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AN ANALYSIS OF THE PARENTAL REFLECTIVE FUNCTION, THE QUALITY OF TRIADIC INTERACTION AND ITS INFLUENCE ON EARLY CHILDHOOD DEVELOPMENT

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León, M.J., & Olhaberry, M. Family Triadic Interactions, couple satisfaction and Parental Reflective Function in early infancy: ¿How work together? *Infant Mental Health.* (Sent to review)

León, M.J., Olhaberry, M., Hernández, C., & Sieverson. Satisfacción de Pareja y Depresión: ¿Es la Función Reflexiva una variable interviniente? *Psykhe.* Artículo en revisión.

Summary

The prevalence of social-emotional problems in early childhood continues at a high level (Centro de Microdatos-Universidad de Chile, 2014). This stage is a critical period in which the immediate family is the most influential system in childhood development (Bronfenbrenner, 1987). Conversely, the parental reflective function (RF) is considered a protective factor in early parenting (Stacks et al., 2014), assuming a relevant role in social-emotional development in early childhood (Ensink, Bégin, Normandin, & Fonagy, 2016; Smaling, Huijbregts, van der Heijden, van Goozen, & Swaab, 2016a).

Objective: To describe and analyze the relationship between fathers' and mothers' RFs, the quality of the mother-father-child triadic interaction, and children's psychomotor development and social-emotional difficulties.

Method: A non-experimental, transversal and correlational study was developed. Fifty mother-father-child triads, each in a current relationship that included at least one child from 12–36 months of age, were evaluated. Sociodemographic background, triadic interaction (LTP, Fivaz-Depeursingue & Corboz-Warnery, 1999), parental RF (PDI-S, Slade, Aber, Berger, Bresgi, & Kaplan, 2012, assessed by RF Scales, Fonagy, Steele, Steele, & Target, 1998), psychomotor development (ASQ-3, Squires & Bricker, 2009) and social-emotional difficulties (ASQ SE, Squires, Bricker, & Twombly, 2002) were measured. Couple relationship satisfaction (RAS, Hendrick, 1988) and depressive symptoms in the parents (BDI-I, Beck, Ward, Mendelson, Mock & Erbaugh, 1961) were included as control variables.

Results: A significant effect of the triadic interaction on the child's social-emotional difficulties was found. The effect explained 20% of the variance. However, this effect was not found in the psychomotor development. In addition, the mothers' RF had a significant

influence on the triadic interaction, explaining 21% of the variance. However, in contrast to the hypothesis, the mothers' and fathers' RFs were not significant variables as direct or indirect predictors to explain the child's socio-emotional difficulties or psychomotor development.

These findings show the importance of the RF on the quality of the mother-father-child interaction, which in turn influences the child's social-emotional development. Additionally, the role of the father and the implications of these findings for research and clinical purposes are discussed.

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I would like to say thank you to the people that support me during this journey. Thanks to my husband, Gonzalo for his support and for fly away together. Thanks to my mother, because she was the first that always impelled to reach my dreams.

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2. Introduction

Early childhood is considered a critical and sensitive period in a human being's life, worthy of in-depth study. When a baby is born, it is especially vulnerable to certain events and experiences that, depending upon their presence or absence, have a specific effect on the child's growth (Siegel, 1999). Thus, the post-natal environment and initial interpersonal experiences influence the structural and functional growth of an individual's brain, general development, and current and subsequent mental health (Schore, 2000).

National and international studies in early childhood development and mental health show that 11%–37% of children have some social-emotional difficulties between ages 6–60 months (Bian, Xie, Squires, & Chen, 2017; Briggs-Gowan et al., 2013; Centro de Microdatos-Universidad de Chile, 2014; Wendland et al., 2014). Similarly, psychomotor development is an issue that we have not resolved as a society in either Chile or in other countries of the world; 12–30% of children from 0–3 years present a delay or risk of delay in psychomotor development (ASQ-3 Technical Report, Centro de Microdatos-Universidad de Chile, 2014; Schonhaut, Armijo, Schönstedt, Alvarez, & Cordero, 2013). This prevalence is highly important because early development lays the foundations for later development, and studies show the links between early developmental difficulties and later behavioral, cognitive and social-emotional problems (Briggs-Gowan & Carter, 2008; Cheng, Palta, Kotelchuck, Poehlmann, & Witt, 2014; Essex et al., 2006; Giannovi & Kass, 2012; Pihlakoski et al., 2006).

Thus, in early childhood, the immediate family (mother, father and child) is the central and most influential relationship system in which a child develops (Bronfenbrenner, 1987). Interactions occurring in the mother-father-child triad constitute a complex process;

consequently, studies show that parental behavior observed in dyadic contexts is not necessarily the same as that observed in triadic contexts (Goldberg, Clarke-Stewart, Rice & Dellis, 2002; Johnson, 2001; Lindsey & Caldera 2006). The ecological model and systems theory allows us to understand the complexity of childhood development. These models propose a holistic and integrated approach to observing reality, allowing the complexity of human interaction to be appreciated and the evolution of the early family system to be understood in which another hierarchically superior system is imposed that fosters the new system's growth (Bronfenbrenner, 1987; Fivaz-Depeursinge, Fivaz & Kaufmann, 1982).

Attachment theory and intersubjective currents coincide with the above, showing that the human being, more specifically the human baby, is a psychologically active agent with an intrinsic tendency to grow and a motivation to establish bonds of affection, to communicate and to share with human beings who are "wiser" or have a greater likelihood of survival (Bowlby, 1969; Trevanthen, 1892, 1993, 1998, 2001; Trevanthen & Aitken, 2001; Tronick, 1989). The actions of these "wise beings" integrate the baby into a "human world" and provide him or her with knowledge of life in society and continuous and coherent psychological organization (Stern, 1977, 1985).

The persons who are wiser and integrate the child into the "human world" are the parents. However, although the child's natural context exceeds dyadic interactions, historically in psychology, the approach to understanding early child development has primarily been by studying the dyadic interaction, centered in the mother-child relationship (Fivaz-Depeursinge, & Corboz-Warnery, 1999). Given the dyadic understanding of childhood social-emotional development, focusing on the fathers' characteristics and the mother-father-child triadic interaction has been secondary. However, we now know that the father and mother interacting with their child is a key part of family and early childhood

development (Bronfenbrenner, 1987; Fivaz-Depaursinge, 1991; Fivaz-Depaursinge, Fivaz & Kaufmann, 1982), particularly in terms of organization and coordination of the tasks associated with raising children. The importance of this interaction is reflected in the type of triadic function observed among father-mother-child. For the child, the ability to interact in a triad is one of the main tasks in developing an autonomous self and in acquiring social skills (Hedenbro, 2006; Leidy, Schofield & Parke, 2013)

For the other hand, the scientific literature concurs on which characteristics underlie the development of sensitive parenting. One is the parental reflective function (Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Slade, 2005). Various studies have linked the parental reflective function with the intergenerational transmission of the attachment (Fonagy et al., 1991; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005), with parental sensitivity (Grienenberger, Kelly, & Slade, 2005; Rosenblum, McDonough, Sameroff, & Muzik, 2008) and with the child's development of social skills and reflective capacities (Ensink, Bégin et al., 2016; Smaling et al., 2016a; Steele & Steele, 2008).

Additionally, studies have considered the parental reflective function a protective factor in early parenting (Borelli, Hong, Rasmussen, & Smiley, 2017; Stacks et al., 2014) and a factor in the transmission of psychopathology (Ensink, Bégin, Normandin, & Fonagy, 2017; Esbjørn et al., 2013; Rothschild-Yakar, Waniel, & Stein, 2013).

Examination of the link between the triadic interaction, the parental reflective function and child development is ongoing. To date, only one study has linked triadic interaction and insightfulness (Marcu, Oppenheim & Koren-Karie, 2016). Hence, questions relating these variables to child development remain open.

The above leads to the following research question: What is the relationship among the mother's reflective function, father's reflective function, the quality of the triadic interaction and the child psychomotor development and social-emotional difficulties?

This question leads us to the general objective of this investigation: To describe and analyze the relationship between fathers' and mothers' reflective functions, the quality of the triadic interaction, and children's psychomotor development and social-emotional difficulties.

To respond to the proposed general objective, a quantitative methodology with a non-experimental, cross-sectional and correlational design was used. Fifty families were evaluated, comprising a mother and father in a current relationship with one child from 12–36 months.

Additionally, to achieve the aim of this study, the following variables were evaluated: the parental reflective function was evaluated via individual interviews of each parent, the triadic function was evaluated by recording family interactions, and childhood development and control variables such as couple relationship satisfaction and parental depression were measured using scales and questionnaires.

This study provides new information to help understand early childhood development, which has traditionally been addressed from a dyadic perspective focused on the mother-baby relationship. Understanding the relationship between 1) two fundamental variables such as the quality of the father-mother-child interaction and the ability of parents to reflect on their children's mental states and 2) the influence of both on childhood development allows exploring in greater depth and from another perspective the development of children and family mental health. Additionally, the approach opens a new area of research and intervention in family and child development and mental health in

which the role of the family and the father in early child development is considered at the same level as that of the mother.

As you read this thesis, you will review research work done over a four-year period. Beginning with the establishment of the problem, the document proceeds to describe the theoretical and scientific framework that underlies it, the methodology that provides robustness and reliability to the study, and the development of the findings. Finally, the discussion and implications of these findings are presented.

I invite you to enjoy this journey and discover what happens beyond the dyad!

3. Theoretical and empirical background

3.1. Early Childhood Development

The first three years of life are the most rapid period of development in the human lifespan. In this critical period, all areas of the child experience incredibly fast growth. The brain increases in size four-fold during the preschool period, reaching approximately 90% of adult volume by age 6, which is reflected in the children's behavior and skills (Reiss, L., Abrams, Singer, Ross, & Denckla, 1996; Iwasaki et al. 1997; Courchesne et al. 2000; Kennedy & Dehay 2001; Paus et al. 2001; Kennedy, Makris, Herbert, Takahashi, & Caviness 2002; Lenroot & Giedd, 2006).

A wide range of theories has tried to describe and understand child development, but no single one has been able to account for all aspects of child development. However, developmental authors are agreed that early child development depends on constitutional, maturational and environmental variables in which the environmental and mostly the early family relationships play a crucial role, affecting how the brain grows and develops and how the children build their cognitive, motor and social-emotional skills (Benz & Scholtes-Spang, 2015; Greenspan, DeGangu, & Wieder, 2001).

Because of the multiples theories, finding a clear definition of child development is not easy. A clear definition of psychomotor development is a gradual and continuous process of acquiring motor, cognitive and communication skills that begins at conception and culminates in maturity in which it is possible to identify stages of increasing complexity. This development has a similar sequence in all children but with a variable rhythm that depends upon the interaction of the child's constitution and his/her context (Illingworth, 1983 in Vericat, & Orden, 2013).

Developing a definition of social-emotional development is more complex because some social and emotional competences are family, community and culturally dependent. However, it is known that this development also occurs in a continuum process that is meaningfully integrated into more advanced levels of complex functioning. The social area refers to the development of behaviors, abilities and competences that permit engaging and positively interacting with others (e.g., siblings, peers, and adults) (Rose-Krasnor, 1997; Squires et al., 2002). For its part, the emotional area, which overlaps with the social competences, refers to the gradual ability to regulate the emotions effectively to achieve some goal such as having positive social interaction, learning, and play. The development of this competence is strongly embedded in early family interactions (Campos, Mumme, Kermoian, & Campos, 1994; Lyons-Ruth, & Zeanah, 1993; Squires et al., 2002).

Thus, Greenspan and collaborators (2001) indicate that each stage of early development can be understood as the result of specific patterns of interaction between the caregiver and the infant. Similarly, Benz, and Scholtes-Spang (2015) propose that one of the main developmental milestones in early childhood is the achievement of emotional regulation, which occurs in early interactions with the caregivers and is key to successful development.

Based on the theoretical background of child development mentioned, it is relevant to review how the different abilities emerge in the first three years of life. Thus, among development scientists, there is now a consensus that babies are born with an innate ability to relate affectively and psychologically with others (Bowlby, 1969; Stern, 1985; Trevanthen, 1892, 1993, 1998; Trevanthen & Aitken, 2001; Tronick, 1989). At the beginning, the baby's interaction is centered on person-to-person. At 3–4 months, empirical studies have shown that babies already manifest indicators of coordination of attention and

affection toward both parents when interacting with them together. These findings suggest that a child's capacity to interact with two partners develops concurrently and not subsequently to dyadic competences (Fivaz-Depeursinge, Favez, Lavanchy, De Noni, & Frascarolo, 2005; Frascarolo, Favez, Carneiro, & Fivaz-Depeursinge, 2004; McHale, Fivaz-Depeursinge, Dickstein, Robertson, & Daley, 2008).

At approximately 7–9 months, the ability to participate in three-person interactions is clearer. The baby has developed purposeful communication, meaning that the child can show his or her preferences by pointing, sharing states of mind by attracting attention and influencing the mental states of adults (Wobber, Herrmann, Hare, Wrangham, & Tomasello, 2014; Tomasello, Carpenter, Call, Behne, & Moll, 2005). The child also can exchange looks with his or her father and mother in response to their affection and his or her own emotional states (Fivaz-Depeursinge, & Corboz-Warnery, 1999), becomes able to recognize the thoughts of others, and can share his or her own emotional states (Carpenter, Nagell, & Tomasello, 1998; Trevarthen, 1993; Stern, 1985). These skills favor the regulation of emotional states in contexts of more than two people because the child can use positive emotional states to indicate its desire to continue the interaction and, in stressful or annoying exchanges, the baby can express signs of upset to show its desire for the exchange to stop (Fivaz-Depeursinge & Philipp, 2014).

Additionally, in the first year, the child acquires a whole set of new motor and communication skills that significantly change how the body moves in and interacts with the environment (Iverson, 2010). In the toddler years, the development of social competence is based on milestones in other domains, including symbolic thought, focused attention, and emotion understanding and regulation that allow the child to engage in more complex social interactions, join in group activities, begin to form friendships, cooperate

with other people to achieve a goal, and function competently within a non-familial social context (Denham et al., 2003; Feldman, Masalha, & Alony, 2006).

From birth, a nutritive context and sensitive care promote healthy development; alternatively, a risky environment and conflictive family context negatively affect child development (Hart & Risley, 1995; Sirin, 2005). Thus, the links between early psychomotor and social-emotional difficulties and behavioral, cognitive and social-emotional problems in late infancy are well documented (Briggs-Gowan & Carter, 2008; Cheng et al., 2014; Essex et al., 2006; Giannovi & Kass, 2012; Pihlakoski et al., 2006). Additionally, the number of children who today have early social-emotional problems remains quite high. Different studies show ranges from 11%–37% of children with social-emotional difficulties in children aged 6–60 months (ASQ-SE Technical Report; Bian et al, 2017; Briggs-Gowan et al., 2013; Wendland et al., 2014). In Chile, 17,1%–24,2% of children from 12–60 months present social-emotional difficulties (Centro de Microdatos-Universidad de Chile, 2014).

Concerning the psychomotor area, typically including the communication, cognitive and motor skills, approximately 69% of the children from 0–66 months experience typical development, 7,4% present one risk area of delay, and the remaining percentage have problems in two or three areas (ASQ-3 Technical Report). In Chile, 71%–88% of children 0–3 years of age are in the range of typical development; the rest present a delay or risk of delay in psychomotor development (Centro de Microdatos-Universidad de Chile, 2014; Schonhaut et al., 2013).

The national and international data that were exposed show that we continue to owe children developmental and mental health. Therefore, various countries have been developing the ability to assess child development in the first year during medical visits

(e.g., in Chile, this process is called “healthy child control”). Thus, screening child development from birth is a powerful tool to detect and prevent later problems (Committee on Children with Disabilities, 2001; Squires, Bricker & Twombly, 2004).

3.2 Study of the Father-Mother-Child Triad and the Early Family Group

How infant and toddler development is highly influenced by early relationships was described in the above paragraphs. Thus, although the child’s natural context exceeds dyadic interactions, historically in psychology, the approach to understanding child development has primarily been by studying the mother-child interaction (Fivaz-Depeursinge, & Corboz-Warnery, 1999). Fathers have been studied through the father-child dyad. Such studies have ranged from research on fathers’ presence/absence and on gender roles to the evaluation of closeness and involvement in rearing and their relationship with childhood adjustment and development (Lamb, 2013). Conversely, triadic father-mother-infant family relationships have long been ignored despite being a fundamental domain of family and childhood development (Fivaz-Depeursinge, & Corboz-Warnery, 1999). However, in the last decade, a growing number of researchers have been interested in this important dimension of child and family adjustment.

3.2.1. Origin of the study of the father-mother-child triad

The study of the family, which developed from family therapy, arose in the 1950s in the United States (Pereira, 1994). From the field of childhood, John Bowlby (1949) studied the early family group to understand childhood adjustment problems. In 1985, Minuchin developed structural family therapy, arguing that the parent-child dyad operates in the context of family subsystems.

One of the pioneers in studying the family triad in early childhood was Michael Lamb (1976), who observed 18-month-old children interacting with their parents. Parke, Power and Gottman (1979) developed a model to conceptualize and quantify influence patterns in the family triad. Belsky, Gilstrap and Rovine (1984) studied mother/father-baby and mother-father dyads and proposed family classifications to analyze different combinations of the three dyads. By the end of the 1980s, Lewis, in his study "The Birth of the Family", came close to determining that the triad is a total system (Lewis, 1989). Elizabeth Fivaz-Depeursinge and collaborators also began studying triadic family interactions in the 1980s, seeking to understand family and childhood development, and in 1987 published the first article on the family group addressing families with children in early childhood (Fivaz-Depeursinge, 1987). At the beginning of the 1990s, an observational system for analyzing triads was developed called "The Lausanne Triadic Play" (Corboz-Warnery, Fivaz-Depeursinge, & Bettens, 1993).

The above studies show that the mother-father-child triad can be understood as a unit with its own structure and characteristics, an entity with a different interaction from that of the sum of the dyads in which the addition of another person alters the dynamics of the interaction between dyadic subsystems and gives rise to a more diverse and complex socio-emotional environment (Fivaz-Depeursinge, & Corboz-Warnery, 1999; McHale & Fivaz-Depeursinge, 1999; Minuchin, 1985). From this perspective, the Lausanne team proposed the structural and dynamic foundations of the family triadic interaction, which has a hierarchical embedded function necessary to establishing a successful interaction. They indicate that the family must first be corporally available to interact; then, they must recognize and respect each role. They must also have a common focus of exchange and sharing and the capacity to share affect. Concerning the dynamic foundation, the authors

indicate that every interaction must address fluctuations, transitions and adjustment (Frascarolo et al., 2004; Favez, Lavanchy, Tissot, Darwiche, & Frascarolo, 2011).

3.2.2. Triadic Interactions, couple relationship satisfaction and early childhood development

In the study of triad family interactions, the parental subsystem has been extensively studied in terms of its effect on parenting. In this context, couple satisfaction, defined as the global and subjective assessment of attitudes, feelings, and assessments of the positive and negative aspects of the partner and the relationship (Hendrick, 1988), has been conceived as a variable that plays an important role in the quality of family functioning (Shapiro, Gottman & Carrère, 2000).

Empirical studies have considered the association between couple satisfaction and co-parental alliance, triadic interaction and child outcomes. Longitudinal studies with preschool children and their parents show a relationship between couple satisfaction and family function, associating discord between parents with negative effects on parenting, co-parenting and the child (Cummings & Davies, 2010; Davies, Cummings, & Winter, 2004). Thus, low relationship satisfaction and high levels of conflict between parents have negative emotional consequences in the child, primarily on his or her emotional regulation skills and externalizing behavior at school age (El-Sheikh et al., 2009). Furthermore, well-adjusted couple relationships positively correlate with greater family warmth, cohesion and interactions and with a greater ability to resolve conflicts (Altenburger, Schoppe-Sullivan, Lang, Bower & Kamp Dush, 2014).

Teubert and Pinquart (2010) conducted a meta-analysis with longitudinal studies only, and detected that co-parenting is a significant predictor of change in child

psychological adjustment over the time; however, the size effect was small, so the results should be interpreted with caution. Nevertheless, other longitudinal studies with a non-referred sample show that marital satisfaction is not linked with child behavior or the quality of the triadic interaction (Favez et al., 2012).

Additionally, marital satisfaction in a couple with children has a decreasing trend over time, measured with a 24-month-old child (Kohn et al., 2012), a 30-month-old child (Trillingsgaard, Baucom, & Heyman, 2014) and at preschool age (Simonelli, Parolin, Sacchi, De Palo, & Vieno, 2016). Thus, Favez and collaborators (2006) found that for a triad whose interaction was high quality during pregnancy, a decrease in that quality by when the child was 18 months old was paradoxically predicted by particularly high marital satisfaction. In contrast, a decrease in marital adjustment perceived by partners during the transition to parenthood and until preschool age is associated with an improvement in the quality of family interactions in this period (Favez, Frascarolo, Carneiro, Montfort, & Corboz-Warnery, 2006). This observation suggests that a decrease in marital satisfaction is a necessary and adaptive process for the transition from the dyadic system to the establishment of triadic family interactions (Simonelli et al., 2016).

The exposed studies show some controversial results. On the one hand, some studies report a positive and negative association between the variables (e.g., higher couple satisfaction, higher co-parenting and lower couple satisfaction, lower co-parenting). On the other hand, some studies show non-association between couple satisfaction and the other variables, or when couple satisfaction decreases over time, the triadic interaction has better quality. In summary, the association between couple satisfaction, triadic interaction and child behavior is not completely consensual. One explanation could be how the studies assess the variables (questionnaires, observational or interviews). Other possible

intervening variables that are not studied in these studies but affect the results (such as parental stress and some sociodemographic variables) include the homogeneity or heterogeneity of the sample, the range of the results of the assessed variables, and the duration of the study, among others.

3.2.3. Triadic Interactions and Childhood Development

Because couple satisfaction has been associated with the quality of triad interaction, the influence of the quality of early triadic interactions on child development has also been studied. The ability to interact in a triad has been proposed as one of the main tasks developing an autonomous self and in acquiring social skills, which are develop from experiences with primary caregivers and depend on the quality of these interactions (Fincham, 1998; Sroufe, 1996). Consequently, when the child learns to create and maintain relationships involving more than two people, he or she learns to share affection, attention and a common objective among three people, learning to address feelings of exclusion by developing greater social abilities (Liszkowski, Carpenter, Henning, Striano, & Tomasello, 2004; Fivaz-Depeursinge, & Corboz-Warnery, 1999). Thus, researchers have shown how more positive experience in a triad prepares children to function more competently with adults and peers in a non-family, multi-person environment (Feldman & Masalha, 2010).

Empirical studies have shown the effect of the quality of the family triadic interaction on child social-emotional competence. This influence can be seen at an early age. For example, mothers and fathers demonstrated more positive and cooperative interpersonal engagement and coordination in the triadic interaction and the Still-Face procedure; when their babies were three months old, the infants showed more coordinated gaze shifts from one parent to the other during the Still-Face challenge (McHale et al.,

2008). Likewise, Hedenbro and Rydelius (2014) found that a child's capacity to make child contributions and initiate turn-taking sequences at 3 months in the family triad is associated with the parents' responsiveness, which in turn correlates with the child peer and social competence at 48 months. Additionally, a higher degree of family coordination is associated with more relational and social competence with peers at preschool age (Cigala, Venturelli, & Fruggeri, 2014).

These results can also be found in other cultures. For example, in a normative sample of Israeli and Palestinian children, infant reciprocity with the mother, engagement with the father, and harmonious experience in the triad are important contributors to toddler social competence (Feldman, & Masalha, 2010). Higher marital hostility, a higher level of co-parental undermining behavior, and ineffective discipline were predictors of toddler aggression in both cultures (Feldman, Masalha, & Derdikman-Eiron, 2010). Thus, a longitudinal study that assessed children at infancy, preschool and adolescence indicated that early maternal and paternal reciprocity were each uniquely predictive of social competence and lower aggression in preschool, which, in turn, shaped dialogical skills in adolescence (Feldman, 2010; Feldman, Bamberger, & Kanat-Maymon, 2013).

The evolution of the quality of the triadic interaction has also shown an effect in the development of the theory of mind in early childhood. Thus, Favez et al. (2012) found three different patterns of triadic coordination among infants to 5-year-olds (high to high, high to low, and low to low). They also found that children in a family with stable, high-coordination interactions obtained higher scores on theory of mind tasks and better affective outcomes than did children in a family with a trajectory of high-to-low coordination interaction over time. Moreover, children of the high-to-low group had better outcomes in theory of mind tasks than did children of the families with a low stable

coordination group. These results illustrate the importance of the quality of the triadic interaction in early childhood (3, 9 and 18 months) in the develop of the theory of mind, which in turn shows the effect of early family interactions on the development of the structure of the brain (Shore, 1997).

In terms of attachment, Frascarolo and Favez (1999) found no association between problematic alliances and insecure attachment. However, in a low-medium income normative Chilean and German sample, a study found that triadic family interactions were linked to preschoolers' attachment security levels (Pérez, Moessner, & Santelices, 2017).

Moreover, scientific evidence shows that mothers in nuclear families in Chile have a higher quality of mother-child interaction compared with similar mothers in single-parent families, suggesting that the father plays a favorable role in family heath and child development (Olhaberry, & Santelices, 2013). Thus, different studies suggest that father involvement has a positive effect on child development, the mother-father-child relationship and the couple subsystem (Frascarolo, 2004; Pleck and Masciadrelli, 2004; Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008; Wilson & Prior, 2010). For example, higher levels of father involvement reported by parents corresponded with better interactive competences in the triadic interaction (Simonelli et al., 2016).

Finally, Fivaz-Depeursinge and Favez (2006) suggest that the interaction between the child and his or her mother and father can help resolve dysfunctional dyadic interactions with the other parent because the intervention of a third party with adequate interaction skills encourages the child to adopt new emotional regulation strategies during the interaction, thereby reducing tension and stress. However, this proposal is controversial because studies show contradictory results. For example, Johnson (2001) reports that triadic contexts displayed less-negative parental behavior than in dyadic situations, and no

difference in warmth and responsiveness of the parental behavior between the two contexts. Another study claims that mothers showed less-sensitive behavior to the child and more intrusive behavior to the father in triadic contexts in which fathers participated than they did during dyadic mother-child interaction (Lindsey & Caldera, 2006). Higher levels of engagement between mother and toddler were associated with lower levels of father positive parenting and children engaging with him in the triadic context (Kwon, Jeon, Lewsader, & Elicker, 2012). More recently, Udry-Jørgensen, Tissot, Frascarolo, Despland, and Favez (2016) showed that parents were significantly more sensitive in the dyad within the triad context than only in the dyad context. Likewise, family alliance was globally associated with sensitive parenting, suggesting that the triad is a protective factor for early infant-parent dyads.

