An exploration of the efficacy of parent-only interventions for reducing symptoms of anxiety in children

A thesis submitted to the University of Manchester for the degree of Doctor of Clinical Psychology in the Faculty of Biology, Medicine and Health

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Contents

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Thesis Abstract

This thesis explored the efficacy of low intensity parent-only interventions in reducing symptoms of anxiety in young children. The thesis is presented as three papers: a systematic literature review, an empirical study and a critical reflection of the research process.

Paper 1 is a systematic review and meta-analysis investigating the efficacy of parent-only interventions in reducing symptoms of anxiety disorders in school aged children. A total of 29 studies which varied in design were included in the review. Results suggested that low intensity parent-only interventions can have a positive impact on clinical outcomes, reducing symptoms of anxiety disorders in children. Improvements were typically maintained or improved at follow up, suggesting that parent-only interventions can have long term benefits. Clinical implications and key areas for future research are highlighted.

Paper 2 is an empirical investigation exploring the feasibility and acceptability of a brief cognitive behavioural group intervention for parents of children experiencing mild to moderate anxiety. A preliminary evaluation of the efficacy of the intervention was conducted. Results suggest that the intervention was feasible, indicated by high retention rates and satisfaction scores. Qualitative analysis of interview data identified both benefits and challenges associated with attending the intervention. Strengths and limitations and recommendations for future research are discussed.

Paper 3 is a critical reflection of the research process. Methodological considerations, decision making, strengths and limitations, challenges faced, and the clinical impact of the research are considered, alongside suggestions for future research. Personal reflections on the research process are provided.

Declaration

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Paper 1

The impact of parent-only interventions on child anxiety:

A systematic review and meta-analysis

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Abstract

Background: Parent-only interventions for childhood anxiety may be an important alternative to resource and time intensive child-focused cognitive behavioural therapy (CBT). The aim of this systematic review and meta-analysis was to investigate the efficacy of parent-only interventions in reducing symptoms of anxiety disorders in school aged children.

Methods: A systematic search of five databases (inception to March 2021), identified 29 eligible studies. A range of study designs were captured, including randomised controlled trials (RCTs) and case series. A narrative synthesis was conducted. Random effects meta-analyses were performed on parent- and child-reported outcomes and pre-test post-test effect sizes were calculated for uncontrolled studies.

Results: Findings indicated a significant treatment effect for parent-only interventions compared to waitlist controls. No significant differences were found when comparing parent-only interventions with other active interventions; anxiety symptoms were reduced in both conditions. Calculated effect sizes for uncontrolled studies were typically large, although sample sizes were small. No clear evidence was found for a superior type, duration or format of intervention.

Limitations: The methodological quality of many studies in this review (19/29) was rated to be 'weak'. Only English language papers were included.

Conclusions: To date, this is the first systematic review and meta-analysis of the efficacy of parent-only interventions for reducing symptoms of child anxiety disorders. Our results suggest that parent-only interventions can be effective in reducing symptoms of child anxiety disorders. These findings are important for clinical practice because they suggest that efficient, low intensity interventions can lead to positive outcomes for children.

Keywords: *Parenting, childhood anxiety disorder, treatment*

Introduction

Anxiety disorders are the most prevalent mental health problem reported in children and young people. National survey data on the mental health of 5- to 19-year-olds in the United Kingdom demonstrated that 7.2% were diagnosed with an anxiety disorder, compared to 2.1% experiencing depression, with generalised anxiety disorder and panic disorder reported most frequently (1.5% and 1.1% respectively) (NHS Digital, 2017). Children may present with multiple anxiety disorders; comorbidity with other mental health problems, such as depression, is common (Rapee et al., 2009). Anxiety disorders that begin in childhood often continue into adolescence and adulthood (Keller et al., 1992), causing significant distress and impairment in academic, social and emotional functioning (Albano et al., 2003). Childhood anxiety disorders are likely to have persistent negative consequences (Bittner et al., 2007), highlighting the importance of early intervention.

Child-focused cognitive behavioural therapy (CBT) is an effective treatment for child anxiety disorders (Cartwright-Hatton et al., 2004; James et al., 2013; Reynolds et al., 2012; Seligman & Ollendick, 2011); however, this level of intervention is time and resource intensive. Increasing demands on children's mental health services often result in long wait lists, which may prevent children from receiving timely psychological interventions. For those who do access services, child-focused CBT requires high motivation and frequent practice from the child which can be difficult, particularly for younger children (Lebowitz et al., 2014). Involving parents in the treatment of childhood anxiety disorders could improve child mental health outcomes, with the aim that parents themselves will learn more helpful ways of thinking, behaving and responding to their child's anxiety, which could have a positive impact on child treatment outcomes (Breinholst et al., 2012). Parents can also support the continued use and generalisation of therapeutic strategies after intervention delivery has been completed (Barmish & Kendall,

2005). However, evidence regarding the additional effect of parent involvement in child-focused CBT is mixed and inconsistent (Breinholst et al., 2012). As such, increasing emphasis has been placed on investigating the impact of working exclusively with parents in the treatment of child anxiety disorders.

Over the last 30 years, psychological interventions delivered solely to parents have been utilised to support children of all ages with a wide range of behavioural and emotional problems (Sanders et al., 2014; Webster-Stratton, 2011). Parents have valued them and believe them to be acceptable interventions (Butler et al., 2020). Parent-only interventions are generally brief, low intensity treatments delivered as part of a stepped care model. Interventions are often much shorter in duration than individual therapy, which may take up to 20 sessions, and can be group based thus reducing demands on therapists and services. Working exclusively with parents can enable access to psychological support for families when the child does not want to, or is unable to attend therapy themselves (Lebowitz et al., 2014). In addition, parent-only interventions may be more able to target aetiological and maintaining factors for child anxiety disorders specifically related to parents and parenting, such as overprotective and controlling parenting styles (van der Bruggen et al., 2008). There is an association between parental anxiety and the development and maintenance of child anxiety disorders (Eley et al., 2015), with a review demonstrating that up to 60% of children whose parents experience anxiety also met diagnostic criteria for an anxiety disorder themselves (Ginsburg & Schlossberg, 2002). Anxious parents may inadvertently model or reinforce anxious and/or avoidant patterns of thinking and behaviour to their child (Murray et al., 2009). Whilst evidence suggests that anxiety runs in families, more research is needed to investigate the direction of the association and underlying mechanisms.

A range of parent-only interventions have been described in the literature. These usually involve attending individual or group-based face-to-face sessions, or accessing bibliotherapy, in which self-help materials are the main focus of the intervention. Parent-only interventions often employ a transfer of control model (Ginsburg et al., 1995) whereby knowledge and skills are transferred from professionals to parents, who then apply the learning with their child (Cobham et al., 2017). However, there is wide variability regarding the length, content and therapist contact during these programmes. The majority of parent-only interventions for child anxiety utilise approaches from CBT; this may include psychoeducation, identifying and testing out anxious thoughts, graded exposure and problem-solving training. Other approaches include a) play therapy, during which parents read books and play games focused on reducing anxiety with their children using modelling, role play and positive reinforcement (Santacruz et al., 2006), b) interventions targeting the relationship dynamics between parent and child (Lebowitz et al., 2014) and c) cognitive bias modification therapy, which involves computerised training in interpreting ambiguity in a benign way to reduce threat related interpretations in uncertain situations (Reuland & Teachman, 2014).

Previous reviews and meta-analyses in this area have investigated the association between parents and the development of child anxiety disorders (Murray et al., 2009), parent interventions for the prevention of child anxiety and depression (Yap et al., 2016), the additional contribution of parents to child-focused interventions (Breinholst et al., 2012; Thulin et al., 2014) or the impact of parent interventions on parent wellbeing (Barlow et al., 2014). Two other reviews have evaluated the efficacy of parent interventions for child mental health: a meta-analysis of six randomised controlled trials (RCTs) investigating parent-only CBT interventions for child anxiety disorders (Yin et al., 2021) and a systematic review and meta-analysis focusing on both externalising problems

(e.g., conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder) and internalising problems (e.g., anxiety and depression) which included parent interventions delivered alongside child treatment (Buchanan-Pascall et al., 2018). Significant treatment effects were found for parent interventions compared to control in a meta-analysis of six studies of anxiety disorders (g = -0.72, 95% CI -1.41 to -0.03, p = 0.04; Yin et al., 2021) and 13 studies of internalising problems (g = −0.18, 95% CI −0.36, −0.01, z = 2.03, p =.04; Buchanan-Pascall et al., 2018). Parent-only CBT was slightly less effective than child-focused CBT with parent involvement, although this finding was non-significant (g = 0.21, 95% CI -0.09 to 0.50, p = 0.17; Yin et al., 2021). A meta-analysis of 11 studies examining parent interventions with a sample of children with externalising problems did not find a statistically significant change in internalising problems (g = −0.16, 95% CI −0.34, 0.01, z = 1.87, p =.06; (Buchanan-Pascall et al., 2018). Lastly, a meta-analysis conducted on two studies comparing parent group interventions for child anxiety with a control group found no significant change in internalising problems (p =.48; (Buchanan-Pascall et al., 2018).

To date, no other review has focused solely on parent-only interventions for child anxiety. Therefore, the primary aim of the current systematic review and meta-analysis was to provide a comprehensive review of the quantitative evidence regarding parent-only interventions for child anxiety. Specifically, this review aimed to examine the efficacy of parent-only interventions for reducing symptoms of anxiety disorders in children.

Method

Search Strategy

Five electronic databases were searched for peer reviewed articles and grey literature from their inception to present day (PsycINFO, CINAHL Plus, EMBASE, Medline and Web of

Science). Database searches were completed on 20 March 2021 using the terms described in Table 1. Search terms were identified through a scoping search of titles, abstracts and keywords from other relevant studies and reviews, synonyms, and Medical Subject Heading (MeSH) terms. Searches included Boolean operators and were not restricted by publication date. The review protocol was registered with the PROSPERO international prospective register of systematic reviews (http://www.crd.york.ac.uk/prospero, registration number CRD42020213471).

Duplicates of studies were removed and ineligible papers were excluded. Titles and abstracts were screened by the first author (CJ). Another researcher independently screened 10% of the titles and abstracts. Agreement on ratings was almost perfect (96.56%; kappa = 0.85). Full text versions of potentially relevant publications, identified from the title and abstract screening, were then screened against inclusion criteria. Backwards and forwards searches of references and citations were conducted to identify any further relevant articles.

Study Inclusion and Exclusion Criteria

Studies including psychological interventions for parents of children with anxiety disorders were included (see Table 2 for details). Psychological interventions were broadly defined as non-pharmacological interventions based on psychological theory, which aim to facilitate understanding of difficulties, reduce psychological distress and improve functioning (Ricou et al., 2019). Interventions which specifically aimed to treat obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and health anxiety/hypochondriasis were excluded because these diagnoses are not included within anxiety disorder criteria in either the Diagnostic and Statistical Manual of Mental Disorders–5th Edition (DSM-5) (American Psychiatric Association, 2013) or the

International Classification of Diseases, 11th Revision (ICD-11) (World Health Organisation, 2019). Studies reporting on parent interventions for anxiety within specific groups were also excluded (e.g., physical health conditions, intellectual disabilities and neurodevelopmental disorders).

Data Extraction

Information extracted from each of the eligible studies included author and year of publication, study design, sample size, descriptive characteristics of parent participants, child age range, intervention characteristics, outcome measures and relevant findings.

