Axis II focuses on Relationship Classification, which aims to understand various behaviours across key caregiving relationships. This includes relational disorders such as overinvolved, under-involved, anxious/tense, angry/hostile, mixed relationship disorder, and abusive (Zero to Three, 2005, 2016). Together, these alternative systems highlight the value of relationally

focused diagnostic frameworks and classifying problems at the level of relationships, rather than individuals.

Moreover, the Inventory of Interpersonal Problems (IIP) is a self-report instrument designed to identify an individual's interpersonal difficulties (Horowitz et al., 1988). The IIP was developed based on the Interpersonal Circumplex (IPC) model, which conceptualizes interpersonal behaviour along two orthogonal, bipolar dimensions: dominance (dominant vs. submissive) and affiliation (warm vs. cold). These dimensions form a circular structure generally divided into eight octants, each representing a distinct interpersonal style (Boudreaux et al., 2018; Gurtman, 1992). Drawing from this framework, the original IIP included 127 items grouped into six subscales: assertive, sociable, intimate, submissive, responsible, and controlling (Horowitz et al., 1988). This was later revised into a 64-item version, with items equally divided across eight subscales, mapping onto the IPC: dominant, intrusive, dependent, exploitable, non-assertive, social inhibited, cold, and competitive (Boudreaux et al., 2018). These subscales allow clinicians to identify specific patterns of interpersonal challenges, providing insight that can guide targeted interventions to improve relational functioning.

Person-Centered Approaches to Family-Wide Science

Understanding family systems and complex relational dynamics requires careful consideration of methodological approaches. Although a range of analytical approaches exist, much of the existing research has focused on specific relational subsystems—most commonly the mother-child dyad. While these studies have contributed significantly to the field, they may offer only a partial view of the family system. As Tolstoy (2002) famously wrote, “Happy families are all alike; every unhappy family is unhappy in its own way.” This notion highlights

the growing recognition that different families may exhibit qualitatively different relational patterns, highlighting the importance of person-centered approaches.

Variable- and Person-Centered Research Approaches

In the context of family science, variable-, case-, and person-centered approaches offer different, yet valuable information (Mandara, 2003). Variable-centered approaches help uncover nomothetic processes through predominantly quantitative methods, by reducing systems (e.g., families) to specific variables of interest (e.g., warmth). These approaches provide valuable information about major elements within a system, yet there are some limitations. Most notably, variable-centered methods assume the associations between variables of interest hold true across populations. In contrast, case-centered approaches examine the interactions of the various components within a system for a given individual or family. The rich qualitative information obtained from these methods can be especially useful in clinical contexts. However, there are also limitations, as with variable-centered approaches. Particularly, generalizability of case-centered research is limited due to the idiographic nature of individuals. Moreover, there can be concerns with internal validity of these approaches, due to researcher bias. Person-centered research offers a balance between variable- and case-centered approaches, by retaining information on behaviour and systems interactions while also yielding generalizable findings based on quantitative measures, by reducing within-group variance (Mandara, 2003).

Latent Profile Analysis

Latent profile analysis (LPA) is a person-centered, data-driven mixture modeling approach used to identify heterogeneous, unobserved (i.e., latent) subgroups within a sample based on patterns across observed indicators (Collins & Lanza, 2010). The resulting subgroups represent individuals who are most similar to each other and most different from others in

different subgroups (Petersen et al., 2019). In family clinical science, LPA has been applied in several meaningful ways. Profiles of family functioning have been linked with various outcomes including adjustment and disruptive behaviour in school-aged children, school readiness, adolescent internalizing symptoms, and substance use patterns (Browne et al., 2018; Cordova et al., 2014; Racz et al., 2016; Simpson et al., 2018; Sturge-Apple et al., 2010). However, existing person-centered research on family functioning often examines one relational subgroup at a time. For example, Simpson and colleagues (2018) explored adolescents' closeness with their mothers, fathers, and overall family satisfaction, along with adolescent outcomes as a function of profile. Similarly, Xia and colleagues (2022) investigated profiles of the mother-father-adolescent triad, while also exploring profiles of change in closeness in the triad over time. Moreover, Withers (2020) examined dimensions of closeness, communication, conflict, and autonomy within the relationship between adolescents and their caregivers. This study also explored depression symptoms in both adolescents and caregivers and adolescent delinquency as outcomes. While these studies provide critical information about the caregiver-child relationship, information about the interaction across relational subsystems remains limited. To address this gap, Tang and colleagues (2022) examined the caregiver-child and sibling relationships concurrently and how they shifted following the COVID-19 pandemic. Interestingly, while they observed temporal changes in relationship quality, both subsystems were generally similar in terms of warmth and conflict. Importantly, person-centered approaches have also been utilized to explore contextual and social factors. For instance, LPA has been used to examine adversity, risk, and resilience within the family context, both as predictors and as outcomes (Barton et al., 2023; Dong et al., 2021; X. Li et al., 2025; Liu et al., 2025; Oshri et al., 2015; C. Wang et al., 2025). Furthermore, LPA has been used to explore youth's social and relational environments, including their

relationships with caregivers, siblings, and peers (Dishion et al., 2019; Han et al., 2025; Lee et al., 2020; Persram et al., 2025; Xia et al., 2022). Such approaches provide valuable insight into the interaction between families, subsystems, and their contexts; however, further research examining the interconnectedness of all major subsystems, and how they collectively shape family functioning, is still needed.

One of the key advantages of LPA is its ability to uncover distinct subgroups within a population that differ in meaningful ways, including those that may be at greater risk for mental health challenges (Petersen et al., 2019). By identifying these subgroups, researchers, clinicians, and policymakers can develop more targeted and effective approaches to prevention and intervention. Additionally, LPA provides information about a given individual's probability of being in a specific subgroup. Despite these benefits, there are critiques to this methodology, including its exploratory nature and variability in selection criteria. Moreover, given LPA's data-driven nature, some argue that identified subgroups may be sample-specific (Petersen et al., 2019). Nevertheless, this approach supports a deeper understanding of families' unique profiles, enabling the development of tailored supports that are well matched to their strengths and needs. Importantly, it also helps in identifying which families are most likely to benefit most from certain interventions—a goal closely aligned with the emerging field of precision mental health (Pelham et al., 2017).

Precision Mental Health

Building on the goals of individualized care, precision mental health seeks to answer the question: “what works for whom?” (DeRubeis, 2019). Originating from principles of precision medicine, this interdisciplinary movement emphasizes tailoring mental health care based on an accurate and dynamic understanding of individuals' needs, characteristics, vulnerabilities, and

preferences (Bickman et al., 2016; Purgato et al., 2021). Through individualized assessment, monitoring, and feedback, precision mental health aims to improve treatment outcomes by matching individuals—or families—with the most effective interventions for their specific presentations (Fonagy et al., 2014). The precision approach can be particularly helpful for family clinical science, where multiple evidence-based interventions exist for a given concern, but none are universally effective. While research has examined moderating factors (e.g., factors that lead to differential outcomes), few studies have examined multiple moderators concurrently. Person-centered approaches, like LPA, may be a solution to better understand how moderators interact to predict treatment outcomes (Bonadio & Tompsett, 2018; Pelham et al., 2017). Ultimately, the application of person-centered methodologies within the precision mental health framework holds promise in understanding complex family dynamics and advancing family-centered care.

The Present Study

Despite extensive literature emphasizing the systemic nature of families and the importance of studying families across multiple hierarchical levels (i.e., individual, subsystem, and whole-family), mixture modeling remains significantly underutilized in family-wide research. Person-centered approaches, such as latent profile analysis, are a powerful tool to uncover heterogeneity within a population, offering between- and within-family insights that variable-centered approaches may overlook. Yet, few studies have applied these techniques to understand the complexity of family functioning across relational subsystems. Even fewer studies have compared family typologies across clinical and non-clinical samples, limiting replicability and generalizability of findings. Moreover, the clinical utility of these methodological approaches has yet to be fully realized. Indeed, relational diagnosis and classification systems remains underutilized in clinical science, limiting the application of

precision mental health approaches at the family level. While this was not examined explicitly in the present study, data were collected during the COVID-19 pandemic, a period which was marked by heightened stress and disruptions for many families. As such, this investigation will provide important insights into family functioning and contextual factors during a unique period.

To address these limitations, using two longitudinal samples with harmonized measurement protocols, the present study aimed to empirically identify underlying subgroups of families based on relational subsystems and examine associations with child and caregiver mental health. The present study was preregistered (<https://osf.io/db95c>) and examined three interconnected research questions: (Q1) How do latent profiles represent variations in whole-family functioning, based on indicators relating to subsystems in the family (e.g., parent-child, marital, sibling, family-wide functioning) and contextual factors (e.g., perceptions of resilience, social supports and socioeconomic resources)?; (Q2) How do the identified latent profiles predict child and caregiver mental health at a later timepoint (i.e., 12 and 18 months later)?; and (Q3) Are there variations in family profiles seen in general population and treatment-seeking cohorts? While these questions were exploratory in nature, I hypothesized that (H1) distinct latent profiles would emerge representing variations in whole-family functioning, that (H2) families experiencing challenges in multiple areas will have the lowest child and caregiver mental health, and that (H3) there will be some evidence of overlap in clinical profiles across the general population and clinical samples, yielding some evidence of replicability.

Methods

Participants and Procedure

Data for this study were drawn from two longitudinal projects that examined various elements of family functioning, child and caregiver wellbeing, and service utilization patterns. Caregivers in both studies completed online Qualtrics® surveys, reporting on themselves, their children (the children reported on varied by cohort), and their family. Domains covered in the surveys included family functioning, relationship quality, mental health, changes related to the pandemic, and service utilization patterns.

General Epidemiological Sample

The first sample was a general epidemiological cohort from the *Child Resilience and Managing Pandemic Emotional Distress in Families* (CRAMPED) study recruited through the Prolific® research panel, with 549 caregivers with at least two children between 5-18 years of age ($n = 1098$ children). Caregivers were required to be at least 18 years old and were selected as the most knowledgeable respondent for their families. Children were required to reside with the responding caregiver, to ensure consistent interactions between family members. As well, caregivers were required to have at least two children to allow for the exploration of sibling relationships. Children were required to be at least five years old, as some measures were not validated for children younger than five. Participants were followed for seven waves of data collection from May 2020 to October 2022. The present study utilized data from baseline (May 2020) and the fifth follow-up, 18 months later (October 2021). The 18-month follow-up was selected because it was the closest in time to the 12-month follow-up period from the clinical sample (described below), thereby providing a recall period of at least one year later. Additionally, this wave had higher retention rate than later waves (see Missing Data).

Data was collected about the primary caregiver (i.e., reporting caregiver), the child closest to five years old (but not younger than five), and the next oldest child after the first child. Caregivers also reported on household characteristics and family-wide functioning.

Participants lived in the United Kingdom (76%), the United States (19%), Canada (4%), and Australia (1%). At baseline, caregivers were 41.33 years of age (SD = 6.33) on average and were primarily female (71%), White (73%), married or common-law (90%), and from two-caregiver households (90%). On average, the youngest child was 9.17 years old (SD = 3.03) and 54% male and the next oldest sibling was 12.14 years old (SD = 3.13) and 50% male. Across the sample, the median annual household income for the previous year (i.e., 2019) was \$50,000-74,999 USD in this sample. For context, in the United Kingdom, the median annual household income was £30,500 for the 2020 fiscal year, or \$38,942 USD, converted based on the 2019 average annual exchange rate of 1.2768 (Board of Governors of the Federal Reserve System (US), n.d.-b; Office for National Statistics, 2021). In the United States, the median annual household income was \$68,703 in 2019 according to the U.S. Census (Semega et al., 2020). Caregiver, child, and household sociodemographic characteristics for the sample are presented in Tables 1, 2, and 3, respectively.

Table 1

Sociodemographic Characteristics of Caregivers at Study Baseline in the CRAMPED Sample

	M	(SD)
Age	41.33	(6.33)
	<i>n</i>	%
Sex		
Female	372	67.76
Male	158	28.78
Unreported	19	3.46
Race		
Asian – East	2	0.36

Asian – South	17	3.10
Asian – South East	9	1.64
Black – African	12	2.19
Black – Caribbean	1	0.18
Black – North American	6	1.09
First Nations	1	0.18
Middle Eastern	1	0.18
White – European	336	61.20
White – North American	61	11.11
Mixed Heritage	12	2.19
Other / Not Listed	10	1.82
Prefer Not To Answer	1	0.18
Unreported	80	14.57
Country of Residence		
Australia	6	1.09
Canada	20	3.64
United Kingdom	418	76.14
United States	105	19.13
Relationship Status		
Lone Parent	44	8.01
Living Apart Couple ^a	8	1.46
Married/Common-Law	497	90.53
Employment Status		
Full-Time	276	50.27
Part-Time	129	23.50
Unpaid Work ^b	93	16.94
Unemployed	14	2.55
Other	17	3.10
Unreported	20	3.64
Education		
Secondary Education (e.g. GED/GCSE)	57	10.38
High School Diploma / A-Levels	87	15.85
Technical / Community College	67	12.20
Undergraduate Degree (BA/BSc/Other)	172	31.33
Graduate Degree (MA/MSc/MPhil/Other)	96	17.49
Doctorate Degree (PhD/Other)	17	3.10
No Formal Qualifications	4	0.73
Don't Know / Not Applicable	1	0.18
Unreported	48	8.74

Note. Percentages may not add to 100% due to rounding.

^a Lone parent at home with romantic partner outside of household

^b Includes homemaker, retired, and disabled.