The differences between the dyadic and triadic interactions again show, as Minuchin (1985) noted, that the family interactions are more than the sum of the various family subsystems. These differences, could explain other factors that these studies do not include; it could be that role distribution into the family, the time that each parent expends with his/her child and the quality of the couple relationship influence these findings. In addition, the parents' reflective abilities facilitate think in the other partner and include and support when interact in three.

3.2.4. Parental Depression, Triadic Interactions, reflective function and Early Childhood Development

Depression commonly affects adults of parenting age. Depressive disorder had the highest proportion of total burden across all regions of the world (Whiteford et al., 2010), and it is one of the main disorders influencing the father/mother-child relationship. From 10%–

20% of mothers will be depressed at some time in their lives (National Research Council and Institute of Medicine, 2009). In Chile, 27.9% (n = 1526) of the women and 11% (n = 908) of the men have depression symptoms from 25–44 years of age (Ministerio de Salud, Gobierno de Chile, 2011).

The prevalence of postpartum depression in women has been estimated to be from 13%–19% (O'Hara, & McCabe, 2013) and to be approximately 10.4% in men (Paulson & Bazemore, 2010), with rates three times higher in developing countries (Alvarado et al., 2000; Evans, Vicuña, & Marín, 2003). Studies show that the number of women with postpartum depression increases with time; 10% are diagnosed at 8 weeks postpartum, 22% receive the same diagnosis at 12 months after the baby is born (Barlow et al., 2010), and many of them can be chronified over time. In Chile, post-natal depressive symptoms affect approximately 40% of women (Jadresic, 2010).

Scientific evidence has shown that postpartum depression has a significantly negative effect on the child psychomotor, cognitive, emotional and behavioral development (Agnafors, Sydsjö, & Svedin, 2013; Pilowsky et al., 2008; Podestá et al., 2013; Weissman et al., 2006). Research consistently associates maternal depression with difficulties in mother-infant interaction (Olhaberry, Escobar et al., 2013; Hayes, Goodman & Carlson, 2013) and low levels of self-confidence in themselves and in their role as mothers at the child's pre-school age (Zietlow, Schlüter, Nonnenmacher, Müller, & Reck, 2014).

The effect of maternal depression on toddlers has been shown to have similar results as the effect of postpartum depression on infants. Studies report that mothers with depression symptoms experienced higher rates of conflict, more negativity, and were more likely to respond destructively to child oppositional behavior than were mothers without depression symptoms. Offspring of depressed mothers also displayed more tantrums

(Caughy, Huang, & Lima, 2009; Leckman-Westin, Cohen, & Stueve, 2009). Additionally, children with mothers who had depression symptoms were more often excluded by peers (Cummings, Keller, & Davies, 2005; Kam et al., 2011).

Conversely, mothers' depression and hostility subclinical symptoms induce in their infants motor behavior characterized by a major control of the environmental space (Piallini et al., 2016)

However, causally linking maternal depression with outcomes in children is fraught; other factors often moderate and mediate the links between maternal depression and the child outcome. For example, studies show that maternal and paternal depression and negative parenting behavior can be driven by elevated parental stress (Kamalifard, Hasanpoor, Kheiroddin, Panahi, & Payan, 2014; Venta, Velez, & Lau, 2016). Alternatively, the negative effect of the mother's depression is marginal when mother-toddler interactions are positive (Leckman-Westin, Cohen, & Stueve, 2009) or when the mother has good emotional regulation skills (Kam et al., 2011).

Maternal depression also interferes in family function, reducing the ability to interact as a triad and reciprocity in early social relationships (Feldman, 2007; Seifer, Dickstein, Sameroff, Magee, & Hayden, 2001). In a longitudinal study with a low-risk sample, Tissot, Favez, Ghisletta, Frascarolo, and Despland (2017) suggest that parental—mostly maternal—depressive symptoms, even of mild intensity, might jeopardize the development of healthy family-level relationships.

Moreover, cohesive families are associated with lower levels of maternal depression and higher involvement by the father, whereas participation by the father reduces maternal depression and increases family cohesion (Perren et al., 2003). Thus, Chilean studies show that cooperative triads exhibit lower levels of depressive symptoms among parents than do non-

cooperative families, although more studies are required to explore these findings further (Olhaberry, Santelices, Schwinn, & Cierpka, 2013; Pérez & Santelices, 2017).

Paternal depression has been studied less than maternal depression; however, paternal depression also causes adverse effects on the father, on the mother's mental health, on relationship satisfaction, on the father's support of the mother and child and on childhood psychosocial development (Kane & Garber, 2004; Ramchandani et al., 2011).

Paternal depression increases through the child's first 5 years of life (Garfield et al., 2014), and approximately 10% of fathers have depression symptoms in the first year after childbirth (Fletcher, Feeman, Garfield, & Vimpani, 2011; Paulson & Bazemore, 2010). The depression affects the father's style of parenting, reducing positive emotions such as warmth, sensitivity and responsibility and increasing negative emotions such as hostility, intrusiveness, and withdrawal. It also causes decreased involvement with his child (Huang & Warner, 2005; Wanless, Rosenkoetter & McClelland, 2008; Roggman, Boyce, Cook & Cook, 2002; Wilson & Durbin, 2010). Thus, depression increases the risk of adverse behavioral and emotional outcomes and psychiatric problems in the child (Ramchandani et al., 2005, 2008).

Maternal and paternal depression are highly correlated (Paulson & Bazemore, 2010); in comparing maternal and paternal depression, studies show that in fathers, the family environment, including maternal depression, couple conflict and, to a lesser extent, paternal noninvolvement, explain two-thirds of the total effect of paternal depression on the child's behavior at 3 years. The effect of the mother's depression on the child was more strongly associated with subsequent child problems than was paternal depression. Additionally, family factors explain less than one-quarter of the child outcomes; thus, the association appears to be better explained by other factors such as direct mother-infant interaction (Gutierrez-Galve, Stein, Hanington, Heron, & Ramchandani, 2015).

Conversely, depression is also strongly linked with a deficit in the ability to mentalize the other or oneself, primarily affecting the ability to make inferences with respect to affection, because this ability has been distorted by emotional states related to depressive symptoms (Ladegaard, Lysaker, Larsen & Videbech, 2014; Mattern et al., 2015; Uekermann et al., 2008). A higher mentalization focused on itself (e.g., self-absorbent reflection) at the expense of mentalizing others could be one cause of the deficit in reflective ability produced by the depression symptoms, which has been seen in substance abusing mothers with depression symptoms (Borelli, West, Decoste, & Suchman, 2012; Suchman et al., 2010).

3.3. Parental Reflective Function

In the context of familiar mental health and parenting, mentalization has been considered a highly important clinical variable that arose at the beginning of the 1990s from the study of patterns and intergenerational transmission of attachment. It was developed by Fonagy, Steele, Steele, Moran, and Higgitt, who introduced the concept of "Reflective Self-Function" in 1991, which they defined as "the internal observer of mental life" (Fonagy et al., 1991, p. 202). The function is intrinsically related to self-development and organization and is a central aspect of human social function (Fonagy, Gergely, Jurist, & Target, 2004).

The concept of Reflective Function (RF) refers to the operationalization of the psychological process preceding the ability to mentalize (Fonagy et al., 1998). The RF has an intra- and an interpersonal component and measures the capacity to represent one's own and others' behavior in the light of states of mind. This capacity requires the knowledge that experiences give rise to certain beliefs, feelings and desires, which in turn tend to result in certain types of behavior (Fonagy et al., 2004). However, to understand one's own mind and those of others requires underlying abilities such as the self-regulating abilities that typically

develop from secure attachment and that follow the development of the reflective function (Fonagy & Target, 1997). Reflective functioning and affective regulation are highly interconnected because self-regulation plays a fundamental role in the development of a sense of self and agency, which is why the appearance of affective regulation precedes that of mentalization (Fonagy et al., 2004).

Focusing on parenting competences resulted in the development of the concept of Parental Reflective Function, which refers to parents' ability to reflect on themselves as parents, their ability to represent and understand the child's internal experiences and their parent-child relationship, and that links the child's mental states with his or her behavior (Fonagy et al., 1998; Slade, 2005).

Some central aspects of the parental reflective function construct are the following: first, it must be contextualized in the child's development stage; otherwise, his or her state of mind cannot be correctly inferred (Slade, 2005). Second, the parents must recognize that states of mind are opaque; they cannot be fully known and cannot be precisely inferred (Fonagy et al., 1998; Slade, 2007). Third, parents must recognize that their own and their child's states of mind mutually influence one another (Fonagy et al., 1998; Rosenblum, McDonough, Sameroff & Muzik, 2008). Ordway, Sadler, Dixon, and Slade (2014) include parents' curiosity about their children, non-compulsive reflection, recognition of the perspective of the person reflecting on the other's states of mind, and confidence in the child's states of mind.

However, low reflective function levels or prementalizing modes exist and can be characterized as lacking awareness of the subjectivity of the infant mental world (Fonagy et al., 2016; Slade, 2005), as inaccuracy in interpreting the infant's internal states (Meins et al., 2012), and/or as distorted and often malevolent attributions (Allen, 2006). Hypermentalizing and pseudomentalization are means of prementalizing modes. The first is

another cause of inaccuracy caused by the over interpretation of others' mental states, which can be quite intrusive. The second refers to the tendency to engage in mindreading, but without genuineness, it is more a learned or cliché reflection (Allen, Fonagy, Bateman, 2008, Fonagy et al., 1998).

All of these pre-mentalization modes have been developed further from a theoretical perspective because the main instruments to assess the reflective function are narrative based (e.g., Parental development Interview, PDI, Slade et al., 2012; Adult Attachment Interview, AAI, George, Kaplan, & Main, 1985). The modes are codified by the Reflective Function Scale (Fonagy et al., 1998), which provides only a single score. Only the Parental Reflective Function Questionnaire, PRFQ, whose preliminary validation has recently been published (Luyten, Mayes, Nijssens, & Fonagy, 2017), takes some categories of the reflective function concept.

It was mentioned that the reflective function and the parental reflective function have the same origin; however, the focus is different. The first focuses on the general capacity to reflect, whereas the second focuses on the capacity to reflect about the parenting role and his/her child. Thus, the association between adult reflective function (assessed by AAI) and parental reflective function (assessed by PDI) is not expected to be perfect. For example, Steele and Steele (2008) found a medium significant correlation ($r = .50$), showing that the RF is a dynamic, developmental, and bidirectional capacity that might be to a significant extent context- and relationship-specific (Luyten et al., 2017). For example, a sample of pregnant women with trauma experiences measured on the AAI manifested specific deficits in the reflective function about the trauma but not in their general ability to reflect (Bernazzani, Normandin, & Fonagy, 2014).

Other concepts exist that explore the ability of parents to reflect on children's mental states. One of the concepts is Mind-Mindedness, which focuses on the recognition of the child as a mental agent and a proclivity to use language about states of mind in discourse (Meins, 1997). A similar concept is that of Insightfulness, referring to the "ability to consider the motives underlying children's behaviors and emotional experiences in a complete, positive and child-centered way, bearing in mind the child's perspective" (Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002, p. 534). Insightfulness is based on the ability to see and feel from the child's point of view (Koren-Karie et al., 2002). These concepts are closely related to the parental reflective function. However, studies suggest that parenting reflectivity is a more global capacity that, for example, influences mind-minded comments (Rosenblum, McDonough, Sameroff, & Muzik, 2008) because the concept considers more dimensions, including the speaker's own, others' and the influence of each other's reflection and also for the deep way in which the reflective function is assessed.

3.3.1. Parental reflective function and parenting's quality and child outcomes

Mentalization is considered a fundamental human ability allowing the development of inter- and intrapersonal functions such as the regulation of affection and productive social relationships (Slade, 2005). From early experiences with others, the child can find the meaning of those experiences and build and organize representations about the child's self and others, differentiating internal mental reality from external mental reality (Fonagy et al., 2007; Slade, 2005).

From a development perspective, mentalization requires a mental operation in early childhood in which one finds meaning for one's own experiences and states of mind from the states of mind of others (Fonagy et al., 2007). The early experiences with others create the

opportunity for the child to construct and organize representations of others and his or herself. From birth, parents can recognize their children's non-verbal intentions in which the face-to-face interaction between infant and caregiver plays a fundamental role in the baby's development of representations of affection (Fonagy et al., 2004). The parents' ability to bear a representation of their child in mind is fundamental, attributing feelings, desires and intentions to the child and allowing the child to discover his or her own internal experience via the representation provided by the caregiver. A proper development of these representations allows the differentiation of internal and external mental reality (Fonagy et al., 2004; Slade, 2005).

Related to the scientific development of the reflective functions, studies clearly show three areas. The first, with the most research to support the role of reflective functioning, is the intergenerational transmission of attachment and parenting (e.g. Steele & Steele, 2008). The second, which has also been widely investigated, comprises risk samples and parents with a history of childhood abuse and neglect, focusing on the mother and examining how the intergenerational transmission of abuse, neglect, and psychopathology functions (e.g. Ensink et al., 2017). The third area comprises children's social-emotional outcomes, which have been less covered (e.g. Kårstad, Wichstrøm, Reinfjell, Belsky, & Berg-Nielsen, 2015).

First, in terms of attachment and parenting, Fonagy and Target (2005) proposed that the mother's ability to mentalize allows her to create a physical and psychological environment propitious for the creation of a secure base for the baby. This hypothesis has been confirmed in different studies and from different perspectives. For example, one study showed that a low parental RF is associated with the development of insecure attachment in one-year-olds (Fonagy et al., 2016; Slade et al., 2005). Another identified an association with a greater amount of maternal disruption in mother-infant affective communication (Grienenberger et al., 2005). The authors also show that maternal reflective function predicts the security of

attachment beyond maternal sensitivity and the educational level, suggesting that parental mentalization made an independent contribution and underlies the ability to respond sensitively to the baby (Grienenberger et al., 2005; Rosenblum, McDonough, Sameroff, & Muzik, 2008). These findings have also confirmed from the insightfulness (Koren-Karie et al., 2002) and mind-mindedness perspectives (Meins, Ferryhough, Fradley & Tuckey, 2001); studies found that higher reflective capacities and infant-parent attachment security were associated with greater mind-mindedness, with stronger effects for fathers than for mothers (Arnott, & Meins, 2007).

Conversely, Laranjo, Bernier, and Meins (2008) found that maternal sensitivity mediates the relationship between mind-mindedness and infant attachment. Two studies with a mixed sample consisting of women both with and without a history of maltreatment in childhood found a significant association among maternal reflective function, parenting sensitivity and secure attachment in which the parenting behaviors mediated the relationship between reflective function and infant attachment (measured on PDI-RF, Stacks et al., 2014; measured on AAI-RF, Ensink, Normandin, Plamondon, Berthelot, & Fonagy, 2016). Finally, in a recently published meta-analysis, Zeegers, Colonnesi, Stams, and Meins, (2017) suggest that parental mentalization and sensitivity play complementary roles in explaining attachment security in which the mentalization exerts both a direct and indirect influence on infant-parent attachment.

Not only the mother-child attachment and parental sensitivity studies have seen the important role of the reflective function. Studies developed with the PRFQ show a relationship between parental reflective functioning in mothers and distress tolerance of their child (Rutherford, Goldberg, Luyten, Bridgett, & Mayes, 2013), which was replicated and corroborated with a large sample, showing that pre-mentalizing modes correlated with

less persistence in a distress-tolerant task (Rutherford, Booth, Luyten, Bridgett, & Mayes, 2015). Currently, the same author suggests that parental RF might be associated with neural responses to infant affective cues (Rutherford, Maupin, Landi, Potenza, & Mayes, 2017).

Conversely, studies that include a social risk sample have also been centered on the mother, showing the reflective function as a protector factor to the parenting role. On the one hand, the results have shown that higher reflective function is a protector factor of intergenerational transmission of the trauma in mothers (Fonagy, Steele, Steele, Higgitt, & Target, 1994). On the other hand, mothers with unresolved trauma and low reflective functioning about the trauma were independent predictors of child disorganization attachment (Berthelot et al. 2015). Additionally, reflective function was inversely associated with social risk (education, social support, and substance use) and parenting negativity (Smaling et al., 2015; Stacks et al., 2014). A study showed that mothers with lower risk and higher prenatal reflective function when their baby was six months old exhibited more positive behavior in interaction with their babies (Smaling et al., 2016a). Mothers with higher risk and poor prenatal reflective function were related to relatively high infant physical aggression, moderated by maternal intrusiveness (Smaling et al., 2016b).

Similarly, in Chile, a medium-low socioeconomic sample of mothers studied with the PRFQ found that insecure attachment and physical neglect in adults were related to adult pre-mentalization scores (San Cristobal, Santelices, & Fuenzalida, 2017).

In the case of the fathers, the studies centered on substance abuse problems and partner violence, showing that the fathers had a very limited capacity to think about the thoughts and feelings of their children (Stover & Spink, 2012). Reflective function was significantly negatively related to drug use and was correlated with years of education. This

relationship was consistent with the literature on mothers (Pajulo et al., 2012). However, it was reported that the reflective function was not associated significantly with the quality of the observed and self-reported parenting behaviors (Stover & Coates, 2016).

Related to child social-emotional outcomes, the relationship between mental and emotion state understanding has been positively associated with social competence at the preschool age (Cassidy, Werner, Rourke, Zubernis, & Balaraman, 2003), and the influence of the parents' (mother and fathers) mental understanding of that ability has been demonstrated. Kårstad et al., (2015) found that the accuracy of parental mentalization predicts in the child a greater emotional understanding at ages 4–6. A similar result was found by Steele and Steele (2008), who showed that the mother reflective functioning influenced the child's development of emotional understanding and that the mother's reflective function is associated with the child's reflective function at age 9 (Ensink et al., 2015).

Heron-Delaney et al. (2016) found that preterm infants of high PDI-RF mothers showed the most-negative affect and more self-soothing behavior during the Still Face procedure, whereas infants whose mothers were rated lower on PDI-RF exhibited the most-negative affect during the reunion-episode in the Strange Situation. Smaling et al. (2017) found that in a young, pregnant, high-risk woman, prenatal RF was related to lower child physical aggression when the child was 6, 12, and 20 months old. They also observed moderating effects of intrusiveness and sensitivity in which higher prenatal reflective functioning was particularly associated with less infant physical aggression in mothers who showed no or low signs of intrusiveness. These findings show that a child with a mother with a higher reflective function has more possibilities to express his/her discomfort when doing so is expected and has more regulation skills.

As was mentioned, the main method to assess reflective function provides only a single score despite being a long, expensive and energy-consuming tool. For that reason, some years ago, mentalization was studied as a multidimensional construct, observing two dimensions for PDI-RF: self-focused (parent's capacity to mentalize about personal emotions) and child-focused (parent's capacity to mentalize about the child's emotions and their effect on the parent). The study showed that self-focused RF, compared with child-focused RF, was a stronger predictor of maternal contingent behavior (Suchman, DeCoste, Leigh, & Borelli, 2010). Smaling et al. (2016a) included one more dimension—relationship-focused mentalization (mentalization about how dynamics in mental processes influence interpersonal interaction and behavior)—and found that higher levels of self-focused RF were related to more negative emotionality and externalizing problems in the child. In addition, higher levels of relationship-focused maternal RF were linked with less reported child physical aggression at age 20 months. These studies show that there might be adequate reflective capacities about oneself but less about others, which, for example, might occur in interventions that are focused on a person outside their relationships and context.

The reflective function also has been shown to have an influence later in development. Despite not being the focus of this study, it is interesting to understand how the parental reflective function affects older children. For example, in preadolescents, higher maternal reflective function was associated with fewer externalizing difficulties (Ensink, Bégin et al., 2016; Ensink et al., 2017), and low maternal AAI-RF (but not low paternal AAI-RF) was a predictor of higher levels of anxiety (Esbjørn et al., 2013). Additionally, it was shown that children's mentalization was significantly predicted by maternal reflective functioning (Scopesi, Rosso, Viterbori, & Panchieri, 2015). In

adolescents, the mothers' and fathers' reflective function was associated with adolescents' reflective abilities, but only the fathers' mentalization was associated with social competence (Benbassat & Priel, 2012). Adolescent females with eating disorders also presented significantly lower reflective functioning levels. However, in the case of high mentalization, these lower levels helped to reduce eating disorder symptomatology (Rothschild-Yakar, Levy-Shiff, Fridman-Balaban, Gur, & Stein, 2010; Rothschild-Yakar, Waniel, & Stein, 2013).

Recently, in a mother-child school-age sample, greater increases in cortisol in mothers with low levels of reflective function were associated with more over-controlling behaviors and predicted lower children's reflective abilities, whereas mothers with high reflective function were associated with fewer over-controlling behaviors (Borelli et al., 2017). These findings suggest that the maternal reflective function would facilitate emotional regulation, reducing hostile and controlling behavior with children in times of stress.

Through the infant life cycle, the study of RF has had different focuses of interest. In the first years of the child's life, the focus has largely been on parental sensitivity and attachment, on the mother-child relationship in particular. Later in development, studies have included a greater variety of social and emotional variables and have examined the child's outcomes. Conversely, the father, as a study variable, has been included later in the child's life cycle, with an increasing number of studies that include him as the child's age increases.

To summarize, the studies presented show how the parental reflective function plays an important role in the exercise of parenthood and throughout child and youth development. The studies suggest that the function is a variable that favors parental

competences (Borelli et al., 2017), enhances children's emotional and social development (Ensink et al., 2015) and is suggested as a protective factor for psychopathology (Ensink, Bégin et al., 2016; Ensink et al., 2017; Esbjørn et al., 2013; Rothschild-Yakar, Waniel, & Stein, 2013). Additionally, other studies have shown the RF to be a moderator or mediator in the relationship between different variables. For example, the maternal reflective function mediates the association between mother and child attachment (Grienenberger et al., 2005; Slade, 2005); between mothers' depressive symptoms and sensitive parental behaviors (Wong, 2012); among experiences of child abuse in parents and adolescent attachment style (Borelli, Compare, Snavely, & Decio, 2015); and between the effects of accumulated risk and maternal behavior (Smaling et al., 2016b). These points suggest that the parental reflective function plays a central role in the intergenerational transmission of attachment and psychopathology.

4. Present Study

Despite the scientific development in early mental health, the number of young children who continue having developmental difficulties is quite high (Bian et al, 2017; Briggs-Gowan et al., 2013; Centro de Microdatos-Universidad de Chile, 2014; Schonhaut et al., 2013; Wendland et al., 2014). The findings of the reviewed studies found that the mechanism underpinned sensitive parenting, a good parent-child relationship and good child adjustment in which parental mentalization plays an important role. Nevertheless, the study of the parental reflective function has been centered on the mother-child relationship and how maternal characteristics contribute to explain the child's development, despite increasing evidence of the significant role of the father in child development and family adjustment (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000; Lamb & Lewis, 2004). Likewise, researchers have seen that the dyadic perspective does not reveal the complexity and richness of triadic interaction and that the behavior of the mother, father and child in a triad is not comparable to their behavior in dyadic interactions (Fivaz-Depeursinge & Favez, 2006; Johnson, 2001; Kwon et al., 2012; Lindsey & Caldera, 2006).

Therefore, considering the antecedents exposed, study of the early father-mother-child interaction together with the maternal and paternal reflective abilities is especially relevant and is an important contribution toward understanding child development and family mental health.

Therefore, the present study will contribute to answering the following research question: What is the relationship among the mother's reflective function, father's reflective function, the quality of the triadic interaction and the child's psychomotor development and social-emotional difficulties?

4.1. General Objective

To describe and analyze the relationship between father's and mother's reflective function, the quality of triadic interaction, and child's psychomotor development and social emotional difficulties.

4.2. Specific Objective

1. To assess the relationship between the father's and mother's reflective function and the quality of the triadic interaction.
2. To assess the relationship between the father's and mother's reflective function and the child's psychomotor development and socio-emotional difficulties.
3. To assess the relationship between the quality of the triadic interaction and the child's socio-emotional development.
4. To evaluate the influence of the father's and mother's reflective function and the quality of the triadic interaction on the child's psychomotor development and social emotional difficulties.

4.3. General Hypothesis

It is expected that the father's and mother's reflective function, the quality of triadic interaction and the child's psychomotor development will be positively associated and negative associated with the child's social emotional difficulties. And the first three variables will influence the early childhood development.

4.4. Specific Hypothesis

1. It is expected that the level of father's and mother's reflective function will be positively associated with the quality of the triadic interaction.
2. It is expected that the level of mother's and father's reflective function will be positively associated with the child's psychomotor development and negative associated with the child's social emotional difficulties.
3. It is expected that the quality of the triadic interaction will be positively associated with the child's psychomotor development and negative associated with the child's social emotional difficulties.
5. It is expected that the level of father's and mother's reflective function, and the quality of the triad interaction will influence the child's psychomotor development and social emotional difficulties.

5. Methods

5.1. General design of the investigation

This research uses a quantitative methodology with a non-experimental, transversal and cross-sectional design. It is non-experimental as the variables will not be controlled and participant selection will not be randomized. It is transversal as triads will be evaluated in a single temporal and correlational moment, as the aim is to find a relationship between evaluated variables.

The variables studied will be:

- **Dependent variables:** dependent variables are determined by their association with the child and their importance in the concept of childhood development, including psychomotor development and social-emotional difficulties.
- **Independent variables:** triadic interaction and level of paternal and maternal reflective function were defined as independent variables.
- **Control variables:** couple relationship satisfaction, and paternal and maternal depression symptoms were measured as co-variables.

5.2. Participants

The universe of the group of cases corresponded to 85 families participating in Fondecyt Start-up Project No. 11140230 (see Figure 1). The sample was non-probabilistic, selected by convenience. Of the 85 families, 60 were invited to participate in this sub-study

corresponding to the thesis to opt for the doctorate degree for the author of this study. Of these 60 families, 8 rejected participating, and the data for two were incomplete. Additionally, two triads were excluded from the database; in one case, the mother's PDI interviews were not complete, and in the other case, the father's PDI interviews were not complete. Concerning the social-demographic characteristics, the data about child birth order (n=46) and attending nursery or daycare (n=47) were not complete; however, those triads were maintained in the study.