Table 1

Search Terms

Concept	Search Terms
Parents	parent* or famil* or mother or mum or father or dad or caregiver
Children	child* or schoolchild or youth or infant* or adolescen* or paediatric or minor or boy or girl or kid* or juvenile or teen or preteen or young people or preschool or offspring
Intervention	clinical or intervention or group or program* or treatment or prevent* or therapy or workshop or outcome or education or psychoeducation or bibliotherapy
Parent participants only	"parent only" or "parent based" or "parent focused" or "parent cent*" or "parent led" or "parent guided" or "parent training" or "parent deliver*" or "parent mediated" or "parent manage*" or "parent implement*" or "parent engage*" or "parent involve*" or "parent inclu*" or "parent targeted" or "parent particip*" or "parent administered" or "parent coached" or "parent direct*" or "working with parents"
Anxiety disorders	anx* or anxiety disorder or worry or agoraphobia or "panic disorder" or phobia or social anxiety or "generalised anxiety disorder" or GAD or separation anxiety

Table 2

Inclusion/Exclusion Criteria

Criteria	Inclusion Criteria	Exclusion Criteria
Population	Parents (mothers and/or fathers) of children under the age of 18 years. Children must have at least one diagnosed anxiety disorder (panic disorder, agoraphobia, generalised anxiety disorder, specific phobia, social anxiety disorder, separation anxiety disorder or selective mutism).	• Children with PTSD, OCD or health anxiety/hypochondriasis. • Grandparents, teachers or other professionals as main participants. • Children described as 'at risk' of developing an anxiety disorder. • Specific groups e.g., physical health problems, intellectual disability, neurodevelopmental disorders.
Intervention	Parents are the only direct participants of the intervention. Interventions specifically aiming to reduce anxiety in children.	• Interventions which include children as a direct participant. • Interventions including an additional parent component as part of a child-focused intervention. • Interventions targeting other difficulties such as substance misuse, behavioural difficulties. • Preventative interventions. • Interventions aimed at reducing parental stress only. • No intervention delivered
Comparator	Comparators included individual therapy for the child, combined parent and child interventions, a non-treatment / waitlist control group, or studies with no comparison group.	
Outcomes	Outcome of child anxiety as measured by the presence or absence of the anxiety disorder diagnosis, based on a semi-structured interview/assessment. Changes in child anxiety symptoms as reported by the children themselves, parents or teachers.	• Focus on parent outcomes e.g., experiences, attitudes, changes in own mental health symptoms.
Study design	Any quantitative design e.g., RCT, pilot/feasibility study, treatment comparison, control group study.	• Qualitative methodology, mixed methods papers, review papers and book reviews.

Quality Assessment

The methodological quality of each study was assessed using the Effective Public Health Practice Project (EPHPP) Quality Assessment Tool for Quantitative Studies (Thomas et al., 2004). This tool was chosen because it has good content validity, construct validity (Thomas et al., 2004) and inter-rater reliability (Armijo-Olivo et al., 2012); it can be applied to quantitative studies with varied designs. Papers were rated according to six quality components: selection bias, design, confounders, blinding, data collection methods and withdrawals and dropouts. All studies were given a quality rating of 'strong', 'moderate' or 'weak' for each of the six components, from which global ratings were assigned. A rating of 'strong' was assigned to studies with no weak component ratings; a rating of 'moderate' was given to studies with one weak component rating and a rating of 'weak' was assigned for studies with two or more weak component ratings (Thomas et al., 2004). Quality assessments were completed by the lead author (CJ). A second independent researcher assessed the quality of 20% of studies. Agreement on ratings was substantial (83.33%; kappa =0.74). Any disagreement was resolved through discussion.

Data Analysis

Firstly, a narrative synthesis was conducted (Popay et al., 2006). Study outcomes were reviewed according to change in diagnostic status or change in reported symptoms of anxiety disorders. It was expected that each study would include a variety of outcome measures; for the purposes of this review, only questionnaires relating specifically to child anxiety symptoms were considered.

Random effects meta-analyses were undertaken on parent- and child-reported symptoms of anxiety. The random effects model was used to allow for differences in treatment effects between studies. Studies which met inclusion criteria and provided

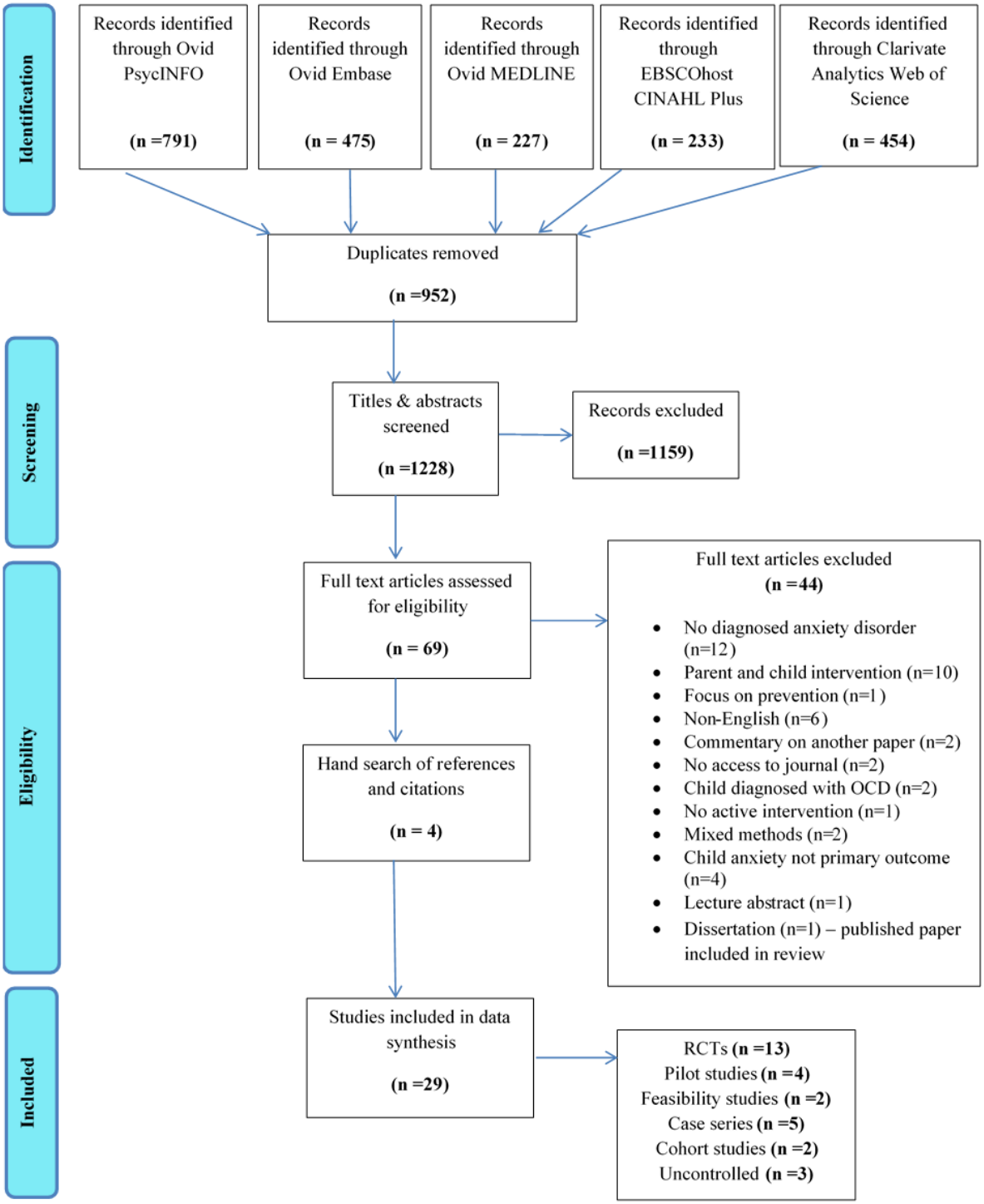
sufficient data to complete the analyses were included. Separate meta-analyses were conducted depending on the treatment conditions; parent-only intervention versus waitlist control and parent-only intervention compared with another intervention. When studies reported multiple outcomes, data from each treatment arm was combined into a single group. (Higgins & Green, 2011).

Standardised mean differences and associated confidence intervals were calculated using Hedges *g* to account for small sample bias. Effect sizes were interpreted as follows: 0.2 = small effect; 0.5 = moderate effect; 0.8 = large effect. Heterogeneity was assessed using the I^2 statistic. Typically, I^2 values of 25% represent low heterogeneity, 50% represent moderate heterogeneity and 75% represent high heterogeneity (Higgins et al., 2003). Meta-analyses were performed using Review Manager 5.4 (The Cochrane Collaboration, 2020).

Pre-test post-test effect sizes were calculated for single group pre/post designs (Morris & DeShon, 2002) to determine the magnitude of reported symptom changes associated with receiving the intervention. Uncontrolled designs were not suitable for a meta-analysis because participant scores are not independent from each other (Cuijpers et al., 2017).

Figure 1

PRISMA Flow Chart Describing Identification and Selection of Studies for Inclusion



Results

Study Characteristics

A total of 29 papers, published between 1999 and 2020, were identified as eligible for inclusion (see Table 3). Three were unpublished dissertations; one study (Brown et al., 2017) reported a long-term follow up of the sample described by Thirlwall et al. (2013). Figure 1 describes the identification and screening process based on PRISMA guidelines (Moher et al., 2009). A range of study designs was captured, including 13 RCTs, two feasibility trials, four pilot trials, two cohort studies, three uncontrolled pre/post studies and five case series. Trials were defined using CONSORT guidelines (Eldridge et al., 2016). Thirteen studies compared one or more treatments to a waitlist control group; nine compared two or more treatments without control and seven studies were uncontrolled with no comparator.

Most studies were conducted in the USA (n=10); others were carried out in Australia (n=6), UK (n=5), Canada (n=3), Brazil (n=1) and Europe (n=3; Denmark, Spain and Turkey, respectively). One study used a pooled sample which included participants from Australia, UK, USA and Europe (McKinnon et al., 2018).

The 29 studies included a total of 2916 participants, ranging from six to 1253 (pooled sample). Fifteen studies reported on parent gender which totalled 654 mothers and 183 fathers. Whilst the majority of studies included parents of children with a range of anxiety diagnoses, five papers focused on specific diagnoses: separation anxiety, specific phobia of the dark or selective mutism (Eisen et al., 2008; Neuhoff, 2006; Rafihi-Ferreira et al., 2018; Santacruz et al., 2006; Stone, 2000). Child age ranged from 4 to 17 years.

Twenty-three studies evaluated a CBT intervention. Intervention duration was described in 26 studies; this ranged from four to 22 weeks, with the majority of interventions taking place over 10 or 12 weeks (seven and nine studies respectively).

Twenty-four studies involved interventions which required parents to attend face-to-face sessions, six of which combined these sessions with telephone support and/or bibliotherapy. The number of face-to-face sessions ranged from two to 12, with a duration of 45 minutes to two hours; telephone support ranged from two to 10 sessions, with a duration of 15 to 40 minutes. Across all 29 studies, therapist contact during the intervention ranged from zero (purely bibliotherapy) up to a maximum 24 hours (12 two-hour-sessions).