Table 2

Sociodemographic Characteristics of Children at Study Baseline in the CRAMPED Sample

	Younger Child		Older Child	
	M	(SD)	M	(SD)
Age	9.17	(3.03)	12.24	(3.13)
	<i>n</i>	%	<i>n</i>	%
Sex				
Female	250	45.54	269	49.00
Male	293	53.37	275	50.01
Trans – Male to Female	0	0.00	1	0.18
Other / Not Listed	2	0.36	1	0.18
Unreported	4	0.73	3	0.55

Note. Percentages may not add to 100% due to rounding.

Table 3

Household Sociodemographic Characteristics at Study Baseline in the CRAMPED Sample

	<i>n</i>	%
Number of Children in the Home		
1	15	2.73
2	250	45.54
3	188	34.24
4	76	13.84
5	12	2.19
6	6	1.09
7	0	0.00
8	2	0.36
Number of People in the Home		
2	3	0.55
3	17	3.10
4	228	41.53
5	178	32.42
6	87	15.85

7	16	2.91
8	20	3.64
Annual Household Income Last Year (USD)		
<\$15,000	21	3.83
\$15,000-\$24,999	49	8.93
\$25,000-\$49,999	154	28.05
\$50,000-\$74,999	133	24.23
\$75,000-\$99,999	90	16.39
\$100,000-\$124,999	48	8.74
\$125,000-\$149,999	17	3.10
\$150,000-\$175,999	19	3.46
\$175,000+	17	3.10
Unreported	1	0.18

Note. Percentages may not add to 100% due to rounding.

Treatment-Seeking Sample

The second sample consisted of caregivers who completed a two-day Emotion-Focused Family Therapy (EFFT) intervention to support a child with mental health concerns at a medium-sized, private, outpatient psychological clinic in Toronto, Canada. Clients were offered the EFFT intervention on a sliding scale, with some pro bono spots, based on financial need. Participants included 159 caregivers of 259 children in 124 families. Caregivers were required to be at least 18 years old. Families with children of any ages were allowed to participate in the study; however, least one child in the family was required to be eight years of age or older. Families were recruited on a rolling basis through ongoing cohorts who completed the EFFT intervention every two months. The first cohort started data collection in September 2020 and was followed for five follow-ups, with the final follow-up being in September 2021. The present study utilized data from baseline and the fifth follow-up, 12 months later, as there was an acceptable attrition rate (see Missing Data) and it was the longest period of follow-up.

Data was collected about the primary caregiver (i.e., reporting caregiver) in all families. A second caregiver also responded in 35 families. Caregivers reported on the child presenting

with the most difficulties and up to three other children. Additional children were reported on in order of age, based on closeness to the first child. Analyses primarily included the first and second child reported on, though some analyses involved mean scores across all children (described in more detail within specific measures below). Caregivers also reported on household characteristics and family-wide functioning. Lastly, caregivers also reported on their partners, however, this data was not included in the analyses in the present study.

Caregivers were 46.84 years of age (SD = 7.10) on average, and primarily female (72%), White (72%), and married or common-law (74%). On average, the child for which the family sought out the intervention was 12.42 years old (SD = 4.80). The average age of all other children reported on was 12.30 years old (SD = 5.73). The median monthly household income for the previous year (i.e., 2019) was \$6,601-8,300 CAD, or \$4,975-6,255 USD, converted based on the 2019 average annual exchange rate of 0.7536 (Board of Governors of the Federal Reserve System (US), n.d.-a). For context, in 2019, the median after-tax annual income for Canadian families and unattached individuals was \$62,900 CAD, equivalent to approximately \$5,242 CAD monthly (Statistics Canada, 2021). Caregiver, child, and household sociodemographic characteristics for the sample are presented in Tables 4, 5, and 6, respectively.

Table 4

Sociodemographic Characteristics of Caregivers at Study Baseline in the EFFT Sample

	M	(SD)
Age	46.84	(7.10)
	<i>n</i>	%
Gender		
Woman	115	72.33
Man	40	25.16
Gender Non-Conforming	1	0.63
Unreported	3	1.89
Ethnicity ^a		

Asian – East	13	8.18
Asian – South	16	10.06
Black	5	3.14
Hispanic	4	2.52
Indigenous	3	1.89
Middle Eastern	1	0.63
Pacific Islander	1	0.63
White / European	114	71.70
West Indian	1	0.63
Other / Not listed	10	6.29
Relationship Status		
Lone Parent	21	13.21
Living Apart Couple ^b	8	5.03
Married/Common-Law	117	73.58
Other	9	5.66
Unreported	4	2.52
Education		
Less than High School Diploma	0	0.00
High School Diploma or Equivalent	7	4.40
Trade Certificate or Diploma	2	1.26
College, CEGEP, or Other Non-University Certificate or Diploma (Other than Trades)	26	16.35
University Certificate or Diploma Below the Bachelor's Level	5	3.14
Bachelor's degree (e.g., B.A., B.Sc., etc.)	58	36.48
University Certificate, Diploma, or Degree Above the Bachelor's Level	57	35.85
Unreported	4	2.52

Note. Percentages may not add to 100% due to rounding.

^a Frequencies and percentages may add to more than 100% as caregivers were able to select more than one response option.

^b Lone parent at home with romantic partner outside of household

Table 5***Sociodemographic Characteristics of Children at Study Baseline in the EFFT Sample***

	Primary Child (<i>n</i> = 124)		Other Children ^a (<i>n</i> = 135)	
	M	(SD)	M	(SD)
Age	12.29	(4.71)	12.30	(5.73)
	<i>n</i>	%	<i>n</i>	%
Sex				
Girl	57	45.97	83	61.48
Boy	60	48.39	51	37.78
Transgender Boy	1	0.81	0	0.00
Gender Non-Conforming	6	4.84	0	0.00
Other / Not Listed	0	0.00	1	0.74

Note. Percentages may not add to 100% due to rounding.

^a Includes all other children reported on for the study.

Table 6***Household Sociodemographic Characteristics at Study Baseline in the EFFT Sample***

	<i>n</i>	%
Number of Children in the Home		
1	38	23.90
2	85	53.46
3	25	15.72
4	1	0.63
Unreported	10	6.29
Number of People in the Home		
1	4	2.52
2	11	6.92
3	30	18.87
4	73	45.91
5	32	20.13
6	4	2.52
Unreported	5	3.14
Monthly Household Income Last Year (CAD)		
\$0-\$1,600	3	1.89
\$1,601-\$3,300	8	5.03
\$3,301-\$5,000	18	11.32

\$5,001-\$6,600	16	10.06
\$6,601-\$8,300	28	17.61
\$8,300+	70	44.03
Unreported	16	10.06

Note. Percentages may not add to 100% due to rounding.

Measures

Profile Indicators

Family Dysfunction. Family functioning was measured using the six positive items from the General Functioning Subscale of the McMaster Family Assessment Device (FAD-GF6+; (Boterhoven de Haan et al., 2015; Epstein et al., 1983). This subscale reflects various facets of family functioning, including support, acceptance, and planning. Items were rated on a four-point Likert scale, ranging from “*Strongly Agree*” (1) to “*Strongly Disagree*” (4). Mean scores were calculated, with higher scores indicating greater dysfunction and scores greater than two indicating clinically significant family dysfunction. This measure had good internal consistency (Cronbach’s $\alpha = .87$) in the general epidemiological sample and excellent internal consistency (Cronbach’s $\alpha = .90$) in the treatment-seeking sample.

Parenting Practices. The caregiver-child relationship was assessed using the parenting practices scale from the 2014 Ontario Child Health Study (OCHS), comprised of 10 items adapted from the Parent Behaviour Inventory (Boyle et al., 2019; Lovejoy et al., 1999). The OCHS collected information about the physical and mental health of Ontarian youth aged four to 17 and their families. Five items examined negative parenting practices and five items examined positive parenting practices. Items were rated on a five-point Likert scale, ranging from “*Never*” (1) to “*Always*” (5). Negative items were reverse coded and item scores were summed, with higher scores representing greater parenting quality. In the general epidemiological sample, the internal consistency for this measure was good for the younger child (Cronbach’s $\alpha = .82$) and

for the older child (Cronbach's $\alpha = .83$). In the treatment-seeking sample, the internal consistency for this measure was acceptable for the primary child (Cronbach's $\alpha = .79$) and for the secondary child (Cronbach's $\alpha = .78$). Family-level differential parenting (i.e., the *amount* of favouritism, or the degree of discrepancy in the parenting scores across siblings in the family) was measured by taking the standard deviation of parenting quality for all children in the family. In the general epidemiological sample, this reflected the difference between both children. However, in the treatment-seeking cohort, the standard deviation was calculated with up to four children per family to represent the true variation in parenting practices across children.

Marital Relationship. The couple relationship was assessed using two measures. First, caregivers completed four items from the Couple Satisfaction Index (CSI; Funk & Rogge, 2007). One item examined the overall happiness of the relationship and was rated on a seven-point Likert scale, ranging from “*Extremely Unhappy*” (0) to “*Extremely Happy*” (6). The other items focused on the warmth, reward, and satisfaction of the relationship and were rated on a six-point Likert scale, ranging from “*Not at all*” (0) to “*Completely*” (5). Item scores were summed, with higher scores indicating greater relationship satisfaction. In the general epidemiological sample, this measure had excellent internal consistency (Cronbach's $\alpha = .94$). The internal consistency was also excellent (Cronbach's $\alpha = .94$) in the treatment seeking sample. Second, caregivers completed two items measuring frequency of major and minor disagreements in the previous month. This measure's internal consistency was moderate in the general epidemiological sample (Cronbach's $\alpha = .68$) and acceptable in the treatment-seeking sample (Cronbach's $\alpha = .75$).

Sibling Relationship. The sibling relationship was measured using six items from the Parental Expectations and Perceptions of Children's Sibling Relationships Questionnaire (PEPC-SRQ; Kramer & Baron, 1995). Three items were positively worded and three items were

negatively worded. Examples of areas explored were aggressive behaviours, sharing, and kindness between siblings. Items were rated on a five-point Likert, ranging from “*Never*” (1) to “*Always*” (5). Positive items were reverse coded and item scores were summed, with higher scores representing greater sibling relationship challenges. This measure had acceptable internal consistency in the general epidemiological sample (Cronbach’s $\alpha = .73$) and in the treatment-seeking sample (Cronbach’s $\alpha = .75$).

Resilience. Child and caregiver resilience were assessed using the 10-item Connor-Davidson Resilience Scale (CD-RISC-10; Campbell-Sills & Stein, 2007; Connor & Davidson, 2003). This measure examines one’s ability to adapt, handle challenges, and cope. Items were rated on a five-point Likert scale, ranging from “*Not true at all*” (0) to “*True nearly all the time*” (4). Item scores were summed, with higher scores indicating greater resilience. In the general epidemiological sample, the internal consistency for this measure was excellent for caregivers (Cronbach’s $\alpha = .92$), for the younger child (Cronbach’s $\alpha = .91$), and for the older child (Cronbach’s $\alpha = .93$). In the treatment-seeking sample, the internal consistency for this measure was good for caregivers (Cronbach’s $\alpha = .87$), good for the primary child (Cronbach’s $\alpha = .87$), and excellent for the secondary child (Cronbach’s $\alpha = .94$). As well, variation in resilience across children was included as a profile indicator, to explore differences in child resilience and how they contribute to family functioning.

Social Supports. Caregiver social supports were measured using items from the National Longitudinal Survey of Children and Youth, which were based on items from the Social Provisions Scale (Orpana et al., 2019). Six items were used in the general epidemiological sample and three were used for the treatment-seeking sample. Items explored if caregivers felt like they had someone they could rely on, trust, and feel close to. Items were rated on a four-

point Likert scale, ranging from *Strongly Disagree* (1) to *Strongly Agree* (4). Negatively worded items were reverse coded. Scores were calculated by summing responses, with higher scores indicating greater social support. This measure had good internal consistency (Cronbach's $\alpha = .88$) in the general epidemiological sample and moderate internal consistency (Cronbach's $\alpha = .62$) in the treatment-seeking sample.

Socioeconomic Status. Caregiver socioeconomic status was measured using caregiver-reported household income for the previous year and the highest level of education completed by the primary caregiver (i.e., reporting caregiver).

Outcome Measures

Children's Mental Health. Children's mental health was assessed using the Patient-Reported Outcomes Measurement Information System (PROMIS) parent-proxy reports (Health Measures, 2024; Irwin et al., 2012). Caregivers reported on the domains of anger (five items), anxiety (eight items), depression (six items), and sleep (seven items). Items were rated on a five-point Likert scale, ranging from "*Never*" (1) to "*Always*" (5). Item scores were summed into domain-specific scores, with higher scores indicating greater problems in that domain. In the general epidemiological sample, internal consistency ranged from good to excellent (Cronbach's $\alpha = .88-.93$) for the younger child and was excellent (Cronbach's $\alpha = .91-.95$) for the older child, across domains. In the treatment-seeking sample, internal consistency was excellent for the primary child (Cronbach's $\alpha = .90-.94$) and ranged from good to excellent (Cronbach's $\alpha = .89-.93$) for the secondary child, across anger, anxiety, and depression domains. In this sample, caregivers were asked one item their child's sleep quality, instead of the PROMIS items.