The sample of this study consisted of 50 Mother-Father-Child triads from Santiago, Chile, with children from 12–36 months of age who have social-emotional difficulties. The families were contacted through family health care centers or kindergartens or were referred by study participants. All of these triads were participants in the Fondecyt Start-up Project No. 11140230 (2014–2017).

The inclusion criteria were fathers and mothers over 18 years of age, in a current heterosexual couple relationship and with at least one child between 12 and 36 months, who presents at least one of the follow social-emotional difficulties: sleep, feeding, behavioral and emotional or relationship difficulties reported by the parents or by professionals.

Exclusion criteria considered in the parents and children included the presence of some disability (intellectual or of the senses), psychoses and/or addictions diagnosed in adults as evaluated by the health services, by the educational institutions from which they were referred, or at the first interview with the family.

5.3. Procedure

The population participating in this study was part of the Fondecyt Start-up Project Number 11140230. Participants were referred from the family health care center, nursery and kindergarten JUNJI (National Board of Children's Gardens of the Ministry of Education of the Government of Chile) or by the study participants. Participants were contacted by telephone by members of the research team, who explained the study in detail and evaluated the inclusion and exclusion criteria. With those triads who met the criteria and agreed to participate, the first evaluation sessions were coordinated and were held in the triad's home.

The Fondecyt Project had two groups of participants, one experimental group and one control group. Families are intentionally referred to one of two groups and were paired by parents' educational level and child's age. Figure 1 shows the study procedure in detail.

The study begun with the triad's assessment; two evaluators, one clinical psychologist and one psychology student with previous training on the instruments, evaluated the family. Both parents first signed the informed consent and then completed surveys about their social demographic and psychological characteristics. Parents then responded to the questionnaire related to their child's psychomotor and social-emotional difficulties. Triadic interactions were then video recorded. Each assessment took approximately one and a half hours.

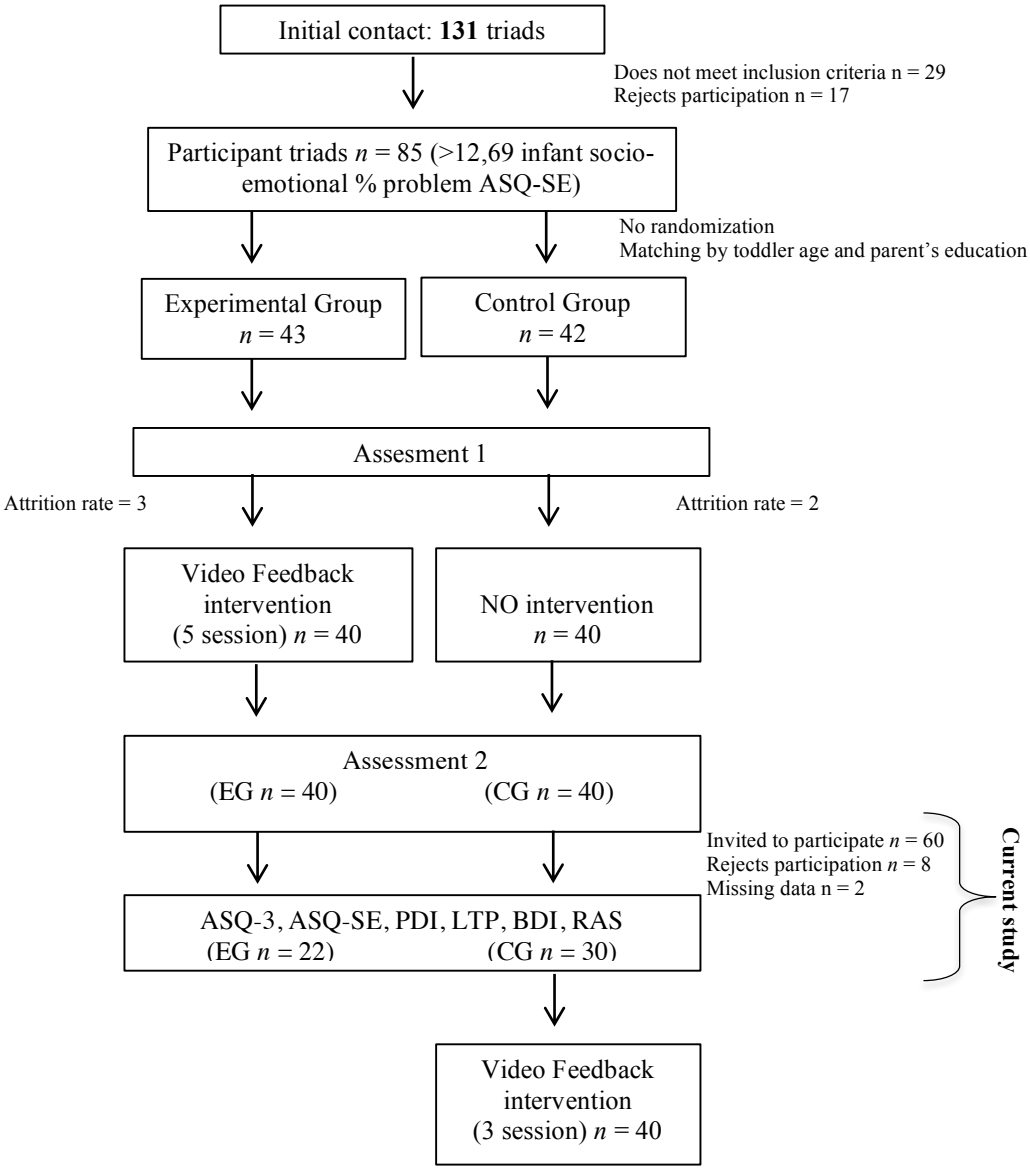
The participants of the experimental group then had a clinical intervention that included seven sessions, two of assessment and five weekly sessions of video feedback, using video recordings of interactions between adults and children. However, the participants from the control group had two assessment sessions and a five-week wait.

Then, both groups had a second assessment; parents again completed questionnaires about their psychological characteristics and their child's psychomotor and social-emotional difficulties, and a new triadic interaction video was recorded. Finally, fathers and mothers were invited to participate in an individual interview about parenting, which is unique to this doctoral investigation project and was the author's contribution to Fondecyt Start-up Project No. 11140230. The parents who agreed to participate signed a new informed consent with respect to this particular study. The interview was performed by a subgroup of psychologists from the Fondecyt Project who were trained by the doctoral student in charge of this project.

At the end of the second evaluation, all of the triads from the control group participated in a brief intervention that included three video feedback sessions. The assessments were conducted in 2016 and 2017.

Figure 1

Study flow chart



5.4. Ethical Considerations

The Fondecyt study had the approval of the institutional Ethics Committee of Human Research from the Catholic University of Chile and from the Chilean National Commission of Scientific and Technological Research. This current study also received ethical approval from the institutional Ethics Committee of Human Research of the University of Chile.

Participating triads signed the informed consent forms of the Fondecyt Start-up Project No. 11140230 and of this doctoral research. Both informed consent forms explained the objective of the investigation, its benefits and risks, data confidentiality, and the voluntary nature of participation. At the end of the study, triads with a need were referred to their health services to continue treatment.

Only the responsible investigators of the Fondecyt and of this doctoral research had access to participant names. The participants were identified in the database by a file number, guaranteeing their anonymity. However, anonymity could not be guaranteed in the case of the audio, transcription and videos; therefore, members of the investigation team that accessed the data also signed a confidentiality agreement. Specific information on each triad cannot be shared; however, general information obtained from the study can be published in the scientific field.

5.5. Measures and Variables

The following Table 1 shows the variables of the study, how they are measured and how they are administrated.

Table 1

Variables and measures

Variable Type	Variable description	Instrument	Administration
Dependent	Child's psychomotor development	ASQ-3	Child
	Social-emotional difficulties	ASQ-SE	Child
Independent	Triadic interaction quality	LTP	Father-mother-child
	Reflective function	RF scale in the PDI	Father and mother
Control	Couple relationship satisfaction	RAS	Father and mother
	Depression symptoms	BDI	Father and mother
	Sociodemographic variables	Socio-demographic sheet	Father-mother-child

5.5.1. Sociodemographic background sheet

These sheets were used to collect participant sociodemographic information. They included questions about child age, gender and birth order, child attending nursery or kindergarten, parental age, parents' number of children, parental education, parent job, parental psychological/ pharmacological treatment and group of origin in the Fondecyt study (control or experimental group).

5.5.2. Psychomotor development

To assess psychomotor development, the Ages & Stages Questionnaires, Third Edition (ASQ-3) (Squires & Bricker, 2009) was used. This instrument is a self-reporting questionnaire for caregivers evaluating the development of children from 1–66 months of age. It consists of 21 questionnaires and scoring sheets at 2–60 months of age. It evaluates 5 areas of psychomotor development: communication (babbling, vocalization, listening, and understanding), gross movements (focused on arm, body and leg movements), fine motor development (focused on hand and finger movements), problem solving (assess learning and playing with toys) and the personal/social area (focused on solitary play and play with toys and other children). Each area has 6 questions, in total 30 per set, and takes around 15 minutes. Parents must try activities to assess their child and respond to the items with Yes (10 points), Sometimes (5 points), or Not Yet (0 point); the maximum score is 60 points for each scale.

The empirically cut off score provides 3 categories of results: at the expectation (child is developing typically), the child is barely on the expectation (and must be closely monitored) and below the expectation (the child might be at risk for developmental delays and should be referred for further assessment; 2 standard deviations below the mean). Because each set has different cutoff points depending on the questionnaire's associated age, one type of scale was created that consists of counting the number of standard deviations that the child is from his or her age cutoff (see Table 2).

This instrument has a level of validity of 0.82–0.88, a test-retest reliability of 0.91, and an inter-rater reliability of 0.92 (Squires & Bricker, 2009). In Chile, a validation was developed, and the result shows adequate psychometric properties (sensitivity of 75%, specificity of 81%,

positive predictive value of 47%, and negative predictive value of 9%) and concurrent agreement compared with the Bayley-III (Schonhaut et al., 2013).

Table 2

Psychomotor cutoff points depending on the questionnaire's age

Months	Communication	Gross motor	Fine motor	Problem solving	Personal-social
12	15.64	21.49	34.50	27.32	21.73
14	17.40	25.80	23.06	22.56	23.18
16	16.81	37.91	31.98	30.51	26.43
18	13.06	37.38	34.32	25.74	27.19
20	20.50	39.89	36.05	28.84	33.36
22	13.04	27.75	29.61	29.30	30.07
24	25.17	38.07	35.16	29.78	31.54
27	24.02	28.01	18.42	27.62	25.31
30	33.30	36.14	19.25	27.08	32.01
33	25.36	34.80	12.28	26.92	28.96
36	30.99	36.99	18.07	30.29	35.33

5.5.3. Social-emotional difficulties

To assess the social-emotional difficulties, the Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) (Squires et al., 2002) was used. It is a self-reporting questionnaire for caregivers that solely evaluates the social-emotional development of children from 3–65 months of age. It consists of 8 questionnaires covering the ages (6, 12, 18, 24, 30, 36, 48, and 60 months) and evaluates 7 areas of social-emotional development:

Self-regulation: Evaluates the child's ability or willingness to calm down, settle down or adjust to psychological or environmental conditions or stimulation.

Docility: Evaluates the ability or willingness to conform to directions and instructions

given by others and obey them.

Communication: Evaluates the ability or willingness to respond or initiate verbal or non-verbal cues that indicate feelings, affections or internal states. Adaptive Functioning: Evaluates the ability or willingness to cope with psychological needs, such as sleeping, eating, safety, etc.

Adaptive function: Evaluates the ability or willingness to start by itself or to respond to others without instructions (independence movements).

Affection: Evaluates the ability or willingness to demonstrate your own feelings and empathy for others.

Person interaction: Evaluates the ability or willingness to respond or initiate social responses to parents, other adults or peers.

To score the questionnaires, the parents' responses to each item are covered with the following points: 0 (often or always), 5 (sometimes) and 10 (rarely or never). In addition, parents indicate whether the behavior of that item is a concern; if the parents check the box, 5 points are added to that item score. Thus, the maximum score by items is 15 points. The results show two categories: (1) when the child is below the cutoff point, meaning above expectations (indicating typical social-emotional development), and (2) when the child is above the cutoff point, meaning below expectations, with more social-emotional difficulties (diagnostic assessment is required). Because each questionnaire has different numbers of items and cutoff points (see Table 3), to have one type of score, a percentage of each child's social-emotional

difficulties was calculated in relation to the maximum score possible for his/her age. According to this criterion, the cut-off scores of the forms used vary from 12.69%–14.54%.

The questionnaire takes 15 minutes. This instrument has a level of concurrent validity ranging from 71%–90%, with an overall agreement of 84%. Test-retest reliability is 89%, and intra-class correlations were .91 (Squires et al., 2002).

Table 3

ASQ-SE questionnaires description and cutoff points

Questionarie's months	Number of items	Max. Total Score	Cutoff	Cutoff in %
12	22	330	48	14.55
18	26	390	50	12.82
24	26	390	50	12.82
30	29	435	57	13.10
36	31	465	59	12.69

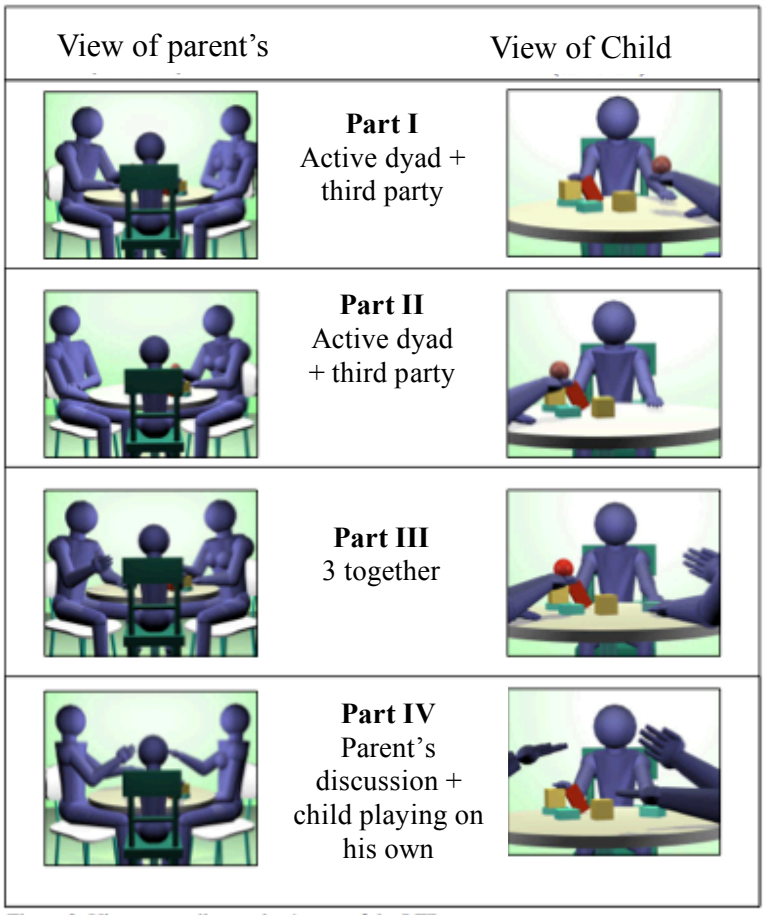
5.5.4. Mother-father-child triadic interaction

To assess the triadic interaction, the Lausanne Trilogue Play (LTP; Fivaz-Depeursinge & Corboz-Warnery, 1999) was used. This systematic observational tool assesses mother-father-child interactions. The activity begins with the triad sitting around a table forming a triangle. The following instructions are given: "Now you are going to play as a family in four separate parts. (a) One parent plays actively with the child while the other parent is present; (b) the parents switch roles; (c) then all play actively together; and (d) the mother and father talk, and the child is simply present." The family has between 10 and 15 minutes to complete the task. The interaction is recorded using two cameras, one focused on the body and face of the parents, the other focused on the child. Figure 2 shows

the procedure.

Figure 2

The Lausanne Triadic Play (LTP) procedure



Note. Sourse. Centre d'Etude de la Famille (2007). Views according to the 4 parts of the LTP. Indications for the LTP Setting for Toddlers, in Pérez and Santelices (2017).

To codify the LTP, the Family Alliance Assessment Scales (FAAS; Lavanchy, Tissot, Frascarolo, & Favez, 2013) procedure was used. The triadic interaction was analyzed by FAAS (see Table 4). The scale assesses five triadic aspects and two subsystem

aspects, yielding one triadic total score and three subgroup scores: (a) triadic subsystem score, (b) the co-parenting dyad, and (c) the child. (a) The triadic subsystems score includes 5 main scales with each subscale: Participation – postures and gazes; Organization – role implication and structure; Focalization – co-construction and parental scaffolding; Affect sharing – family warmth and validation; and Interactive sequence – interactive mistakes during activities and interactive mistakes during transition. (b) The Co-parenting scales included Support and Conflicts, and (c) the child contribution included Assertiveness and Toddler engagement. Each dimension is scored (2 = adequate, 1 = moderate, 0 = inadequate), and the sum of all of the triadic subscale scores ranges from 0–22 points. The Co-parenting and Child Involvement aggregates, each of which could range from 0–4, plus the sum of triadic aspects plus the subsystem aspects constitute the "family interaction score", ranging from 0–30 points and representing the functionality level of the interaction.

Table 4

The FAAS scales—Brief summary

Theoretical concepts	Scales	Brief description of appropriate criteria
Triadic susbcales		
Participation	Postures and gazes	The non-verbal cues of the families indicate readiness and willingness to interact with one another
	Inclusion of partners	Each and all partners in the interaction are included; no one is excluded or excludes him/herself from the interaction
Organization	Role implication	Each partner sticks to his or her role during the play
	Structure	The game follows the expected interactive structure; all the tasks requested by the instructions are implemented
Focalization	Co-construction	Turn-taking is respected, and each can participate without being interrupted; the topic of the game is shared by all participants

	Parental scaffolding	Stimulation is adapted to the child's age and state, in the proximal zone of development
Affect sharing	Family warmth	Affects are mainly positive during the interaction, the atmosphere is warm and supportive
	Validation	Partners react implicitly to the emotional state of each other by adjusting to it; if the child expressing negative affects, the parents help him or her to regulate
	Authenticity	Affects are congruent with the situation and the behaviors displayed by the partners; they are not forced or exaggerated
Timing/ synchronization	Interactive mistakes during activities	There are few communication mistakes (misunderstanding, miscoordinations), and when they occur, they are repaired quickly
	Interactive mistakes during transitions	When a change in activities occur, the interaction is reorganized in a smooth manner, with quick and resolved negotiations
Subsystem aspects		
Co-parenting	Support	Both parents cooperate and support each other, at either an instrumental or an emotional level
	Conflicts	No conflict is expressed between the parents, either at a direct, verbal level, or indirectly by one parent's interfering in the activities of the other
Toddler	Engagement	Is expected to give to her parents enough signals (gazes, use of words, emotional expressions) about her internal states to allow them being adjusted
	Assertiveness	Has to deal with her/his will to impose her ideas, defy her parents at moments but also negotiating with parents in order to reach a triadic sharing.

Note. Adapted from Favez et al, 2011.

Studies conducted by the Lausanne team report mean scores of 19 points in a normative sample and 10.3 in a clinical sample (Favez et al., 2011). Studies developed in Chile report an average of 10.09 in a nonclinical population at a medium or low socioeconomic level (Pérez, Moessner, & Santelices, 2017).

The FAAS showed moderate-to-good inter-rater reliability, $\kappa = .61–.90$, $p < .05$ (Favez et al., 2011). The alpha value obtained by the triads of the study was .901. Three reliable coders, trained with the developers of the FAAS coding in Swiss, evaluated all of

the videos, 25% of them were three time coded to calculate the inter-rater reliability for family scores, ICC=.97, showing an excellent score.

Additionally, categorical evaluation allows three types of Family Interaction to be determined, with two possible classifications in each type, as revealed by the interactive function analysis.

- Cooperative (Fluid or tense): the members of the triad work as a team. They participate, collaborate, and are able to coordinate "well enough" around a joint task.
- Conflictive (covert or over): are a conflict among the triad, which permeates and influences the family interactions. The triad are unable to coordinate "well enough" to carry out the task. The conflict would be covert or over and observed in the parent subsystem or as couple's coalition towards the child.
- Disorder (with exclusion or chaotic): families with interactions characterized by the self or hetero exclusion of one of their members. There is a lack or structure and organization.

5.5.5. Parental reflective function (RF)

The parental reflective function was measured using the Parent Development Interview – Revised, Short Version, PDI-S (Slade et al., 2012). The PDI-S is a semi-structured individual interview of parents of children between the ages of 3 months and 14 years that assesses the narratives of the current and specific relationship with a child. The PDI-S is used to assess and code the parental reflective function in relation to the child, one's own parents, and the self, with questions such as "Describe a time in the last week when you (and your child) really "clicked", "What gives you the most joy in being a parent?", "Does (your child) ever feel rejected?", and "How do you think your experiences being parented

affect your experience of being a parent now?" There are 29 questions; 15 demand the use of reflective functioning, and those are coded. The interview takes approximately 40 minutes to complete and is videotaped and transcribed for coding purposes.

To assess RF, each set of questions was coded with the scoring system developed by Fonagy and colleagues (Fonagy et al., 1998), as adapted for the PDI (Slade, Bernbach, Grienenberger, Levy, & Locker, 2004). Scoring was based on an 11-point scale, from -1 (negative RF) to 9 (full or exceptional RF). Scores of 5 or greater are considered high reflective and show clear and solid mental state understanding (Slade et al., 2005).

Scores equal to 3 show a questionable or low RF capacity, frequently use mental state language such as "happy" or "sad" but without making a clear reflection about them, and appear somewhat clichéd, banal or superficial. Otherwise, this score might represent excessively deep and detailed but unconvincing and/or irrelevant responses (Slade, Bernbach, Grienenberger, Levy, & Locker, 2004). Finally, scores of less than 3 show poor RF capacity and are characterized as concrete explanations of behavior, avoiding references to mental states or possibly containing self-serving statements or distortions. Additional behavioral characterizations could include hostile, bizarre and negative (Slade et al., 2004).

Based on the "Poor", "Low" and "High" RF, different combinations of the couple RF level were formed—for example, one poor and one low or both low—that will be presented later.

Studies conducted using the PDI and parental RF scale and reporting mean scores of 5 indicate typical RF in normative samples (Slade et al., 2005); however, in a high risk simple, a score over 4 has also been found (M = 5.0, Perry, Newman, Hunter, & Dunlop, 2015; M = 4.57, Stacks et al., 2014). To date, no studies have been developed in Chile using these tools.

Reliability estimates using the coding manual have been shown to be good, with ICCs ranging from .78–.95 (Slade et al., 2005). Two reliable coders evaluated the interviews. Inter-rater reliability was calculated on 25% of interviews. Kappa and intra-class correlation coefficient (ICC) analyses were κ=.76, $p < .0001$, ICC=.89, ranging from .77–.95, which is considered adequate by the author of the instrument.

Considering the evidence shown in the theoretical and empirical background of this study, parental depression symptom and couple satisfaction were included as a control variable because of their influence in child development (El-Sheikh et al., 2009; Kam et al., 2011; Leckman-Westin et al., 2009; Piallini, Brunoro, Fenocchio, Marini, Simonelli Biancotto, & Zoia, 2016; Ramchandani et al., 2008), in the reflective function (Ladegaard et al., 2014; Mattern et al., 2015; Uekermann et al., 2008) and in the quality of the triadic interaction (Olhaberry, Santelices et al., 2013; Pérez & Santelices, 2017; Perren et al., 2003; Simonelli et al., 2016). Socio-demographic characteristics that were significantly associated with the study variables were also included as control variables.

5.5.6. Depression symptoms

The Beck Depression Inventory (BDI; Beck et al., 1961) was used to assess the maternal and paternal depression symptoms. This questionnaire is self-reporting and is composed of 21 items, each scored from 0–3 points, with a total score varying from 0–63 in which higher scores indicate the presence of more symptoms. Additionally, four categories of depression are identified: minimum, 0–9; mild, 10–18; moderate, 19–29; and severe, 30–63. This questionnaire has been widely used and shows good reliability and validity levels, with an α coefficient of .92 (Beck et al., 1961). The reliability analysis from the Spanish

version was adequate, with an α coefficient of .90 (Vázquez & Sanz, 1999). The Chilean validation study of the instrument reports an alpha value of .92 (Valdés et al., 2017), and the alpha values obtained by the participants of this study were .828 for the fathers and .832 for the mothers.

5.5.7. Relationship couple satisfaction

The Relationship Assessment Scale (RAS; Hendrick, 1988) was used to assess couple satisfaction. The RAS is a self-reporting questionnaire that evaluates overall satisfaction with the couple relationship with a unifactorial structure. It consists of seven items (e.g., "How do you consider your partner satisfies your needs? In general, how satisfied are you with your relationship?"), each scored by a five-point Likert scale in which 1 corresponds to the lowest level of satisfaction and 5 to the maximum score, with a total score varying from 7 to 35, where higher scores indicate higher couple satisfaction.

For this study, we used the version adapted by the Chilean authors Rivera and Heresi (2011), who reported an internal consistency of .90 in a Chilean sample. In the present study, an α coefficient of .91 was obtained for the mothers and fathers.

5.6. Data Analysis Procedure

Data were analyzed using the statistical software IBM SPSS statistics version 21.0.

First, the triads were characterized by their socio-demographic characteristics and subsequently by child psychomotor development, social-emotional difficulties, family interaction, reflective function, parents' depression symptoms and couple satisfaction. T-tests were then conducted to assess the equivalence in the means of the parents' and child

variables. “Couple reflective function” groups were created based on the “Poor”, “Low” and “High” RF combinations of the mother and father RF—for example, one parent poor and one low or both low). Then, analyses of covariance (ANOVA) were conducted to examine the differences in the child psychomotor and social-emotional difficulties and in family interaction scores among the “couple reflective function” groups.

Thereafter, a correlation matrix was computed with the main and control variables to obtain preliminary results and to assess which co-variables and socio-demographic characteristics would be used as a control variable in the next analyses.

Thereafter, different models of multiple linear regression analyses were performed in which the child psychomotor development and social-emotional difficulties were the dependent variables and the reflective function and family interaction were the independent variables.