Twenty-seven studies provided information regarding change in symptoms of child anxiety disorders. Of these 27 studies, 14 collected questionnaire data on anxiety symptoms from both parents and children. Five collected data from just parents and eight collected questionnaire data from children only. Two studies included additional outcome measures rated by the child's teacher. All 27 studies included pre- and post-intervention scores. Eighteen studies reported at least one follow up time point. Key study characteristics and outcomes, ordered by study design, are described in Table 3.

Table 3

Study Characteristics

No.	Author (Year) *Country*	Study design Sample size (N)	Child age (years) Parent sample characteristics	Treatment condition (parent only intervention): type, format, duration and description	Comparator condition: type, format, duration and description	Outcome measure *Rater*	Time points	Summary of main findings relevant to this review
Randomised Controlled Trials (RCTs)								
1	Lebowitz et al. (2020) *USA*	RCT N=124	7-14 124 mothers **Mean age:** 42.3 years (SD=5.9) **Marital status:** 92% married, 4% single, 4% divorced **Education:** 40% masters, 28% bachelors, 12% college, 9% professional/technical degree, 6% associate's, 3% high school, 2% PhD **Employment:** 76% employed **Annual family income:** 49% >$125,000, 19% $100,000-$124,999, 10% $81,000-$99,999, 9% $61,000-$80,999, 7%	SPACE (n=64) 12, 60-minute sessions 12 weeks Supportive responses to child anxiety, conveying confidence in child's ability to cope, mapping out and modifying family accommodations	CBT child focused intervention (n=60) 12, 60-minute sessions 12 weeks Psychoeducation, identifying and challenging thoughts, graded exposure, relapse prevention	ADIS *Parent & Child* PARS *Clinician* CGI *Clinician* SCARED *Parent & Child* FASA *Parent & Child* PSI *Parent* CCQ *Parent & Child* CSQ-8 *Parent & Child*	Pre/Mid/ Post	**SPACE not inferior to CBT (non-inferiority trial)** **Diagnosis:** 68.8% SPACE and 63.3% CBT recovered from anxiety diagnosis post-treatment (p =.57). 58.4% SPACE and 59.2% classed as remitted post-treatment on CGI (p =.88). **Anxiety symptoms:** 97.5% confidence intervals were below the non-inferiority margin for PARS (p<.001), SCARED parent (p<.01) and SCARED child (p<.01). Reduction in family accommodation in both treatments across time (FASA time p<.05; treatment p=.03).

			$41,000-$60,999, 4% $21,000-$40,999, 2% $0-$20,999. No further information reported					
2	Ozyurt et al. (2019) *Turkey*	RCT N=55	8-12 20 mothers; 35 fathers **Mothers education:** 53% less than high school, 47% high school and more than high school **Fathers education:** 44% less than high school, 56% high school and more than high school No further information reported	Triple P (n=26) 5, 2-hour group sessions & 3, 15-30min individual telephone consultations 8 weeks Improving parent-child interaction, applying positive parenting skills to a broad range of target behaviours	Waitlist control (n=29) 8 weeks	K-SADS-PL *Parent & Child* SCARED *Parent & Child* CGAS *Clinician* CGI-S *Clinician* SDQ *Parent* GHQ *Parent* STAI *Parent*	Pre/post	**Treatment > Waitlist control** **Anxiety symptoms:** Parent-rated and child self-reported anxiety symptoms and anxiety disorder severity were significantly lower following treatment compared to control on SCARED, CGAS, CHI and SDQ. No significant differences found for STAI and GHQ.
3	Rafihi-Ferreira et al. (2018) *Brazil*	RCT N=68	4-6 68 mothers **Mean age:** Intervention 36.21 years (SD 3.70), waitlist 36.59 SD 4.22) **Marital status:** Intervention 85% married, 12% divorced, 1% single;	Parent intervention (n=34) 1, 60min parent session, 4, 10-20min telephone contacts & bibliotherapy materials 4 weeks	Waitlist control (n=34) 4 weeks	Children's interview *Child* PAS *Parent* Sleep log *Parent* SHIPC *Child* FSSIP *Parent* CBCL *Parent*	Pre/post 3 month follow up	**Treatment > Waitlist control** **Anxiety symptoms:** Significant reduction in scores found on total PAS, separation anxiety PAS (both $p < 0.001$) and all measures assessing sleep problems (all $p < 0.001$). Results were maintained at 3 month follow up.

			waitlist 85% married, 15% divorced **Education:** Intervention 71% higher education, 29% basic and secondary education, waitlist 82% higher education, 18% basic and secondary education **Social status:** Intervention 26% high, 52% medium, 21% low, waitlist 29% high, 55% medium, 15% low. No further information reported.					
4	Salari et al. (2018) *Canada*	RCT N=42	6-12 36 mothers, 6 fathers **Mean age:** intervention 35.5 years (SD 5.2), waitlist 34.1 years (SD 4.8) **Education & Employment:** Mothers: 80-90% housekeepers and educated at the level of high school and higher.	FRIENDS for life (CBT) (n=20) 6, 2-hour group sessions over 6 weeks Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, deep breathing/relaxation, observational learning, praise and	Waitlist control (n=22) 6 weeks	K-SADS-PL *Clinician* RCMAS *Child* CDI *Child* SDQ *Parent* DASS *Parent* CGAS *Clinician* GRAF Consumer Satisfaction Questionnaire *Parent*	Pre/Post	<u>Parent report</u> **Treatment > Waitlist control** Children's emotional problems decreased significantly based on parent and clinician report (SDQ emotion subscale p = .009; CGAS (p = .001) <u>Child report</u> **Treatment = Waitlist control** No significant differences on RCMAS scores except for worry/oversensitivity (p =.006) and social concerns/ concentration (p = .003) which increased post treatment.

			No further information reported.	reinforcement, ignoring, promoting positive family skills				
5	Hiller et al. (2016) *UK*	RCT N=60	7-12 46 mothers; 13 fathers (1 parent did not start treatment) **Family composition:** 58% two parent household **Employment:** 88% employed High parental anxiety No further information reported	Guided parent-delivered CBT promoting parental tolerance of child's negative emotions (n=32) 6, 45-60min sessions & 2, 15min telephone review sessions over 16 weeks & self-help book Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, promoting parental tolerance of child's negative emotions through cognitive and mindfulness-based techniques	Guided parent-delivered CBT (n=28) 6, 45-60min sessions & 2, 15min telephone review sessions over 16 weeks & self-help book Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving	ADIS *Parent & Child* CGI-I *Independent Assessor* SCAS *Parent & Child* CAIS *Parent & Child* PAAQ *Parent*	Pre/Post	**Novel Treatment = Comparison Treatment Diagnosis:** 55% novel treatment and 61% comparison treatment recovered from primary diagnosis. 77% novel treatment rated as much/very much improved compared to 70% in control condition. No significant differences found between novel and comparison treatments on diagnostic status (p = 0.67) or clinical improvement (p = 0.56). **Anxiety symptoms:** Significant reduction over time in parent and child reported anxiety symptoms on SCAS and CAIS. No significant differences between conditions post treatment. Change in parent tolerance of children's negative emotions was not associated diagnosis (p = 0.88) or clinical improvement (p = 0.94).
6	Donovan and March (2016) *Australia*	RCT N=52	3-6 **Annual family income:** 55.8% > $100,000	Parent sessions of BRAVE-ONLINE for Children Program (CBT) (n=23)	Waitlist control (n=29)	ADIS *Parent* Clinical Severity Rating CGAS *Clinician* PAS *Parent*	Pre/Post 6 month follow up	**Treatment = Waitlist control (Diagnosis)** No significant differences between treatment and waitlist control on number of children free of primary or any anxiety diagnosis post-treatment in completer and intention to treat (ITT) samples.

			13.5% $81,000-$100,000 15.4% $61,000-$80,000 9.6% $41,000-$60,000, 5.8% $21,000-$40,000 No further information reported.	6, 1-hour sessions; weekly emails; 1, 15-30min telephone consultation; 2 booster sessions over 22 weeks. Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, reinforcing brave behaviour, relaxation	Duration not reported	CBCL-Int *Parent* Treatment satisfaction questionnaire *Parent*		**Treatment > Waitlist Control (Anxiety symptoms)** Parents in treatment group reported greater reduction in child anxiety symptoms and severity of anxiety diagnosis compared to control (PAS p = .011) Steadily improving diagnostic outcomes at follow up. Significant reduction in child anxiety symptoms on PAS and CBCL pre-treatment to follow up and post-treatment to follow up.
7	Thirlwall et al. (2013) *UK*	RCT N=194	7-12 190 mothers, 4 fathers **Marital status:** 4% not recorded, 6% single, 58% married (first time), 11% remarried, 11% divorced/separated, 8% living with partner, 2% widowed **Education:** 7.2% not recorded, 20.1% school completion, 44.3% further education, 18% higher education, 10.3%	1) Full guided parent delivered CBT (n=64) 4, 1-hour sessions & 4, 20min telephone sessions over 8 weeks & self-help book 2) Brief guided parent delivered CBT (n=61) 2, 1-hour sessions & 2, 20min telephone sessions over 8 weeks & self-help book	Waitlist control (n=69) 12 weeks	ADIS *Parent & Child* CGI-I *Assessment team* SCAS *Parent & Child* CAIS *Parent* SMFQ *Parent & Child* SDQ *Parent*	Pre/Post; 6 month follow up	**Full guided CBT > Waitlist control** **Diagnosis:** 50% recovered from primary diagnosis in full guided CBT condition compared to 25% in waitlist (p = .013). 34% recovered from any anxiety diagnosis compared to 11% in waitlist (p = .006). Significant differences pre-post treatment on CGI-I (p <0.001). 76% reported a much/very much improved in full guided CBT compared to 25% in waitlist. **Anxiety symptoms:** No significant differences between full guided CBT and waitlist on parent/child SCAS. Significant reduction in impact of anxiety (CAIS p = .0045). **Brief guided CBT = Waitlist control** **Diagnosis:**

			postgraduate qualification **Employment:** 8% not recorded, 61% higher professional, 25% other employed, 6% unemployed No further information reported	Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, responses to child anxiety				39% recovered from primary diagnosis in brief guided CBT condition compared to 25% in waitlist ($p = .119$). 15% recovered from any anxiety diagnosis compared to 11% in waitlist. Significant difference pre-post treatment on CGI-I ($p = .011$). 54% reported as much/very much improved in brief guided CBT compared to 25% in waitlist. **Anxiety symptoms:** No significant differences between brief guided CBT and waitlist on any parent or child report measures. Steadily improving diagnostic outcomes at follow up for both full and brief guided CBT. No significant differences on parent/child SCAS at follow up.
8	Cartwright-Hatton et al. (2011) *UK*	RCT N=74	2.7-9 **Mean age**: 35years **Education:** presented as ratios postgraduate: bachelors: completed high school: some high school: no qualifications Intervention group 10:6:9:7:1 Control group 5:9:5:5:2 **Financial situation:** Presented as rations - comfortable: managing: struggling.	Timid to Tiger (CBT) (n=38) 10, 2-hour group sessions over 10 weeks Psychoeducation, graded exposure, managing worry, child-centred play, praise/rewards, behavioural strategies (e.g., consequences, time out)	Waitlist Control (n=36) 10 weeks	ADIS *Parent* CBCL *Parent & Teacher* SCARED *Parent* MASC *Child*	Pre/Post 12 month follow up	**Treatment > Waitlist control** **Diagnosis:** 56.7% free from primary diagnosis compared to 15.1% in control group ($p < .001$). 32.4% free from any anxiety diagnosis compared to 6% in control group ($p < .05$). **Anxiety symptoms:** Significant differences post treatment compared to waitlist control on CBCL DSM anxiety & internalising scores (both $p < .05$) and SCARED ($p < .01$). No significant difference between treatment and control condition on MASC ($p > .05$). Diagnostic outcomes maintained at follow up. Further reduction in CBCL and SCARED scores at follow up for intervention group, but improvements in the control group mean that significant group differences were no longer present. No significant