Caregiver Mental Health. Caregiver mental health was assessed using three measures. First, caregiver psychological distress was measured using the Kessler Psychological Distress

Scale (K10; Kessler et al., 2002). The K10 is comprised of 10 items which examine various symptoms of depression and anxiety over the past 30 days. Items were rated on a five-point Likert scale, ranging from “*None of the time*” (1) to “*All of the time*” (5). Item scores were summed, with higher scores indicating greater distress. Internal consistency for this measure was excellent in the general epidemiological sample (Cronbach’s $\alpha = .93$) and in the treatment-seeking sample (Cronbach’s $\alpha = .91$). Second, caregivers completed four items from the PROMIS Anxiety short form (Pilkonis et al., 2011). Items were rated on a five-point Likert scale, ranging from “*Never*” (1) to “*Always*” (5). Item scores were summed, with higher scores representing greater concerns related to anxiety. Internal consistency for this measure was excellent (Cronbach’s $\alpha = .93$) in the general epidemiological sample and good in the treatment-seeking sample (Cronbach’s $\alpha = .87$). Finally, caregivers answered one item about sleep disturbances over the past seven days. Responses ranged from “*Not at all*” (1) to “*Extremely*” (5), with a higher score indicating greater sleep disturbances.

Covariates

Caregivers reported on their age, sex, race/ethnicity, relationship status, and immigration/citizenship status. Due to differences in racial/ethnic data availability across both samples, racial/ethnic background was not included as a covariate.

Analytical Plan

Data analysis included multiple stages. Data cleaning and descriptive analyses were conducted in RStudio (version 2024.12.1+563; Posit Team, 2025), using the *tidyverse*, *haven*, *dplyr*, and *psych* packages (Revelle, 2025; Wickham et al., 2023, 2025; Wickham & RStudio, 2023). The *corrplot* package was used for visualizing correlations between study variables (Wei

et al., 2024). Lastly, data was prepared for analysis in Mplus using the *MplusAutomation* package (Hallquist et al., 2024).

Latent Profile Analysis

Latent profile analysis (LPA) was performed in Mplus (version 8.8; Muthén & Muthén, 2017). LPA is a person-centered, mixture modelling approach that identifies distinct subgroups (i.e., latent profiles) within a larger sample based on various observable variables (i.e., indicators). Although sample sizes of 500 or more are generally recommended for LPA, the inclusion of the smaller treatment-seeking sample remains valuable (Nylund et al., 2007; Spurk et al., 2020). Despite its smaller size, it allows for meaningful comparison between clinical and non-clinical populations, supporting enhanced interpretation of profiles and generalizability of findings. Models with between two to six profiles were compared and the best-fitting model was selected following Asparouhov and Muthén's (2012) guidelines. Model fit was evaluated through the Akaike Information Criterion (AIC), Bayesian Information Criterion (BIC), and the sample size adjusted Bayesian Information Criterion (aBIC) posterior fit indices. Lower values on these indices indicate a greater model fit. As well, we assessed model fit and utility using entropy values, which range from 0 to 1, with higher values indicating greater precision in the placement of individuals into profiles. Finally, we conducted Lo-Mendell-Rubin (LMR) adjusted likelihood ratio tests and bootstrapped likelihood ratio tests (BLRT) to compare the fit of models with k profiles against models with $k-1$ profiles. After selecting the best-fitting LPA model, participants were assigned to the profile with the highest probability of membership. Note, due to the presence of 35 caregivers from the same family in the treatment-seeking sample, the "cluster" option was utilized, which corrects standard errors for data non-independence with a sandwich estimator.

Validation Analysis with BCH & Covariates

Child and caregiver mental health was examined to validate the latent profiles. Using the Bolck-Croon-Hagenaars (BCH) procedure in Mplus, we compared mental health concerns for children and caregivers in each profile (Asparouhov & Muthén, 2021). This method allows for the comparison of profiles across auxiliary outcome variables without altering latent profile membership (i.e., accounting for the uncertainty in latent profile membership). Finally, the distribution of covariates across profiles were examined using multinomial logistic regressions in Mplus (Asparouhov & Muthén, 2013).

Missing Data

In the general epidemiological sample, the final cohort at the 18-month follow-up included 342 families (62.3% retention). In the treatment-seeking sample, the cohort at the final follow-up was comprised of 136 caregivers (85.5% retention). For the latent profile analysis, missing values on the profile indicators were subjected to the full information maximum likelihood estimation (FIML) with robust standard errors (MLR) estimator in Mplus (Muthén & Muthén, 2017). The MLR estimator provides standard errors and a chi-square statistic that are robust in accounting for non-normality in the data.

Results

General Epidemiological Sample

Descriptive Statistics & Correlations of Study Variables

Descriptive statistics for the indicator and outcome variables are presented in Table 7 and 8, respectively. For indicators, caregiver education and household income are included with participant characteristics above (Table 1 and 3). Bivariate correlations between all study variables are presented in Figure 1.

Table 7

Descriptive Statistics of Indicator Variables at Study Baseline in the CRAMPED Sample

	<i>n</i>	M	Range	(SD)	Skewness	Kurtosis
Family Functioning	549	10.01	6-24	(2.89)	0.43	0.59
Parenting Quality	545	40.4	27-50	(4.89)	-0.18	-0.59
Differential Parenting	545	2.67	0-19	(2.84)	2.10	6.02
Couple Satisfaction	507	13.92	0-21	(4.88)	-0.67	-0.10
Marital Conflict	507	5.85	2-10	(1.49)	0.36	0.02
Sibling Relationship Quality	548	15.73	6-28	(3.48)	0.27	0.11
Caregiver Resilience	547	28.43	6-40	(6.69)	-0.43	0.03
Child Resilience (Mean)	544	25.2	4-39	(5.91)	-0.21	0.12
Child Resilience (Standard Deviation)	544	6.34	0-28	(5.22)	1.26	1.56
Social Supports	547	20.41	8-24	(3.48)	-0.85	0.21

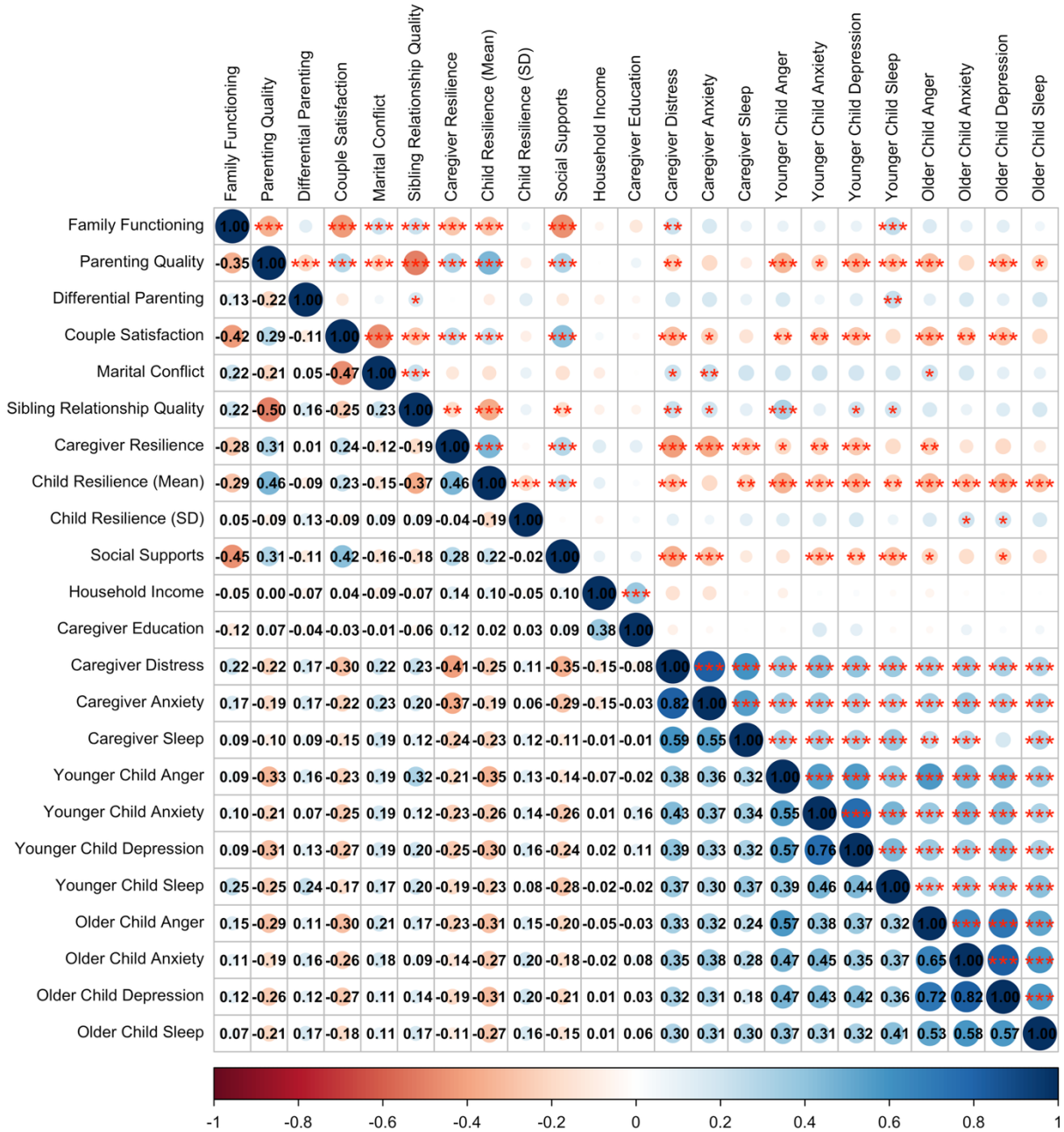
Note. The Differential Parenting variable was winsorized to +/- 3 standard deviations to correct its skewness and kurtosis.

Table 8***Descriptive Statistics of Outcome Variables at 18 Month Follow-Up in the CRAMPED Sample***

	<i>n</i>	M	Range	(SD)	Skewness	Kurtosis
Caregiver Outcomes						
Distress	335	18.94	10-47	(8.02)	1.21	1.02
Anxiety	335	7.06	4-20	(3.64)	1.34	1.27
Sleep	335	2.37	1-5	(1.14)	0.69	-0.40
Younger Child Outcomes						
Anger	328	8.58	5-22	(3.69)	1.25	1.37
Anxiety	328	12.29	3-38	(5.38)	1.69	2.90
Depression	328	9.44	6-29	(4.21)	1.71	3.34
Sleep	328	14.47	8-40	(6.25)	1.34	1.91
Older Child Outcomes						
Anger	312	8.72	5-23	(3.75)	0.92	0.19
Anxiety	313	12.81	8-35	(5.90)	1.34	1.21
Depression	313	10.03	5-25	(4.59)	1.08	0.37
Sleep	313	15.45	8-40	(6.65)	1.15	1.36

Figure 1

Bivariate Pearson Correlations of Study Variables in the CRAMPED Sample



Note. Pearson correlation coefficients presented in the bottom diagonal. Significance level presented in the top diagonal. * $p < .05$; ** $p < .01$; *** $p < .001$

Latent Profile Analysis

Model fit statistics are presented in Table 9. The AIC, BIC, and aBIC values decreased from models with two to six profiles. Entropy values were similar across models, ranging from 0.69 to 0.77. While the Likelihood Ratio Test was only significant for the model with two profiles, this may not be the most accurate measure due to a smaller sample size and limited power. The Bootstrapped Likelihood Ratio Test, which is more robust with smaller sample sizes, was significant for all models. Although the five-profile solution showed slightly better statistical fit, it produced profiles with considerable overlap and not enough differentiation. The model with six profiles was not selected due to poorer fit statistics and profiles that were too small (i.e., less than 5%; Prime et al., 2022). Ultimately, the model with four profiles was selected as the best-fitting solution, as it yielded distinct profiles, and based on parsimony and theoretical interpretability.