First, the requirements for OLS (Ordinary Least Squares) multiple linear regression analysis were assessed for each regression model (Stevens, 2009). An analysis of influential cases was performed for each model, considering potentially influential those with a Leverage value greater than 2 points and those with a Cook distance greater than 1 point. A non-case with these characteristics was found. Then, to ensure the absence of multicollinearity, variance inflation factors (VIF) were reviewed. Both to assist with interpretation of the data and to avoid the problems of collinearity, all of the predictors were centered on their grand mean (Shieh, 2011). Only two moderator models had collinearity problems, which will be mentioned later. Normal distribution of residuals was assessed using a histogram of studentized residuals. Homogeneity of variance and linearity of the model were assessed by plotting standardized residuals vs. standardized predicted

values. All procedures used indicated no significant deviation from the requirements of multiple regression analysis.

First, to analyze the contribution of the mothers' and fathers' reflective function and the family interaction on the five dimensions of the child's psychomotor development, a stepwise regression was conducted controlling for depression symptoms of the mother and for some of the sociodemographic characteristics according to the correlation that they had with the study variables.

Second, the contributions of the mothers' and fathers' reflective function and the triadic interaction to the child social-emotional difficulties using an entry method were analyzed with multiple linear regression. Two models were tested that, based on the previous significant correlations, were controlled by mothers' depression symptoms. One used the eleven-point reflective function scale, and a second one used the reflective function score as a dichotomous category (0 = not good enough RF, 1 = good enough RF). All of the models in which the child social-emotional difficulties are the dependent variable were conducted with the triadic subscale score instead of the triadic total score because the triadic total score includes the child subsystem, which assesses the child engagement and assertiveness, which in turn are parts of the child social-emotional development construct.

Thereafter, the reflective function as a moderator was examined. Four models were tested, two for the mothers and two for the fathers. The first uses an eleven-point reflective function scale, and the second uses the reflective function score as a dichotomous category controlled by maternal depression symptoms. All of them were conducted with the center on their grand mean to avoid problems of collinearity and to facilitate the data's interpretation.

Finally, and according to the results, the influence of the mothers' and fathers' reflective functioning on the family interaction was studied using a linear regression with an entry method. Two steps were tested; first, the fathers' reflective function was introduced in the equation, and then the mothers'.

All regression models were performed with variables centered on the grand mean to avoid problems associated with collinearity. Only the coefficients that contribute significantly to explain the variance of the study variables will be interpreted.

6. Results

The results are presented in three segments. In the first section, a descriptive analysis of the socio-demographic data and the study variables is presented. The second section responds to objectives one, two and three; in this part, bivariate correlations between the main variables, the control variables and the socio-demographic data were tested to understand the relationship of the variables and to select which variables would be retained for further analysis. To respond to objective four, a different multiple regression model and moderator analysis was conducted to test the contribution of the triadic interaction and the triadic interaction and the mothers' and fathers' reflective function on the child's psychomotor and social-emotional development.

6.1. Descriptive Analysis

First, a t test (independent sample) was performed to assess the homogeneity of the sample between groups of origin (experimental or control) in child's age, parent's age and years of education, child psychomotor and social-emotional difficulties, triadic interaction, parental reflective function, depressive symptoms and couple satisfaction scores. It was found that children's fine motor movements and mothers' reflective function had significant differences across groups. Children from the experimental group had $M = 1.86$ ($SD = 1.15$) in fine motor, and the control group had $M = 1.08$ ($SD = 1.10$), $t = -2.41$, $df = 48$, $p = .02$. The mothers, who were participants from the experimental group in RF, had $M = 4.15$ ($SD = 1.09$), and mothers from the control group had $M = 3.33$ ($SD = 1.06$), $t = -2.64$, $df = 48$, $p = .01$. The other variables did not differ significantly (see annexed table 1).

6.1.1. Sociodemographic characteristics.

With respect to the child's sociodemographic characteristics, the range of the child's age was from 12–36 months, and the mean age in months was *M* = 26.57 (*SD* = 7.59). As shown in Table 5, most of our sample was firstborn, and one-half of the children attend a nursery or daycare.

Table 5

Children's sociodemographic characteristic

Variable	*f*	%
Girls	21	42
Boys	29	58
Months' age		
12 to 14 months	3	6
15 to 20 months	12	24
21 to 26 months	8	16
27 to 32 months	12	24
33 to 36 months	15	30
Desired pregnancy	38	76
Type of birth		
Vaginal	30	60
Cesarean section	20	40
Was breastfed	46	92
Child birth order (n=46)		
1	32	64
2	8	16
3 o 4	6	13
Attending nursery or daycare (n=47)	24	51.1

Concerning the parents' sociodemographic characteristics, the mothers' mean age was *M* = 31.52 (*SD* = 4.84, range = 20–43), and the fathers' was *M* = 33.58 (SD = 5.83, range = 22–49). The range of children in these families was a minimum of 1 and a maximum of 4, and the mean of children was slightly different from those of men (*M* =

1.57, *SD* = 0.71) and women (*M*= 1.72, *SD* = 0.86) because some members of couples had children from other relationships. Of the participating couples, 69.6% were raising their first child.

The level of education of this sample was high compared with the Chilean national mean (*M*=13.1, range 19–20 years, and *M*=12.4, range 30–44, Ministerio de Desarrollo Social, 2015). The mean in years was M = 15.16 (*SD* = 2.39) for women and *M* = 15.32 (*DS* = 2.39) for men. The range of education for mothers and fathers was 8–17 years, and most of the couples were employed.

Table 6 shows more details about the social and clinical characteristics. To highlight the clinical characteristics, the women of this sample have had more psychological and pharmacological treatment than men.

Table 6

Parents' sociodemographic and clinical characteristics

Variable	Mothers		Fathers	
	f	%	*f*	%
Level of schooling				
Elementary	2	4	4	8
High School	11	22	5	10
Tecnical studies	8	16	11	22
Universitary	29	58	30	60
Has current paid work	39	78	48	96
Full-time work	25	62.5	47	95.9
Part-time work	14	35	1	2
Have had previous treatment	30	60	21	42
Psychological treatment	11	22	12	24
Pharmacological treatment	4	8	3	6
Psychological and pharmacological	15	30	6	12

6.1.2. Child psychomotor and social-emotional difficulties.

First, t test (independent sample) was performed to assess the homogeneity of the sample between boys and girls in child psychomotor development and social-emotional difficulties. No significant differences were found (see annexed table 2). Therefore, the analysis consecutively analyzes grouped boys and girls.

Concerning the frequency of children below expectations in the psychomotor development, 70% of the children were above expectations for their age in the five areas assessed by the ASQ-3. Fourteen percent had one area below the expectation, 10% had two areas below the expectation, 4% had three areas below the expectation, and 2% of the children had four areas below the expectation for their age.

With respect to the areas in which the children were below the expectations for their ages, 8 (16%) children were below the expectations in communication, 1 (2%) in gross motor, 6 (12%) in fine motor, 5 (10%) in problem solving, and 7 (14%) in personal-social development. In summary, the areas in which the children had slightly more difficulties were communication and personal and social development, which are more related to relationships with others.

Table 7 provides the means of the number of standard deviations of the cut-off point in each area of child psychomotor development. Again, the means of standard deviations are positive, showing that the average of children meets the expectations by age for each area of psychomotor development.

Table 7

Means of the number of standard deviations of the cutoff point in each area of child psychomotor development

Variables	M	SD	Min	Max
Communication	1.46	1.26	-2.01	2.94
Gross motor	1.90	0.83	-.32	2.87
Fine motor	1.39	1.17	-1.70	3.06
Problem solving	1.50	1.08	-.95	3.21
Personal-social	1.50	1.07	-1.18	2.93

In relation to social-emotional development, 46% (f = 23) of the children were above the cutoff at the ASQ-SE, which means that they presented social-emotional difficulties. The mean of social-emotional difficulties was M = 13.67. Note that the limit scores to consider social-emotional difficulties are from 12.69% to 14.55%. The mean of social-emotional difficulties was greater than the limit score, indicating that the mean of children in this sample have social-emotional difficulties. Additionally, the areas in which the children showed more difficulties were in the self-regulation and interaction with people difficulty area (see Table 8).

Table 8

Means (SDs) on child's percentage of socio-emotional difficulties

Variables	M	SD	Min	Max
Overall percentage of social-emotional difficulties	13.67	7.14	2.56	37.93
Self regulation difficulties	18.74	12.33	0	55.55
Complacence difficulties	12.00	20.49	0	100
Communication difficulties	8.44	15.32	0	77.77
Adaptative functioning difficulties	14.00	14.56	0	58.33
Autonomy difficulties	15.00	18.21	0	66.66
Affect difficulties	5.11	6.43	0	22.22
Person interaction difficulties	12.85	11.46	0	55.55
% of social-emotional difficulties by range of age				
12 – 17 months (n = 3)	19.70	4.55	15.15	24.24
18 – 29 months (n = 20)	13.65	7	2.56	28.21
30 – 35 months (n = 12)	12.45	5.41	6.9	24.14
36 months (n = 15)	13.46	8.78	5.38	37.93
	f	%		
Children with social-emotional difficulties	23	46		
Children without social-emotional difficulties	27	54		

6.1.3. Triadic interaction, parental reflective function, couple satisfaction and parental depressive symptoms.

First, differences between the means of the fathers' and mothers' reflective function scores, depression symptoms and couple satisfaction were explored with t test (independent sample). No significant differences were found (see Table 9).

Table 9

Means (SDs) on mother's and father's reflective function, depressive symptoms and couple satisfaction

Variable	Mothers (n = 50)		Fathers (n = 50)				95% CI	
	M (SD)	*Min-max*	*M (SD)*	*Min-max*	*t(df=48)*	*p*	*LL*	*UL*
Reflective function	3.64 (1.12)	1 - 6	3.56 (1.11)	2 a 6	0.45	.66	-0.34	4.42
Depression symptoms	7.40 (6.06)	0 - 34	5.36 (5.34)	0 a 28	1.7	.09	-2.15	1.59
Couple satisfaction	29.96 (4.84)	13 - 35	30.24 (5.94)	14 a 35	-.297	.77	-0.35	0.55

Note. CI = confidence interval; LL = lower limit, UL = upper limit, SE = Social-emotional.

The descriptive analysis of the triadic interactions and their subscale scores are presented in Table 10. Subsequently, the analysis of the triadic interaction categories shows that 24% of the triads have a cooperative interaction. This type of interaction is characteristic of triads whose members work as a team to perform a given task, and the partners coordinate, negotiate, and cooperate with each other to achieve an engaged interaction. Some triads can be fluid and optimal, whereas others might be less fluid and more tense.

Conversely, 54% show a conflictive interaction in which 52% of the triads have a conflictive covert interaction that characterizes parents who do not coordinate themselves "well enough" for the task to be performed. Occasionally the parents compete to attract the

child's attention and create a special relationship, or other families present a couple's coalition toward the child. Commonly, in this type of triad, the parents express pseudo-positivity affect despite the tension felt during the interaction. Only 2% of the triads have overt conflictive behavior, with aggressiveness and hostile interactions.

Finally, 22% of triads have a disordered interaction, with 16% having an exclusion interaction that characterizes partners whose main characteristic is the self or hetero exclusion. This exclusion might result from the withdrawal of one of the family members from the situation or from the exclusion of one of the family members by the other interaction partners. Six percent of the triads have a chaotic interaction characterized by partners who interact in a confused context, lacking structure or roles. The stimulations they propose to the child are chaotic, not synchronous, discontinuous and unpredictable.

Related to the depressive symptomatology, 66% of the women and 78% of the men presented minimum or non-depressive symptoms (score from 0–9), 32% of the women and 20% of the men presented mild depressive symptoms (score from 10–18), and 2% of the women and 2% of the men presented moderate or severe depressive symptoms (score from 19–63).

Table 10

Triadic interaction total and subscales means and standard deviation

LTP's subscales	*M*	*SD*	*Min*	*Max*
Participation	2.56	.97	0	4
Organization	2.4	1.1	0	4
Focusing and scaffolding	2.34	.69	1	4
Affect	3.70	1.43	1	6
Timing and synchronization	2.14	.86	0	4
Triadic Subscales Score	13.22	3.59	0	20
Subsystem subscales				
Coparenting	2.76	.92	1	4
Toddler: engagement & assertiveness	2.46	1.1	0	4
Triadic Total Score	18.44	4.90	8	26
Quality of the triadic total interaction	*f*	%		
Cooperative	12	24		
Conflictive				
Covert	26	52		
Overt	1	2		
Disordered				
Exclusion	8	16		
Chaotic	3	6		

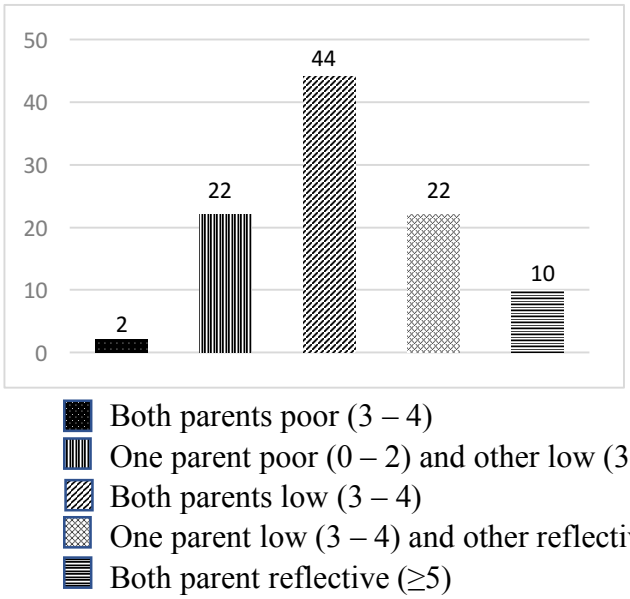
Concerning the parental reflective function, the results show that 24% of the women and 18% of the men presented reflective functioning, showing a solid and clear understanding of their own and others' mental states. Sixty-four percent of the mothers and 68% of the fathers presented questionable or low reflective functioning, with frequent use of mental state language such as "happy" or "sad" but without showing a clear or explicit understanding of their statement. Finally, 12% of the mothers and 14% of the fathers presented poor reflective functioning characterized by concrete explanations of behavior,

avoidance of references to mental states, or possibly containing self-serving statements or distortions.

To understand how reflective functioning in the parent couples works, “couple reflective functioning” groups based on “Poor”, “Low” and “High” reflective function were created, and different combinations between the couple reflective function level were formed. Graphic 1 shows the couple reflective function groups and distribution. It is interesting to appreciate how in most couples, both parents have low reflective functioning, and the extremes, both poor and both reflective, were less represented. Additionally, it is interesting to notice that the group in which one parent scored poorly and the other scored reflective does not appear in this sample, showing that couples are similar in their level of reflective functioning.

Figure 3

Percentage of couple reflective function groups



To compare the mean of triadic interaction, child psychomotor development and child social-emotional difficulties across the couple reflective functioning groups, the five groups were redistributed in three categories to increase the number of couples in each group. The new distribution was (1) Poor/Low (included both parents poor and one parent poor and other low), (2) Low (included both parents low) and (3) Low/high (included one parent low and the other reflective or both parents reflective). Table 11 shows the one-way ANOVA with the couple reflective function groups as the independent variable and triadic score as the dependent variable.

Follow-up contrast analyses using a Bonferroni post hoc test revealed a significant difference between the triadic scale means among the couple reflective groups, showing that the main differences are in the extreme groups (Poor/Low and Low/High). In the co-parenting mean, the difference was between the Poor/Low and Low/High couples. Concerning the toddler contribution mean, a barely significant difference between Poor/Low and Low/High couples was found. In the triadic subscale score and triadic total score, the analyses revealed significant differences between Poor/Low and Both Low couples and between Poor/Low and Low/High couples; no differences were found between Both Low and Low/High couples. These results show that triads with Poor/Low reflective functioning couples had a significantly lower mean in the quality of their triadic interaction than did the other groups, the Low/High couples in particular.

With respect to social-emotional difficulties and psychomotor development, no differences were found between the different couple groups.

Table 11

Differences in the triadic scores, child's psychomotor development and child's social-emotional difficulties between the three couple's reflective function groups

	Poor/Low[a] (n = 12)	Low[b] (n = 22)	Low/High[c] (n = 16)	
	M (SD)	*M (SD)*	*M (SD)*	*F*
Coparenting	2.08 (0.55)[ac]	2.82 (0.91)	3.19 (0.91)[ac]	6.12*
Toddler contribution	1.83 (0.72)[ac]	2.41 (1.18)	3.00 (0.97)[ac]	4.53*
Triadic Subscales Score	10.25 (3.02)[abc]	13.23 (4.42)[ab]	15.44 (2.61)[ac]	9.68*
Triadic Total Score	14.17(3.10)[abc]	18.45(4.66)[ab]	21.63(3.44)[ac]	11.28*
Social-emotional difficulties	14.90 (8.51)	14.22 (6.72)	11.99 (6.77)	0.67
Communication	1.14 (1.07)	1.60 (1.24)	-1.51 (1.44)	0.53
Gross motor	1.71 (.62)	2.07 (.78)	1.82 (1.01)	0.86
Fine motor	1.28 (1.32)	1.47 (1.11)	1.36 (1.22)	0.11
Problem-solving	1.37 (.76)	1.69 (1.12)	-1.32 (1.23)	0.64
Personal-social	1.88 (0.80)	1.45 (1.05)	1.28 (1.25)	1.13

Note. *p < .01. < >=different; a < >c; a < >b< >c; a < >b.
Poor/Low = Both parents poor (0-2), or one poor and one low (3-4)
Both Low = Both parents Low Reflective (3-4)
Low/High = One parent Low (3-4) and one High, or both High (≥5)

6.2.Correlational analysis

First, the associations between the main study's variables (mother and father reflective function, LTP scores, child psychomotor and social-emotional development) and sociodemographic variables (group, child age, gender and birth order, child attending nursery or daycare, parent age, parent number of children, parent years of education, parent has a job, and parent has/had psychological/ pharmacological treatment[1]) were examined. The associations are presented in Table 12. The significant correlation between the study variable and the sociodemographic variables is controlled in the subsequent analysis; in the

[1] Group (0 = control, 1= experimental), child attending nursery or daycare (0 = no, 1 = yes), parent has a job (0 = no, 1 = yes), parental psychological/ pharmacological treatment (0 = no, 1 = yes)

case of child psychomotor development, the significant associations were as follows: child's communication correlates positively with attending a nursery, negative birth order, and the mother's number of children. Gross motor development correlates negatively with the mother's and father's years of education. Fine motor development correlates positively with the child's age and group. Personal-social development correlates negatively with the mother's years of education and with the father's years of education. With respect to child social-emotional difficulties, a non-significant association between this measure and the sociodemographic variables was found.

Table 12

Correlation between study's variables and sociodemographic variables

Variable	Group	Child age	Child sex	Child birth order	Child nursery	Mother Age	Father Age	Mother kids	Father kids	Mother years edu.	Father years edu.	Mother job	Father Job	Mother treat.	Father treat.
Communication	.16	.23	-.25	-.42**	.38**	-.16	-.06	-.29*	-.26	-.06	-.12	-.02	-.16	-.13	.18
Gross motor	.05	.24	-.07	.08	.13	-.20	-.02	-.02	-.05	-,34*	-.30*	-.13	-.18	.01	.08
Fine motor	.33*	.34*	-.10	.07	.12	-.04	.24	.15	.19	-.12	-.05	-.12	-.21	.19	.03
Problem solving	.27	-.05	-.20	-.14	.24	-.18	-.04	-.08	-.19	.04	.02	-.05	-.28	.13	.25
Personal-social	-.12	-.11	.02	.03	.13	-.21	-.10	-.06	-.12	-.36*	-.32*	-.13	-.26	-.12	.08
% SE difficulties	-.24	-.09	.20	-.27	-.26	-.09	-.15	-.12	-.08	.17	.10	-.19	.08	-.08	.19
Triadic total score	.14	.18	.04	-.04	.05	-.01	.09	-.07	-.07	.01	.14	-.02	-.21	.01	.00
Mother RF	.36*	.11	-.08	-.08	.03	-.02	.02	-.06	-.03	.18	.16	.23	-.06	.10	.01
Father RF	.22	-.01	-.08	.14	.03	.09	.11	.02	-.02	.24	.28	.18	.01	.11	-.03
Mother DS	-.27	-.15	-.04	.06	-.39**	.05	.12	.01	.00	.18	.10	-.10	.05	.27	.07
Mother CS	.13	.13	-.02	.14	.08	.01	-.06	.16	.17	-.14	.02	-.03	.04	-.09	-.04
Father DS	-.13	-.29*	-.11	.23	-.14	.12	.13	.06	.01	-.06	-.08	-.01	-.11	-.04	.13
Father CS	.10	.22	-.04	-.05	-.04	-.09	-.15	.04	.08	-.09	.03	.02	.15	.00	-.09

Note. Edu = education; Treat = treatment; SE = social-emotional; RF = reflective function; DS = depressive symptoms; CS = couple satisfaction.
*. Correlation is significant at the .05 level (2-tailed).
**. Correlation is significant at the .01 level (2-tailed).

Second, the associations between the study variables and the control variables (parents' depression symptoms and parents' couple satisfaction) were tested (see Table 13). Maternal depression symptoms were the only control variable that correlated significantly with the dependent variables, particularly with child psychomotor development and social-emotional difficulties. In addition, father couple satisfaction correlated significantly with father reflective function. Additionally, it is interesting to see in Table 13 how the parents' variables correlate significantly, showing that the parents' characteristics are associated and can influence each other.

6.2.1. Aims one, two and three. Associations between the mothers' and fathers' reflective functions, triadic interaction and child psychomotor and social-emotional difficulties.

To test the first hypothesis that the levels of the fathers' and mothers' reflective function will be positively associated with the quality of the triadic interaction, bi-variate correlations between the mothers' and fathers' reflective functioning and triadic interaction scores were assessed. As was hypothesized, the mothers' and fathers' reflective functioning was significantly positively correlated with triadic total interaction (see Table 13). Therefore, when the mother and the father have higher reflective function levels, the triadic total interaction also tends to have higher levels of coordination.

To test the second hypothesis, that the level of mothers' and fathers' reflective function will be positively associated with the child psychomotor development and socio-emotional difficulties, bi-variate correlations between these variables were conducted (see Table 13). In contrast to the hypothesis, mothers' and fathers' reflective functioning was

not significantly correlated with the child psychomotor development or socio-emotional difficulties.

Finally, to assess the third hypothesis, that the quality of the triadic interaction will be positively associated with the child psychomotor development and socio-emotional difficulties, bi-variate correlations between these variables were again performed. The hypothesis was partially corroborated. First, there was no significant correlation between the triadic total score and the child's psychomotor development. However, as expected, a significantly negative correlation was found between the triadic interaction score and socio-emotional difficulties (see Table 13) in which triads with higher triadic scores tended to have children with a lower level of social-emotional difficulties.

Table 13

Correlations among study variables and covariables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Communication	1															
2. Gross motor	.44**	1														
3. Fine motor	.39**	.19	1													
4. Problem solving	.65**	.37**	.42**	1												
5. Personal-social	.54**	.49**	.31*	.51**	1											
6. % SE difficulties	-.29*	-.41**	-.24	-.19	-.38**	1										
7. Triadic Total Score	.22	.22	.18	.10	.07	-.40**	1									
8. Triadic Subscale Score	.20	.19	.17	.09	.04	-.32*	.98**	1								
9. Coparenting	-.09	.03	-.12	-.13	-.07	-.23	.68**	.61**	1							
10. Toddler contribution	.40**	.361*	.339*	.28*	.23	-.52**	.70**	.59**	.21	1						
11. Mother RF	-.07	-.14	.03	-.15	-.325*	-.05	.43**	.40**	.41**	.28	1					
12. Father RF	-.10	-.15	-.05	-.04	-.20	-.09	.38**	.37**	.34*	.204	.43**	1				
13. Mother DS	-.37**	-.276	-.135	-.269	-.38**	.40**	-.14	-.10	-.22	-.13	.17	-.12	1			
14. Mother CS	-.03	.02	.06	-.02	.00	-.01	-.10	-.15	.07	-.02	-.04	.21	-.34*	1		
15. Father DS	-.10	.02	.01	-.05	.04	-.05	.08	.09	.06	.02	.14	.07	.16	-.34*	1	
16. Father CS	-.10	-.02	-.12	-.08	-.12	.14	-.10	-.12	.07	-.14	.07	.29*	-.19	.72**	-.62**	1

Note. SE = social-emotional; RF = reflective function; DS = depressive symptoms; CS = couple satisfaction.
*. Correlation is significant at the .05 level (2-tailed).
**. Correlation is significant at the .01 level (2-tailed).

Correlation among triadic interaction, reflective function, child psychomotor development and socio-emotional difficulties and the control variables

To understand these associations more deeply, a bi-variate correlational analysis among mothers' and fathers' reflective functions, triadic interaction subscales, and child psychomotor and social-emotional development subscales was examined (see annexed table 3).

As expected, some of the child psychomotor and social-emotional difficulties subscale variables correlate with each other. Specifically, child self-regulation difficulties correlate negatively with fine motor development, $r = -.33$, $p < .01$, child communication difficulties correlate negatively with the child personal-social, $r = -.53$, $p < .01$, problem solving, $r = -.45$, $p < .01$, and communication development, $r = -.42$, $p < .01$. Child adaptive difficulties correlate negatively with gross motor, $r = -.51$, $p < .01$ and personal-social development, $r = -.33$, $p < .05$.

Oddly, mothers' reflective function correlates negatively with personal-social development, $r = -.33$, $p < .05$. The fathers' reflective function correlates with the child person-interaction difficulties, $r = -.28$, $p < .05$.

Conversely, mothers' reflective function correlates positively with the triadic subscales, specifically with affect, $r = .41$, $p < .01$, interactive sequence, $r = .32$, $p < .05$, and co-parenting, $r = .41$, $p < .01$. In addition, the fathers' reflective function correlates positively with focus and scaffolding, $r = .41$, $p < .01$, affect, $r = .37$, $p < .05$, and co-parenting, $r = .34$, $p < .01$.