			Intervention group 13:13:9 Control group 11:13:4 No further information reported					difference between treatment and control at follow up on MASC (p >.05).
9	Waters et al. (2009) *Australia*	RCT N=80	4-8 **Family composition:** 88% two parent household **Employment:** 65.6% mothers and 82.4% fathers employed No further information reported	Take ACTION (CBT) 1) Parent only (n=38) 2) Parent + Child (n=31) *Same format and content for both treatment conditions 10, 1-hour group sessions over 10 weeks & booster sessions 8 weeks after final session Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, relaxation, identifying support, social skills training	Waitlist control (n=11) 10 weeks	ADIS *Parent & Child* CSR SCAS *Parent* CBCL *Parent* PS *Parent* PSCS *Parent* DASS-42 *Parent* Treatment satisfaction *Parent*	Pre/Post 6 & 12 month follow up	**Parent only & Parent + Child > Waitlist Control** **Diagnosis:** <u>Completer:</u> 74% parent + child (p <.001) and 84% parent only (p <.001) recovered from primary anxiety diagnosis compared to 18% waitlist control. 61% parent + child (p <.002) and 60% parent only (p <.005) no longer met criteria for any anxiety disorder diagnosis compared to 9% waitlist. <u>ITT:</u> 54.8% parent + child and 55.4% in parent only free from primary anxiety diagnosis compared to 18.2% in waitlist control. 54.8% parent + child (p <.05) and 44.7% parent only (p <.05) no longer met criteria for any anxiety disorder diagnosis compared to 18% waitlist. Significant reduction in CSR for parent only & parent + child (both p<.001). **Anxiety symptoms:** Significant reduction in both groups on parent SCAS (parent + child p <.0; parent only p <.01) and CBCL-Int (p <.01) No significant differences found between the two active treatment conditions.

								Steadily improving diagnostic outcomes at 6 month follow up; maintained at 12 month follow up for both completer and ITT samples. No significant differences between active treatment conditions at 6 months (p =.12) or 12 months (p =.85).
10	Rapee et al. (2006) *Australia*	RCT N=267	6-12 **Marital status:** 86.5% married **Annual family income:** 14.2% below $30,000 No further information reported	Bibliotherapy (CBT) (n=90) Self-help materials completed over 12 weeks Psychoeducation, identifying and challenging thoughts, graded exposure, relaxation, anxiety management	Cool Kids Programme (CBT) 1) Parent & child intervention (n=90) 9, 2-hour group sessions over 12 weeks Psychoeducation, identifying and challenging thoughts, graded exposure, relaxation, anxiety management, assertiveness/ dealing with teasing 2) Waitlist control (n=87) 12 weeks	ADIS-C-IV *Parent & Child* Global Severity Scale *Clinician* SCAS *Parent & Child* CATS *Child* CBCL *Parent*	Pre/Post, 3 month follow up	**Bibliotherapy > waitlist control** **Diagnosis:** Completer: 25.9% bibliotherapy free from any anxiety disorder compared to 6.7% in control group (p <.005) ITT: 17.8% bibliotherapy free from any anxiety disorder compared to 5.7% in waitlist control group (p <.05). **Anxiety symptoms:** Significant difference on SCAS and CBCL between bibliotherapy and waitlist for completer (both p <.05) but not ITT samples (SCAS parent p>.32; CBCL internalising p=.60; CBCL externalising p=.20). **Group CBT > bibliotherapy** **Diagnosis:** Completer: 61.1% group CBT free from any anxiety disorder compared to 25.9% in bibliotherapy (p <.001) ITT: 48.9% group CBT free from any anxiety disorder compared to 17.7% in bibliotherapy (p <.001). **Anxiety symptoms:** Significant difference between groups on SCAS parent (p <.01) and CBCL internalising (p <.05).

								Children in all groups including waitlist showed significant change over time; differences between groups were not significant. Treatment gains maintained at follow up.
11	Lyneham and Rapee (2006) *Australia*	RCT N=100	6-12 100 mothers, 74 fathers (100 families) **Family composition:** 88% two parent household, 12% single parent **Annual family income (AUD):** 7% $20,000, 25% $20,001–$40,000, 22% $40,001–$60,000, 20%, $60,001–$80,000, 13% $80,001–$100,000, 13%>$100,000 No further information reported.	Bibliotherapy (CBT) 1) Telephone (n=28) 2) Email (n=21) 3) Client-initiate (n=29) Self-help materials completed over 12 weeks 9 telephone calls or emails with therapist for telephone & email conditions respectively Psychoeducation, identifying and challenging thoughts, graded exposure, relaxation, anxiety management	Waitlist control (n=22) 12 weeks	ADIS *Parent* SCAS *Parent & Child* RCMAS *Child* CDI *Child* CATS *Child* CBCL *Parent* PSI *Parent* DASS P*arent*	Pre/Post 3 & 12 month follow up	**Any treatment condition > Waitlist control** **Diagnosis:** 92% telephone, 75% email and 47% client-initiate free of primary diagnosis compared to waitlist control (p <.01). 80% telephone, 58% email and 40% client initiate free of any anxiety diagnosis post treatment. Improvements in CSR in all conditions compared to waitlist (all p <.01). Greater reduction in severity rating for telephone than email (p <.05; d = .62) and client-initiate (p <.01; d =.77). Greater reduction in severity for email than client-initiate (p <.01; d =.77). **Anxiety symptoms:** Significant reductions in child SCAS, RCMAS, CATS in telephone condition (p <.01, d =1.42), email condition (p <.01), d=.97) and client-initiate condition (p <.01, d=.80) compared to waitlist. Significant reductions in parent SCAS and CBCL between waitlist and telephone (mother p <.01, d=1.65; father p <.01, d =1.26), waitlist and email (mother p <01; d=1.18; father p <.01, d =1.03) and waitlist and client-initiate conditions (mother p <.01, d=1.03; father p <.01, d=1.18). No significant differences between treatment groups on mother (p =.70), father (p =.42) or child (p =.77) rated anxiety symptoms.

								Treatment gains maintained or improved at follow up.
12	Santacruz et al. (2006) *Spain*	RCT N=78	4-8 No information reported	1) Bibliotherapy and games (play therapy) (n=27) Imaginary and in vivo exposure 2) Emotive performances (play therapy) (n=28) Exposure, play, token economy and modelling 5, 45 minutes sessions over 5 weeks	Waitlist control (n=23) Duration not reported	DFI *Parent* CFSS-R *Parent* DFS *Parent* BTR *Parent* DBR-M *Parent*	Pre/Post 3, 6 & 12 month follow up	**Emotive Performances (EP) > Bibliotherapy & Games (BG) > Waitlist Control** Significant differences between treatment conditions and control on bed time recordings scores (p =.000) and DBR-M (p =.000) with greatest improvements in EP group. Improvements from both treatments maintained at follow up.
13	Mendlowitz et al. (1999) *Canada*	RCT N=62	7-12 **Family composition:** 79% two parent household, 21% single parent (mothers) No further information reported.	Coping Bear Workbook & Keys to Parenting Your Anxious Child (CBT) 1) Parent + Child (n=18) 2) Child only (n=23) 3) Parent only (n=21) 12, 1.5-hour sessions over 12 weeks	Waitlist control (n=40)	Diagnostic Inventory for Children and Adolescents – Revised *Parent* RCMAS *Child* CDI *Child* CCSC *Child* Global Improvement Scale *Parent/Clinician*	Pre/Post	**Any treatment > Waitlist Control** **Better outcomes for parent + child condition** **Anxiety symptoms:** Males reported more anxiety over time post-treatment on RCMAS; opposite trend found in females (p <.04). Parents in parent-child group rated their children as more improved than parents in child or parent only groups (Global Improvement Scale p <.05) Parent-child condition used coping strategies more often after treatment compared to child only and parent only conditions (CCSC p <.04)

				Psychoeducation, graded exposure, problem solving, responses to anxiety, anxiety management, relaxation				
Feasibility Trials								
14	Chavira et al. (2018) *USA*	Feasibility trial N=31	8-13 **Mean age** = 31years **Marital status:** 71% married or living together **Education:** 16.1% some high school, 45,2% high school graduate, 29% some college, 9.7% college graduate No further information reported	Cool Kids Outreach (CBT): Telephone delivered, therapist assisted bibliotherapy (n=15) 11 telephone sessions & self-help materials completed over 3-4 months Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, parent management exercises, assertiveness skills	Cool Kids Outreach (CBT): Self-directed bibliotherapy (n=16) Self-help materials completed over 3-4 months & option to call therapist for extra support Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, parent management exercises, assertiveness skills	ADIS *Parent & Child* Parental Literacy *Parent* ARSMA-II *Parent* BTPs *Parent* Parent Consumer Satisfaction Scale *Parent* TAQ *Parent*	Pre/Post	**Therapist-assisted > Self-directed condition** **Diagnosis:** 61.5% of therapist-assisted condition and 36.4% of self-directed condition free of primary anxiety disorder diagnosis post-intervention. 50% of therapist-assisted condition and 36.4% of self-directed condition free of all anxiety disorders post-intervention

15	Chavira et al. (2014) *USA*	Feasibility trial N=48	8-13 **Mean age:** Face to face (41.69 years, SD 5.44), Bibliotherapy (42.31 years, SD 3.18) **Marital status:** 85.4% married or living together **Education:** 14.6% high school or tech, 20.8% some college, 64.6% college graduate No further information reported	Cool Kids Outreach (CBT): Therapist supported bibliotherapy (n=24) 10, 35-40min telephone sessions over 3-4 months Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, parent management exercises, assertiveness skills	Cool Kids face-to-face (CBT): Individual therapy with parent and child (n=24) 10, 60-90mins sessions over 3-4 months Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, parent management exercises, assertiveness skills	ADIS *Parent & Child* CSR SCARED *Parent & Child* CGI-I *Clinician* C-GAS *Clinician* Parent Consumer Satisfaction Scale *Parent* Barriers to Treatment Participation Scales *Parent*	Pre/Post 3 month follow up	**Bibliotherapy = Face to face sessions** **Diagnosis:** 54.3% free of any anxiety diagnosis in therapist supported bibliotherapy and 75% face to face. Diagnostic outcomes maintained at follow up. **Anxiety symptoms:** Statistically significant effect of time on CSR, SCARED parent and child and CGAS (all p <.001) No significant differences between the two groups.
Pilot Trials								
16	Cobham et al. (2017) *Australia*	Pilot trial N=61	7-14 30 mothers, 2 fathers (Treatment only; not reported for controls) **Family composition:** 74% intact biological family, 18% single parent, 8% blended family **Mothers education:** 7% not recorded, 15% completed high school, 70%	Fear-less Triple P (CBT) (n=32) 6, 90min group sessions over 6 weeks Psychoeducation, identifying and challenging thoughts, avoidance, graded exposure, problem solving, promoting	Waitlist control (n=29) 6 weeks	ADIS *Parent & Child* SCAS *Parent & Child* CBCL *Parent*	Pre/Post; 3, 6 & 12 month follow up	**Treatment > Waitlist control** **Diagnosis:** 64.5% free from primary diagnosis compared to 16.2% in waitlist condition (p <.001). 38.7% free from any anxiety diagnosis compared to 3.4% in waitlist condition (p <.001). Significant reduction post treatment compared to waitlist control on number of anxiety diagnoses (p <.001) and clinical severity of diagnosis (p <.001). **Anxiety symptoms:** Significant reduction post treatment compared to waitlist control on Maternal SCAS (p <.001), child