Table 9

Fit Statistics for Models with Two to Six Latent Profiles in the CRAMPED Sample

Number of profiles	AIC	BIC	aBIC	Entropy	<i>p</i> -LRT	<i>p</i> -BLRT	Smallest Profile (%)
2	17,519.65	17,679.05	17,561.59	.75	<.001	<.001	46.45
3	17,411.29	17,626.69	17,467.97	.69	.341	<.001	25.32
4	17,334.31	17,605.72	17,405.74	.72	.303	<.001	16.39
5	17,247.93	17,575.34	17,334.09	.73	.139	<.001	9.65
6	17,178.81	17,562.23	17,279.71	.77	.555	<.001	3.83

Note. The four-profile model (in bold) was evaluated to be the best-fitting solution. AIC =

Akaike Information criterion; BIC = Bayesian Information Criterion; aBIC = Sample Size

Adjusted Bayesian Information Criterion; *p*-LRT = *p*-value of the LMR likelihood ratio test for *k*

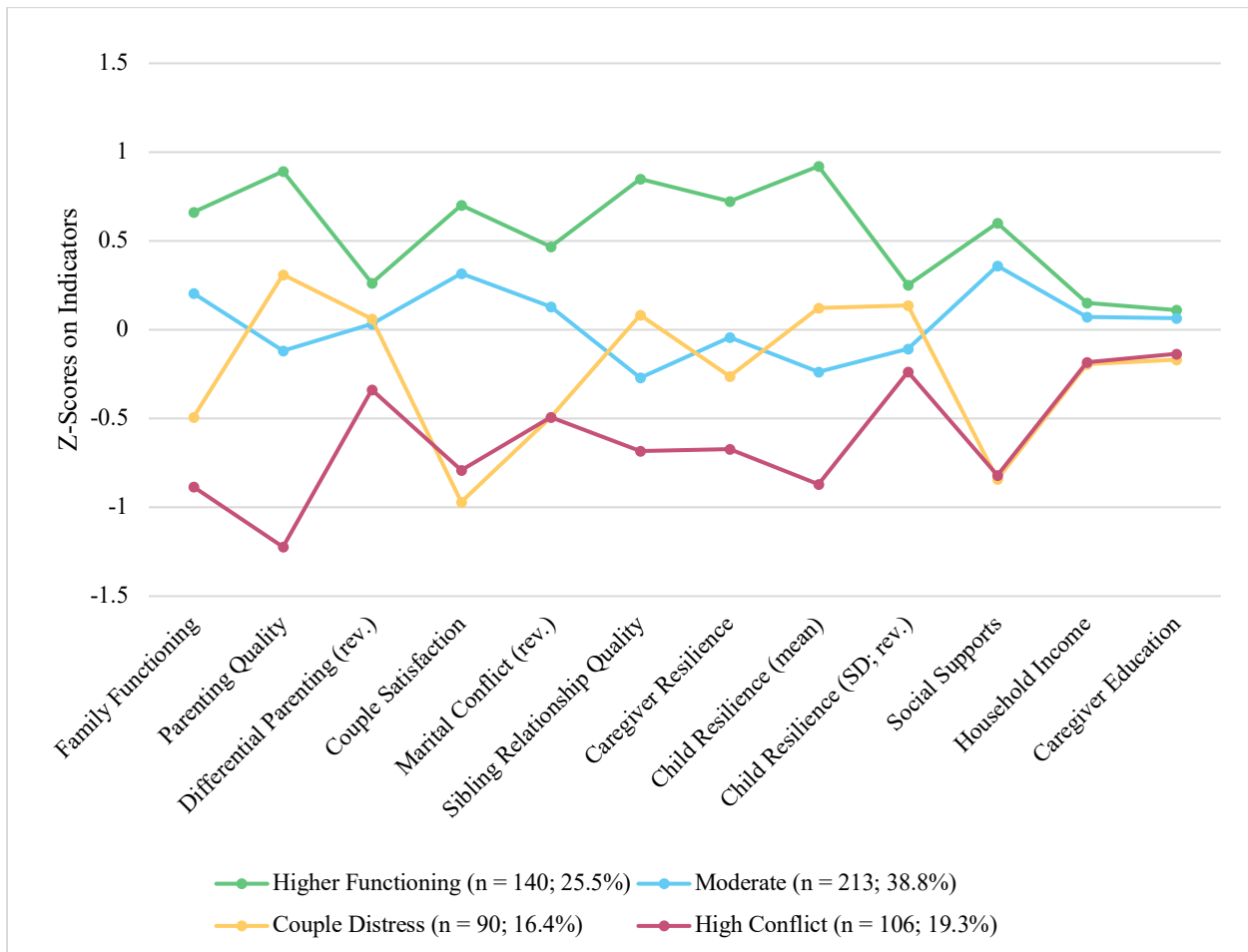
versus *k*-1 classes; *p*-BLRT = *p*-value of the bootstrapped likelihood ratio test for *k* versus *k*-1

classes.

Figure 2 illustrates the four-profile solution (see Table 15 in the Appendix for scores on indicators across profiles). Families in the largest profile, *Moderate* ($n = 213$; 38.8%), were characterized by average levels of family functioning, relative to all families in the CRAMPED sample. While parenting quality was slightly below average, there were no concerns with the other relational subsystems. Families reported child and caregiver resilience slightly below average, but average levels of perceived social support. The second largest profile, *Higher Functioning* ($n = 140$; 25.5%), was characterized by families with the highest family functioning and fewest challenges across relational subsystems. They reported the highest child and caregiver resilience and social supports. Families in the *High Conflict* profile ($n = 106$; 19.3%) were the third most common. These families reflect the opposite pattern as those in the *Higher Functioning* group, as they reported lowest family functioning and greater challenges across relational subsystems. They also reported below average levels of child and caregiver resilience and low levels of perceived social support. Lastly, the *Couple Distress* profile ($n = 90$; 16.4%) represented the smallest group. These families were characterized by slightly below average overall family functioning, slightly above average parenting quality, and average sibling relationship quality. However, they reported low couple satisfaction and high marital conflict. Caregiver resilience was average, while child resilience was slightly above average. They also reported slightly below average levels of perceived social supports. There was not much variation in socioeconomic variables (e.g., household income and caregiver education) across the four profiles.

Figure 2

Latent Profiles of Family Functioning in the CRAMPED Sample



Note. Indicators were Z-scored. Select scores (i.e., Family Functioning, Differential Parenting, Marital Conflict, Sibling Relationship Quality) were reversed so higher scores indicated better functioning on the graph. Standard Deviation (SD) of Child Resilience was reversed, such that a higher score on the graph indicated less variation between children.

Covariates

Once latent profiles were identified, we performed multinomial logistic regression analyses to explore whether covariates of caregiver age, sex, relationship status, and immigration/citizenship status predicted profile membership. The *Higher Functioning* profile

was selected as the reference group, due to the lowest levels of concerns reported across relational and contextual domains. While the covariates generally did not significantly predict profile membership there was one significant predictor (Table 10). Compared to female caregivers, male caregivers were 76% less likely to be in the *Couple Distress* profile, relative to the *Higher Functioning* profile (OR = 0.24, $B = -1.45$, $p = .024$).

Table 10

Multinomial Logistic Regression Model Examining Covariate Predictors of Family Latent Profiles in the CRAMPED Sample

	Moderate vs. Higher Functioning				Couple Distress vs. Higher Functioning				High Conflict vs. Higher Functioning			
	<i>B</i>	<i>(SE)</i>	OR	OR CI _{0.95}	<i>B</i>	<i>(SE)</i>	OR	OR CI _{0.95}	<i>B</i>	<i>(SE)</i>	OR	OR CI _{0.95}
Intercept	0.42	(0.19)	–	–	-0.16	(0.21)	–	–	-0.35	(0.20)	–	–
Caregiver-Level Covariates												
Age	-0.02	(0.14)	0.98	0.74-1.30	0.05	(0.29)	1.05	0.71-1.56	0.09	(0.15)	1.09	0.81-1.48
Sex	-0.38	(0.32)	0.69	0.37-1.28	-1.45*	(0.64)	0.24	0.07-0.83	-0.02	(0.32)	0.98	0.53-1.82
Relationship Status	0.54	(0.52)	1.72	0.62-4.79	0.24	(0.64)	1.27	0.37-4.43	0.33	(0.57)	1.40	0.46-4.22
Immigration/Citizenship Status	0.10	(0.63)	1.11	0.32-3.82	-0.94	(1.48)	0.39	0.02-7.15	0.25	(0.61)	1.28	0.39-4.23

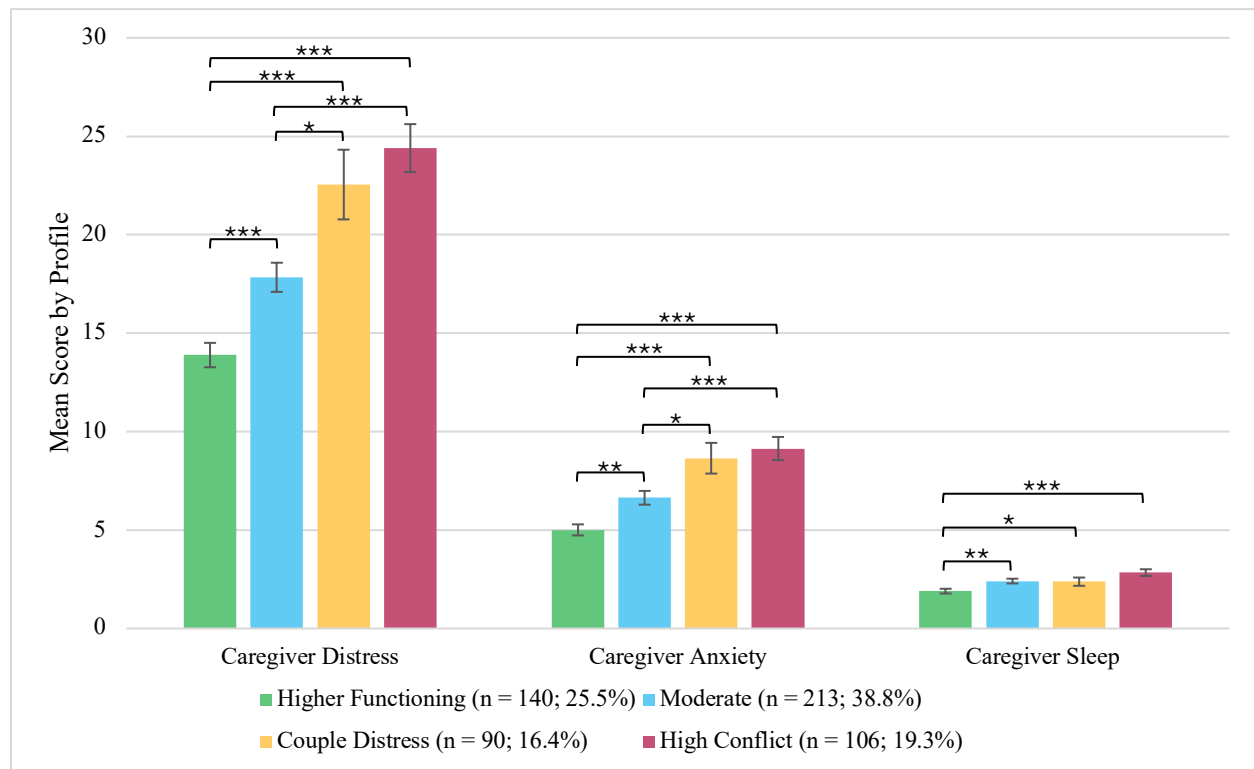
*Note. *p < 0.05*

Mental Health Outcomes Across Profiles

Caregiver Mental Health. Caregiver mental health outcomes, measured at 18-month follow-up, are presented in Figure 3, as a function of profile (see Table 16 in the Appendix for outcome scores across profiles). Results indicated a significant overall difference across profiles for caregiver distress ($\chi^2(3) = 81.72, p < .001$), anxiety ($\chi^2(3) = 61.66, p < .001$), and sleep concerns ($\chi^2(3) = 22.26, p < .001$). Caregivers in the *Higher Functioning* profile were characterized by reporting significantly lower levels of distress, anxiety, and sleep concerns compared to all other groups. Moreover, levels of caregiver distress and anxiety were significantly lower in the *Moderate* profile, compared to the *Couple Distress* and *High Conflict* profiles.

Figure 3

Caregiver Mental Health Outcomes as a Function of Profile in the CRAMPED Sample

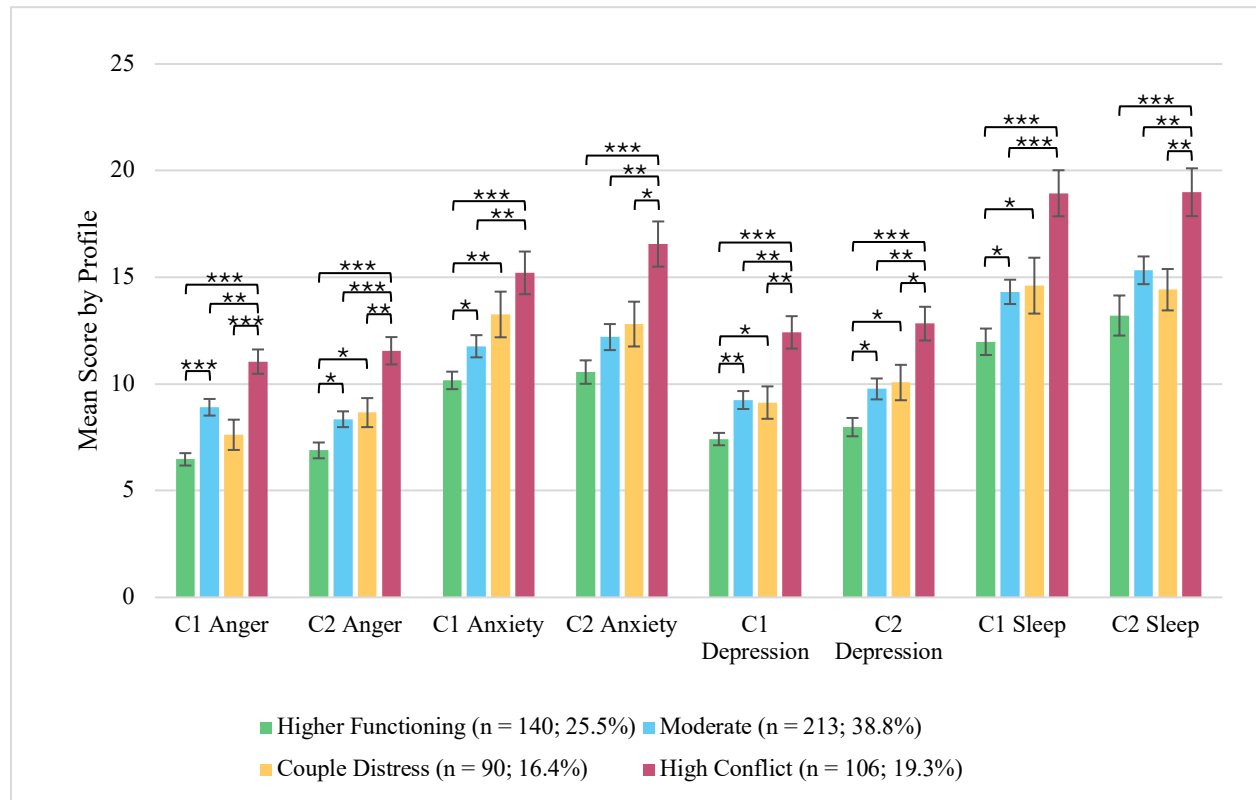


Note. * $p < .05$; ** $p < .01$; *** $p < .001$

Child Mental Health. Child mental health outcomes, measured at 18-month follow-up, are presented in Figure 4, as a function of profile (see Table 17 in the Appendix for outcome scores across profiles). Both children within a family generally followed similar patterns of results on the various outcomes, across profiles. For the younger child, results indicated a significant overall difference across profiles for anger ($\chi^2(3) = 60.33, p < .001$), anxiety ($\chi^2(3) = 30.47, p < .001$), depression ($\chi^2(3) = 47.10, p < .001$), and sleep concerns ($\chi^2(3) = 33.62, p < .001$). Similarly, for the older child, results indicated a significant overall difference across profiles for anger ($\chi^2(3) = 42.81, p < .001$), anxiety ($\chi^2(3) = 27.79, p < .001$), depression ($\chi^2(3) = 33.23, p < .001$), and sleep concerns ($\chi^2(3) = 16.26, p = .001$). Children in the *Higher Functioning* profile were generally characterized by significantly lower levels of anger, anxiety, depression, and sleep concerns, compared to all other groups. Children in the *High Conflict* profile were generally characterized by significantly higher levels of anger, anxiety, depression, and sleep concerns, compared to all other groups. In the *Couple Distress* group, there were some differences between children. For example, anger for the older child was significantly higher than those in the *Higher Functioning* group, whereas there were no differences for the younger child.