Triadic total score correlates negatively with child autoregulation difficulties, $r = -.29$, $p < .05$, and triadic subscale score correlates negatively with child social-emotional

difficulties, $r = -.32$, $p < .05$. For its part, toddler contribution correlates positively with communication development, $r = .40$, $p < .01$, gross motor, $r = .36$, $p < .01$, fine motor, $r = .34$, $p < .05$, and problem solving, $r = .28$, $p < .05$. It correlates negatively with social-emotional difficulties, $r = .52$, $p < .01$, and their subscale autoregulation, $r = -.35$, $p < .05$, communication difficulties, $r = .29$, $p < .05$, adaptive difficulties, $r = .29$, $p < .05$, affect difficulties, $r = -.31$, $p < .05$, and person-interaction difficulties, $r = -.32$, $p < .05$.

6.3. Regression Analysis

Aim four. Evaluate the influence of the fathers' and mothers' reflective function and the quality of the triadic interaction on the child psychomotor development and socio-emotional difficulties.

To test the fourth hypothesis that the level of fathers' and mothers' reflective functions and the quality of the triad interaction will influence child psychomotor development and socio-emotional difficulties OLS (Ordinary Least Squares), multiple linear regression analyses were conducted. In these analyses, the reflective function and the triadic interaction were the independent variables, and the child psychomotor development and social-emotional difficulties were the dependent variables. Based on the significant correlations detected with the dependent variables, subsequent analyses were controlled for maternal depression symptoms and some of the sociodemographic variables that correlated significantly with the dependent variables. Additionally, to facilitate the interpretation of the data and to avoid collinearity problems, all of the predictors were centered on their grand mean (Shieh, 2011).

Additionally, an analysis of influential cases was performed for each model, considering potentially influential those with a Leverage value greater than 2 points and

those with a Cook distance greater than 1 point. A non-case with these characteristics was found.

6.3.1. Triadic interaction, maternal and paternal reflective function as predictors of the child's psychomotor development.

First, the contributions of the triadic interaction, maternal and paternal reflective functions as predictors of the child's psychomotor development were tested. Child psychomotor development has five dimensions: communication, gross motor, fine motor, problem resolution and social-individual development. Because this hypothesis is exploratory, each regression was examined using the stepwise method to achieve a model that explains most of the variance when trimming nonsignificant predictors.

First, communication development was run controlled by mother depression symptoms, child's birth order, child's attending a nursery or daycare (no = 0, yes = 1), and mother's number of children. The results of the analyses showed that only child birth order (b=-0.412, t(43)=-3.18, p = 0.003) and mother's depression symptoms (b=-0.358, t(43)=-2.77, p = 0.008) were significant predictors of child communication development, explaining 28% of the variance. Lower birth position (e.g., be the first sibling in the family order) and lower mother depressive symptoms predict more child communication development.

Gross motor development was run controlled by mothers' and fathers' years of education. The analysis showed that the only significant predictor was mothers' years of education (b=-0.336, t(49)=-2.47, p = 0.017), explaining 9% of the variance. Thus, the child has more gross motor development when the mother has fewer years of education.

Third, fine motor development was run controlled by group (control group = 0, experimental group = 1) and child age. The regression shows that only the age of the child was the significate predictor (b=0.343, t(49)=2.53, p = 0.015), explaining 10% of the variance; greater age predicts improved fine motor abilities.

Next, problem-solving development was not controlled. The results of the analyses reveal that there were no significant predictors.

Finally, personal-social development was controlled by mothers' depression symptoms and mothers' and fathers' years of education. Mothers' depression symptoms (b=-0.326, t(49)=-2.51, p = 0.016) and mothers' years of education (b=-0.302, t(49)=-2.33, p = 0.024) were the significant predictor, explaining 20% of the variance, when lower mother depression symptoms and lower mothers' years of education predict more child personal-social development.

It is interesting to see how only control variables and sociodemographic variables were significant predictors of child psychomotor development, and the study variables appear non-significant predictors of this child development area.

6.3.2. Triadic interaction, maternal and paternal reflective function as predictors of the child's social-emotional difficulties.

The contribution of the triadic interaction, maternal and paternal reflective function as predictors of child social-emotional problems has been more reported than their effect on psychomotor development (e.g., Cassidy et al., 2003; Ensink, Bégin et al., 2016; Steele & Steele 2008). Consequently, the social-emotional difficulties were examined with an initial regression to theoretically and empirically direct the input of the variables. Non-socio-

demographic variables correlated significantly with child social-emotional difficulties; thus, the regression was only controlled by mother depression symptoms.

Additionally, it is important to consider that the LTP procedure and FAAS coding system assess five triadic aspects and two subsystem aspects: co-parenting and the child contribution, which included child engagement and assertiveness, which in turn are parts of the child social-emotional development construct. Thus, to be more rigorous and not assess the same variable in different ways, for the analysis in which social-emotional difficulties was the dependent variable, the triadic subscale score was considered a predictor (not the triadic total score), leaving out the co-parenting and child subsystem.

After controlling for mother depression symptoms, the results revealed a significant effect of the triadic interaction on child social-emotional difficulties, which with the mother depression symptoms explain 21% of the variance. However, in contrast to expectations, there was a non-significant effect of the mothers' and the fathers' reflective function on child social-emotional difficulties (see Table 14).

A second model was tested using the reflective function score as a dichotomous category, where (0 = not good enough RF, 1 = good enough RF). Again, after controlling for maternal depression symptoms, only the triadic interaction had a significant effect, contributing to explain again 21% of the variance (see Table 14).

6.3.3. Moderation analysis

Based on the results obtained, it was hypothesized that the reflective function would have a moderator effect on child social-emotional difficulties; therefore, four moderation analyses were run controlling for mother depression symptoms. Two differences analyses

were proposed for each parent to understand the personal contribution of the reflective capacities on child social-emotional difficulties. The first would use the regular reflective function's eleven-point scale, and the second would use the two reflective function's categories (0 = not good enough RF, 1 = good enough RF). However, the second model could not be used because the collinearity values were greater than the expected parameters; for the mother, moderation was *VIF* = 109.74, and for the father, moderation was *VIF* = 34.41, thus indicating that the moderation's values were not robust and reliable. These values resulted despite all predictors being centered on their main average (Shieh, 2011).

Mothers' reflective function as a moderator. The model analyzed the mothers' reflective function using the eleven reflective function-point scale as a moderator. The regression revealed a non-significant effect as moderator (see Table 14).

Fathers' reflective function as a moderator. The regular reflective function scale was also used to test the fathers' reflective function as a moderator. For the father analysis, the regression found a non-significant effect as moderator (see Table 14).

Table 14

Regression and moderation analysis considering social-emotional difficulties as dependent variable

Variable	*B*	*Std. error*	*B std.*	*t*	*p*	*95% CI* LL	UL	*R*	*R2*	*F*	*p*
Model 1								.40	.14	8.93	.004
Intercepto	13.67	.94		14.58	.000	11.78	15.55				
Mother DS	.47	.16	.40	2.99	.004	.15	.78				
Model 2								.49	.21	7.34	.030
Intercepto	13.67	.90		15.18	.000	11.86	15.48				
Mother DS	.43	.15	.37	2.88	.006	.13	.74				
Triadic Score	-.57	.25	-.29	-2.24	.030	-1.08	-0.06				
Model 3								.49	.18	3.62	.849
Intercepto	13.67	.92		14.91	.000	11.82	15.52				
Mother DS	.45	.16	.38	2.81	.007	.13	.77				
Triadic Score	-.60	.29	-.30	-.06	.046	-1.19	-.01				
Mother RF	-.21	.98	-.03	-.22	.830	-2.19	1.77				
Father RF	.55	.97	.09	.57	.570	-1.40	2.50				
Model 4								.48	.16	3.31	.819
Intercepto	13.67	3.84		14.91	.004	3.94	19.42				
Mother DS	.44	.16	.37	2.81	.008	.12	.75				
Triadic Score	-.57	.29	-.29	-.06	.059	-1.16	-.02				
Mother RF 2 cat	1.74	2.76	.09	.70	.532	-3.82	7.29				
Father RF 2 cat	.49	2.63	.03	.41	.854	-4.81	5.79				
Model 5								.49	.16	2.84	.921
Intercepto	13.71	.1.01		13.57	.000	11.67	15.74				
Mother DS	.45	.16	.38	2.72	.009	.12	.78				
Triadic Score	-.61	.3	-.31	-2.03	.048	-1.21	-.004				
Mother RF	-.21	.99	-.03	-.21	.835	-2.21	1.79				
Father RF	.56	.98	.09	.57	.573	-1.42	2.53				
M RF x TS	-.03	.25	-.01	-.10	.921	-.53	.48				
Model 6								.50	.16	2.90	.612
Intercepto	13.89	.1.02		13.66	.000	11.84	15.94				
Mother DS	.43	.17	.37	2.64	.012	.10	.77				
Triadic Score	-.61	.31	-.33	-2.10	.041	-1.27	-.03				
Mother RF	-.21	.99	-.03	-.19	.850	-2.19	1.81				
Father RF	.56	1.01	.11	.67	.505	-1.35	2.70				
F RF x TS	-.15	.29	-.72	-.51	.612	-.73	0.44				

Note. Dendent variable = Percentage of social-emotional difficulties; CI = confidence interval; LL = lower limit, UL = upper limit; DS = depressive symptoms; M = mother; F = father; RF = reflective function; TS = triadic score.

6.3.4. Maternal and paternal reflective function as predictors of the triadic interaction.

Considering that the mothers' and fathers' reflective functions were not a significant predictor or moderator of child social-emotional difficulties, new analyses were conducted. Based on the correlational results, the contributions of the maternal and paternal reflective function were tested as predictors of quality of the triadic interaction with an entry regression, using the eleven reflective function's point scale (see Table 15).

The first step introduced the fathers' reflective function score, which was a significant predictor of the triadic interaction. In the second step, the mothers' reflective function score was introduced, which was a significant predictor, explaining 17% of the variance. However, in the third step, when the mothers' and fathers' reflective function were together, the father reflective function significant contribution disappeared. This disappearance could indicate that the effect of the fathers' reflective function was due to its correlation with the mothers' reflective function (r=.43), which acted as a confounder variable in the direct relationship; the latter (mothers' RF) is the one more reliably associated with the triadic interaction score. However, in the model with the mother and father reflective function together, father reflective function contributes to increase the explaining variance to 20%.

Table 15

Regression analysis considering triadic interaction as dependent variable

Variable	*B*	*Std. Error*	*B std.*	*t*	*p*	*95% CI*		*R*	*R2*	*F*	*p*
						LL	*UL*				
Model 1								.38	.13	8.19	.006
Intercepto	12.44	2.19		5.67	.000	8.03	16.85				
Father RF	1.69	.59	.38	2.86	.006	0.50	2.87				
Model 2								.19	.17	11.17	.002
Intercepto	11.58	2.15		5.39	.000	7.26	15.99				
Mother RF	1.87	.56	.43	3.34	.002	.75	3.00				
Model 3								.49	.20	7.24	.023
Intercepto	9.44	2.46		3.84	.000	4.50	14.38				
Father RF	1.06	.62	.24	1.69	.097	-0.20	2.31				
Mother RF	1.43	.61	.33	2.35	.023	0.21	2.66				

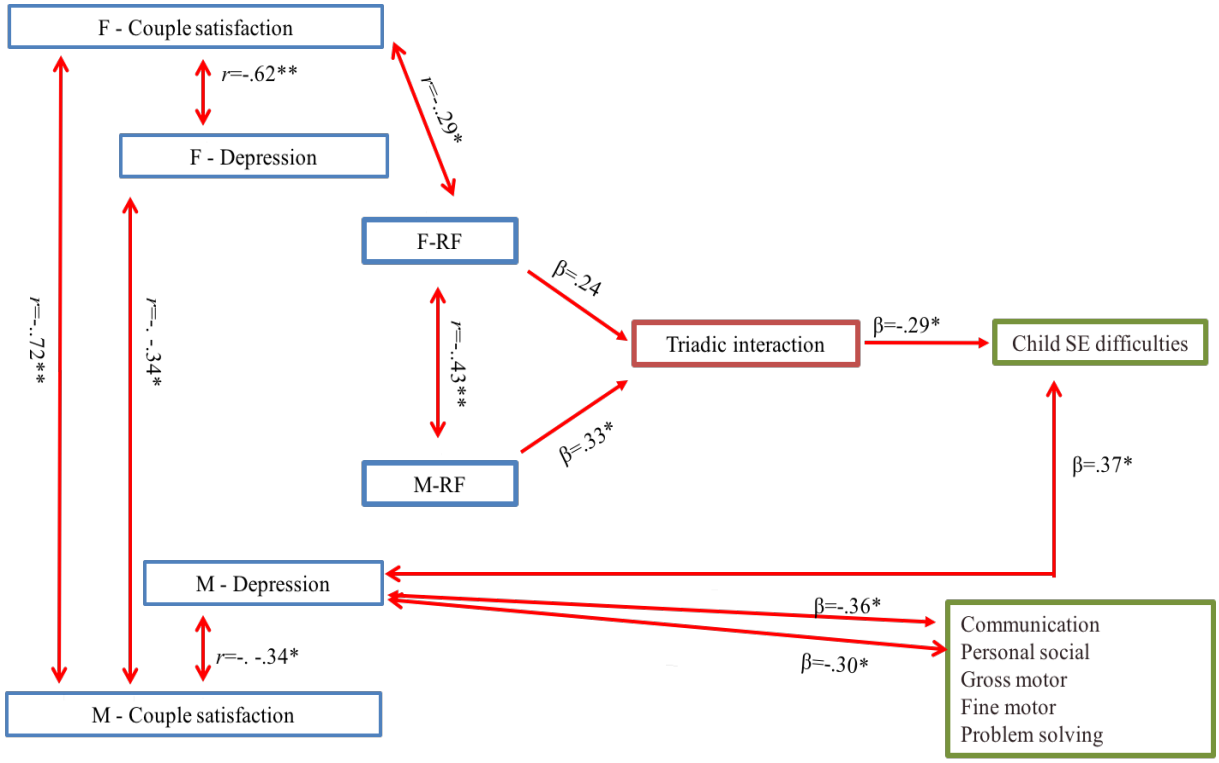
Note. Dendent variable = Triadic interaction; CI = confidence interval; LL = lower limit, UL = upper limit; RF = reflective function.

7. Comprehensive final model

In summary, Figure 3 presents the developed comprehensive model, which represents the relationships between the study variables.

Figure 4

Comprehensive final model



Note. **p < .01. (two tailed); **p < .05 (two tailed). F = father; M = mother; RF = reflective function; SE = social emotional.

8. Discussion

This study provides evidence with respect to the relationship of the fathers' and mothers' reflective function, the quality of triadic interaction, and child psychomotor development and social-emotional difficulties. These variables to date have not been studied together despite their great relevance for understanding the early development and mental health of children and families.

In terms of psychomotor development, the results show that the percentages of children who are under expectations on different scales were in the range of 2 to 16%. The least-lagged area was gross motor development, and the development of communication (16%) and personal-social (14%) were higher lagged areas. These results are in turn directly linked to child social and emotional development. These percentages are similar to those obtained in other Chilean studies, which report that approximately 12 to 29% of the children present a delay risk in psychomotor development (Centro de Microdatos-Universidad de Chile, 2014; Schonhaut et al., 2013). The delay in psychomotor development issue is not resolved. These and other studies show that many children remain who present problems in this area, and if they are not treated in time, many of these lags will generate greater difficulties in the future (Briggs-Gowan & Carter, 2008; Cheng et el., 2014; Essex et al., 2006; Giannovi & Kass, 2012; Pihlakoski et al., 2006).

In relation to socio-emotional development as assessed by the ASQ-SE, the results show that 46% of children are above the social-emotional difficulty cutoff, indicating that they have social-emotional difficulties. That this percentage is higher has been confirmed by other studies, which showed that from 11% to 37% of children have some social-emotional difficulties in early childhood (Bian et al, 2017; Briggs-Gowan et al., 2013;

Centro de Microdatos-Universidad de Chile, 2014; Wendland et al., 2014). However, to interpret these results, it is necessary to consider that these children entered this study because their parents or professionals who work with, reported one or more difficulties in the following areas: sleep, feeding, behavioral and emotional or relationship. Although these reports were subjective evaluations done by the adults, there were real worries about their children concerning problems that interfered in daily life, because almost half of this sample was considered by the ASQ-SE an objective and clinical delay or difficulty.

Related to the parents' variables, the descriptive results show lower averages in relation to mothers' and fathers' parental reflective function than do the results obtained in international investigations (Control mother RF-PDI group, *M*= 3.69, Ensink, Bégin, et al., 2016; Mix clinical and non-clinical mothers RF-AAI, *M* = 4.52, Ensink, Bégin et al., 2016; non-clinical sample, mother RF-AAI, *M* = 4.48; father RF-AAI= 4.22, Fonagy et al., 1991; non-clinical mother RF-PDI, *M* = 5.08, Slade et al., 2005).

In this study, the averages and frequencies obtained between mothers and fathers showed that 24% of mothers and 18% of parents have the capacity to reflect on mental states. More than half of mothers and fathers (64% and 68%, respectively) show low reflective capacities; that is, in their discourse, mentalizing language is present. However, they do not reflect on it. Finally, 12% of mothers and 14% of the parents presented a poor or negative level of reflective functioning; that is, their descriptions presents no evidence of an awareness of mental states and suggests that they might even reject the recognition and use of mental states.

First, to understand these results, note that this sample consisted of parents mostly raising their first child or in early parenting, in the couple adjustment phase, and with children with socio-emotional difficulties, experiences associated with changes and stress.

Additionally, it is important to consider these results and, above all, the last group of parents described because the scientific literature has demonstrated that a poor or negative parental reflective functioning is associated in the adult with less persistence in distress-tolerant tasks (Rutherford et al., 2015). Additionally, poor or negative parental reflective functioning is associated with a higher level of maternal disruption in mother-infant affective communication (Grienenberger et al., 2005) and with insecure attachment and physical neglect (San Cristobal et al., 2017).

For children, having a parent with poor or negative reflective capacities also has negative consequences throughout development. In early childhood, such a problem can cause the development of an insecure attachment (Ensink, Normandin et al., 2016; Slade et al., 2005). In the preschool years, it can cause fewer social competences in children (Ensink, et al., 2015; Kårstad et al., 2015). At school age, more externalizing problems can appear (Ensink, Bégin et al., 2016). Moreover, anxiety (Esbjørn et al., 2013) and fewer reflective function capacities might develop (Scopesi et al., 2015).

Additionally, more than half of the parents have a low or questionable reflective function, or scores from 3–4 in the reflective function scale. However, their having low capacities to reflect might not be negative for their children because they are parents who create a narrative that will recognize other emotions and intentions, although they are not reflective of them. However, that type of explanation of the experience could be sufficient at this age. That is, it is possible that as the child grows up, greater reflective capacities will be demanded of the parents; as Taumoepeau and Ruffman (2006) suggest, maternal mentalization changes and adjusts according to the child's age.

Another finding that was highly interesting was the "couple reflective function level". Based on mother and father reflective function, couple combinations were formed (e.g., one

low and one high), showing that the most frequent is that a parent couple have the same level of reflective function, or one level high or low. However, this result was interesting to see because a parent with high reflective function does not come together with one who has poor capacities. Likewise, the extremes, when both parents present a poor reflective function (2%) and both high reflective function (10%), were less represented.

To compare, the groups were redistributed in three aggregations. The analyses of comparisons between the groups showed that there are significant differences between them in co-parenting; toddler contribution and triadic interaction were the main differences found in the extreme groups. In other words, the major difference in the quality of family interaction is generated when the parents each have Poor/low reflective function, composed of one parent with low reflective function and one poor, or both poor. The Poor/low reflective function couple had a significantly lower mean in the total triadic interaction than did the Low and Low/high reflective function couples. These differences were not found in relation to the child development variables.

These results are in line with what has been found by Marcu et al., (2016) using the insightfulness measurement. This measurement assesses the parent's reflective capacities in interaction with his child, showing that triads in which both parents were insightful had higher family cooperation scores compared with triads in which only one parent was insightful and triads in which neither parent was insightful.

In relation to the quality of the triadic interaction, the average obtained by the families studied was $M = 18.44$, which is similar to other international non-clinical samples ($M = 19$, Favez et al., 2011; Marcu et al., 2016) and higher than clinical samples ($M = 10.3$, Favez et al., 2011). In the case of Chile, our mean of triadic interaction ($M = 13.22$) is greater than that of other Chilean samples ($M = 10.09$, Perez et al., 2017). This result could

occur because, although the other study was not in a clinical sample, it was a population that lived in a poverty context and had high levels of parental stress (Perez et al., 2017).

Conversely, considering the results with respect to the association between the study variables, the first hypothesis expected that mothers' and fathers' reflective functions would be significantly positively correlated with family interaction. As was hypothesized, the result shows that when the mother and the father have higher reflective function levels, the family triadic interaction also has higher levels of coordination.

Related to each family triadic interaction subscale, the reflective function of both parents correlates positively with affect and co-parenting. Mother reflective function was associated with interactive sequence, and the father reflective function positively correlates with focus and scaffolding. Despite both parents' influence on the triadic interaction, these findings show a differentiated contribution between father and mother reflective capacities.

The second hypothesis was rejected, inasmuch as, in contrast to what was hypothesized, mother and father reflective function were not correlated with child psychomotor development and socio-emotional difficulties. However, more deeply, when the child subscales were studied, two weak and odd associations appear. The first was that mothers' reflective function was negatively associated with child personal-social development, which evaluates solitary play and play with toys and other children. The second was father reflective function, which correlated positively with child person-interaction difficulties, which assess the ability to respond or initiate social responses to parents, other adults or peers. These correlations were quite odd because, as studies have shown, it is expected that parents' reflective functions positively influence the child's personal and social interaction at the preschool age (Cassidy et al., 2003). Nonetheless, another possible explanation is that children with fathers and mothers with poor or low

reflective function must seek other interactions to find the stimulus that they do not find in their parents. However, this hypothesis has not been verified by other studies.

The third hypothesis was partially corroborated because family interaction score and child psychomotor development were not significantly correlated. However, as expected, the triadic total interaction score was negatively associated with child socio-emotional difficulties, which indicates that how fathers and mothers coordinate and support each other in the interaction with their children and in their upbringing influences how the child develops social and emotional competences (Feldman, & Masalha, 2010; Greenspan et al., 2001).

Concerning the control variables, the relationship between parents, both fathers and mothers, had an inverse association between couple satisfaction and depressive symptomatology; that is, parents who are more satisfied with their relationship have fewer depressive symptoms, showing the influence of one over the other, but these symptoms do not directly affect the child. Nevertheless, couple satisfaction appears to influence children's outcomes; the contribution was through the couple subsystem to the parents' symptomatology, more specifically through the mother depression symptoms on child psychomotor and social-emotional development. Therefore, incorporating this variable into working with young families is crucial for understanding the functioning of the parent-couple subsystem, including a comprehensive examination of child development beyond the mother/father-child dyad.

The fourth hypothesis was that the level of fathers' and mothers' reflective functions and the quality of the triad interaction would influence child psychomotor development and socio-emotional difficulties. Related to the influence of family interaction and maternal and paternal reflective functions on child psychomotor development, the hypothesis was not

corroborated. In contrast to what was hypothesized, only the social-demographic characteristics (child birth order, child age, mother education and age) and mother depression symptoms contribute to explaining child psychomotor development. Thus, the literature consistently shows how maternal depressive symptomatology affects child psychomotor development, showing that toddlers with mothers with depression are twice as likely to have altered psychomotor development as are mothers with no depressive symptoms (Podestá et al. al., 2013).

The findings were different in relation to child social-emotional difficulties; in this case, the hypothesis was partially corroborated because only mother depression symptoms and triadic interaction contributed to explaining 21% of the variance of child social-emotional development. In other words, families with lower coordination and higher maternal depression symptoms explain part of the child's social-emotional difficulties. For its part, maternal and paternal reflective function had no direct influence on child social-emotional difficulties. On the one hand, these finding are in line with the early family literature, which shows that since the 1980s, the immediate family is the most influential relationship system in which a child develops (Bronfenbrenner, 1987). In the triad, the child learns to share affection, attention and a common objective (Liszkowski et al., 2004; Fivaz-Depeursinge, & Corboz-Warnery, 1999), which influences the acquisition of social competence (Cigala et al., 2014; Feldman, & Masalha, 2010) that, in turn, is reflected in the child's socio-emotional adaptation. On the other hand, the question about the influence of the reflective function remains open.

Additionally, as mentioned, maternal depression symptoms again play an important role in the explanation of child social-emotional difficulties, as shown in the scientific literature (Caughy et al., 2009; Kam et al., 2011; Leckman-Westin et al., 2009).

Based on the results, an additional hypothesis was that reflective function would have an indirect effect, as a moderator, on child social-emotional difficulties. Although the hypothesis and the literature show the reflective function as an intervening variable (Borelli et al., 2015; Grienenberger et al., 2005; Slade, 2005; Smaling et al., 2016a; Wong, 2012), neither the mother's nor the father's reflective function constituted significant moderators in the relationship between the quality of the triadic interaction and child socio-emotional difficulties.

Considering these results and the theoretical background of mentalization, a new hypothesis was developed that expected that reflective function would influence the triadic interaction. As expected, the fathers' reflective function was a significant predictor of the family interaction and of the mother reflective function, but when both were together, only the mother reflective function was a significant predictor. This result is interesting to consider because, although the statistically significant influence of the father disappears when the mother enters the equation, the variance of the father and mother together is greater than that of the mother alone, showing a less obvious contribution from the father than the mother but nonetheless generating a differential contribution.

From a clinical perspective, these results are interesting to interpret; on the one hand, the scientific evidence has shown the influential role of the parental reflective function in child social and emotional development (Ensink et al., 2015; Steele & Steele, 2008). On the other hand, in this study, the contribution is not directly to child development. These findings show the direct influence of the reflective function on the triadic interaction and of the triadic interaction on child social-emotional development. Thus, the activity of mentalizing increases the likelihood that the parent is aware of, for example, the infant's needs, thoughts, and feelings but might not necessarily indicate that the parent is able to

convert his or her thoughts about the infant's mind into direct, sensitive behavioral responses. That approach is how studies show that the relationship between parenting reflective capacities and child outcomes are mediated by parental sensitivity (Laranjo et al., 2008; Stacks et al., 2014).

Another reflection that emerges from these results is that the main scale that evaluates reflective function (Reflective function scale, Fonagy et al., 1998) provides a single overall score. On the one hand, it is a clear and guiding score; on the other hand, it does not capture the complexity and multidimensionality of parental RF, losing theoretical and clinical richness of scale. Especially problematic are the pre-mentalizing or pseudo-mentalizing states, which are difficult to differentiate because the same score can correspond to hyper-mentalizing, a simple and concrete reflective function, or an unstable reflective capacity (Fonagy et al., 1998). Likewise, poor scores might correspond to denial of mental states, distortions, or malevolent attributions (Allen, 2006). These theoretical and clinical differences suggest that the effect on the child of a low, simple reflective function is different from that of a parent who hyper-mentalizes.