			postgraduate qualification **Father's education:** 23% not recorded, 16% completed high school, 61% postgraduate qualification **Annual family income:** 16% <$AUD 61,600 62% >$AUD 61,600 No further information reported	emotional resilience, responses to child anxiety, constructive coping.				SCAS (p <.01) and maternal CBCL (p <.01). No significant difference on paternal SCAS. Steadily improving diagnostic outcomes at follow up. No significant change over time from post treatment to follow up on maternal, paternal and child SCAS or paternal CBCL.
17	Reuland and Teachman (2014) *USA*	Pilot trial N=18	10-15 18 mothers **Family composition:** 94% children do not split time between households **Education:** 61% advanced graduate or professional degree, 22% some college or post-high school, 11% college graduate, 6% high school graduate or GED. **Annual family income:** 5.5% $0–$20,000	CBM-I Parent only (n=5) 8, 20min sessions Read and imagine self in ambiguous scenarios provided – completed word fragments which resolved ambiguity in a positive way then answered a comprehension question which reinforced positive	CBM-I 1) Combo parent + child (n=6) 2) Child only (n=7) 8, 20min sessions Read and imagine self in ambiguous scenarios provided – completed word fragments which resolved ambiguity in a positive way then answered a	ADIS *Parent & Child* WASI *Child* SAS-A *Child* Recognition Ratings *Parent & Child* Behavioural Avoidance Task *Clinician* PAQ *Parent & Child*	Pre/Post; 1-2 month follow up	**Modest treatment effect** **Diagnosis:** 82.3% children still met criteria for social anxiety disorder post treatment. **Anxiety symptoms:** 35% all participants showed clinically significant change on SAS-A.

			11% $40,000–$60,000 28% $60,000–$80,000 22% $100,000-$120,000 11% $120,00 –$140,000 17% >$200,000 5.5% Prefer not to say No further information reported	interpretation of the situation	comprehension question which reinforced positive interpretation of the situation			
18	Smith et al. (2014) *USA*	Pilot trial N=31	7-13 33 mothers, 23 fathers **Mean age:** mothers 42.04 years (SD 6.03), fathers 45.07 years (SD 6.07) **Family ethnicity:** 97% Hispanic/Latino **Marital status:** 93.5% married, 6.5% divorced (not remarried) **Mean household income:** treatment $131,000 (SD $82,417), waitlist control $123,571(SD $74,202)	10, 1-hour sessions over 10 weeks Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, breathing/relation, positive reinforcement	Waitlist control (n=13) 10 weeks	ADIS *Parent* AMAS *Parent* MASC *Parent & Child* PPS *Parent*	Pre/Post; 3 month follow up	**Treatment > Waitlist control** **Diagnosis:** Significant reductions post treatment on total number of child anxiety disorder diagnoses ($p < .01$) and CSR ($p < .01$). Mean scores for these variables decreased significantly in the treatment group but not waitlist control. **Anxiety symptoms:** Significant reduction in parent interference scores post treatment ($p < .001$); mean scores decreased significantly in the treatment group but not waitlist control. No significant interactions or main effects reported on MASC or AMAS. Maternal (but not paternal) PPS sores reduced significantly in treatment group compared to control ($p < .05$). Treatment gains were maintained at 3 month follow up, with CSR decreasing significantly again at follow up.

			No further information reported					
19	Leong et al. (2009) *Australia*	Pilot trial N=27	7-14 25 mothers, 2 fathers **Mean age**: 41.3 years (SD 4.86) Age range 27-54 years **Ethnicity:** 100% Caucasian **Education:** 41% left school in year 12 or earlier, 59% completed tertiary education No further information reported	Bibliotherapy (CBT) (n not reported) 1, 2-hour training session; 6, 60-90min sessions & fortnightly telephone support over 12 weeks Do As I Do parent manual & Facing Your Fears child manual (CBT) (CBT) Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, relaxation	Individual therapy (parent & child) (n not reported) 6 parent sessions, 6 child sessions over 12 weeks Do As I Do parent manual & Facing Your Fears child manual (CBT) Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, relaxation, rewards	ADIS Parent RCMAS *Child* SDQ *Parent* CBCL *Parent* Client Satisfaction Questionnaire *Parent*	Pre/Post 3 & 6 month follow up	**Bibliotherapy = Individual therapy** **Diagnosis:** 69% bibliotherapy free from primary diagnosis compared to 57% individual therapy. Significant reduction for both bibliotherapy and individual therapy in number of anxiety diagnoses post-treatment (both p = .000) and severity of diagnosis post-treatment (both p = .0000). No significant difference between treatment conditions. **Anxiety symptoms:** Significant reduction in RCMAS scores for bibliotherapy pre-post treatment (p = .02); trend for improvement on SDQ emotional subscale (p = .09). No significant changes on RCMAS or SDQ for individual therapy; trend for reduction in scores over time on both measures. No significant differences between groups for RCMAS, SDQ. No significant difference between groups for diagnostic status at follow up. Symptom reduction maintained at follow up for both groups.
Cohort Studies								

20	McKinnon et al. (2018) *Australia, UK, Europe, USA*	Cohort study N=1253	5-12 No information reported	Parent-led CBT (n=260) Format/duration not reported Core CBT skills (not specified)	1) Individual CBT (n=341) 2) Group CBT (n=652) Format/duration not reported Core CBT skills (not specified)	ADIS *Parent & Child* CSR *Clinician*	Pre, Post & Pooled Follow up (3, 6 & 12 months)	**Individual CBT > group CBT & guided parent-led CBT for specific phobia only** No significant effect of treatment format on remission rates or clinical severity for primary anxiety diagnosis of GAD, social anxiety disorder or separation anxiety disorder. Children with primary diagnosis of specific phobia receiving individual CBT were significantly more likely to be free of diagnosis post-treatment compared to children in guided parent-led CBT (p =.005). Individual CBT associated with significantly greater improvements in clinical severity than group CBT and guided parent-led CBT (both p <.001) Treatment effects were not maintained at follow up.
21	Brown et al. (2017) *UK*	Cohort study - long term follow up N=65	11-17 No information reported	Full or brief guided parent delivered CBT (n=65) 4, 1-hour sessions & 4, 20min telephone sessions & self-help book (full) or 2, 1-hour sessions & 2, 20min telephone sessions (brief) over 8 weeks Psychoeducation, identifying and challenging thoughts, graded exposure, problem	Treatment only	ADIS *Parent & Child* CSR *Clinician* CGI-I *Clinician* SCAS *Parent & Child* CAIS *Parent* SMFQ *Parent & Child* SDQ *Parent*	3-5 year follow up	**Long term treatment effects for full and brief guided parent-delivered CBT** 79% children no longer met criteria for primary diagnosis and were rating as very much or much improved on CGI-I. 19% who met diagnostic criteria at last assessment had recovered, 60% had maintained recovery, 12% had relapsed and 9% continued to meet criteria for an anxiety disorder. Mean scores on SCAS, CAIS, SMFQ and SDQ-C were comparable to normative scores.

				solving, responses to child anxiety				
Uncontrolled Pre/Post								
22	Esbjørn et al. (2016) *Denmark*	Uncontrol led pre/post N=20	7-13 20 mothers, 17 fathers (Total 20 families) **Mean age:** mothers 39.9 years (SD 4.3), fathers 44.0 years (SD 6.8) **Ethnicity:** 100% Caucasian **Marital status:** 80% married **Education:** 65% mothers and 58% fathers completed college education or higher **Annual family income:** 70% mothers and 76% fathers annual income >$75,000 35% mothers and 25% fathers reported previous psychological difficulties. No further information reported	Cool Kids (CBT) (n=20) 2, 2-hour group sessions over 12 weeks, Facebook group and self-help materials Psychoeducation, identifying and challenging thoughts, graded exposure, parent management training	Treatment condition only	ADIS Parent & *Child* CSR *Clinician* RCADS *Parent & Child* DASS-21 *Parent*	Pre/Post	**Effective treatment** **Diagnosis:** 76.5% completers free of any anxiety diagnoses post-intervention. 65% ITT free of any anxiety diagnoses post-intervention. **Anxiety symptoms:** Significant change post-treatment on RCADS child reported anxiety symptoms (p =.000) and parent reported child anxiety symptoms (mother reported p =.000; father reported p =.005).

23	Thienemann et al. (2006) *USA*	Uncontrol led pre/post N=24	7-16 24 mothers **Mean age**: 46.5 years (SD 4.6) 45.8% had anxiety disorder diagnoses	Cool Kids CBT Program (n=24) 12, 2-hour group sessions over 12 weeks Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, helpful and unhelpful parenting strategies, rewards, mindfulness techniques, social skills training	Treatment condition only	ADIS *Parent & Child* MASC *Parent & Child* GAF *Clinician* MASC-10 *Parent* Target Problems Scale *Parent* Attitudes Toward My Child *Parent*	Pre/Post	**Effective Treatment** **Diagnosis:** 25% free of primary diagnoses and 54.9% free of all anxiety diagnoses. For patients still meeting diagnostic criteria for an anxiety disorder, primary diagnosis severity reduced significantly (p = .005; d =1.12) **Anxiety symptoms:** Significant differences pre-post treatment on MASC parent (p = .001), MASC-10 (p = .002; d = 0.97), CGI-I (P <.001; d = 0.92), GAF (p = .005; d = .90), parent's attitudes towards children over time (p = .001; d = 0.73) and parent rating of target problems (p <.001; d = 1.51). No significant change pre-post treatment on child self-report measures.
24	Creswell et al. (2010) *UK*	Uncontrol led pre/post N=52	5-12 No information reported	Guided self-help CBT (n=52) 4, 1-hour face to face sessions & 4, 15min telephone sessions with therapist over 8 weeks & self-help materials Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving	Treatment condition only	ADIS *Parent & Child* CSR *Clinician* CGI-I *Clinician* SCAS *Parent & Child* CAIS *Parent* SMFQ *Parent & Child* DASS-21 *Parent* Parent Satisfaction Questionnaire *Parent* Mental Health Worker Satisfaction	Pre/post	**Effective Treatment** **Diagnosis:** 61% completers & 50% ITT no longer met diagnostic criteria for primary anxiety diagnosis. 44% completers % 35% ITT free of all anxiety diagnoses. 76% completers & 60% ITT rated as much/very much improved on CGI. **Anxiety symptoms:** Significant differences pre-post treatment on SCAS parent (p <.001), SCAS child (p =.006), CAIS (p<.001), SMFQ parent (p =.002) and SMFQ child (p =.006).