Figure 4

Child Mental Health Outcomes as a Function of Profile in the CRAMPED Sample



Note. C1 = younger child; C2 = older child; * $p < .05$; ** $p < .01$; *** $p < .001$

Treatment-Seeking Sample

Descriptive Statistics & Correlations of Study Variables

Descriptive statistics for the indicator and outcome variables are presented in Table 11 and 12, respectively. For indicators, caregiver education and household income are included with participant characteristics (Table 4 and 6). Bivariate correlations between all study variables are presented in Figure 5.

Table 11***Descriptive Statistics of Indicator Variables at Study Baseline in the EFFT Sample***

	<i>n</i>	M	Range	(SD)	Skewness	Kurtosis
Family Functioning	158	12.35	6-24	(3.39)	0.46	1.10
Parenting Quality	159	38.33	24-47	(4.92)	-0.37	-0.34
Differential Parenting	124	3.21	0-26.87	(3.08)	4.11	26.62
Couple Satisfaction	131	11.37	0-20	(4.96)	-0.27	-0.67
Marital Conflict	130	6.25	2-10	(1.69)	0.00	-0.25
Sibling Relationship Quality	123	16.34	6-27	(3.88)	0.06	0.42
Caregiver Resilience	155	27.81	0-40	(6.37)	-0.98	3.08
Child Resilience (Mean)	158	20.42	1-34.33	(5.86)	-0.56	0.57
Child Resilience (Standard Deviation)	119	8.26	0-27.58	(5.50)	0.95	0.94
Social Supports	155	10.09	6-12	(1.61)	-0.41	-0.67

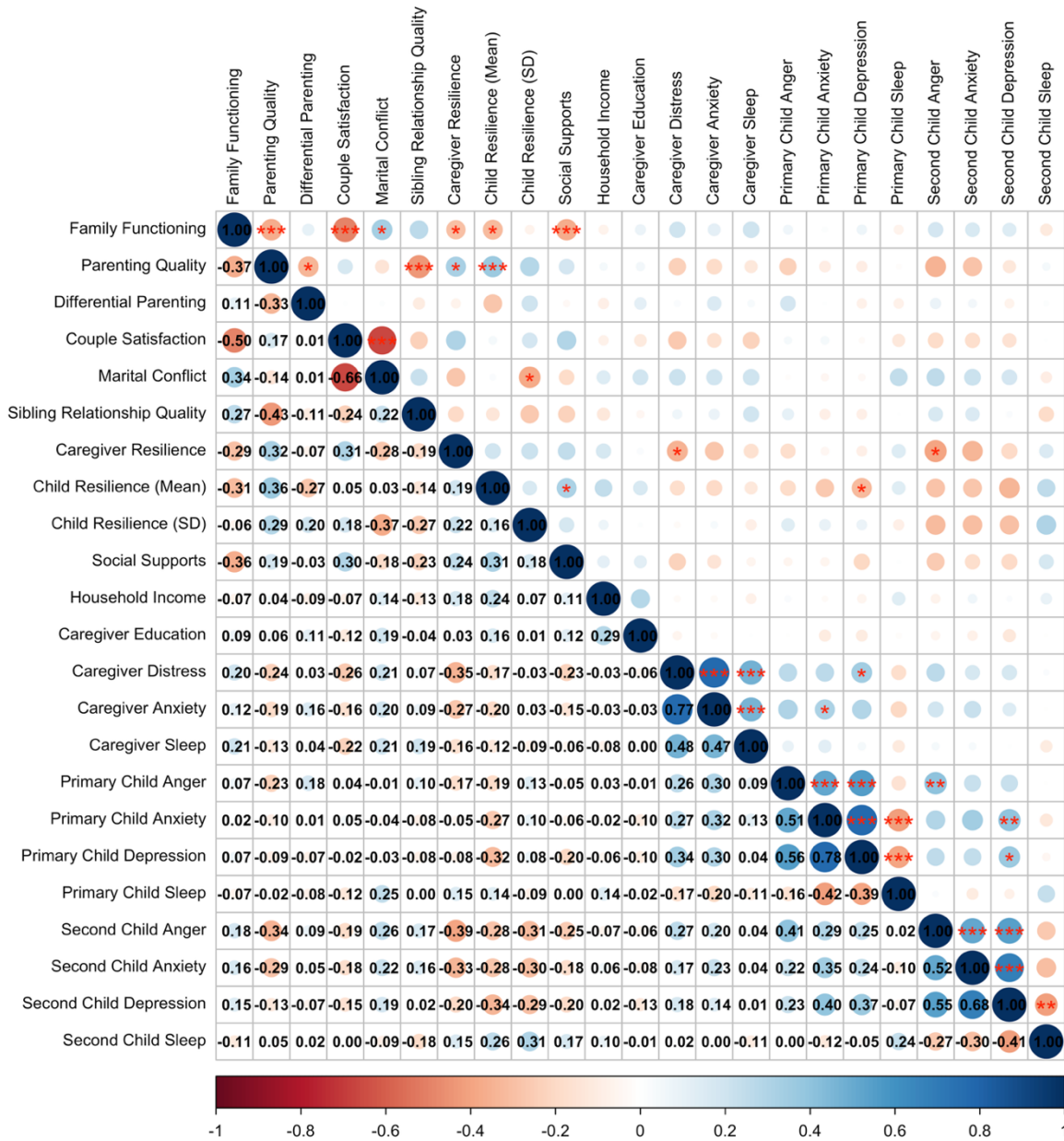
Note. The Differential Parenting variable was winsorized to +/- 3 standard deviations to correct its skewness and kurtosis.

Table 12***Descriptive Statistics of Outcome Variables at 18 Month Follow-Up in the EFFT Sample***

	<i>n</i>	M	Range	(SD)	Skewness	Kurtosis
Caregiver Outcomes						
Distress	132	19.47	10-47	(6.91)	1.07	0.98
Anxiety	133	7.96	4-17	(3.31)	0.68	-0.30
Sleep	133	2.74	1-5	(1.09)	0.46	-0.59
Primary Child Outcomes						
Anger	131	11.70	5-20	(3.97)	-0.14	-0.84
Anxiety	132	16.49	3-33	(6.63)	0.36	-0.77
Depression	132	12.85	6-29	(5.11)	0.43	-0.43
Sleep	130	3.58	1-5	(0.99)	-0.55	0.09
Second Child Outcomes						
Anger	103	9.84	3-18	(3.57)	0.24	-1.03
Anxiety	103	14.36	2-31	(5.81)	0.66	-0.26
Depression	103	10.46	6-23	(3.89)	0.96	0.28
Sleep	104	3.77	1-5	(0.95)	-0.55	0.00

Figure 5

Bivariate Pearson Correlations of Study Variables in the EFFT Sample



Note. Pearson correlation coefficients presented in the bottom diagonal. Significance level presented in the top diagonal. * $p < .05$; ** $p < .01$; *** $p < .001$

Latent Profile Analysis

Model fit statistics are presented in Table 13. The AIC and aBIC values decreased from models with two to six profiles. The BIC values decreased for models with two to four profiles, but increased thereafter, likely due to the smaller sample size. Entropy values ranged from 0.75 to 0.90 across models. While the Likelihood Ratio Test was not significant for any models, this may not be the most accurate measure due to a smaller sample size. The Bootstrapped Likelihood Ratio Test accounts for the smaller sample size and was significant for all models. Models with four to six solutions were not selected, as some profile sizes were too small, and due to many similarities between some profiles. The model with three profiles was selected as the best-fitting and most parsimonious solution.

Table 13

Fit Statistics for Models with Two to Six Latent Profiles in the EFFT Sample

Number of profiles	AIC	BIC	aBIC	Entropy	<i>p</i> -LRT	<i>p</i> -BLRT*	Smallest Profile (%)
2	4,687.08	4,800.63	4,683.51	.75	.096	<.001	48.43
3	4,636.99	4,790.43	4,632.15	.81	.629	<.001	13.21
4	4,600.34	4,793.68	4,594.25	.88	.355	<.001	3.77
5	4,569.65	4,802.89	4,562.31	.90	.690	<.001	3.77
6	4,548.92	4,822.05	4,540.31	.86	.363	<.001	2.52

Note. The three-profile model (in bold) was evaluated to be the best-fitting solution. AIC =

Akaike Information criterion; BIC = Bayesian Information Criterion; aBIC = Sample Size

Adjusted Bayesian Information Criterion; *p*-LRT = *p*-value of the LMR likelihood ratio test for *k*

versus *k*-1 classes; *p*-BLRT = *p*-value of the bootstrapped likelihood ratio test for *k* versus *k*-1

classes. *BLRT *p*-values were obtained from the model without family clustering and may

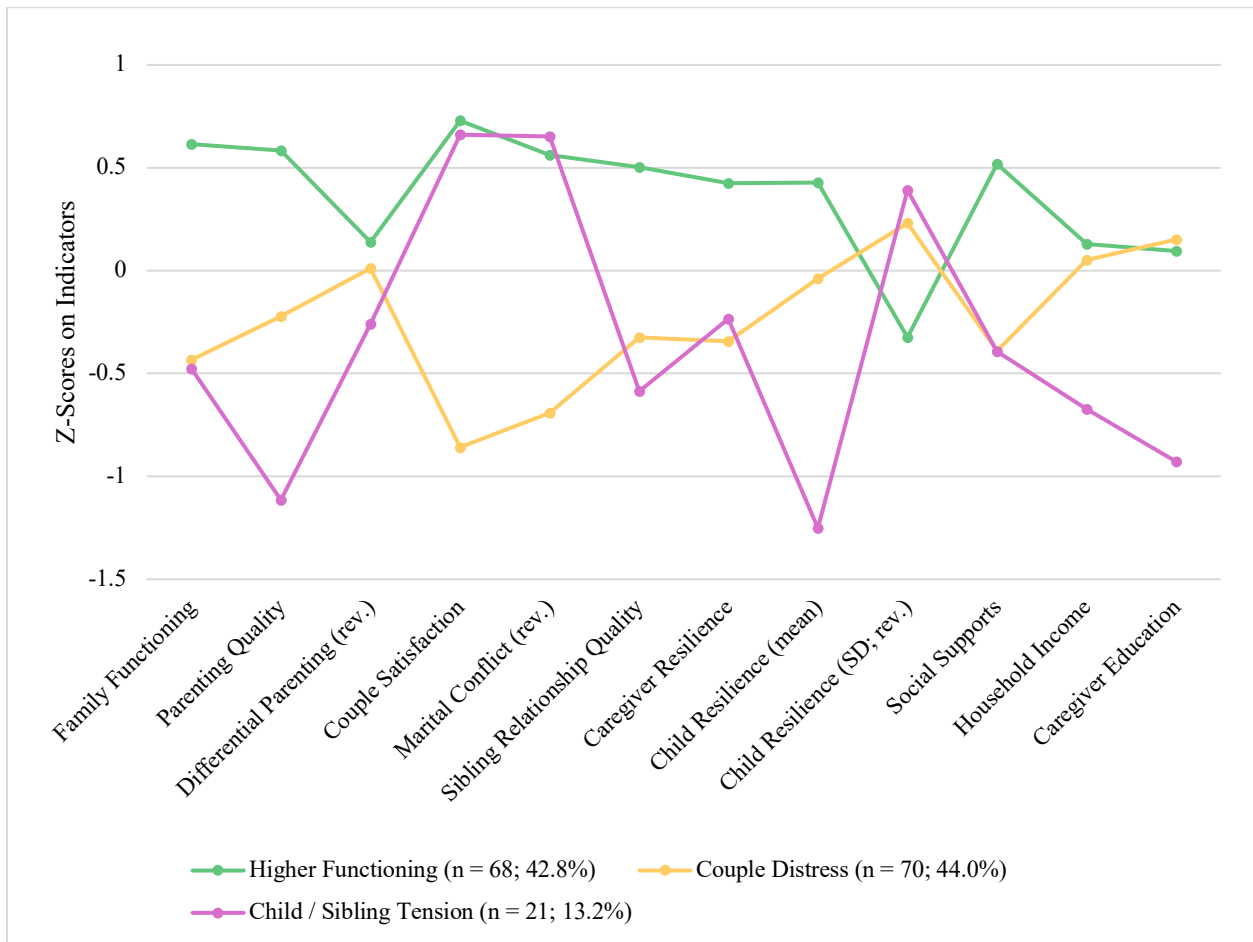
represent a slight overestimation of significance. AIC, BIC, aBIC and Entropy values remained

the same across both models.