Thus, Suchman et al. (2010) and Smaling et al. (2016a) have observed three dimensions of reflective operation using PDI-RF. These dimensions are self-focused, child-focused and relationship-focused mentalization, showing that self-focused reflective function was related to less maternal contingency, more negative emotionality and externalizing problems in the child. Child-focused was associated with more maternal contingent behavior, and reflective function relationship-focused were reported with less reported child physical aggression. This type of analysis shows how different forms of reflective functioning differentially affect the exercise of parenting and child development.

To summarize, the findings of this study confirm the contribution of family coordination and cooperation on child social and emotional development (Cigala et al., 2014; Feldman, & Masalha, 2010), providing evidence based on a study of families with children at an early age. This study shows that the father's contribution does not directly affect the child's early development; rather, it is in the triad interaction that the father, in interaction with the mother and child, influences his child's development, making special contributions in the focus and scaffolding, affection and co-parenting, which influences the quality of the triad's functioning. This result has been found by other authors, suggesting that parent involvement and reciprocity have a positive effect on child development, the mother-father-child relationship and the couple subsystem (Feldman, 2010; Feldman et al., 2013; Sarkadi et al., 2008, Wilson & Prior, 2010, Simonelli et al., 2016).

This study shows a leading role of the mother and a secondary role of the father in child development. This indirect influence of the father can be explained based on the distribution of social and family roles and the time and type of activities that the father performs with his child. The reorganization of domestic and foster care has contributed to increased parental involvement in early childcare and promoted multiple roles within the family (Lamb, 2013). In recent decades, the rate of economic participation of women has increased in Chile. However, it remains lower than that of men, male heads of household predominate (Instituto Nacional de Estadística, 2012), and the mother continues as the main person in charge of child raising (Fares, Fields, & Kamboukos, 2009; Pleck & Masciadrelli, 2004). This sample is not the exception; 62.5% of the mothers had a full-time job compared with 95.9% of the fathers, showing that the mother was the main child caregiver.

The distribution of roles and tasks and the time that the father and the mother spend with their child allow us to understand these findings in which, although family interaction influences child development, the mother more directly influences early child development.

Additionally, these results again confirm the effect of maternal depressive symptomatology on child development, having an effect not only emotionally but also in the acquisition of psychomotor skills such as communication and personal-social development. This finding is in line with broad scientific evidence that demonstrates the effects of maternal depression on child development and mental health (Caughy et al., 2009; Cummings et al., 2005; Kam et al., 2011), which appear to affect the child through direct mother-infant interaction and care. However, a father's depression appears to exert its influence on children's outcomes through an effect on the couple's relationship satisfaction (Gutierrez-Galve et al., 2015).

These results invite professionals who work in early childhood to consider changing the focus of attention from the dyad to the early family, promoting the inclusion of the father. As shown by these results, the quality of family interaction can be constituted as a factor that is protective of or detrimental to the social and emotional development of children. Conversely, reflective function appears to be a variable that influences the quality of early family interactions because to represent one's own and others' mental states permits understanding, regulating and giving sense to one's own and others' behavior (Fonagy et al., 2004).

Finally, although these results are preliminary and descriptive, the couple reflective function levels show that the combination of poor and low levels of couple reflective function is the real source of harm to the triad interaction. As in the attachment theory, which is disorganized attachment that generates greater childhood psychopathology

(Madigan, Moran, Schuengel, Pederson, & Otten, 2007), in this case, it is the poor reflective function that generates worse quality family interaction, and it is the poor quality of family interaction that generates greater socio-emotional difficulties in the child.

Nevertheless, these findings must be confirmed using larger samples. It is also recommended to reduce the age gap in children because from 12–36 months, there are major changes in development, primarily in communication and regulation skills.

Another limitation is that the measures of this study were performed post intervention, despite having been analyzed and controlled when it was statistically relevant. Thus, it is recommended that the study subjects perform the evaluation on the same baseline.

The (non-randomized) recruitment characteristics and the lack of follow-up evaluations in this study constitute a limitation that prevents the generation of prediction models that permit observation of causality and the direction of the variables.

In term of the instruments, although the ASQ is a great and broadly used instrument that can be used by any mental health professional, it is only a screening assessment; therefore, it only detects more general aspects of child development. Thus, future studies would benefit from including other means of evaluating child psychomotor and social-emotional difficulties, such as child symptomatology or some observational task to complement the ASQ results, particularly for the social and emotional dimension.

It is important to consider that this study constitutes the second study that linked family interaction and parents' reflective capacity, and it is the first that additionally assesses child social-emotional difficulties. Therefore, future studies would benefit from considering other family members who are in charge of daily childcare, such as grandmothers, stepmothers, stepfathers, or nannies. Additionally, it is important in early

family development to consider the role of siblings and consider how the triad might actually be an interaction of four or more people.

Moreover, future studies should consider additional reflective function dimensions to capture the richness, complexity and multidimensionality of parental RF.

8.1. Ethical considerations

As mentioned in the procedure description of this study, this thesis, which is to be inserted into a Fondecyt project, received the approval of the institutional Ethics Committee of Human Research from the Catholic University of Chile and from the Chilean National Commission of Scientific and Technological Research. Additionally, this current study received ethical approval from the institutional Ethics Committee of Human Research at the University of Chile.

The participants agreed to participate based on a verbal explanation of the study and by signing the informed consent forms of Fondecyt Start-up Project No. 11140230 and of this doctoral research.

During the study, the family data were treated with extreme confidentiality; families agreed with informed consent that the data would only be used for specialized teaching purposes. The names were guarded, and it was verified that none of those present had personal knowledge of the families.

Apart from all formal ethical aspects, all families participated in a brief intervention with video-feedback. The families in the experimental group did so prior to the evaluation in this study, and the families in the control group did so after the evaluation of this study. The intervention was focused on parents' concerns about their child's socio-emotional development, with a focus on the parents-child relationship. Some of the intervention

families were advised to continue with a psychological treatment. The options offered were the following: increase the number of home intervention sessions, referral to another professional in the area, or the therapist in charge of the family will continue the treatment in their private practice with the associated costs. Additionally, for the families who required it, the therapist in charge contacted family-related professionals, for example, a preschool teacher or psychiatrist, and generated a report of the final evaluation.

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10. Annexed

10.1. Informed Consent Letters

CARTA DE CONSENTIMIENTO INFORMADO

Le estamos invitando a participar en el proyecto de investigación *"Análisis de la función reflexiva parental, la calidad de la interacción tríadica y su influencia en el desarrollo infantil temprano",* el cual es la investigación de Tesis para optar al grado de Doctor en Psicoterapia, otorgado por las Escuelas de Psicología de la Universidad de Chile y la Pontificia Universidad Católica de Chile. Este a su vez forma parte del proyecto FONDECYT de Iniciación Nº 11140230 (2014 – 2017) titulado *"Implementación y Evaluación de una Intervención con Videofeedback focalizada en la Calidad Vincular y la Función Reflexiva Parental, dirigida a Tríadas Madre-Padre-Hijo/a con dificultades en el Desarrollo Socioemocional Infantil"*, y del Fondo de Innovación para la Competitividad (FIC) del Ministerio de Economía, Fomento y Turismo, a través de la Iniciativa Científica Milenio, Proyecto IS130005.

La investigación propuesta consiste en una entrevista individual, dirigida a padres y madre de niños/as entre 1 y 3 años, mayores de 18 años y en relación de pareja actual que sean participantes del Proyecto FONDECYT de Iniciación Nº 11140230. Esta entrevista busca conocer la capacidad de padres y madres de reflexionar sobre los sentimientos, deseos y necesidades de uno mismo y de su hijo/a.

Esta investigación tiene por objetivo analizar la relación entre la capacidad de los padres de reflexionar sobre los sentimientos de sí mismo y de su hijo/a y la interacción madre-padre-hijo/a, evaluando la influencia en el desarrollo infantil. El estudio incluirá a un número total de 50 familias conformadas por padre – madre – hijo.

Si usted acepta participar se le realizará una entrevista que tiene una duración aproximada de 40 minutos, la que será grabada en audio y luego transcrita. Esta entrevista considera preguntas sobre la descripción del niño/a, sobre la relación padre/madre-hijo/a y sobre la experiencia de ser padre/madre. Esta será realizada por un Psicólogo Clínico. La entrevista podrá ser realizada en su domicilio o en dependencias de la Escuela de Psicología de la Pontificia Universidad Católica de Chile, pudiendo usted elegir el lugar.

Su participación no implica riesgos para usted, salvo la posibilidad de sentirse incómoda/o al contestar algunas preguntas. Una vez finalizada la entrevista y en caso de que usted lo requiera, recibirá contención emocional y una devolución de los aspectos relevantes vistos en la entrevista y se le orientará para que acceda a atención profesional de mayor duración para abordar sus dificultades si usted lo requiere y desea recibirla**.**

En cuanto a los beneficios, además del beneficio que este estudio significará para el progreso del conocimiento, su participación le podrá ayudar a ampliar su perspectiva sobre la relación que establece con su hijo/a y la forma en que se influyen mutuamente, contribuyendo a mejorar la comprensión de sus conductas y sentimientos, así como la relación entre ambos.

Es necesario aclarar que usted no recibirá ninguna compensación económica por su participación en el estudio, como también que la entrevista realizada no presenta costo alguno para usted.

Si usted decide no participar en esta investigación, de igual forma seguirá siendo parte del estudio *"Implementación y Evaluación de una Intervención con Videofeedback focalizada en la Calidad Vincular y la Función Reflexiva Parental, dirigida a Tríadas Madre-Padre-Hijo/a con dificultades en el Desarrollo Socioemocional Infantil"*.

Toda la información derivada de su participación en este estudio será conservada en forma de estricta confidencialidad. Sólo la investigadora responsable tendrá acceso a los nombres de los participantes, identificando a los participantes por un número de entrevista.

Los resultados de esta investigación serán utilizados sólo para este estudio y contribuirán al desarrollo de herramientas para el trabajo con familias con niños/as pequeños/as que presentan alguna dificultad en su desarrollo, su comportamiento o sus relaciones familiares. Cualquier publicación o comunicación científica de los resultados de la investigación será completamente anónima.

Su participación en esta investigación es totalmente voluntaria y se puede retirar en cualquier momento comunicándolo al investigador, sin que ello esto afecte en nada su participación en el estudio *"Implementación y Evaluación de una Intervención con Videofeedback focalizada en la Calidad Vincular y la Función Reflexiva Parental, dirigida a Tríadas Madre-Padre-Hijo/a con dificultades en el Desarrollo Socioemocional Infantil"*. De igual manera el investigador podrá determinar su retiro del estudio si consideran que esa decisión va en su beneficio.

Usted recibirá una copia íntegra y escrita de este documento firmado. Si usted requiere cualquier otra información sobre su participación en este estudio puede comunicarse con: María José León Papic, al +56 2 **23341262 investigador responsable de este estudio o con Marcia Olhaberry Huber, mpolhabe@uc.cl o al teléfono +56 2 23341262, investigadora responsable del proyecto** FONDECYT de Iniciación Nº 11140230, **Escuela de Psicología, Pontificia Universidad Católica de Chile, ubicada en Vicuña Mackenna 4860, Comuna de Macul, Santiago.**

En caso de duda sobre sus derechos debe comunicarse con el Presidente del "Comité de Ética de Investigación en Seres Humanos", Dr. Manuel Oyarzún G., Teléfono: 2-978.9536, Email: comiteceish@med.uchile.cl, cuya oficina se encuentra ubicada a un costado de la Biblioteca Central de la Facultad de Medicina, Universidad de Chile en Av. Independencia 1027, Comuna de Independencia.

Después de haber recibido y comprendido la información de este documento y de haber podido aclarar todas mis dudas, otorgo mi consentimiento para participar en el proyecto *"Análisis de la función reflexiva parental, la calidad de la interacción tríadica y su influencia en el desarrollo infantil temprano"*.

Muchas gracias por su valiosa cooperación.

Acepto que la transcripción de la entrevista sea usada con fines de investigación, resguardando nuestras identidades. **Sí __ No___**

Acepto que la información obtenida de la transcripción de la entrevista sea usada con fines de publicación científica resguardando nuestras identidades. **Sí __ No___**

Acepto que la transcripción de la entrevista sea usada con fines de docencia especializada, resguardando nuestros nombres y verificando que ninguno de los presentes tenga conocimiento personal de la familia videada. **Sí __ No___**

Acepto que el investigador responsable, finalizada la evaluación pueda volver a contactarme en futuras ocasiones **Sí __ No___**

Nombre: _____ Rut:_____
Firma: _____ Fecha: _____
Nombre del investigador: María José León Papic Rut: 15.911.969-6
Firma:_____ Fecha: _____

CARTA DE CONSENTIMIENTO INFORMADO

El presente estudio, titulado: ***"Implementación y Evaluación de una Intervención con Videofeedback focalizada en la Calidad Vincular y la Función Reflexiva Parental, dirigida a Tríadas Madre-Padre-Hijo/a con dificultades en el Desarrollo Socioemocional Infantil",*** forma parte del proyecto FONDECYT de Iniciación Nº 11140230 (2014 – 2017), el cual a su vez es parte del Fondo de Innovación para la Competitividad (FIC) del Ministerio de Economía, Fomento y Turismo, a través de la Iniciativa Científica Milenio, Proyecto IS130005. y cuenta con el patrocinio de la Pontificia Universidad Católica de Chile. La presente carta tiene por objetivo ayudarle a tomar la decisión de participar o no en este estudio junto a su hija/o.

La investigación propuesta consiste en una intervención psicoterapéutica que utiliza la grabación en video de interacciones entre adultos y niños como herramienta. Se dirige a tríadas compuestas por la madre, su hijo(a) pequeño y su padre u otro adulto que desempeñe el rol de cuidador primario. Busca favorecer la comprensión del comportamiento infantil y las relaciones familiares, contribuyendo positivamente a mejorar los vínculos y la salud mental.

Los resultados de esta investigación serán utilizados sólo para este estudio y contribuirán al desarrollo de herramientas para el trabajo con familias con niños/as pequeños/as que presentan alguna dificultad en sus vínculos, su comportamiento o sus relaciones familiares. Una vez finalizado el estudio, si usted lo desea, se le entregarán los resultados cualitativos obtenidos en la evaluación final y se les invitará a una presentación de los resultados generales. En caso de identificar alguna dificultad que implique riesgo para su salud física y/o mental o la de su hijo/a, esta le será comunicada y posteriormente informada a un profesional competente del Centro de Salud en el cual ustedes se atienden.

Si decide participar en el estudio, se le solicitará a usted y al padre/madre de su hijo (u otro adulto en el rol parental) que firmen esta carta de consentimiento. La participación consistirá en ser parte de 2 evaluaciones de aproximadamente una hora y media de duración y de una intervención en apego y en la capacidad de reflexionar sobre los sentimientos, deseos y necesidades en uno mismo y los otros o función reflexiva. Será realizada por 1 Psicólogo Clínico y 1 Estudiante de Psicología en su último año. Las 2 evaluaciones mencionadas consisten en: una grabación de juego madre-padre-niño/a de aproximadamente 10 minutos, dos grabaciones de 3 minutos de juego libre adulto niño/a (madre-niño y padre-niño), contestar preguntas sobre el comportamiento y las emociones de su hijo(a), responder preguntas sobre sus sentimientos y sobre sus vínculos significativos. Las evaluaciones y la intervención podrán ser realizadas en el Consultorio en el que ustedes se atienden o en su domicilio, pudiendo usted elegir el lugar.

Su participación no implica riesgos para usted y su hijo(a), salvo la posibilidad de sentirse incómoda/o al contestar algunas preguntas. En relación a los beneficios de participar, muchos estudios muestran el efecto positivo para la madre, el padre y sus hijos/as pequeños de ser parte de un programa de apoyo en apego y función reflexiva, especialmente cuando los niños/as muestran dificultades en su comportamiento (lloran mucho, les cuesta dormir, no comen bien, entre otros). Una vez finalizada la intervención y en caso de que usted, su hijo/a o su padre (u otro adulto en el rol parental) lo requieran, recibirán contención emocional y se les orientará para que accedan a atención profesional de mayor duración para abordar sus dificultades**.**

A pesar de lo anterior, su participación es voluntaria y usted es libre de dejar el estudio en cualquier momento, sin que esto afecte en nada la atención que su hijo(a) y su familia reciben en el Centro de Salud al que asisten.

Toda la información que usted entregue, así como la información obtenida en la observación de su hijo(a) es **confidencial**. Sólo la investigadora responsable tendrá acceso a los nombres de los participantes, el equipo de investigación y quienes analicen los videos, accederán a los datos identificando a los participantes por un número de folio, lo cual asegurará su anonimato. No obstante, es importante considerar que en el caso de los videos el anonimato no puede asegurarse. Por lo mismo, los miembros del equipo de investigación que accedan a los datos firmarán también un compromiso de confidencialidad. No se compartirá con nadie la información particular de usted o su hijo(a), sin embargo la información general que se obtenga del estudio puede ser publicada en el ámbito científico si usted lo autoriza.

Muchas gracias por su valiosa cooperación.

CONSENTIMIENTO:

Declaro que he leído el presente documento, se me ha explicado en qué consiste esta investigación y mi participación en la misma, he tenido la posibilidad de aclarar mis dudas y tomo libremente la decisión de participar en la Intervención en videofeedback para mejorar la calidad de mis relaciones familiares, a cargo de la Psicóloga Marcia Olhaberry Huber. Además se me ha dado entrega de un duplicado firmado de este documento.

Acepto que los videos e información obtenida sean usados con fines de investigación, resguardando nuestras identidades.

Sí __ No___

Acepto que la información obtenida en el estudio sea usada con fines de publicación científica resguardando nuestras identidades.

Sí __ No___

Acepto que los videos sean usados con fines de docencia especializada, resguardando nuestros nombres y verificando que ninguno de los presentes tenga conocimiento personal de la familia videada.

Sí __ No___

_____	_____
Nombre Participante	Firma Participante
_____	_____
RUT Participante	Relación con el niño/a
_____	_____
Firma Investigador Responsable	Fecha

Si tiene alguna pregunta puede comunicarse con Marcia Olhaberry Huber, mpolhabe@uc.cl o al teléfono 23341262, Escuela de Psicología, Pontificia Universidad Católica de Chile, Vicuña Mackenna 4860, Comuna de Macul, Santiago. Si usted tiene alguna consulta o preocupación respecto a sus derechos como participante de este estudio, puede contactar al Comité de Ética de la Escuela de Psicología de la Pontificia Universidad Católica de Chile, E-mail comité.etica.psicologia@uc.cl, fono 2354-5883.

CARTA DE CONSENTIMIENTO INFORMADO

El presente estudio, titulado: ***"Implementación y Evaluación de una Intervención con Videofeedback focalizada en la Calidad Vincular y la Función Reflexiva Parental, dirigida a Tríadas Madre-Padre-Hijo/a con dificultades en el Desarrollo Socioemocional Infantil",*** forma parte del proyecto FONDECYT de Iniciación Nº 11140230 (2014 – 2017) y del Instituto MILENIO: Intervención y cambio en depresión y cuenta con el patrocinio de la Pontificia Universidad Católica de Chile. La presente carta tiene por objetivo ayudarle a tomar la decisión de participar o no en este estudio junto a su hija/o.

La investigación propuesta consiste en una intervención psicoterapéutica que utiliza la grabación en video de interacciones entre adultos y niños como herramienta. Se dirige a tríadas compuestas por la madre, su hijo(a) pequeño y su padre u otro adulto que desempeñe el rol de cuidador primario. Busca favorecer la comprensión del comportamiento infantil y las relaciones familiares, contribuyendo positivamente a mejorar los vínculos y la salud mental.

Los resultados de esta investigación serán utilizados sólo para este estudio y contribuirán al desarrollo de herramientas para el trabajo con familias con niños/as pequeños/as que presentan alguna dificultad en sus vínculos, su comportamiento o sus relaciones familiares. Una vez finalizado el estudio, si usted lo desea, se le entregarán los resultados cualitativos obtenidos en la evaluación final y se les invitará a una presentación de los resultados generales. En caso de identificar alguna dificultad que implique riesgo para su salud física y/o mental o la de su hijo/a, esta le será comunicada y posteriormente informada a un profesional competente del Centro de Salud en el cual ustedes se atienden.

Si decide participar en el estudio, se le solicitará a usted y al padre/madre de su hijo (u otro adulto en el rol parental) que firmen esta carta de consentimiento. La participación consistirá en ser parte de 2 evaluaciones de aproximadamente una hora y media de duración y de una intervención en apego y en la capacidad de reflexionar sobre los sentimientos, deseos y necesidades en uno mismo y los otros o función reflexiva. Será realizada por 1 Psicólogo Clínico y 1 Estudiante de Psicología en su último año. Las 2 evaluaciones se realizarán al comienzo y luego de terminada la intervención. La intervención estará compuesta por al menos 5 sesiones de frecuencia semanal, de una hora y media de duración. Las 2 evaluaciones mencionadas consisten en: una grabación de juego madre-padre-niño/a de aproximadamente 10 minutos, dos grabaciones de 3 minutos de juego libre adulto niño/a (madre-niño y padre-niño), contestar preguntas sobre el comportamiento y las emociones de su hijo(a), responder preguntas sobre sus sentimientos y sobre sus vínculos significativos. Las evaluaciones y la intervención podrán ser realizadas en el Consultorio en el que ustedes se atienden o en su domicilio, pudiendo usted elegir el lugar.

Su participación no implica riesgos para usted y su hijo(a), salvo la posibilidad de sentirse incómoda/o al contestar algunas preguntas. En relación a los beneficios de participar, muchos estudios muestran el efecto positivo para la madre, el padre y sus hijos/as pequeños de ser parte de un programa de apoyo en apego y función reflexiva, especialmente cuando los niños/as muestran dificultades en su comportamiento (lloran mucho, les cuesta dormir, no comen bien, entre otros). Una vez finalizada la intervención y en caso de que usted, su hijo/a o su padre (u otro adulto en el rol parental) lo requieran, recibirán contención emocional y se les orientará para que accedan a atención profesional de mayor duración para abordar sus dificultades**.**

A pesar de lo anterior, su participación es voluntaria y usted es libre de dejar el estudio en cualquier momento, sin que esto afecte en nada la atención que su hijo(a) y su familia reciben en el Centro de Salud al que asisten.

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Muchas gracias por su valiosa cooperación.

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Sí __ No___

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Sí __ No___

Acepto que los videos sean usados con fines de docencia especializada, resguardando nuestros nombres y verificando que ninguno de los presentes tenga conocimiento personal de la familia videada.

Sí __ No___

_____	_____
Nombre Participante	Firma Participante
_____	_____
RUT Participante	Relación con el niño/a
_____	_____
Firma Investigador Responsable	Fecha

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10.2. Sociodemographic Background Sheet

N. Folio: Grupo:

FECHA:

Evaluador/a:

FICHA DE ANTECEDENTES SOCIODEMOGRÁFICOS

PROYECTO FONDECYT N°11140230

1. Datos de la madre

Nombre madre:

Fecha de nacimiento: Edad: Nacionalidad:

Trabajo remunerado Jornada:

SI __ NO __ Completa ____ Media ____ Menos que media ____

Actividad:

Vivienda: Propia __ Arrendada __ Nº habitaciones: Nº Camas:

Allegada __

Dirección Particular:

Nº personas que viven en esa dirección:

Nº de hijos: Teléfonos de contacto:

Embarazo deseado: Parto:

SI __ NO__ Normal ___ Cesárea ___ Fórceps ___

Estado Civil Actual

1		Soltero/a
2		Conviviente
3		Casado/a
4		Anulado/a/Separado/a
5		Viudo/a

Escolaridad

1		Analfabeto/a
2		Básica Incompleta
3		Básica Completa
4		Media Incompleta
5		Media Completa
6		Técnico-profesional
7		Superior Universitaria

MADRE:

Tratamiento psicológico actual SI ___ NO ___ Motivo_____
Tratamiento psicológico anterior SI ___ NO ___ Motivo _____
Fecha _____ Duración _____
Cantidad de sesiones_____
Tratamiento farmacológico actual SI ___ NO ___ Motivo_____
Tratamiento farmacológico anterior SI ___ NO ___ Motivo _____
Fecha _____ Duración _____

2. Datos del padre

Nombre padre:

Fecha de nacimiento: Edad: Nacionalidad:

Trabajo remunerado
SI __ NO __

Jornada:
Completa ____ Media ____ Menos que media ____

Actividad

Nº hijos:

Contacto con el niño
SI __ NO __

Frecuencia: Diaria ____ Semanal ____ Mensual ____
Trimestral ___ Semestral ____ Anual _____ Otro ____

Actividades que realiza con el niño: Alimentación __ Baño y aseo __ Juego y estimulación __Otra:

_____

Estado Civil Actual

1		Soltero/a
2		Conviviente
3		Casado/a
4		Anulado/a/Separado/a
5		Viudo/a

Escolaridad

1		Analfabeto/a
2		Básica Incompleta
3		Básica Completa
4		Media Incompleta
5		Media Completa
6		Técnico-profesional
7		Superior Universitaria

PADRE:

Tratamiento psicológico actual SI ___ NO ___ Motivo_____
Tratamiento psicológico anterior SI ___ NO ___ Motivo _____
Fecha _____ Cantidad de sesiones_____
Tratamiento farmacológico actual SI ___ NO ___ Motivo_____

Tratamiento farmacológico anterior SI ___ NO ___ Motivo _____
Fecha _____ Duración _____

3. Datos del niño

Nombre del niño: | Edad:

Fecha de nacimiento | Lactancia Materna:
SI ___ NO ___ Edad destete _____

Lugar en la Fratría: | Asistencia a Sala Cuna:
SI ___ NO ___ Desde _____ Hasta _____

Dónde duerme: Cama padres__ Cuna en pieza de padres__ Pieza solo/a o con hmnos_____

Enfermedades Trazadoras:

SI ___ NO ___ Digestivas _____ Respiratorias _____ Cutáneas _____

Otros antecedentes relevantes:

4. Composición familia de la tríada (con quienes viven):

NOMBRE	EDAD	ACTIVIDAD	PARENTESCO CON EL NIÑO(A)

Nivel educacional de quien aporta el ingreso principal del hogar

1		Educación básica incompleta o inferior
2		Básica Completa
3		Media incompleta (incluyendo Media Técnica)
4		Media completa o técnica incompleta.
5		Universitaria incompleta. Técnica completa
6		Universitaria completa.
7		Post Grado (Magíster, Doctorado o equivalente)

¿Cuál es la profesión o trabajo de la persona que aporta el principal ingreso de este hogar? Por favor describa.