						Questionnaire *Clinician*		
Case series								
25	Mayer-Brien et al. (2017) *Canada*	Case series N=6	4-7 6 mothers, 1 father (Total 6 families) **Mean age:** Mothers 38.5 years, fathers 38 years **Ethnicity:** 27% Hispanic, 73% Caucasian **Marital status:** 90% two parent household **Employment:** 82% employed; 9% unemployed, 9% student No further information reported	Parent Training Treatment Manual for Separation-Anxious Children adapted for young children (CBT) (n=6) 10 sessions over 10 weeks Psychoeducation, graded exposure, problem solving, increasing emotional warmth in the parent-child relationship, relaxation	Treatment condition only	ADIS *Parent* Daily Record of Anxiety at Separation (Daily Diary) Parent PAS *Parent* PAS - Anxiety Separation Subscale *Teacher* PPI *Parent* PPS *Parent* PSI – brief form *Parent* TRF – Anxiety Problems Subscale *Teacher* PSA *Teacher*	Pre/post 3 month follow up	**Effective Treatment** **Diagnosis:** 83% no longer met diagnostic criteria for separation anxiety. Diagnostic outcomes maintained at 3 month follow up. **Anxiety symptoms:** Significant change for 50% of children on PAS post intervention – maintained at 3 month follow up.
26	Eisen et al. (2008) *USA*	Case series N=6	7-10 6 mothers, 3 fathers (Total 6 families) No further information reported	CBT parent training manual (n=6) 10, 1.5-hour sessions over 10 weeks Psychoeducation, identifying and challenging thoughts, graded exposure, problem	Treatment condition only	ADIS *Parent & Child* CSR *Clinician* RCMAS *Child* Daily diaries *Parent* PSOC *Parent* PSI *Parent* FQ *Parent* PROS *Parent*	Pre/Post 6 month follow up	**Effective Treatment** **Diagnosis:** 83% no longer met criteria for separation anxiety disorder post-treatment. **Anxiety symptoms:** 100% scored in normative range of RCMAS post-treatment. 60% improvement in separation-anxious days per week. 66% children reported reductions in frequency of separation-anxious events post-treatment which were maintained at follow up.

				solving, relaxation, coping skills				30% reduction in parent interference ratings which were maintained at follow up. 66% parents reported reductions in intensity of child's separation-anxious events which were again maintained at follow up.
27	Neuhoff et al. (2006) *USA*	Case series N=6	7-12 No information reported	Prescriptive CBT n=4 10, 60-75min sessions over 10 weeks Participants allocated according to response class (e.g., anxious parents – parent training) Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, relapse prevention	Non-prescriptive CBT n=2 10, 60-75min sessions over 10 weeks Participants allocated to opposite response class (e.g., anxious parents – child CBT) Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, relapse prevention	ADIS *Parent & Child* CSR *Clinician* RCMAS *Child* STAI *Child* CASI *Child* PSI *Parent* PSOC *Parent* FQ *Parent* PROS *Parent* Daily diaries *Parent & Child*	Pre/Post	**Prescriptive CBT > non-prescriptive CBT Diagnosis:** 100% participants in treatment conditions (child therapy and parent training) no longer met criteria for separation anxiety disorder post-treatment. All participants showed improvements on STAI-C and CASI 50% participants showed improvements on RCMAS (2 child treatment, 1 control) Both child therapy and parent training are effective interventions for child anxiety. Children whose parents received training demonstrated better post-treatment outcomes than in child therapy condition. Prescriptive parent and child treatment produced clinically significant improvement. Non-prescriptive parent training did not produce clinically significant results in child domain.
28	Raleigh et al. (2001) *USA*	Case series N=6	7-10 6 mothers, 3 fathers (Total 6 families)	Parent training program for separation anxiety (CBT) (n=6)	Treatment condition only	ADIS *Parent & Child* CSR *Clinician* RCMAS *Child* CDI *Child*	Pre/Post	**Diagnosis:** 100% participants no longer met criteria for separation anxiety disorder post-intervention. 68% reduction in parent ratings of severity of diagnosis.

			No further information reported	10, 1.5-hour sessions over 10 weeks Psychoeducation, identifying and challenging thoughts, graded exposure, problem solving, relaxation, relapse prevention		CBCL *Parent* PSI *Parent* PSOC *Parent* BDI *Parent* FACES-III *Parent & Child* Daily diaries *Parent* PROS *Parent*		**Anxiety symptoms:** 33.8% fewer anxiety responses on RCMAS post-intervention; 5 out of 6 children scored in normative range (RCMAS total anxiety d = 1.03; physiological anxiety d = 0.97; worry/oversensitivity d = 1.18). No statistically significant change on CBCL.
29	Stone (2000) *USA*	Case series N=6	4-9 No information reported	Videotape training (n=3) Watch 6 videotapes; treatment manual 16 weeks Overview of selective mutism, behaviour therapy techniques - play, praise and rewards and effective limit setting	Self-modelling (n=3) Watch 1 videotape; create own videotapes; treatment manual 16 weeks Overview of selective mutism & behavioural consultation, specific procedures to follow for creating videotapes	Selective Mutism Questionnaire *Parent* CBCL *Parent* TRF *Teacher* RCMAS *Child* GAS Direct observation *Parent, Teacher & Independent Observers* Treatment integrity checklists *Clinician* Problem Identification Interview *Clinician* Treatment evaluation questionnaire *Parent*	Pre/Post 1 month follow up	**Videotape training = self-modelling intervention** **Anxiety symptoms:** No significant differences between videotape training and self-modelling intervention (p >.05) for observations, parent GAS, CBCL or TRF. Statistically significant change in overall behavioural symptoms pre-post treatment found for Internalising and total problems on CBCL. Neither intervention produced a statistically significant treatment effect alone – significant general intervention effect when participants in both conditions were combined (p <.05).

Methodological Quality and Risk of Bias Assessment

The EPHPP ratings are based on strict criteria meaning that a global rating of 'strong' is only awarded when none of the six criteria are weak (Thomas et al., 2004). Thus, the methodological quality or risk of bias of these 29 studies was rated as rather poor overall (see Table 4). Only four (13.8%) were rated as globally strong, six (20.7%) were rated as moderate (or as only showing one weak criterion) and the remaining 19 (65.5%) were judged to be generally weak.

Of the 29 studies, the designs of 18 were rated as being methodologically 'strong' (e.g., RCTs, feasibility/pilot trials). This review captured a range of study designs from RCTs to case series; it was not expected that some of these designs would achieve a 'strong' rating because RCTs receive preferential scoring on the EPHPP. Five of the 12 RCTs were identified as 'controlled clinical' trials during quality assessment due to insufficient information describing the process of randomisation (Lyneham & Rapee, 2006; Mendlowitz et al., 1999; Salari et al., 2018; Santacruz et al., 2006; Waters et al., 2009).

Sixteen studies were rated as methodologically 'strong' due to their management of confounding variables and 27 studies were rated as 'strong' due to the use of reliable and valid outcome measures for data collection. Fourteen studies were rated 'strong' for reporting information on withdrawals and dropouts. However, 24 of the 29 studies were rated to be 'weak' in terms of their methodological quality because of selection bias due to participant self-referral (n=17), lack of information about recruitment procedures (n=3) or less than 60% of eligible participants agreeing to participate in the study (n=4).

Table 4

EPHPP Quality Assessment Rating

No.	Author	Selection Bias	Study Design	Confounders	Blinding	Data Collection Method	Withdrawals/ Drop outs	Global Rating
1	Lebowitz et al. (2020)	Weak	Strong	Strong	Moderate	Strong	Moderate	**Moderate** 3 strong, 2 moderate, 2 weak
2	Ozyurt et al. (2019)	Moderate	Strong	Strong	Moderate	Strong	Moderate	**Strong** 3 strong, 3 moderate, 0 weak
3	Chavira et al. (2018)	Weak	Strong	Strong	Moderate	Strong	Weak	**Weak** 3 strong, 1 moderate, 2 weak
4	Mckinnon et al. (2018)	Weak	Moderate	Weak	Moderate	Strong	Weak	**Weak** 1 strong, 2 moderate, 3 weak
5	Rafihi-Ferreira et al. (2018)	Weak	Strong	Strong	Weak	Weak	Strong	**Weak** 3 strong, 0 moderate, 3 weak
6	Salari et al. (2018)	Weak	Strong	Strong	Weak	Strong	Strong	**Weak** 4 strong, 0 moderate, 2 weak
7	Brown et al. (2017)	Weak	Weak	Weak	Weak	Strong	Strong	**Weak** 2 strong, 0 moderate, 4 weak
8	Cobham et al. (2017)	Weak	Strong	Strong	Moderate	Strong	Strong	**Moderate** 4 strong, 1 moderate, 1 weak
10	Mayer-Brien et al. (2017)	Weak	Weak	Weak	Moderate	Strong	Strong	**Weak** 2 strong, 1 moderate, 3 weak
11	Donovan & March (2016)	Weak	Strong	Strong	Moderate	Strong	Moderate	**Moderate** 3 strong, 2 moderate, 1 weak
12	Esbjørn et al. (2016)	Weak	Moderate	Weak	Moderate	Strong	Strong	**Weak** 2 strong, 2 moderate, 2 weak
13	Hiller et al. (2016)	Moderate	Strong	Strong	Moderate	Strong	Moderate	**Strong** 3 strong, 3 moderate, 0 weak

14	Chavira et al. (2014)	Weak	Strong	Strong	Moderate	Strong	Moderate	**Moderate** 3 strong, 2 moderate, 1 weak
15	Reuland & Teachman (2014)	Weak	Weak	Weak	Moderate	Strong	Strong	**Weak** 2 strong, 1 moderate, 3 weak
16	Smith et al. (2014)	Weak	Strong	Strong	Moderate	Strong	Weak	**Weak** 3 strong, 1 moderate, 2 weak
17	Thirlwall et al. (2013)	Weak	Strong	Strong	Moderate	Strong	Weak	**Weak** 3 strong, 1 moderate, 2 weak
18	Cartwright Hatton et al. (2011)	Weak	Strong	Strong	Moderate	Strong	Strong	**Moderate** 4 strong, 1 moderate, 1 weak
19	Creswell et al. (2010)	Weak	Moderate	Weak	Moderate	Strong	Moderate	**Weak** 1 strong, 3 moderate, 2 weak
20	Leong et al. (2009)	Weak	Strong	Strong	Moderate	Strong	Weak	**Weak** 2 strong, 1 moderate, 2 weak
21	Waters et al. (2009)	Moderate	Strong	Weak	Moderate	Strong	Moderate	**Moderate** 2 strong, 3 moderate, 1 weak
22	Eisen et al. (2008)	Moderate	Weak	Weak	Moderate	Strong	Strong	**Weak** 2 strong, 2 moderate, 2 weak
23	Lyneham & Rapee (2006)	Weak	Strong	Strong	Moderate	Strong	Weak	**Weak** 3 strong, 1 moderate, 2 weak
24	Neuhoff et al. (2006)	Weak	Weak	Weak	Moderate	Strong	Strong	**Weak** 2 strong, 1 moderate, 3 weak
25	Rapee et al. (2006)	Moderate	Strong	Strong	Moderate	Strong	Moderate	**Strong** 3 strong, 3 moderate, 0 weak
26	Santacruz et al. (2006)	Weak	Strong	Weak	Moderate	Weak	Weak	**Weak** 1 strong, 1 moderate, 4 weak
27	Thienemann et al. (2006)	Weak	Moderate	Weak	Weak	Strong	Strong	**Weak** 2 strong, 1 moderate, 3 weak

28	Raleigh (2001)	Weak	Weak	Weak	Moderate	Strong	Strong	**Weak** 2 strong, 1 moderate, 3 weak
29	Stone (2000)	Weak	Weak	Weak	Moderate	Strong	Strong	**Weak** 2 strong, 1 moderate, 3 weak
30	Mendlowitz et al. (1999)	Weak	Strong	Strong	Moderate	Strong	Strong	**Strong** 4 strong, 1 moderate, 1 weak
	TOTAL	0/29 (0%) strong, 5/29 (17.2%) moderate and 24/29 (82.8%) weak ratings	18/29 (62.1%) strong, 4/29 (13.8%) moderate and 7/29 (24.1%) weak ratings	16/29 (55.2%) strong, 0/29 (0%) moderate and 13/29 (44.8%) weak ratings	0/29 (0%) strong, 25/29 (86.2%) moderate and 4/29 (13.8%) weak ratings	27/29 (93.1%) strong, 0/29 (0%) moderate and 2/29 (6.9%) weak	14/29 (48.3%) strong, 8/29 (27.6%) moderate and 7/20 (24.1%) weak ratings	**4/29 (13.8%) strong, 6/29 (20.7%) moderate and 19/29 (65.5%) weak ratings**

Global Ratings Key: Weak = two or more weak component ratings; Moderate = one weak component rating; Strong = no weak component ratings

Anxiety Disorder Diagnosis

Of the 29 eligible studies, 23 reported change in children's diagnostic status as a primary outcome using the Anxiety Disorders Interview Schedule for Children (ADIS) (Silverman et al., 2001) to establish diagnosis and assess changes in diagnostic status. Seventeen studies utilised both parent and child versions, whilst the remaining six used only the parent version of this semi-structured diagnostic interview.