Figure 6 displays the three-profile solution (see Table 16 in the Appendix for scores on indicators across profiles). Two of the profiles have replicated from the CRAMPED sample, while one new profile emerged. In the EFFT sample, most families were captured by *Couple Distress* ($n = 70$; 44.0%) profile. Families in this profile reported below average family functioning. They reported slightly below average parenting quality, sibling relationship quality, caregiver resilience, and perceived social support. Moreover, they reported below average couple satisfaction and above average marital conflict. The second largest group was the *Higher Functioning* ($n = 68$; 42.8%) profile. Families in this group reported above average family functioning and fewer challenges across relational subsystems. They also reported above average child and caregiver resilience and perceived social support. Families in the first two profiles reported average household income and caregiver education, relative to the rest of the sample. Finally, the last profile was the *Child/Sibling Tension* group ($n = 21$; 13.2%). These families also reported below average family functioning. However, caregivers in these families reported above average couple satisfaction and below average marital conflict. Sibling relationship quality, caregiver resilience, and perceived social supports were reported as being slightly below average, while parenting quality and child resilience was much below average. Families in this profile also reported below average household income and caregiver education, likely representing those accessing the EFFT workshop through the psychological clinic's access program.

Figure 6

Latent Profiles of Family Functioning in the EFFT Sample



Note. Indicators were Z-scored. Select scores (i.e., Family Functioning, Differential Parenting, Marital Conflict, Sibling Relationship Quality) were reversed so higher scores indicated better functioning on the graph. Standard Deviation (SD) of Child Resilience was reversed, such that a higher score on the graph indicated less variation between children.

Covariates

Once latent profiles were identified, we performed multinomial logistic regression analyses to explore whether covariates of caregiver age, sex, relationship status, and immigration/citizenship

status predicted profile membership. No covariates significantly predicted profile membership (Table 14).

Table 14

Multinomial Logistic Regression Model Examining Covariate Predictors of Family Latent Profiles in the EFFT Sample

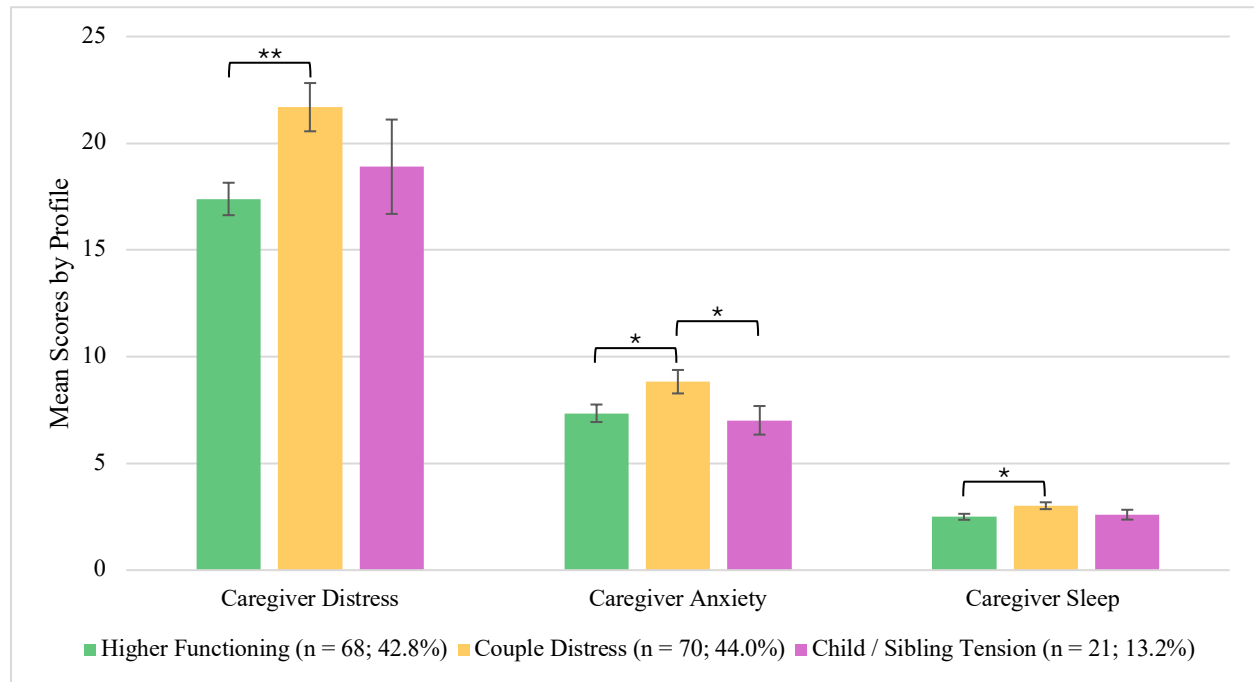
	Couple Distress vs. Higher Functioning				Child / Sibling Tension vs. Higher Functioning			
	<i>B</i>	<i>(SE)</i>	OR	OR CI _{0.95}	<i>B</i>	<i>(SE)</i>	OR	OR CI _{0.95}
Intercept	-0.31	(0.93)	–	–	-5.45	(6.52)	–	–
Caregiver-Level Covariates								
Age	-0.18	(0.23)	0.84	0.53-1.31	-0.13	(0.38)	0.88	0.42-1.86
Gender	-0.10	(0.42)	0.90	0.39-2.07	0.79	(0.81)	2.20	0.45-10.75
Relationship Status	0.10	(0.25)	1.10	0.68-1.78	0.78	(1.56)	2.19	0.10-46.28
Immigration/Citizenship Status	0.18	(0.16)	1.19	0.88-1.63	0.33	(0.22)	1.39	0.91-2.14

Mental Health Outcomes Across Profiles

Caregiver Mental Health. Caregiver mental health outcomes, measured at 12-month follow-up, are presented in Figure 7, as a function of profile (see Table 19 in the Appendix for outcome scores across profiles). Caregiver distress levels were significantly different across profiles, $\chi^2(3) = 8.86, p = .012$. Caregivers in the *Couple Distress* profile reported significantly higher levels of distress compared to those in the *Higher Functioning* groups. While the overall test was not significant for caregiver anxiety ($\chi^2(3) = 5.33, p = .070$), caregivers in the *Couple Distress* group reported significantly more anxiety compared to those in the *Higher Functioning* group ($\chi^2(1) = 4.13, p = .042$) and those in the *Child/Sibling Tension* group ($\chi^2(1) = 4.06, p = .044$). Similarly, for caregiver sleep, while the overall test was not significant ($\chi^2(3) = 5.33, p = .070$), caregivers in the *Couple Distress* group reported significantly more sleep disturbances than to those in the *Higher Functioning* group ($\chi^2(1) = 5.17, p = .023$).

Figure 7

Caregiver Mental Health Outcomes as a Function of Profile in the EFFT Sample

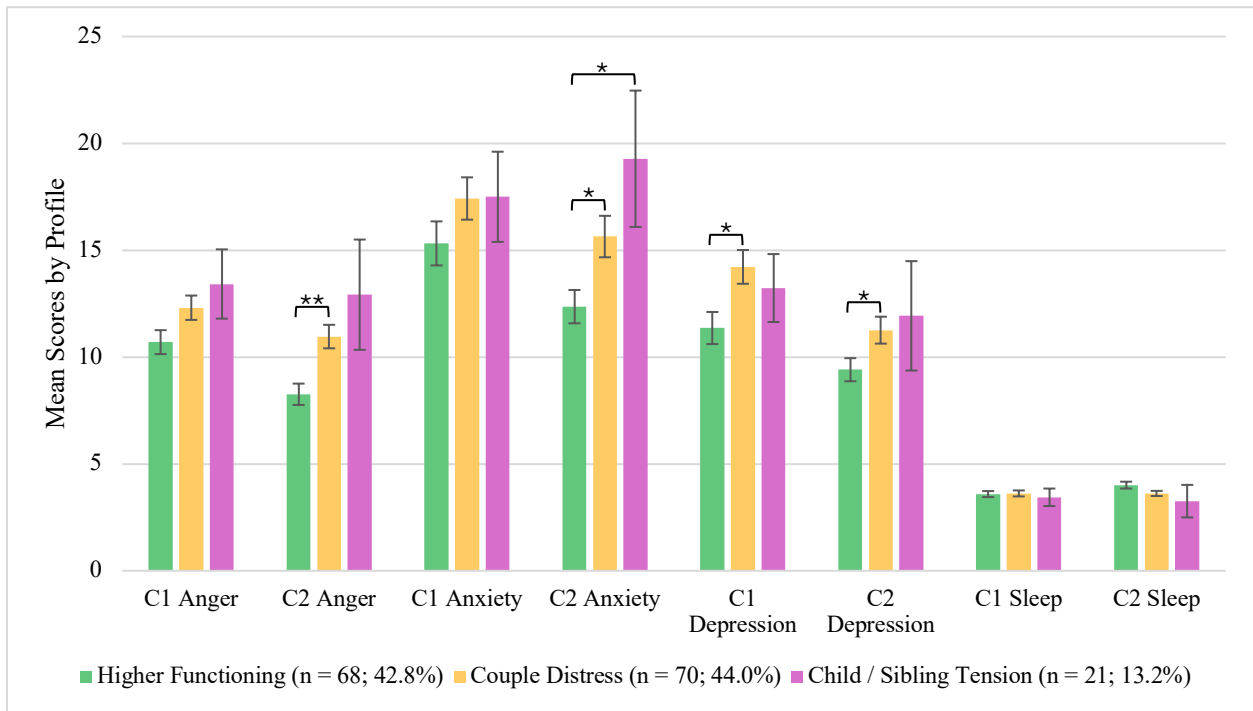


Note. * $p < .05$; ** $p < .01$

Child Mental Health. Child mental health outcomes, measured at 12-month follow-up, are presented in Figure 8, as a function of profile (see Table 20 in the Appendix for outcome scores across profiles). Results indicate differences across profiles for the second child's reports of anger ($\chi^2(3) = 13.35, p = .001$) and anxiety ($\chi^2(3) = 9.56, p = .008$). The second child in the *Couple Distress* group was reported to have significantly higher anger and anxiety, compared to the *Higher Functioning* group. Moreover, the second child in the *Child/Sibling Tension* group was reported to have significantly higher anxiety compared to the *Higher Functioning* group. While the overall test was not significant for depression for the second child, this pattern held true and was significant. For the primary child, there were differences across profiles for depression, $\chi^2(3) = 6.35, p = .042$. Depression was significantly higher for the primary child in the *Couple Distress* group, compared to the *Higher Functioning* group.

Figure 8

Child Mental Health Outcomes as a Function of Profile in the EFFT Sample



Note. C1 = younger child; C2 = older child; * $p < .05$; ** $p < .01$

Discussion

Informed by prominent models in family systems theory and the precision mental health movement, the present study identified unique profiles of families based on relational subsystems (i.e., whole-family functioning, child-caregiver, couple, and sibling systems), resilience (i.e., caregiver/child resilience, sibling differences in resilience), and contextual factors (i.e., perceived social support and socioeconomic status). Profiles were identified in two samples, one general population cohort and one treatment-seeking cohort. The distribution of covariates across profiles was also examined. Subsequently, child and caregiver mental health outcomes were assessed at a later time point, allowing examination of these outcomes as a function of profile membership. Consistent with our hypothesis that distinct profiles would emerge, results of this study revealed a four-profile solution in the general population sample and a three-profile solution in the treatment-seeking sample. Moreover, as hypothesized, profiles predicted child and caregiver mental health outcomes. Interestingly, there were both similarities and differences in profiles and their associations with mental health outcomes across the two samples. These findings contribute to the growing literature supporting the utility of person-centered approaches to studying family-wide patterns and their clinical applications, including tailored conceptualizations and targeted interventions (Bonadio & Tompsett, 2018; Pelham et al., 2017; Petersen et al., 2019).

Representation of Family Functioning by Relational Profiles

Distinct profiles of family functioning emerged in both the general population and treatment-seeking samples, reflecting some shared and unique patterns of relational dynamics. These findings align with prior studies applying LPA to families, supporting the presence of distinct groupings (Browne et al., 2018; Cordova et al., 2014; Simpson et al., 2018; Sturge-Apple

et al., 2010; Xia et al., 2022). Notably, two profiles replicated across both groups, highlighting the utility of person-centered approaches in understanding naturally occurring variations in different contexts. The differences that emerged also provide insight into factors that may help distinguish families in clinical and non-clinical contexts (Dollberg et al., 2010; Sawyer et al., 1988; Willemen et al., 2008).