1		Trabajos menores ocasionales e informales (lavado, aseo, servicio doméstico ocasional, "pololos", cuidador de autos, limosna).
2		Oficio menor, obrero no calificado, jornalero, servicio doméstico con contrato.
3		Obrero calificado, capataz, junior, micro empresario (kiosko, taxi, comercio menor, ambulante).
4		Empleado administrativo medio y bajo, vendedor, secretaria, jefe de sección. Técnico especializado. Profesional independiente de carreras técnicas (contador, analista de sistemas, diseñador, músico). Profesor primario o secundario.
5		Ejecutivo medio (gerente, sub-gerente), gerente general de empresa media o pequeña. Profesional independiente de carreras tradicionales (abogado, médico, arquitecto, ingeniero, agrónomo).
6		Alto ejecutivo (gerente general) de empresa grande. Directores de grandes empresas. Empresarios propietarios de empresas medianas y grandes. Profesionales independientes de gran prestigio.

10.3. Ages & Stages Questionnaires, Third Edition (ASQ-3)

ASQ-3 Ages & Stages Questionnaires®

23 meses 0 días a 25 meses 15 días

Cuestionario de 24 meses

Favor de proveer los siguientes datos. Al completar este formulario, use solamente una pluma de tinta negra o azul y escriba legiblemente con letra de molde.

Fecha en que se completó el cuestionario: _____

Información del niño/a:

Nombre del niño/a: _____ Inicial de su segundo nombre: _____ Apellido(s) del niño/a: _____

Sexo del niño/a:

◯ Masculino ◯ Femenino

Fecha de nacimiento del niño/a: _____

Información de la persona que está llenando este cuestionario

Nombre: _____ Inicial de su segundo nombre: _____ Apellido(s): _____

Dirección: _____

Parentesco con el niño/a:

◯ Padre/madre ◯ Tutor ◯ Maestro/a ◯ Educador/a o asistente de preescolar

◯ Abuelo/a u otro pariente ◯ Madre/padre de acogida ◯ Otro/a: _____

Ciudad: _____ Estado/ Provincia: _____ Código postal: _____

País: _____ # de teléfono de casa: _____ Otro # de teléfono: _____

Su dirección electrónica: _____

Los nombres de las personas que le están ayudando a llenar este cuestionario: _____

Información del programa

de identificación del niño/a: _____

de identificación del programa: _____

Nombre del programa: _____

P102240100

ASQ-3™

Cuestionario de 24 meses

23 meses 0 días a 25 meses 15 días

En las siguientes páginas Ud. encontrará una serie de preguntas sobre diferentes actividades que generalmente hacen los niños. Puede ser que su niño/a ya pueda hacer algunas de estas actividades, y que todavía no haya realizado otras. Después de leer cada pregunta, por favor marque la respuesta que indique si su niño/a hace la actividad regularmente, a veces, o todavía no.

Puntos que hay que recordar:

- ☑ Asegúrese de intentar cada actividad con su niño/a antes de contestar las preguntas.
- ☑ Complete el cuestionario haciendo las actividades con su niño/a como si fueran un juego divertido.
- ☑ Asegúrese de que su niño/a haya descansado y comido.
- ☑ Por favor, devuelva este cuestionario antes de esta fecha: _____.

Notas:

_____

_____

_____

_____

_____

A esta edad, muchos niños no cooperan cuando se les pide hacer cosas. Quizás Ud. tenga que intentar hacer las actividades más de una vez con su niño/a. Si es posible, intente hacer las actividades cuando su niño/a tenga buena disposición. Si su niño/a puede hacer la actividad, pero se niega a hacerla, marque "sí" en la pregunta.

COMUNICACION

	SI	A VECES	TODAVIA NO	
1. Sin enseñarle primero, ¿puede *señalar con el dedo* el dibujo correcto cuando Ud. le dice, "Enséñame dónde está el gatito", o le pregunta, "¿Dónde está el perro?" *(Solamente tiene que identificar un dibujo correctamente.)*	◯	◯	◯	____
2. ¿Imita su niña una oración de dos palabras? Por ejemplo, cuando Ud. dice "Mamá juega", "Papá come", o "¿Qué es?", repite ella la misma frase? *(Marque "sí" aun si sus palabras sean difíciles de entender.)*	◯	◯	◯	____
3. Sin darle pistas señalándole o usando gestos, ¿puede su niño seguir al menos *tres* de las siguientes instrucciones?	◯	◯	◯	____

◯ a. "Pon el juguete en la mesa".

◯ b. "Cierra la puerta".

◯ c. "Tráeme una toalla".

◯ d. "Busca tu abrigo".

◯ e. "Dame la mano".

◯ f. "Agarra tu libro".

4. Si Ud. señala un dibujo de una pelota (gatito, vaso, gorro, etc.) y le pregunta a su niña "¿qué es?", ¿puede *identificar y nombrar* al menos un dibujo?	◯	◯	◯	____
5. ¿Puede decir dos o tres palabras juntas que representen ideas diferentes, como: "Veo perro", "Mamá llega casa", o "¿Se fue gatito"? *(No cuente las combinaciones de palabras que expresen una sóla idea como "se acabó", "está bien", y "¿qué es?")* Escriba un ejemplo de una combinación de palabras que dice su niño:	◯	◯	◯	____

COMUNICACION *(continuación)*

	SI	A VECES	TODAVIA NO	
6. ¿Puede usar correctamente al menos dos palabras como "mi", "yo", "mía", o "tú"?	○	○	○	___

TOTAL EN COMUNICACION ___

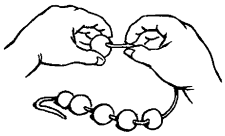
MOTORA GRUESA

	SI	A VECES	TODAVIA NO	
1. ¿Su niño puede bajar las escaleras si usted lo lleva de la mano? Puede agarrarse de la pared o de la barandilla también. *(Ud. puede hacer esta observación en la tienda, en el parque, o en casa.)*	○	○	○	___
2. Al enseñarle cómo se da una patada a un balón, ¿intenta su niño dar la patada moviendo la pierna hacia adelante o caminando hasta tocar el balón? *(Si ya sabe dar una patada al balón, marque "sí" en esta pregunta.)* 	○	○	○	___
3. ¿Su niño sube o baja al menos dos escalones sin ayuda? Puede agarrarse de la pared o de la barandilla. 	○	○	○	___
4. ¿Su niña corre bien y sabe detenerse sin chocar con las cosas o caerse? 	○	○	○	___
5. ¿Puede saltar su niño, levantando ambos pies del suelo a la vez? 	○	○	○	___
6. Sin apoyarse en ningún objeto, ¿sabe su niño dar una patada a un balón moviendo la pierna hacia atrás y luego hacia adelante?* 	○	○	○	___ *

TOTAL EN MOTORA GRUESA ___

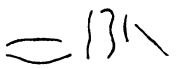
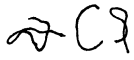
**Si marcó "sí" o "a veces" en la pregunta 6, marque "sí" en la pregunta 2.*

MOTORA FINA

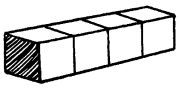
	SI	A VECES	TODAVIA NO	
1. Normalmente, ¿puede su niño meterse la cuchara en la boca sin que se le caiga la comida?	◯	◯	◯	___
2. ¿Sabe darle la vuelta a las hojas de un libro sin ayuda? *(Tal vez pase más de una hoja a la vez.)*	◯	◯	◯	___
3. ¿Rota (gira) la mano su niña al intentar abrir una puerta, darle cuerda a un juguete, jugar con un trompo, o poner y quitar una tapa de un frasco?	◯	◯	◯	___
4. ¿Su niño prende y apaga interruptores (como el de la luz)?	◯	◯	◯	___
5. ¿Puede su niña poner siete cubitos o juguetes uno sobre otro sin ayuda? *(También puede usar carretes de hilo, cajitas, o juguetes que midan aproximadamente 1 pulgada, o 3 centímetros.)*	◯	◯	◯	___
6. ¿Sabe meter un cordón (o agujeta) por el agujero de objetos pequeños como cuentas de madera, sopa de macarrones o de rueditas, o por los agujeros de los zapatos? 	◯	◯	◯	___

TOTAL EN MOTORA FINA ___

RESOLUCION DE PROBLEMAS

	SI	A VECES	TODAVIA NO	
1. Después de observarlo/la a Ud. dibujar una línea de arriba a abajo usando una crayola (o pluma o lápiz), ¿su niño intenta dibujar una línea recta en ***cualquier dirección*** en la hoja de papel? *(Marque "todavía no" si su niño hace rayas o garabatos de un lado para otro.)* Marque "sí"  Marque "todavía no" 	◯	◯	◯	___
2. Después de dejar caer una migaja o un Cheerio (cereal de desayuno) en una pequeña botella transparente, ¿pone la botella al revés para sacarlo? *(No le muestre cómo hacerlo.) (Puede usar una botella de refresco o un biberón.)*	◯	◯	◯	___
3. ¿Su niña juega con objetos imaginándose que son otras cosas? Por ejemplo, ¿se pone un vaso junto a la oreja jugando como si fuera un teléfono? ¿Se pone una caja en la cabeza como si fuera un gorro? ¿Usa un cubito u otro juguete pequeño para revolver la comida?	◯	◯	◯	___
4. ¿Guarda su niño las cosas en el sitio apropiado? Por ejemplo, ¿sabe que sus juguetes deben estar en el estante, que su cobija se pone en la cama, y que los platos se ponen en la cocina?	◯	◯	◯	___
5. Si quiere algo que no alcanza, ¿busca su niña una silla o una caja para subirse encima y alcanzarlo (por ejemplo, para agarrar un juguete que está en el mostrador de la cocina o para "ayudarle" en la cocina)?	◯	◯	◯	___

RESOLUCION DE PROBLEMAS *(continuación)*

	SI	A VECES	TODAVIA NO	
6. Mientras su niño lo/la observa, ponga cuatro objetos, como unos cubos o unos carritos, en línea recta. ¿Lo/la intenta imitar poniendo al menos *cuatro* objetos en línea recta? *(También puede usar carretes de hilo, unas cajitas, u otros juguetes.)* 	◯	◯	◯	___

TOTAL EN RESOLUCION DE PROBLEMAS ___

SOCIO-INDIVIDUAL

	SI	A VECES	TODAVIA NO	
1. ¿Sabe su niño beber de un vaso y bajarlo nuevamente sin que se le caiga mucho del contenido?	◯	◯	◯	___
2. ¿Lo/la imita a Ud. su niña, haciendo las mismas actividades que Ud. hace, por ejemplo limpiar algo que se le ha caído, pasar la aspiradora, afeitarse, o peinarse?	◯	◯	◯	___
3. ¿Come con un tenedor?	◯	◯	◯	___
4. Al jugar con un animalito de peluche o con una muñeca, ¿lo mece, le da de comer, le cambia los pañales, lo acuesta, etc.?	◯	◯	◯	___
5. ¿Su niño empuja un carrito con ruedas, un cochecito de bebé, u otro juguete con ruedas, evitando chocar con las cosas y saliéndose en reversa de un rincón si no puede girar?	◯	◯	◯	___
6. ¿Su niña se refiere a sí misma diciendo "yo" más que su propio nombre? Por ejemplo, suele decir "yo lo hago" en lugar de "Susana lo hace".	◯	◯	◯	___

TOTAL EN SOCIO-INDIVIDUAL ___

OBSERVACIONES GENERALES

Los padres y proveedores pueden utilizar el espacio después de cada pregunta para hacer comentarios adicionales.

1. ¿Cree Ud. que su niño/a oye bien? Si contesta "no", explique: ◯ SI ◯ NO

2. ¿Cree Ud. que su niño/a habla igual que los otros niños de su edad? Si contesta "no", explique: ◯ SI ◯ NO

OBSERVACIONES GENERALES *(continuación)*

3. ¿Puede Ud. entender casi todo lo que dice su niño/a? Si contesta "no", explique: ◯ SI ◯ NO

4. ¿Cree Ud. que su niño/a camina, corre, y trepa igual que los otros niños de su edad? Si contesta "no", explique: ◯ SI ◯ NO

5. ¿Tiene algún familiar con historia de sordera o cualquier otro impedimento auditivo? Si contesta "sí", explique: ◯ SI ◯ NO

6. ¿Tiene Ud. alguna preocupación sobre la visión de su niño/a? Si contesta "sí", explique: ◯ SI ◯ NO

7. ¿Ha tenido su niño/a algún problema de salud en los últimos meses? Si contesta "sí", explique: ◯ SI ◯ NO

OBSERVACIONES GENERALES *(continuación)*

8. ¿Tiene alguna preocupación sobre el comportamiento de su niño/a? Si contesta "sí", explique: ◯ SI ◯ NO

9. ¿Le preocupa algún aspecto del desarrollo de su niño/a? Si contesta "sí", explique: ◯ SI ◯ NO

ASQ-3: Compilación de datos 24 meses

23 meses 0 días a 25 meses 15 días

Nombre del niño/a: _____ Fecha de hoy: _____

de identificación del niño/a: _____ Fecha de nacimiento: _____

Nombre del programa/proveedor: _____

1. **CALIFIQUE EL CUESTIONARIO Y PASE EL PUNTAJE TOTAL DE CADA SECCION AL GRAFICO DE ABAJO:** Véase *ASQ-3 User's Guide* para obtener más detalles, incluyendo la manera de ajustar el puntaje si faltan respuestas a algunas preguntas. Califique cada pregunta (SI = 10, A VECES = 5, TODAVIA NO = 0). Sume los puntos de cada pregunta, anotando el puntaje total en la línea provista al final de cada sección del cuestionario. En el gráfico de abajo, anote el puntaje total de cada sección, y rellene el círculo correspondiente.

Área	Límite	Puntaje Total	0	5	10	15	20	25	30	35	40	45	50	55	60
Comunicación	25.17		●	●	●	●	●	●	○	○	○	○	○	○	○
Motora gruesa	38.07		●	●	●	●	●	●	●	●	○	○	○	○	○
Motora fina	35.16		●	●	●	●	●	●	●	●	○	○	○	○	○
Resolución de problemas	29.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Socio-individual	31.54		●	●	●	●	●	●	●	○	○	○	○	○	○

2. **TRANSFIERA LAS RESPUESTAS DE LA SECCION TITULADA "OBSERVACIONES GENERALES":** Las respuestas escritas en negrita o con mayúsculas requerirán un seguimiento. Véase el capítulo 6 del *ASQ-3 User's Guide* para obtener información sobre las pautas a seguir.

1. ¿Oye bien? Sí **NO**
   Comentarios:
2. ¿Habla como otros niños de su edad? Sí **NO**
   Comentarios:
3. ¿Ud. entiende lo que dice su niño/a? Sí **NO**
   Comentarios:
4. ¿Camina, corre, y trepa como otros niños? Sí **NO**
   Comentarios:
5. Historial: ¿Hay problemas auditivos en la familia? **SI** No
   Comentarios:
6. ¿Preocupaciones sobre la vista? **SI** No
   Comentarios:
7. ¿Hay problemas de salud recientes? **SI** No
   Comentarios:
8. ¿Preocupaciones sobre comportamiento? **SI** No
   Comentarios:
9. ¿Otras preocupaciones? **SI** No
   Comentarios:

3. **INTERPRETACION DEL PUNTAJE Y RECOMENDACIONES PARA EL SEGUIMIENTO DEL ASQ:** Para determinar el nivel de seguimiento apropiado, hay que tomar en cuenta el *Puntaje total* de cada sección, las respuestas de la sección titulada "Observaciones generales", y también factores adicionales, tales como considerar si el niño/a tiene oportunidades para practicar las habilidades.

Si el *Puntaje total* está dentro del área ▭, el puntaje del niño/a está por encima de las expectativas, y el desarrollo del niño/a parece estar bien hasta ahora.

Si el *Puntaje total* está dentro del área ▭, el puntaje está apenas por encima de las expectativas. Proporcione actividades adicionales para ayudarle al niño/a y vigile su progreso.

Si el *Puntaje total* está dentro del área ■, el puntaje está debajo de las expectativas. Quizás se requiera una evaluación adicional más a fondo.

4. **SEGUIMIENTO DEL ASQ:** Marque todos los que apliquen.

_____ Dar actividades adicionales y reevaluar en _____ meses.

_____ Compartir los resultados con su médico familiar (primary health care provider).

_____ Referirlo/la para una evaluación auditiva, visual, o de comportamiento. (Marque con un círculo todos los que apliquen.)

_____ Referirlo/la a un médico familiar u otra agencia comunitaria (favor de escribir la razón): _____.

_____ Referirlo/la a un programa de intervención temprana/educación especial para niños preescolares para hacer una evaluación adicional.

_____ No tomar medidas adicionales en este momento.

_____ Medida adicional (favor de escribirla): _____ .

5. **OPCIONAL:** Anote las respuestas específicas (S = SI, V = A VECES, N = TODAVIA NO, R = falta esta respuesta).

	1	2	3	4	5	6
Comunicación						
Motora gruesa						
Motora fina						
Resolución de problemas						
Socio-individual						

P102240800

10.4. Ages & Stages Questionnaires: Social-Emotional, Second Edition (ASQ:SE)

Edades y Etapas: Social-Emocional

Un Cuestionario Completado por los Padres para Evaluar el Comportamiento Social-Emocional de los Niños*

Por **Jane Squires, Diane Bricker y Elizabeth Twombly**
con la ayuda de **Suzanne Yockelson, Maura Schoen Davis y Younghee Kim**

ASQ-SE™

24 Meses/2 Años Cuestionario

(Para niños de 21 a 26 meses de edad)

Puntos Importantes de Recordar:

- ☑ Las preguntas por turno usan “niño” o “niña” como ejemplos. Por favor conteste todas las preguntas sin importar si usted tiene un niño o una niña.
- ☑ Por favor devuelva este cuestionario antes del día _____ .
- ☑ Si tiene alguna pregunta o preocupación acerca de su bebé o acerca de este cuestionario, por favor llame a _____ .
- ☑ Muchas gracias y por favor espere llenar otro cuestionario en

* Translated from the English:
Ages & Stages Questionnaires®: Social-Emotional: A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors, Squires et al.
© 2002 Paul H. Brookes Publishing Co.

ASQ-SE™

Edades y Etapas: Social-Emocional
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ASQ:SE 24 Meses/2 Años Cuestionario

(Para niños de 21 a 26 meses de edad)

Por favor dé la siguiente información.

Nombre del niño/a: _____

Fecha de nacimiento del niño/a: _____

Fecha de hoy: _____

Persona llenando este cuestionario:

_____

¿Cúal es su relación con el niño/a? _____

Su número de teléfono: _____

Su dirección (para correspondencia): _____

_____

Ciudad: _____

Estado: _____ Código postal: _____

Haga una lista de cualquier otra persona que le asista en llenar este cuestionario: _____

_____

Programa de administración/proveedor: _____

*Translated from the English:
Ages & Stages Questionnaires®: Social-Emotional: A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors, Squires et al.
© 2002 Paul H. Brookes Publishing Co.

ASQ:SE™

Por favor lea cada una de las preguntas con cuidado y

1. Marque el cuadro ❑ que describa mejor el comportamiento de su niño/a *y*
2. Marque el círculo ❍ si este comportamiento le preocupa

	LA MAYORÍA DE LAS VECES	ALGUNAS VECES	RARA VEZ O NUNCA	MARQUE SI ESTO ES UNA PRE-OCUPACIÓN
1. Cuando usted le habla a su niña, ¿le mira a usted?	❑ c	❑ v	❑ x	❍
2. ¿Parece ser su niño demasiado amistoso con los desconocidos?	❑ x	❑ v	❑ c	❍
3. ¿Se ríe o se sonríe su niña cuando usted juega con ella?	❑ c	❑ v	❑ x	❍
4. ¿Tiene su niño el cuerpo relajado?	❑ c	❑ v	❑ x	❍
5. Cuando usted se va, ¿se queda alterada y llorando su niña durante más de una hora?	❑ x	❑ v	❑ c	❍
6. ¿Les saluda o les dice hola su niño a los adultos que él conoce?	❑ c	❑ v	❑ x	❍
7. ¿A su niña le gusta que la abracen o la acurruquen?	❑ c	❑ v	❑ x	❍
8. Cuando su niño está alterado, ¿se puede calmar dentro de 15 minutos? 	❑ c	❑ v	❑ x	❍
9. Al levantar a su niña, ¿se pone rígida y arquea la espalda?	❑ x	❑ v	❑ c	❍
10. ¿A su niño le interesan las cosas alrededor de él, como personas, juguetes y comida?	❑ c	❑ v	❑ x	❍

TOTAL EN LA PÁGINA ___

	LA MAYORÍA DE LAS VECES	ALGUNAS VECES	RARA VEZ O NUNCA	MARQUE SI ESTO ES UNA PRE-OCUPACIÓN
11. ¿Llora, grita o hace berrinche su niña durante mucho rato?	❑ x	❑ v	❑ c	❍
12. ¿Usted y su niño disfrutan de la hora de comida juntos?	❑ c	❑ v	❑ x	❍
13. ¿Tiene su niña problemas con la alimentación, como llenarse la boca, vomitar, comer cosas que no son comida o _____ ? (Usted puede anotar cualquier problema.)	❑ x	❑ v	❑ c	❍
14. ¿Duerme su niño por lo menos 10 horas dentro de un período de 24 horas?	❑ c	❑ v	❑ x	❍
15. Cuando usted señala a alguna cosa, ¿mira su niña en la dirección de que usted señala?	❑ c	❑ v	❑ x	❍
16. ¿Tiene su niño dificultad para dormirse a la hora de la siesta o en la noche?	❑ x	❑ v	❑ c	❍
17. ¿Se estriñe o tiene diarrea su niña?	❑ x	❑ v	❑ c	❍
18. ¿Sigue su niño instrucciones sencillas? Por ejemplo, ¿se sienta cuando se lo piden?	❑ c	❑ v	❑ x	❍
19. ¿Le avisa su niña como se siente con gestos o palabras? Por ejemplo, ¿le avisa cuando tiene hambre, se lastima o está cansada?	❑ c	❑ v	❑ x	❍

TOTAL EN LA PÁGINA ___

	LA MAYORÍA DE LAS VECES	ALGUNAS VECES	RARA VEZ O NUNCA	MARQUE SI ESTO ES UNA PRE-OCUPACIÓN
20. ¿Lo/la busca con la mirada su niño para asegurarse que usted está cerca cuando él está explorando lugares nuevos, como un parque o la casa de un amigo?	❑ c	❑ v	❑ x	❍
21. ¿Hace su niña las cosas una y otra vez y parece incapaz de dejar de hacerlo? Unos ejemplos son mecerse, manotear, dar vueltas o _____ . (Usted puede anotar cualquier otra cosa.)	❑ x	❑ v	❑ c	❍
22. ¿A su niña le gusta escuchar cuentos o cantar canciones?	❑ c	❑ v	❑ x	❍
23. ¿Se lastima su niño a propósito?	❑ x	❑ v	❑ c	❍
24. ¿A su niño le gusta estar con otros niños?	❑ c	❑ v	❑ x	❍
25. ¿Intenta su niña lastimar a otros niños, adultos o animales (por ejemplo, pateando o mordiendo)?	❑ x	❑ v	❑ c	❍
26. ¿Ha expresado alguien preocupación por el comportamiento de su niño? Si usted marcó "algunas veces" o "la mayoría de las veces", por favor explique:	❑ x	❑ v	❑ c	❍

_____

_____

_____

_____

TOTAL EN LA PÁGINA ___

27. ¿Tiene usted preocupación por las costumbres de comer y dormir de su niña? Si así es, por favor explique:

28. ¿Hay algo que le preocupa de su niño? Si así es, por favor explique:

29. ¿Cuáles son las cosas que disfruta más de su niña?

ASQ:SE Sumario Informativo del 24º Mes/2º Año

Nombre del niño/a: _____

Fecha de nacimiento del niño/a: _____

Persona llenando el cuestionario: _____

Relación al niño/a: _____

Dirección (para correspondencia): _____ Ciudad: _____ Estado: _____ Código postal: _____

GUÍA DE CALIFICAR

1. Asegúrese de que el padre haya contestado todas las preguntas y haya marcado la columna de preocupación si es necesario. Si todas las preguntas han sido completadas, avance a la segunda etapa. Si hay preguntas que no han sido completadas, debe ponerse en contacto con los padres para obtener las respuestas o, si es necesario, calcular una calificación de punto medio (refiérase a las páginas 40 y 41 de *The ASQ:SE User's Guide*).
2. Examine cualquier comentario del padre. Si no hay comentarios, avance a la tercera etapa. Si el padre ha anotado una respuesta, refiérase a la sección "Parent Comments" en las páginas 40–42 de *The ASQ:SE User's Guide* para determinar si la respuesta indica un comportamiento que quizás sea de preocupación.
3. Usando el sistema de puntos provisto debajo:

C (por cero) al lado del cuadro marcado	= 0 puntos
V (por el número romano V) al lado del cuadro marcado	= 5 puntos
X (por el número romano X) al lado del cuadro marcado	= 10 puntos
Preocupación marcada	= 5 puntos

Suma:

Puntos totales en la página 3	= _____
Puntos totales en la página 4	= _____
Puntos totales en la página 5	= _____
Calificación total del niño/a	= _____

INTERPRETACIÓN DE LA CALIFICACIÓN

1. *Examine los cuestionarios*
   Examine las respuestas del padre. Tome en consideración de manera especial las preguntas individuales que tienen 10 ó 15 puntos y cualquier comentario hecho por los padres oralmente o por escrito. Ofrezca consejos, apoya e información a las familias y mándelas a un especialista si la calificación y las consideraciones para mandar a una evaluación indican que es necesario.
2. *Transfiera la calificación total del niño/a*
   En la tabla debajo, llene la calificación total del niño/a (transfiera la calificación total de más arriba).