Of the eight studies comparing at least one treatment to a waitlist control group, only one found that a CBT intervention, delivered online, was not significantly superior to controls (Donovan & March, 2014); all others reported significant changes to children's diagnostic status after receiving a CBT intervention (Cartwright-Hatton et al., 2011; Cobham et al., 2017; Lyneham & Rapee, 2006; Rapee et al., 2006; Smith et al., 2014; Thirlwall et al., 2013; Waters et al., 2009). Four of these interventions involved face-to-face sessions with parents, two used multiple methods of treatment delivery and one study solely used bibliotherapy materials (Rapee et al., 2006).

Eight studies reported diagnostic change when comparing two or more interventions; comparison interventions were heterogeneous. Four studies found that the interventions did not significantly differ from each other; each condition was associated with recovery from anxiety diagnoses (Chavira et al., 2014; Hiller et al., 2016; Lebowitz et al., 2020; Leong et al., 2009). Three studies found that one intervention resulted in better diagnostic outcomes than another: 1) individual CBT was superior to group CBT and guided parent-delivered CBT for specific phobia only (McKinnon et al., 2018), 2) therapist-assisted bibliotherapy was superior to self-directed bibliotherapy (Chavira et al., 2018), and 3) prescriptive treatment relevant to specific child or parent characteristics was superior to non-prescriptive treatment (Neuhoff, 2006).

The seven studies reporting diagnostic change post-treatment without a comparator or control group found that the intervention was effective (Brown et al., 2017; Creswell et al., 2010; Eisen et al., 2008; Esbjørn, 2016; Mayer-Brien et al., 2017; Raleigh, 2001; Thienemann et al., 2006).

All 21 studies describing changes in the severity of anxiety diagnosis reported reductions in severity scores over time. Fifteen studies reported statistically significant reductions in severity scores; the remaining six did not report levels of significance.

Parent-Rated Symptoms of Child Anxiety Disorder

Nineteen of the 29 studies collected pre- and post-data from parents regarding child anxiety symptoms. Seven different parent-rated outcome measures were used across the 18 studies; most commonly used was the parent version of Spence Children's Anxiety Scale (SCAS; n=8) (Spence, 1998). Three studies reported mother and father data separately (Cobham et al., 2017; Esbjørn, 2016; Lyneham & Rapee, 2006). Generally, both parents from the same family were included.

Of the 19 studies, 14 reported statistically significant changes between pre- and post-scores on parent-rated measures of child anxiety. Of ten studies comparing at least one treatment to a control group, seven reported a statistically significant reduction in child anxiety symptoms after receiving the intervention (Cartwright-Hatton et al., 2011; Donovan & March, 2014; Lyneham & Rapee, 2006; Özyurt et al., 2016; Rafihi-Ferreira et al., 2018; Rapee et al., 2006; Santacruz et al., 2006). One study found a significant change in scores reported by mothers but not fathers (Cobham et al., 2017).

A random effects meta-analysis was conducted on eight studies comparing intervention to a waitlist control group (Figure 2). A small but significant total effect size

was demonstrated (*g* =-0.48, 95% CI -0.90- 0.07, *z* =2.28, p =0.02), with high heterogeneity (Q =48.06, df =8, I^2 =83%).

Three studies comparing a parent-only intervention with another active treatment found significant reductions over time in parent-rated symptoms for all treatment conditions (Chavira et al., 2014; Hiller et al., 2016; Lebowitz et al., 2020). Consequently, a meta-analysis on five studies comparing a parent-only intervention with another treatment (Figure 3) did not demonstrate a significant treatment effect (*g* =0.13, 95% CI -0.08-0.34, *z* =1.22, p =0.22), although there was a slight preference for the comparison intervention. A low level of heterogeneity was identified (Q =5.02, df =4, I^2 =20%). Three studies reporting parent-rated outcomes were not included in any meta-analysis due to insufficient data regarding scores or parent sample size (Brown et al., 2017; Lyneham & Rapee, 2006; Özyurt et al., 2016).

The four studies without a comparator or control group reporting on parent-rated outcomes reported a significant reduction in child anxiety symptoms post-intervention. Calculated pre-test post-test effect sizes (Morris & DeShon, 2002) were large for three of these four studies (Table 5); however, it should be noted that sample sizes were small (Esbjørn, 2016; Mayer-Brien et al., 2017; Thienemann et al., 2006).

These findings suggest that parent-only interventions can be effective in reducing symptoms of child anxiety disorders as reported by parents.

Figure 2

Forest Plot for Parent-Rated Outcomes: Intervention vs. Waitlist Control

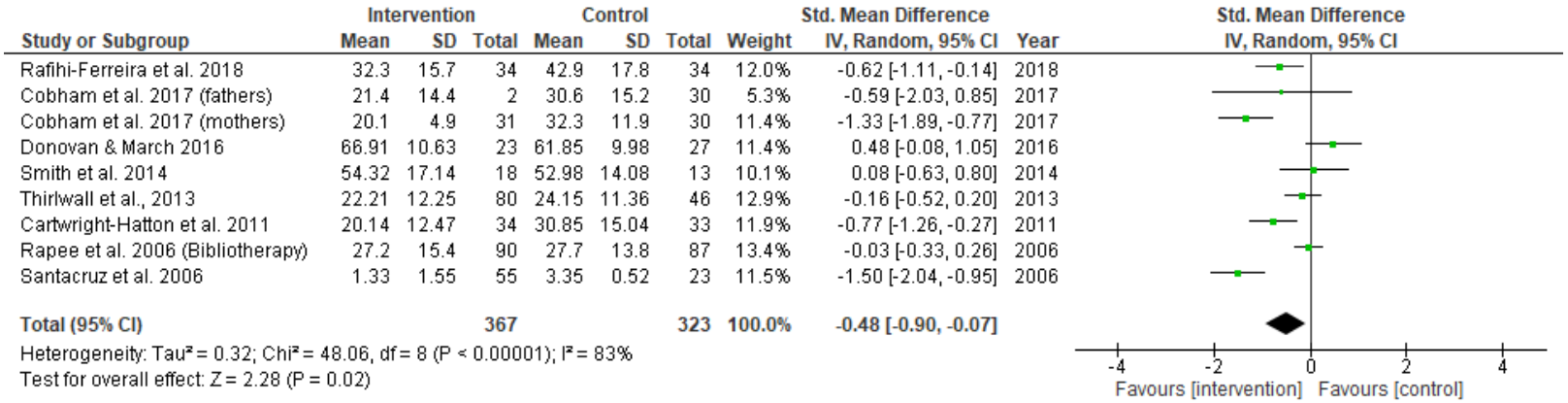


Figure 3

Forest Plot for Parent-Rated Outcomes: Comparing Two Interventions

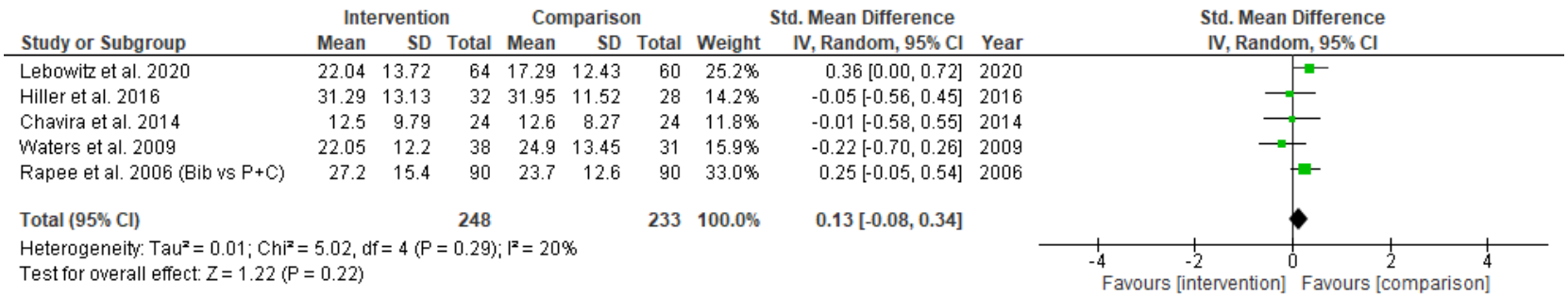


Table 5

Effect Size Calculations for Parent-Rated Outcomes: Uncontrolled Designs

Author (Year)	Pre Mean (SD)	Post Mean (SD)	Calculated Effect Size (d)
Mayer-Brien et al. (2017)	11.5 (1.48)	5.5 (3.90)	-4.054
Esbjørn et al. (2016) Mother ITT	35.15 (12.99)	19.65 (14.01)	-1.193
Esbjørn et al. (2016) Mother Completer	33.71 (12.87)	15.47 (9.60)	-1.417
Esbjørn et al. (2016) Father ITT	30.24 (10.84)	21.94 (10.16)	-0.765
Esbjørn et al. (2016) Father Completer	29.77 (12.34)	18.92 (9.61)	-0.878
Creswell et al. (2010)	36.46 (13.85)	29.71 (10.40)	-0.487
Thieneman et al. (2006)	66.46 (8.58)	58.54 (6.45)	-0.923

Child-Rated Symptoms of Child Anxiety Disorder

Of the 29 studies, 22 included child-reported symptoms of child anxiety disorders. Six different self-report measures were used across the 22 studies reporting pre- and post-child rated outcomes. The most commonly used child measures were the SCAS (n=7) (Spence, 1998) and the Revised Children's Manifest Anxiety Scale (RCMAS; n=7) (Reynolds & Richmond, 1978). Ten studies reported statistically significant reduction of child-reported anxiety symptoms at the end of the intervention (Chavira et al., 2014; Cobham et al., 2017; Creswell et al., 2010; Eisen et al., 2008; Esbjørn, 2016; Hiller et al., 2016; Lebowitz et al., 2020; Leong et al., 2009; Lyneham & Rapee, 2006; Özyurt et al., 2016). Three of these studies comparing two or more treatment conditions found significant reduction in symptoms across all conditions (Chavira et al., 2014; Hiller et al., 2016; Lebowitz et al., 2020).