In the general population cohort, four profiles were identified: *Higher Functioning*, *Moderate*, *Couple Distress*, and *High Conflict*. Nearly three-quarters of families were grouped into profiles characterized by generally average or above-average family functioning across relational subsystems. This distribution aligns with previous person-centered research on child mental health, where the largest subgroups often represent those with no or low symptoms (Petersen et al., 2019). Of the four profiles that emerged, three groups—*High Functioning*, *Moderate*, and *High Conflict*—were characterized by relatively consistent functioning across relational and contextual domains. In other words, families in these groups reported broadly higher, moderate, and lower levels of functioning across subsystems, suggesting the presence of *spillover* effects (Erel & Burman, 1995). That is, strengths or difficulties in one subsystem may have carried over into others. Spillover effects are most often examined in the context of unhealthy conflict carrying over into other subsystems, such as tension in the marital subsystem negatively impacting the caregiver-child relationship (Gao & Cummings, 2019; Ramos et al., 2022). However, positive spillover is also possible. For example, healthy conflict resolution and problem solving skills in the marital relationship have also been associated with fewer problematic parenting practices and beneficial outcomes for children, such as lower psychopathology and greater school adjustment (McCoy et al., 2013; Warmuth et al., 2020). While directionality cannot be inferred due to the cross-sectional nature of the profiles, it is

possible, for example, that tension in the marital relationship contributed to strain in the caregiver-child relationship, subsequently affecting sibling dynamics, and vice versa (Ramos et al., 2022).

In some families, it may be appropriate to cautiously conceptualize family functioning as a unitary construct, as some profiles seem to be differentiated in terms of mean elevation, versus qualitative differentiation across different profiles of strength and difficulty. Thus, at least in certain cases, a family's overall functioning tends to be reflected in the general wellbeing across all relational subsystems. Such a pattern may be explained by similarities in family functioning domains—including communication and problem-solving styles—across subsystems (Epstein et al., 1978; Olson, 2000). From a systems perspective, a family's structure and overall climate may contribute to this unitary conceptualization of family functioning (Cox & Paley, 1997; S. Minuchin, 1974). As a possible mechanism, based on the Circumplex Model of Marital and Family Systems, families with unitary functioning may be higher in cohesion and lower in flexibility, suggesting greater transfer—both positive and negative—across relational subsystems (Olson, 2000). For instance, the pervasive tension observed in the *High Conflict* profile may reflect overly elevated cohesion, resulting in an enmeshed family system where stressors are more likely to spill over across subsystems (Olson, 2000). That said, the cross-sectional nature of the profiles must be considered; longitudinal information about family processes may provide additional information about the interactive nature and variability of family dynamics (Persram et al., 2025; Tang et al., 2022; Xia et al., 2022).

However, a unitary conceptualization of family functioning is not always fitting, as demonstrated by the *Couple Distress* group showing a distinct pattern. Here, relational challenges appeared to be isolated within the couple subsystem, while the caregiver-child,

sibling, and overall functioning remaining relatively intact. While family systems theory emphasizes interdependence within the family, relational subsystems may sometimes function independently. Previous studies have observed similar patterns, wherein marital tension may remain compartmentalized to that unit, without spillover to the caregiver-child or sibling units (Mastrotheodoros et al., 2022; McCoy et al., 2013). This profile may reflect *compensatory* processes, where caregivers actively shield their relationships with their children from the strain in the marital relationship (Erel & Burman, 1995). In this way, families may be maintaining stability and functioning in certain subsystems, despite challenges in others. Moreover, external factors such as child resilience may be protecting the children against the effects of the marital tension (Nicolotti et al., 2003). These findings underscore the value of viewing the family as a dynamic system, with different typologies in a population, where relational subsystems interact with each other to create heterogenous groupings.

In the treatment-seeking cohort, a three-profile solution emerged: *Higher Functioning*, *Couple Distress*, and *Child/Sibling Tension*. Thus, at least in clinical settings, the emergence of subsystem-based profiles suggests that considering differential subgroups may have utility. Compared to the general population sample, fewer families reported above-average scores across domains, likely reflecting the greater relational and clinical needs of treatment-seeking families. Indeed, families with a member experiencing mental health challenges often report greater family dysfunction and stress (Friedmann et al., 1997; Ronan et al., 2008; Trangkasombat, 2006). As in the general population cohort, a *Higher Functioning* group emerged, characterized by above-average functioning across relational and contextual domains, likely maintained by *spillover* effects. The *Couple Distress* profile also replicated across both samples but accounted for a larger proportion of families in the treatment-seeking group. This finding is expected, given

that caregivers of a child with mental health concerns often report greater stress, compared to non-clinical populations (Loose et al., 2023; Ronan et al., 2008). Interestingly, while caregiver-child functioning in this profile appeared more adjusted compared to marital functioning, parenting quality was slightly lower than in the general population cohort, where it was slightly above average. This suggests that, although caregivers in this profile may be protecting their relationship with children from marital strain via *compensatory* processes, they may be under greater relational stress (Erel & Burman, 1995).

Interestingly, the *Child/Sibling Tension* profile was unique to the treatment-seeking cohort, marked by challenges in the caregiver-child and sibling subsystems, potentially reflecting a combination of *spillover* and *compensatory* processes. For example, tension in the caregiver-child relationship could carry into sibling dynamics, or vice-versa. Although it represented the smallest subgroup, its emergence is not surprising given the clinical context: families were participating in an Emotion-Focused Family Therapy workshop to support at least one child who had mental health challenges. Children with such difficulties are more likely to experience relational challenges too, especially with caregivers (Dijk et al., 2022; Kullberg et al., 2023; Neville et al., 2025). Sibling relationships where at least one child has a mental or physical health concern can also be strained, though this is not always the case (Allison & Campbell, 2015; Bojanowski et al., 2020; Fox et al., 2002). Despite these challenges, the marital relationship remained relatively strong in this profile, suggesting that caregivers may be actively working to preserve the health of the marital relationship (Gagat-Matuła, 2022; Matalon & Turliuc, 2023).

Compared to the general population cohort, a subtyping approach to understanding family functioning may be more appropriate in the treatment-seeking cohort. The presence of

both *Couple Distress* and *Child/Sibling Tension* profiles demonstrates the complexity of family dynamics in these contexts. In both subgroups, while some dyads are doing well, the overall family functioning is below average. This highlights that the whole family's functioning cannot merely be understood as the sum of its subsystems' welfare (Fiese et al., 2019; S. Minuchin, 1974). Instead, these profiles emphasize the importance of utilizing typologies when studying the family across multiple hierarchical levels, particularly in clinical settings (Browne et al., 2015). In clinical practice, such typologies can help inform tailored interventions for families' specific goals and also support the development of public health preventative approaches.

Taken together, the emergence of profiles in two distinct cohorts highlights the interconnected nature of relational subsystems within families (Cox & Paley, 1997; Frosch et al., 2021). While some families demonstrated patterns consistent with a more unitary conceptualization of family functioning, others revealed more nuanced patterns of interactions across relational subsystems. This is consistent with previous applications of LPA to families, which had identified distinct typologies relating to family functioning (Simpson et al., 2018; Tang et al., 2022; Withers, 2020; Xia et al., 2022). The present findings, along with the existing literature, demonstrate that family functioning is not uniformly captured across relational subsystems. Instead, distinct subgroups emerge identifying meaningful variations in relational functioning, reinforcing the utility of person-centered approaches in capturing heterogeneity in family systems. Moreover, these findings emphasize the importance of adopting a multilevel, systemic approach to studying family-wide dynamics (Browne et al., 2015; Jenkins & Bisceglia, 2010). Such approaches support a more nuanced understanding of how functioning across relational subsystems interacts with each other and contextual factors.

Predictive Validity of Profiles for Mental Health Outcomes

Consistent with previous person-centered family literature, profile membership demonstrated predictive validity of child and caregiver mental health outcomes (Simpson et al., 2018; Tang et al., 2022; Withers, 2020). These findings provide insight into how group-based variations in family functioning can be related to later psychological wellbeing.

In the general population sample, child and caregiver mental health outcomes were most optimal for those in the *Higher Functioning* group, intermediate in the *Moderate* group, and most elevated in the *High Conflict* group. These findings mirror previous studies applying LPA to family functioning, which found that mental health outcomes varied as a function of relational challenges (Simpson et al., 2018; Withers, 2020). For instance, Simpson and colleagues (2018) found that adolescents with low family functioning or who were only close to their mothers reported greater depression and anxiety symptoms, compared to average and high family functioning. Similarly, Withers (2020) observed that adolescents in families with detached and avoidant family profiles reported greater delinquency, while parents' depression was lowest in the detached group and highest in the avoidant group. However, outcomes in the *Couple Distress* group were more nuanced. Caregivers in this group reported levels of distress comparable to those in the *High Conflict* group, suggesting that they experienced the highest levels of distress and anxiety. This is consistent with past literature showing that caregivers in high-conflict marital relationships report more distress and physical symptoms (Choi & Marks, 2008; Lin et al., 2017). Similarly, Hannighoffer and colleagues (2017) found that marital relationship quality was positively associated with maternal mental health. In contrast, children in the *Couple Distress* group showed outcomes more comparable to those in the *Higher Functioning* and *Moderate* groups. This suggests caregivers were most affected by the marital relational

challenges, while children remained relatively less affected. This finding is promising, suggesting that there may be other protective factors that buffer against children's wellbeing, despite caregiver tension. Supporting this, previous studies have observed a similar pattern, where various factors can buffer against marital discord. For instance, sibling relationships have been found to be protective against stressors (Davies et al., 2019; Gass et al., 2007). Moreover, children's positive coping moderated the impact of marital conflict against internalizing symptoms (Tu et al., 2016). Within a clinical context, these areas of strength can be leveraged to promote more adaptive functioning across the entire family (Walsh, 2016a). Moreover, both *Couple Distress* and *High Conflict* groups reported the lowest perceived social supports. Social supports have long been associated with improved caregiver wellbeing, which may explain why these caregivers report the most mental health challenges (Harandi et al., 2017).

Contrary to the general population cohort, fewer differences in mental health outcomes emerged across profiles in the treatment-seeking group. In other words, profiles demonstrated greater predictive validity in the general population sample than in the treatment-seeking sample. Among caregivers, one significant difference was observed: those in the *Couple Distress* group reported higher levels of distress compared to those in the *Higher Functioning* group, consistent with findings from general population sample (Choi & Marks, 2008; Lin et al., 2017). For children, significant differences primarily emerged for the second child, with those in the *Couple Distress* group showing greater challenges than those in the *Higher Functioning* group. While children in the *Child/Sibling Tension* group descriptively reported the highest levels of mental health concerns, more significant distinctions may not have emerged due to the profile's smaller size, limiting statistical power. Previous studies have similarly found that children experiencing greater conflict with their caregivers and siblings were reported to have more mental health and

behavioural challenges (Iturralde et al., 2013; Lei et al., 2023; J. Li et al., 2025; Tschan et al., 2019).

The differences in predictive validity of profiles may partly reflect the composition of both cohorts. The general population sample likely captured greater variability and was more representative of diverse families, showcasing clearer distinctions between profiles (Haslbeck & Fried, 2017). In contrast, the treatment-seeking group reflected a highly specific subgroup of the population—families motivated and able to participate in an intensive, two-day family therapy workshop. Previous research has demonstrated that caregivers who participate in these types of interventions tend to have higher parental self-efficacy (Gonzalez et al., 2021). Additionally, external factors—such as household income, caregiver education, and social support—were predictors of caregiver participation in interventions (Argiros et al., 2023; Fleming et al., 2015). As such, these factors may have contributed to reducing variability in the range of caregiver outcomes. As well, it is possible that there were no differences across profiles for the primary child, as their baseline levels of concerns were already elevated, since caregivers in the treatment-seeking cohort sought out intervention for that child. In general, children who are referred to such interventions are reported to experience higher levels of mental health concerns, relative to their non-clinical counterparts (Low et al., 2008; MacLeod et al., 1999). This reduced variability may have obscured differences across profiles in their outcomes, compared to children in the general population sample.

Overall, profile membership offers stronger predictive validity in the general population sample, likely related to greater variability in family and individual functioning and fewer clinical concerns (Haslbeck & Fried, 2017). In that cohort, the nuances observed in mental health outcomes across profiles highlight the interactions between relational dynamics and individual

wellbeing (Simpson et al., 2018; Withers, 2020). In contrast, the more subtle differences across profiles in the treatment-seeking group may be more reflective of sample characteristics, including pre-existing mental health concerns and greater caregiver motivation for intervention (Argiros et al., 2023; Fleming et al., 2015; Gonzalez et al., 2021). Overall, this study's results suggest that there may be other factors contributing to variations in child and caregiver mental health within treatment-seeking families, beyond profile membership.

The predictive validity of profiles in two distinct samples reinforce the value of adopting a person-centered understanding of family dynamics, particularly in the context of relational diagnosis and precision mental health. The evidence that there is heterogeneity within the population predicting later mental health outcomes affirms that clinical conceptualization should consider the natural variation in family typologies, ranging from healthy to dysfunctional (Denton, 2007; Kaslow, 1996). Moreover, the differing mental health outcomes across family profile highlight the need to move beyond a one-size-fits-all approach and to consider families' unique relational needs for assessment and intervention (Bickman et al., 2016; Purgato et al., 2021). These differences may provide important clinical insight for predicting treatment outcomes and allow clinicians to adjust treatment accordingly for optimal outcomes (Bonadio & Tompsett, 2018; Pelham et al., 2017). These patterns underscore the importance of considering family dynamics together with contextual factors, when assessing family wellbeing.

Clinical Applications

The present study offers several promising clinical applications. The use of LPA to examine family dynamics across multiple relational subsystems emphasizes the value of moving beyond a broad assessment of overall family functioning. Instead, it highlights the importance of simultaneously considering the unique contributions of each subsystem (Browne et al., 2015;

Cox & Paley, 1997; Fiese et al., 2019). This is especially relevant in clinical samples, where family functioning often cannot be captured as a unitary construct and instead reflects meaningful variations across subsystems (Borden et al., 2014; Dong et al., 2021). Compared to traditional variable-centered techniques, person-centered approaches like LPA allow for the identification of distinct patterns of family functioning, shedding light on important variations between normative and dysfunctional family dynamics (Simpson et al., 2018; Withers, 2020; Xia et al., 2022).