Intervalo del cuestionario	Calificación de límite	Calificación del ASQ:SE del niño/a
24 meses/2 años	50	

3. *Criterio para mandar a una evaluación de la salud mental*
   Compare la calificación total del niño/a con la calificación de límite en la tabla más arriba. Si la calificación del niño/a cae arriba de la calificación de límite y los factores en la cuarta etapa han sido considerados, mande al niño/a para una evaluación de la salud mental.
4. *Consideraciones para mandar a una evaluación de la salud mental*
   Siempre es importante interpretar la información de una evaluación en el contexto de otros factores que están influyendo la vida de un niño/a. Considere los siguientes variables antes de mandar para una evaluación de la salud mental. Refiérase a las páginas 45–50 en *The ASQ:SE User's Guide* para consejos adicionales relacionados a estos factores y para sugerencias para dar seguimiento.

- Factores del ambiente/tiempo
  (Por ejemplo, ¿El comportamiento del niño/a es igual en la casa que en la escuela?, ¿Han sido uno sucesos difíciles en la vida reciente del niño/a?)
- Factores del desarrollo
  (Por ejemplo, ¿El comportamiento del niño/a está relacionado a una etapa del desarrollo o a un desarrollo retrasado?)
- Factores de la salud
  (Por ejemplo, ¿El comportamiento del niño/a está relacionado a los factores de la salud o a los factores biológicos?)
- Factores de la familia/la cultura
  (Por ejemplo, ¿El comportamiento del niño/a es aceptable dado el contexto cultural o el contexto familiar?)

10.5. Lausanne Triadic Play Procedure (LTP)

Global comments

Parents and toddler's seats make an equilateral triangle that facilitate a triadic play. Parents are asked not to move their seats because of the cameras (which couldn't film them correctly if they move); but of course, parents can move their bodies on their seats. This is a way to guarantee a setting as more identical as possible between families, and so to allow rigorous comparisons.

We give to the parents a clock, visible to both parents, to help them to manage the time (according to the instructions).

Cameras

Camera 1: this camera is mounted on a tripod and focuses the child's torso and face. Camera 2: this camera is mounted on a tripod and focuses the parents torso and face.

Needed material for the LTP

42. - Seats, table and toys.

- Parents' and child seats in a child chair.

43. - Child table

44. - Toys. They are thought to stimulate symbolic play and co-constructed activities. Comments about toys: Toys actually used in our setting:

- Tree puppetry

- Tree spoons

- Tree animals

LTP Instructions

The consultant shows there are two cameras, and invited to the parents to seat in each chair and play with the child. We are going to ask you to play together, as a family. Try to do as you usually do. This play is going to take place in four parts. In the first

part, one of you will play with your child and the other one will simply be present. Do you decide who begins. During this time, the other parent will be simply present. Second part: After a few minutes, when you will feel ready, you can change roles and the other parent play with X, and the other will be simply present. After a few minutes, you will pass on to the third part of the play, in which you will all three plays together during a few minutes. Then, at the end, you will pass on the fourth part: you, the couple, will discuss with each other and X is on his own, playing with toys. Take your time. It is up to you to decided when you move from one part to the next. Generally, it takes between 8 – 12 minutes. You can begin as soon as you are ready. For each part, you can choose how long you play.

During the play child wants to get out to the seat or cry or need something, you can try to calm and bring him back to the play.

Do you have any questions?

I will be outside this room. Please give a signal to the cameras when you start and when you finish and call me when you are finished and if there is any problem.

10.6. FAAS coding sheet

Coding sheet FAAS

Coder :

Family n° :
Infant/toddler/Child's age:

Alliance :
- o Cooperative
- o Conflicted
- o Disordered

(A) Fluid / (B) Tense

(C1) Covert / (C2) Overt

(D1) Exclusive / (D2) Chaotic

			Appropriate	Moderate	Inappropriate
STRUCTURE	Participation	Postures			
		Gazes			
	Organization	Role implication			
		Task fulfillment			
	Focalization	Co-construction			
		Parental scaffolding			
	Affect sharing	Family warmth			
		Validation			
		Authenticity			
DYNAMIC	Interactive sequence	Mistakes during shared activities			
		Mistakes during transitions			
Total					

Family score:

SUB-SYSTEMS

			Appropriate	Moderate	Inappropriate
	Coparenting	Support			
		Conflict			
	Child contribution	Engagement			
		Self-regul. / assert. / partnership			

Comments

STRUCTURE	Participation	Postures	
		Gazes	
	Organization	Role implication	
		Task fulfillment	
	Focalization	Co-constr.	
		Parental scaffolding	
	Affect sharing	Family warmth	
		Validation	
		Authenticity	

DYNAMIC	Interactive sequence	Mistakes during shared activities	
		Mistakes during transitions	

SUB-SYSTEMS	Coparenting	Support	
		Conflicts	
	Child contribution	Engagement	
		Self-regul. / assert. / partnership	

Global comments :

10.7. Parent Development Interview Revised, Short Version (PDI-S)

Authors: Slade, Aber, Berger, Bresgi & Kaplan (2003)

A. Perspectiva del niño/a.

Hoy, vamos a conversar sobre usted y sobre su hijo/a (C). Empezaremos, hablando sobre la relación entre su hijo/a y usted, y luego, un poco acerca de su propia experiencia como hijo/a.

Vamos a comenzar, hablándome un poco sobre su familia, ¿Quien vive en su familia? ¿Cuantos hijos tiene? ¿Que edades tienen? (Aquí el entrevistador desea saber cuántos hijos, edades, -incluyendo a los que vivan fuera de casa-, los padres y otros adultos que vivan en casa. Si se da una situación de crianza atípica, (adopción, acogida), una historia de acogidas o adopciones diversas, quienes han sido sus cuidadores primarios, etc.; Asimismo, si se observa, una historia de divorcio, o de múltiples desplazamientos o cambios, tratar de obtener algunos detalles, o bien lo necesario para crear un contexto que haga comprensible la entrevista).

1. Me gustaría empezar, intentando comprender, el tipo de persona que es su hijo/a…., vamos a ver, ¿Podríamos comenzar, escogiendo tres adjetivos, (palabras) que describan a su hijo/a…? (Hacer una pausa mientras escoge los adjetivos.) Ahora, volvamos a cada adjetivo. ¿Le viene a la memoria algún recuerdo o incidente con respecto a _____? (Examine y obtenga un recuerdo específico para cada adjetivo).

2. Muy bien. Ahora, volvamos a su hijo /a… En una semana corriente, ¿Qué es lo que describiría como las cosas que prefiere hacer, sus ratos preferidos?

3. ¿Y los momentos o situaciones, con los que tiene más problemas o dificultades?

4. ¿Qué le gusta mas de su hijo /a?

5. ¿Y qué le gusta menos de su hijo/a?

B. Perspectiva de la relación.

1. Me gustaría que escogiera tres adjetivos, que usted sienta que reflejan la relación entre usted y su hijo/a. (Pausa mientras se escogen los adjetivos). Ahora, volvamos a cada adjetivo, ¿Le viene a la mente alguna memoria o incidente en relación a_____? (Examine y obtenga un recuerdo específico para cada adjetivo).

2. *Describa un momento, en la última semana, en el que usted y (su hijo/a), conectaran completamente, se encontraran en perfecta sintonía. (Sondee e investigue si es necesario) ¿Puede decirme algo sobre estos momentos? ¿Como se sentía? ¿Cómo le parece que se sentía su hijo/a?).*

3. *Ahora, descríbame, por favor, un momento en la última semana, en el que (su hijo/a) realmente no se encontraran en sintonía para nada., no conectaran, o no hubiera forma de coincidir en nada. (Sondear si es necesario: ¿Puede contarme un poco más sobre este momento? ¿Cómo se sentía usted? ¿Como cree que se sintió (su hijo/a)?*

4. *¿Cómo le parece que su relación con (su hijo/a) está afectando el desarrollo de la personalidad de (su hijo/a)?*

C. Experiencia afectiva de la paternidad.

1. ¿Puede describirse como padre?

2. *¿Qué le da su mayor alegría como padre/madre?*

3. *¿Cual es su mayor dolor o dificultad siendo padre o madre?*

4. Cuando esta preocupado/a o inquieto/ a por (su hijo/a), ¿Qué suele sentir que le preocupa más?

5. *¿Como le parece que su hijo/a le ha cambiado?*

6. *Cuénteme sobre un momento durante la última semana en el que se sintiera realmente enfadado/a o irritado como madre/padre. (Sondee si es necesario: ¿Puede contarme un poco más sobre la situación?, ¿Cómo maneja los sentimientos de enfado?). 6a. ¿Qué efecto cree usted, que estos sentimientos tiene sobre su hijo?*

7. *Cuénteme acerca de algún momento de la semana pasada o la anterior, en la que usted se sintiera culpable como madre/padre. (Sondear si es necesario: ¿Puede hablarme un poco más sobre la situación? ¿Como maneja su sentimientos de culpa hacia su hijo/a?). 7a. ¿Qué tipo de efecto tiene estos sentimientos sobre su hijo/a?*

8. *Cuénteme sobre un momento en las dos últimas semanas, en el que se sintiera realmente necesitado/a de que alguien cuidara de usted. (Investigar si es necesario: ¿Puede hablarme un poco más sobre esta situación? ¿Cómo maneja estos sentimientos de estar necesitado?). 8a.¿Qué tipo de efecto cree usted que estos sentimientos tiene sobre (su hijo/a)?*

9. *Cuando su hijo está alterado o disgustado o contrariado, ¿Qué es lo que él/ella hace? ¿Qué hace usted en estos momentos?*

10. *¿Se ha sentido su hijo/a rechazado alguna vez?*

D. Historia familiar de los padres.

Ahora, me gustaría preguntarle algunas cosas acerca de sus padres, y de cómo las experiencias de su infancia podrían haber afectado a sus propias experiencias sobre la paternidad. (como madre o padre).

1. *¿Cómo le parece que sus experiencias de pequeño con sus padres, afectan a sus experiencias actuales siendo madre/padre?*

2. *¿En qué quiere ser como su madre y en qué no quier serlo como madre?*

3. *¿Y como su padre?*

4. *¿En qué es usted como su madre y en qué no lo es?*

5. *¿Y como su padre?*

E. Separación /pérdida.

1. *Ahora, me gustaría que pensara un poco en los momentos en que usted y su hijo, por algún motivo, no se encontraran juntos, cuando se hayan separado alguna vez. ¿Me los puede describir? (Sondear: ¿Qué tipo de efecto ha tenido en el niño/a? ¿Y qué tipo de efecto ha tenido (tuvo) en usted?). Nota: Si el padre describe una separación no reciente (por ejemplo, mas de un año), repita la pregunta intentando algo más cercano.*

2. *¿Recuerda algún momento en la vida de su hijo/a en que sintiera como si lo estuviera perdiendo un poco? ¿Cómo lo sintió eso, para usted?*

3. ¿Hay alguien que sea importante para usted, y que (su hijo/a) no conozca, pero que le gustaría que fuera más cercano a su hijo/a?

4. ¿Piensa usted que en la vida de su hijo/a, han habido experiencias que hayan sido un revés o contratiempo para el/ella?

F. Mirando hacia atrás, mirando hacia delante.

1. Ahora, su hijo tiene ya_____ años/meses, y usted es una madre/padre con experiencia (modificar si es más apropiado). Si tuviera la oportunidad de hacerlo todo otra vez, ¿Qué cambiaría? ¿Qué es lo que no cambiaría? ¿Alguna cosa más que le gustara añadir? Muchas gracias y mucha suerte.

10.8. Coding sheet of Parental Reflective Function for Parent Development Interview Revised

Sujeto:			Puntaje total:
Codificador:			Fecha:
	Tipo	Puntaje RF	Notas
Sintonía			
No sintonía			
Personalidad			
Alegría			
Dolor, tristeza			
Cómo te ha cambiado			
Enojo			
Culpa			
Necesidad			
C upset			
Rechazo			
Padres			
Separación niño			
Separación adulto			
Pérdida			

10.9. Beck Depression Inventory (BDI-I)

En este cuestionario aparecen varios grupos de afirmaciones. Por favor, lea con atención cada una. A continuación, señale cuál de las afirmaciones de cada grupo describe mejor cómo se ha sentido **DURANTE ESTA ÚLTIMA SEMANA, INCLUIDO EL DIA HOY.** Rodee con un círculo el número que está a la izquierda de la afirmación que haya elegido. Si dentro de un mismo grupo, hay más de una afirmación que considere aplicable a su caso, puede marcarla también. **Asegúrese de leer todas las afirmaciones dentro de cada grupo antes de efectuar la elección.**

A	F
0. No me siento triste 1. Me siento triste 2. Me siento triste continuamente y no puedo dejar de estarlo 3. Ya no puedo soportar esta pena	0. No siento que esté siendo castigado/a 1. Me siento como si fuese a ser castigado/o 2. Siento que me están castigando o que me castigarán 3. Siento que merezco ser castigado/a
B	**G**
0. No me siento pesimista, ni creo que las cosas me vayan a salir mal 1. Me siento desanimado/a cuando pienso en el futuro 2. Creo que nunca me recuperaré de mis penas 3. Ya no espero nada bueno de la vida, esto no tiene remedio	0. No estoy decepcionado de mí mismo/a. 1. Estoy decepcionado de mí mismo/a. 2. Estoy muy descontento/a conmigo mismo/a 3. Me odio, me desprecio
C	**H**
0. No me considero fracasado/a 1. Creo que he tenido más fracasos que la mayoría de la gente 2. Cuando miro hacia atrás, sólo veo fracaso tras fracaso 3. Me siento una persona totalmente fracasada	0. No creo ser peor que otras personas 1. Me critico mucho por mis debilidades y errores 2. Continuamente me culpo de todo lo que va mal 3. Siento que tengo muchos y muy graves defectos
D	**I**
0. Las cosas me satisfacen tanto como antes 1. No disfruto de las cosas tanto como antes 2. Ya nada me llena 3. Estoy harto/a de todo	0. No tengo pensamientos de hacerme daño 1. Tengo pensamientos de hacerme daño, pero no llegaría a hacerlo 2. Siento que estaría mejor muerto/a o que mi familia estaría mejor si yo me muriera 3. Me mataría si pudiera
E	**J**
0. No me siento culpable 1. Me siento culpable en bastantes ocasiones. 2. Me siento culpable en la mayoría de las ocasiones. 3. Todo el tiempo me siento una persona mala y despreciable	0. No lloro más de lo habitual 1. Ahora lloro más de lo normal 2. Ahora lloro continuamente, no puedo evitarlo 3. Antes podía llorar, ahora no lloro aunque quisiera

K	Q
0. No estoy más irritable que normalmente 1. Me irrito o enojo con más facilidad que antes 2. Me siento irritado/a todo el tiempo 3. Ya no me irrita ni lo que antes me irritaba	0. No me canso más de lo normal 1. Me canso más fácilmente que antes 2. Cualquier cosa que hago me cansa 3. Estoy demasiado cansado/a para hacer nada
L	**R**
0. No he perdido el interés por los demás 1. Me intereso por la gente menos que antes 2. He perdido casi todo mi interés por los demás 3. Los demás no me importan en absoluto	0. Tengo el mismo apetito que siempre 1. No tengo tan buen apetito como antes 2. Ahora tengo mucho menos apetito 3. He perdido totalmente el apetito
M	**S**
0. Tomo mis decisiones como siempre 1. Estoy inseguro/a de mi mismo/a y evito tomar decisiones 2. Ya no puedo tomar decisiones sin ayuda 3. Ya no puedo tomar decisiones en absoluto	0. No he perdido peso últimamente 1. He perdido más de 2 kilos 2. He perdido más de 5 kilos 3. He perdido más de 8 kilos Estoy bajo dieta para adelgazar: SI NO
N	**T**
0. No me siento con peor aspecto que antes 1. Me preocupa que ahora parezco más viejo/a o poco atractivo/a 2. Creo que se han producido cambios permanentes en mi aspecto que me hacen parecer poco atractivo/a 3. Creo que tengo un aspecto horrible	0. No estoy más preocupado/a por mi estado de salud que lo habitual 1. Estoy preocupado/a por problemas físicos como dolores, molestias, malestar de estómago, o estreñimiento 2. Estoy preocupado/a por mi salud y me es difícil pensar en otra cosa 3. Estoy tan preocupado/a por mis problemas de salud que soy incapaz de pensar en otra cosa
O	**U**
0. Puedo trabajar tan bien como siempre 1. Tengo que hacer un esfuerzo especial para iniciar algo 2. Tengo que obligarme mucho para hacer algo 3. Soy incapaz de hacer algún trabajo	0. No he notado ningún cambio en mi atracción por el sexo 1. Estoy menos interesado/a en el sexo que antes 2. Actualmente me siento mucho menos interesado/a en el sexo 3. He perdido todo mi interés por el sexo
P	
0. Duermo tan bien como siempre 1. Me despierto más cansado/a por la mañana 2. Me estoy despertando una o dos horas más temprano de lo habitual y no puedo volver a quedarme dormido/a 3. Me despierto varias horas más temprano todas las mañanas y no logro dormir más de 5 horas	

Subtotal Página 1	
Subtotal Página 2	
Total	

10.10. Relationship Assessment Scale (RAS)

Hendrick, 1988 adaptado por Rivera & Heresi, 2011

Por favor indique con una X el número que mejor corresponde a su relación de pareja. Conteste lo más sinceramente posible pues no hay respuestas ni buenas ni malas, o adecuadas o inadecuadas.				
1. ¿De qué manera considera Ud. que su pareja satisface sus necesidades?				
1 Pobremente	**2**	**3** Término medio	**4**	**5** Extremadamente bien
2. ¿En general, ¿Hasta qué punto está satisfecho/a con su relación de pareja?				
1 Insatisfecho	**2**	**3** Término medio	**4**	**5** Muy satisfecho
3. ¿En comparación con la mayoría las parejas, ¿cómo calificaría a la suya?				
1 Pobremente	**2**	**3** Término medio	**4**	**5** Excelente
4. ¿Con qué frecuencia desea NO haberse casado con su esposa/o?				
1 Siempre	**2**	**3** Con frecuencia	**4**	**5** Nunca
5. ¿Hasta qué punto su relación de pareja satisface sus expectativas iniciales?				
1 En absoluto	**2**	**3** Término medio	**4**	**5** Absolutamente
6. ¿Cuánto ama a su pareja?				
1 Muy poco	**2**	**3** Término medio	**4**	**5** Mucho
7. ¿Cuántos problemas hay en su relación de pareja?				
1 Muchos	**2**	**3** Lo normal	**4**	**5** Pocos
Compruebe que no ha dejado ninguna frase sin contestar				

10.11. Annexed tables

10.11.1. Annexed table 1. *Mean comparison between participants from control group and experimental group*

Variable	EG (n=20)		CG (n=30)				95% IC	
	M	*SD*	*M*	*SD*	t(*df*=48)	*p*	*LL*	*UL*
Child's age				7.61	-1.84	.07	-8.23	0.37
Mother's Age	32.15	4.99	31.10	4.773	-0.75	.46	-3.87	1.77
Father's Age	34.15	5.30	33.20	6.21	-0.56	.58	-4.36	2.46
Father years' education	15.90	1.92	14.93	2.61	-1.42	.16	-2.34	0.40
Mother years' education	15.30	2.23	15.07	2.52	-0.34	.74	-1.63	1.16
Communication	1.70	1.16	1.30	1.31	-1.10	.28	-1.13	0.33
Gross motor	1.95	0.87	1.87	0.81	-0.31	.76	-0.56	0.41
Fine motor	1.86	1.15	1.08	1.10	-2.41	.02	-1.43	-0.13
Problem solving	1.85	0.97	1.26	1.10	-1.92	.06	-1.19	0.03
Personal-social	1.34	1.08	1.60	1.08	0.84	.41	-0.36	0.89
% SE difficulties	11.57	6.87	15.07	7.09	1.73	.09	-0.56	7.57
Family Score	19.30	4.16	17.87	5.33	-1.01	.32	-4.28	1.41
Mother's RF	4.15	1.09	3.33	1.06	-2.64	.01	-1.44	-0.19
Father's RF	3.85	1.27	3.37	.96	-1.53	.13	-1.12	0.15
Mother's depression	5.45	3.80	8.70	6.95	1.91	.06	-0.18	6.68
Mother couple satisfaction	30.70	4.21	29.47	5.24	-0.88	.38	-4.05	1.58
Father's depression	4.45	6.80	5.97	5.32	0.88	.38	-1.94	4.97
Father couple satisfaction	30.80	3.86	29.87	5.03	-0.70	.49	-3.60	1.74

Note. EG = experimental group; CG = control group; CI = confidence interval; LL = lower limit, UL = upper limit, SE = Social emotional; RF = reflective function.

10.11.2. Annexed table 2. Mean comparison between boys and girls in child psychomotor and social-emotional development

Variable	Girsl (n = 21)		Boys (n = 29)				95% CI	
	M	*SD*	*M*	*SD*	*t (df* = 48*)*	*p*	*LL*	*UL*
Communication	1.82	1.03	1.20	1.36	1.75	.09	-0.09	1.33
Gross motor	1.97	0.77	1.85	0.87	0.50	.62	-0.36	0.60
Fine motor	1.53	1.21	1.29	1.16	0.71	.48	-0.44	0.92
Problem solving	1.75	1.16	1.31	1.00	1.41	.16	-0.18	1.05
Personal-social	1.47	1.08	1.52	1.09	-0.14	.89	-0.67	0.58
% SE difficulties	12.01	6.46	14.87	7.48	-1.41	.16	-6.94	1.21

Note. CI = confidence interval; LL = lower limit, UL = upper limit, SE = Social emotional.

10.11.3. Annexed table 3. *Correlations among study variables and its subscales and covariables*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
1	1																											
2	.44*	1																										
3	.39*	.19	1																									
4	.65*	.37*	.42*	1																								
5	.54*	.49*	.31^{+}	.51*	1																							
6	-.29^{+}	-.41*	-.24	-.19	-.38*	1																						
7	-.17	-.18	-.33^{+}	.03	-.14	.70*	1																					
8	.05	-.13	.06	-.02	-.15	.53*	.23	1																				
9	-.42*	-.24	-.13	-.45*	-.53*	.21	-.16	.13	1																			
10	-.19	-.51*	-.20	-.21	-.33^{+}	.54*	.42*	.11	.00	1																		
11	-.21	-.07	-.10	.02	.01	.27	.23	-.07	-.04	.10	1																	
12	-.03	.05	-.04	-.20	-.16	.29^{+}	.00	.40*	.12	-.02	-.09	1																
13	-.17	-.24	.08	-.12	-.14	.64*	.22	.45*	.06	.17	.14	.22	1															
14	.22	.22	.18	.10	.07	-.40*	-.29^{+}	-.19	-.07	-.10	-.26	-.07	-.29^{+}	1														
15	.20	.19	.17	.09	.04	-.32^{+}	-.24	-.20	-.04	-.04	-.23	-.07	-.26	.98*	1													
16	.22	.08	.12	.12	.03	-.23	-.18	-.11	.01	-.12	-.32*	.00	-.22	.65*	.69*	1												
17	.10	.09	.21	.03	.10	-.27	-.13	-.10	-.03	-.13	-.20	.02	-.17	.65*	.67*	.56*	1											
18	.15	.01	-.07	-.04	-.07	-.13	.00	-.22	-.17	.28	-.09	-.14	-.29^{+}	.63*	.64*	.23	.22	1										
19	.07	.14	.10	.01	-.08	-.21	-.23	-.18	-.01	.00	-.05	-.08	-.10	.74*	.75*	.26	.16	.60*	1									
20	.10	.32^{+}	.06	.10	.08	-.23	-.16	-.10	.03	-.09	-.17	.04	-.24	.79*	.78*	.42*	.49*	.44*	.52*	1								
21	-.09	.03	-.12	-.13	-.07	-.23	-.20	-.08	.15	-.01	-.13	-.04	-.16	.68*	.61*	.25	.39*	.42*	.55*	.54*	1							
22	.40*	.36$^{"}$	.34^{+}	.28^{+}	.23	-.52*	-.35^{+}	-.11	-.29^{+}	-.29^{+}	-.31^{+}	-.05	-.32^{+}	.70*	.59*	.43*	.39*	.36^{+}	.39*	.54*	.21	1						
23	-.07	-.14	.03	-.15	-.33^{+}	-.05	-.08	-.16	.08	.16	-.01	.12	-.13	.43*	.40*	.14	.18	.33^{+}	.41*	.32^{+}	.41*	.28	1					
24	-.10	-.15	-.05	-.04	-.20	-.09	-.05	-.05	-.02	.14	-.03	-.15	-.28^{+}	.38*	.37*	.21	.23	.41*	.37*	.11	.34^{+}	.20	.43*	1				
25	-.37*	-.28	-.14	-.27	-.38*	.40*	.27	.03	.00	.38*	.15	.20	.24	-.14	-.10	-.19	-.19	.29*	.026	-.12	-.22	-.13	.17	-.12	1			
26	-.03	.02	.06	-.02	.00	-.01	-.15	.11	-.07	-.02	.06	.04	-.03	-.10	-.15	-.17	-.16	-.13	-.01	-.14	.07	-.02	-.04	.21	-.34^{+}	1		
27	-.10	.02	.01	-.05	.04	-.05	.10	-.11	.11	.03	.10	-.23	-.12	.08	.09	-.16	.08	.19	.12	.15	.06	.02	.14	.07	.16	-.34^{+}	1	
28	-.10	-.02	-.12	-.08	-.12	.14	-.08	.08	-.05	.15	.04	.15	.07	-.10	-.12	-.04	-.23	-.10	-.02	-.11	.07	-.14	.07	.29^{+}	-.19	.72*	-.62*	1

Note. 1 = Communication; 2 = Gross motor; 3 = Fine motor; 4 = Problem solving; 5 = Personal-social; 6 = Percentage of social emotional difficulties; 7 = Percentage autoregulation difficulties; 8 = Percentage complacence difficulties; 9 = Percentage communication difficulties; 10 = Percentage adaptative difficulties; 11 = Percentage affect difficulties; 12 = Percentage autonomy difficulties; 13 = Percentage person-interaction difficulties; 14 = Triadic Total Score; 15 = Triadic Subscales Score; 16 = Participation; 17 = Organization; 18 = Focusing; 19 = Affect; 20 = Interactive mistakes; 21 = Coparenting; 22 = Toddler contribution; 23 = Mother reflective function; 24 = Father reflective function; 25 = Mother depressive symptoms; 26 = Mother couple satisfaction; 27 = Father depressive symptoms; 28 = Father couple satisfaction.