Additionally, person-centered approaches can also be more conducive to a strengths-based perspective. For instance, while a family may face challenges in one domain, they may also demonstrate resilience in another—strengths that may be overlooked from a variable-centered lens. Specifically, a family experiencing stress within one relational subsystem but not in others could be seen as an important area of strength and resilience (Walsh, 2016a). In therapeutic settings, clinicians may be able to leverage such strengths. For example, they could draw on effective communication and conflict resolution strategies in the caregiver-child relationship and apply them to challenges within the marital relationship (Furrow et al., 2019; Sexton & Turner, 2010).

Indeed, many therapeutic orientations involving the family emphasize identifying and utilizing existing strengths within the family system. While most are manualized—meaning there is a predetermined structure to the therapeutic process—they are also designed with the flexibility to be tailored to clients' specific needs, striking a balance between standardized, evidence-based care and personalized treatment (Holder et al., 2020; Levinson et al., 2025; Torsteinsson & Hægland, 2024). One such orientation is Emotion Focused Family Therapy (EFFT), a family-based intervention initially developed for parents supporting a child recovering

from an eating disorder, that has since been adapted to other contexts (LaFrance Robinson et al., 2015). The EFFT framework targets four core domains: emotion coaching, therapeutic apologies, emotional blocks, and recovery/behaviour coaching. These domains are each tailored to a family's specific areas of strength and need. Similarly, Brief Strategic Family Therapy and Multidimensional Family Therapy both work by enhancing familial relationships and strengths towards improving problematic behaviours (Liddle et al., 2001; Szapocznik & Williams, 2000).

Furthermore, applying person-centered approaches to family-wide science and clinical practice holds promise for advancing relational diagnosis and precision mental health. These techniques support more nuanced case conceptualization—while also considering the effects of relational challenges—and enable clinicians to tailor interventions to a family's specific areas of strength and need (Almirall & Chronis-Tuscano, 2016; Petersen et al., 2019). Recent studies have begun to apply person-centered analysis to various public health parenting interventions, such as the Family Check-Up (FCU), a tailored family-centered intervention (Dishion & Kavanagh, 2003). For example, Dishion and colleagues (2019) applied LPA to examine adolescents' relational functioning with caregivers and peers, lending insights into how the FCU intervention can be tailored based on distinct adolescent profiles. Similarly, person-centered techniques have been applied to explore differential efficacy of the FCU across different youth and family profiles (Connell et al., 2018; Pelham et al., 2017). This approach allows clinicians to concentrate support where it is most needed, by identifying the particular subsystems that may be driving family-wide dysfunction (Dishion et al., 2019). In turn, this can enhance treatment precision and effectiveness. Finally, identifying families who exhibit profiles associated with elevated risk can help inform early screening and prevention efforts, ensuring interventions are directed and accessible to those most in need (Bonadio & Tompsett, 2018; Persram et al., 2025).

Strengths, Limitations, and Future Directions

The present study has several strengths. First, the use of a longitudinal design enabled validation analyses using data from a later timepoint, providing support for the predictive validity for the latent profiles. Second, this study is among the few to concurrently examine relational and contextual indicators for latent profiles, allowing for the investigation of factors operating at various levels within the familial environment. Lastly, a notable strength of this study is the inclusion of both general population and treatment-seeking (clinical) samples. In person-centered research, the ability to replicate profiles or identify group differences is essential, as it offers insight into factors that distinguish families who seek treatment from those who do not.

Despite these strengths, the present study also has several limitations. First, data from both samples were collected through single informant (caregiver) report measures, which raises concerns about shared method variance and reliability. Caregivers' perceptions of family functioning, relational health, and child wellbeing may not align with how other family members report these experiences (De Los Reyes et al., 2015; Korelitz & Garber, 2016). Additionally, data collection for both cohorts started during the first wave of the COVID-19 pandemic, a period marked by heightened stress and unique challenges. This reduces generalizability of the current findings to post-pandemic contexts. Relatedly, mental health outcomes were only examined at follow-up and were not compared to baseline mental health. Future research could address these limitations by examining the stability of family profiles over time, using latent transition analysis, allowing for longitudinal family groupings and the exploration of temporal influences. Moreover, the sample size of the treatment-seeking sample was smaller than the recommended 500, limiting statistical power. Future studies should aim to have two samples with at least 500

participants each. There are also limitations regarding to the generalizability of the identified profiles. Both samples were limited in the diversity of participants and consisted of predominantly White, educated, middle class, and married participants. A more representative sample may have shifted the proportion of individuals within each profile or altered the profiles themselves. Moreover, the two cohorts differed geographically, with one sample primarily based in the United Kingdom and the other in Canada. Variations in sociocultural context and pandemic-related policies may have contributed to differences in profiles across the samples. Future research should aim to include more diverse and representative samples, incorporate multi-informant reports, and continue to compare clinical and non-clinical contexts, to strengthen our person-centered understanding of relational dynamics within the family system.

Conclusion

Despite the well-established influence of relational processes on family functioning and individual wellbeing, relational diagnosis remains underutilized within clinical practice (Cox & Paley, 1997; Kaslow & Patterson, 2006). Similarly, person-centered approaches to family-wide science are often overlooked, limiting our understanding of variations within families (Browne et al., 2015; Lanza & Rhoades, 2013). This study sought to address these gaps by identifying latent profiles of family dynamics across relational and contextual factors, in both general population and treatment-seeking samples. These profiles were then used to predict later child and caregiver mental health. Findings revealed distinct typologies across both samples, with meaningful differences in mental health outcomes. Together, these results underscore the value of studying relational patterns within families from a person-centered perspective. Families are dynamic, interconnected systems and clinical practice must recognize this complexity by tailoring interventions and supports to best meet each family's unique needs.

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Appendix

Table 15

Mean Scores and Standard Deviations on Indicators Across Four Latent Profiles of Family Dynamics in the CRAMPED Sample

	Higher Functioning (<i>n</i> = 140)		Moderate (<i>n</i> = 213)		Couple Distress (<i>n</i> = 90)		High Conflict (<i>n</i> = 106)	
Family Functioning	-0.66	(0.08)	-0.20	(0.18)	0.49	(0.23)	0.88	(0.16)
Parenting Quality	0.89	(0.13)	-0.12	(0.21)	0.31	(0.28)	-1.22	(0.17)
Differential Parenting	-0.26	(0.08)	-0.03	(0.08)	-0.06	(0.19)	0.34	(0.17)
Couple Satisfaction	0.70	(0.08)	0.32	(0.13)	-0.97	(0.32)	-0.79	(0.32)
Marital Conflict	-0.47	(0.10)	-0.13	(0.11)	0.49	(0.27)	0.49	(0.26)
Sibling Relationship Quality	-0.85	(0.15)	0.27	(0.19)	-0.08	(0.19)	0.68	(0.15)
Caregiver Resilience	0.72	(0.13)	-0.04	(0.14)	-0.26	(0.23)	-0.67	(0.22)
Child Resilience (Mean)	0.92	(0.19)	-0.24	(0.16)	0.12	(0.16)	-0.87	(0.20)
Child Resilience (SD)	-0.25	(0.12)	0.11	(0.09)	-0.14	(0.17)	0.24	(0.16)
Social Supports	0.60	(0.06)	0.36	(0.12)	-0.84	(0.26)	-0.82	(0.27)
Household Income	0.15	(0.12)	0.07	(0.14)	-0.20	(0.18)	-0.18	(0.15)
Caregiver Education	0.11	(0.11)	0.06	(0.16)	-0.17	(0.27)	-0.14	(0.21)

Note. Indicators were Z-scored. Values in this table represent the original values, before being reversed for visualization. Higher scores for Family Functioning and Sibling Relationship Quality indicate greater challenges.

Table 16***Mean Scores and Standard Deviations on Caregiver Mental Health Outcomes Four Latent******Profiles of Family Dynamics in the CRAMPED Sample***

	Higher Functioning (<i>n</i> = 140)		Moderate (<i>n</i> = 213)		Couple Distress (<i>n</i> = 90)		High Conflict (<i>n</i> = 106)	
	M	(SD)	M	(SD)	M	(SD)	M	(SD)
Distress	13.89	(0.62)	17.84	(0.74)	22.55	(1.77)	24.40	(1.22)
Anxiety	5.01	(0.28)	6.64	(0.35)	8.65	(0.78)	9.14	(0.59)
Sleep	1.90	(0.12)	2.41	(0.12)	2.38	(0.21)	2.84	(0.17)

Table 17***Mean Scores and Standard Deviations on Child Mental Health Outcomes Four Latent******Profiles of Family in the CRAMPED Sample***

	Higher Functioning (<i>n</i> = 140)		Moderate (<i>n</i> = 213)		Couple Distress (<i>n</i> = 90)		High Conflict (<i>n</i> = 106)	
	M	(SD)	M	(SD)	M	(SD)	M	(SD)
Young Child Anger	6.47	(0.29)	8.91	(0.39)	7.62	(0.71)	11.05	(0.57)
Older Child Anger	6.89	(0.37)	8.35	(0.37)	8.66	(0.68)	11.56	(0.64)
Younger Child Anxiety	10.17	(0.41)	11.77	(0.52)	13.26	(1.07)	15.21	(1.00)
Older Child Anxiety	10.56	(0.55)	12.2	(0.61)	12.81	(1.05)	16.56	(1.06)
Younger Child Depression	7.42	(0.29)	9.25	(0.42)	9.13	(0.76)	12.42	(0.76)
Older Child Depression	7.98	(0.43)	9.77	(0.49)	10.07	(0.83)	12.83	(0.79)
Younger Child Sleep	11.98	(0.62)	14.32	(0.57)	14.61	(1.31)	18.94	(1.08)
Older Child Sleep	13.21	(0.94)	15.33	(0.65)	14.42	(0.97)	18.99	(1.12)

Table 18***Mean Scores and Standard Deviations on Indicators Across Three Latent Profiles of Family******Dynamics in the EFFT Sample***

	Higher Functioning (n = 68)		Couple Distress (n = 70)		Child / Sibling Tension (n = 21)	
	M	(SD)	M	(SD)	M	(SD)
Family Functioning	-0.62	(0.13)	0.43	(0.15)	0.48	(0.38)
Parenting Quality	0.58	(0.14)	-0.22	(0.14)	-1.11	(0.59)
Differential Parenting	-0.14	(0.12)	-0.01	(0.12)	0.26	(0.50)
Couple Satisfaction	0.73	(0.11)	-0.86	(0.18)	0.66	(0.44)
Marital Conflict	-0.56	(0.17)	0.69	(0.16)	-0.65	(0.45)
Sibling Relationship Quality	-0.50	(0.17)	0.33	(0.14)	0.59	(0.52)
Caregiver Resilience	0.43	(0.12)	-0.34	(0.15)	-0.23	(0.28)
Child Resilience (Mean)	0.43	(0.11)	-0.04	(0.14)	-1.25	(0.79)
Child Resilience (SD)	0.32	(0.19)	-0.23	(0.14)	-0.39	(0.81)
Social Supports	0.52	(0.11)	-0.39	(0.16)	-0.39	(0.30)
Household Income	0.13	(0.16)	0.05	(0.17)	-0.67	(0.40)
Caregiver Education	0.10	(0.18)	0.15	(0.16)	-0.93	(0.49)

Note. Indicators were Z-scored. Values in this table represent the original values, before being reversed for visualization. Higher scores for Family Functioning and Sibling Relationship Quality indicate greater challenges.

Table 19***Mean Scores and Standard Deviations on Caregiver Mental Health Outcomes Four Latent******Profiles of Family Dynamics in The EFFT Sample***

	Higher Functioning (<i>n</i> = 68)		Couple Distress (<i>n</i> = 70)		Child/Sibling Tension (<i>n</i> = 21)	
	M	(SD)	M	(SD)	M	(SD)
Distress	17.39	(0.76)	21.69	(1.13)	18.9	(2.21)
Anxiety	7.35	(0.41)	8.83	(0.55)	7.02	(0.67)
Sleep	2.5	(0.14)	3.02	(0.16)	2.6	(0.23)

Table 20***Mean Scores and Standard Deviations on Child Mental Health Outcomes Four Latent******Profiles of Family Dynamics in the EFFT Sample***

	Higher Functioning (<i>n</i> = 68)		Couple Distress (<i>n</i> = 70)		Child/Sibling Tension (<i>n</i> = 21)	
	M	(SD)	M	(SD)	M	(SD)
Young Child Anger	10.7	(0.56)	12.31	(0.57)	13.42	(1.62)
Older Child Anger	8.26	(0.50)	10.96	(0.55)	12.92	(2.58)
Younger Child Anxiety	15.32	(1.03)	17.42	(0.99)	17.5	(2.11)
Older Child Anxiety	12.36	(0.78)	15.64	(0.97)	19.28	(3.19)
Younger Child Depression	11.36	(0.75)	14.22	(0.79)	13.23	(1.59)
Older Child Depression	9.41	(0.54)	11.26	(0.63)	11.93	(2.56)
Younger Child Sleep	3.59	(0.14)	3.62	(0.14)	3.44	(0.41)
Older Child Sleep	4.01	(0.16)	3.62	(0.12)	3.26	(0.76)