A meta-analysis of seven studies comparing an intervention to waitlist controls did not reveal a statistically significant difference between groups for child-rated outcomes (*g*

=-0.16, 95% CI -0.40-0.08, *z* =1.29, p =0.20), with low heterogeneity (Q =11.79, df =9, I^2 =49%) (Figure 4).

Another meta-analysis of six studies comparing two active interventions did not reveal a statistically significant difference between groups (*g* = 0.16, 95% CI -0.04-0.36, *z* =1.58, p =0.11); again, results indicated that the comparison intervention was marginally more effective in reducing symptoms of anxiety. The level of heterogeneity was very low (Q =5.11, df =5, I^2 =2%) (Figure 5). Six studies reporting child-rated outcomes were not included in any meta-analysis because either mean scores or information regarding the sample size of each condition was not provided (Brown et al., 2017; Leong et al., 2009; Özyurt et al., 2016; Reuland & Teachman, 2014; Salari et al., 2018; Thienemann et al., 2006).

Calculated effect sizes for three of the four single group studies were large (Table 6), although again the sample sizes in these studies were small (Eisen et al., 2008; Esbjørn, 2016; Raleigh, 2001).

Table 6

Effect Size Calculations for Child-Rated Outcomes: Uncontrolled Designs

Author (Year)	**Pre Mean (SD)**	**Post Mean (SD)**	**Calculated Effect Size (d)**
Esbjørn et al. (2016)	36.50 (14.92)	21.00 (13.44)	-1.038
Creswell et al. (2010)	34.90 (14.23)	32.50 (11.86)	0.168
Eisen et al. (2008)	13 (4.28)	9 (0.81)	-0.934
Raleigh (2001)	13 (4.28)	9 (0.81)	-0.934

Figure 4

Forest Plot for Child-Rated Outcomes: Intervention vs. Waitlist Control

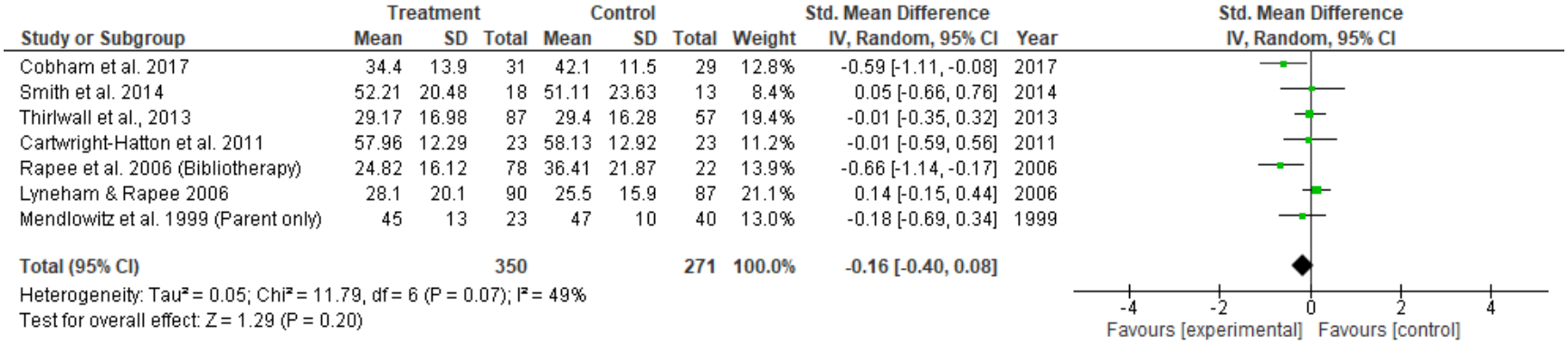
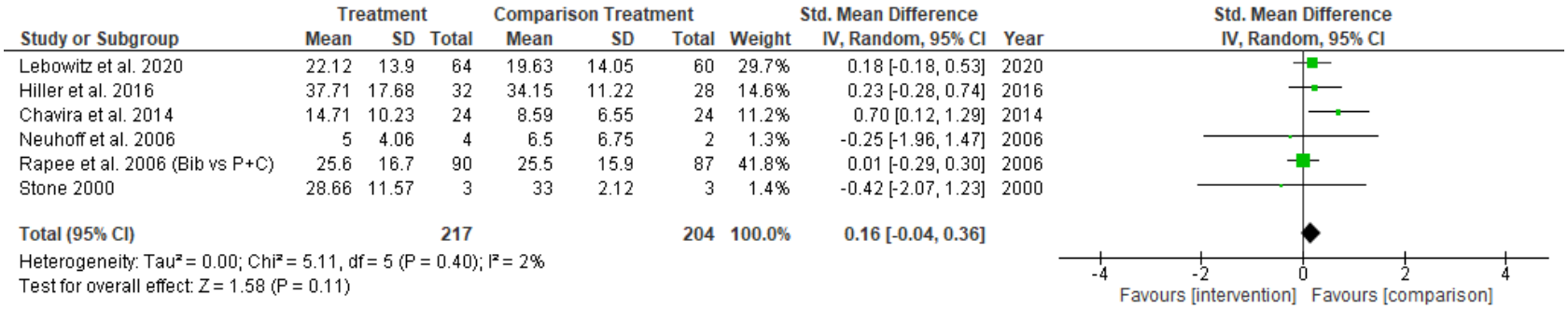


Figure 5

Forest plot for Child-Rated Outcomes: Comparing Two Interventions



The findings from child self-report measures did not find a significant treatment effect for parent-only interventions compared to waitlist controls. When compared with other interventions, such as child-focused CBT with or without parent involvement, or even a different parent-only intervention, results indicated that active treatments were marginally less effective than comparison interventions, although no significant differences between groups were found.

Follow Up

A total of 17 studies reported follow up outcome data; an additional study by Brown et al. (2017) reported a three- to five-year follow up using the sample originally described by Thirlwall et al. (2013). Eleven studies reported one follow up time point, varying from one, three, six or 12 months. Three studies included two follow up time points (Leong et al., 2009; Lyneham & Rapee, 2006; Waters et al., 2009) and three included three follow ups at three, six and 12 months (Cobham et al., 2017; McKinnon et al., 2018; Santacruz et al., 2006).

Fifteen studies reported follow up data on child anxiety diagnoses, 13 of which reported that diagnostic outcomes were maintained or improved at follow up (Brown et al., 2017; Cartwright-Hatton et al., 2011; Chavira et al., 2014; Cobham et al., 2017; Donovan & March, 2014; Eisen et al., 2008; Leong et al., 2009; Lyneham & Rapee, 2006; Mayer-Brien et al., 2017; Özyurt et al., 2016; Rapee et al., 2006; Thirlwall et al., 2013; Waters et al., 2009).

Sixteen studies reported follow up data on parent and/or child reported symptoms of anxiety disorders. Thirteen studies reported reductions in parent or child reported anxiety disorder symptoms which were maintained or improved at follow up (Brown et al., 2017; Cartwright-Hatton et al., 2011; Chavira et al., 2014; Donovan & March, 2014; Eisen

et al., 2008; Leong et al., 2009; Lyneham & Rapee, 2006; Mayer-Brien et al., 2017; Rafihi-Ferreira et al., 2018; Rapee et al., 2006; Reuland & Teachman, 2014; Santacruz et al., 2006; Stone, 2000). However, two studies found reductions in parent-reported scores were maintained from pre-treatment to follow up but not post-treatment to follow up (Rapee et al., 2006; Santacruz et al., 2006). Lyneham and Rapee (2006) found improvements in symptom reduction from post-treatment to follow up was reported by fathers and children but not mothers, whilst Cartwright-Hatton et al. (2011) noted a significant reduction in parent-reported scores at follow up in both treatment and control groups.

Three studies reported no significant change at follow up in parent and child-rated outcomes (Cobham et al., 2017; Smith et al., 2014; Thirlwall et al., 2013); two further studies reported no significant change over time in child self-report questionnaires (Cartwright-Hatton et al., 2011; Rapee et al., 2006).

Overall, these findings suggest that parent-only interventions can have long-term positive effects for reducing symptoms of child anxiety disorders.

Discussion

The aim of this systematic review and meta-analysis was to provide a comprehensive review of the quantitative evidence regarding parent-only interventions for child anxiety, specifically addressing the efficacy of these interventions in reducing symptoms of anxiety disorders in children. These aims were met; findings across the 29 studies included in this review demonstrated that parent-only interventions can be effective in reducing symptoms of child anxiety disorders, with improvements in symptoms generally maintained at follow up. However, no clear evidence was found for a superior type, duration or format of intervention.

The results of the meta-analyses demonstrated a small but significant treatment effect for parent-only interventions compared to waitlist controls in parent-rated outcomes but not child-rated outcomes. Calculated effect sizes were generally large for single group pre/post designs, although these studies typically involved smaller sample sizes. These findings support previous research; subgroup analyses from a Cochrane review indicated that CBT delivered in a group or parent/family format led to greater reduction in anxiety symptoms compared to waitlist control than individual child-focused CBT (James et al., 2020). Meta-analyses did not find a significant treatment effect for parent-only interventions when compared with another active treatment; evidence of reduced anxiety was apparent across all conditions although the comparison intervention was found to be slightly more effective. Comparatively, a meta-analysis of eight studies comparing parent and child CBT to individual child-focused CBT for child anxiety disorders found a small but significant treatment effect for interventions involving both parents and children ($g = 0.26$, 95% CI 0.05-0.47, $p < .05$) (Brendel & Maynard, 2013). The results from this review are consistent with findings from a recent meta-analysis of six RCTs investigating parent-only CBT interventions for child anxiety (Yin et al., 2021); five of which are included in this review. These findings complement the results of our narrative review. The four studies which received a global 'strong' rating on the EPHPP also reported results in line with the overall findings of this review (Hiller et al., 2016; Mendlowitz et al., 1999; Özyurt et al., 2016; Rapee et al., 2006). However, the results of the meta-analyses should be interpreted with caution due to the small number of studies included in each analysis (minimum n=5, maximum n=8).

The review highlighted variations within results across diagnostic, parent-rated and child-rated outcomes, reported in 15 studies. For example, studies may have reported statistically significant change in diagnostic status but non-significant changes in parent

and/or child rated symptoms (or vice versa). A discrepancy between parent- and child-reported outcomes was also identified: a significant treatment effect was only found for parent-rated outcomes and over 70% of parent-rated outcomes showed significant change post-treatment compared to 50% of child-rated outcomes. This is consistent with previous research highlighting limited agreement between parent and child measures of anxiety (Engel et al., 1994). The reasons for this are unclear. It may be that parent and child perceptions of child anxiety differ, leading to over- or under-reporting of symptoms (Barbosa et al., 2002). Children may be unable or unwilling to accurately describe their own level of anxiety (Thienemann et al., 2006). Child questionnaire measures may lack sensitivity to change (Salari et al., 2018) or these findings may be linked to self-reporting biases demonstrated by the use of questionnaires.

Strengths and Limitations

Studies included in this review were subject to language bias because only those written in English were included. Only quantitative studies were included in this review to ensure meaningful synthesis of the results; the addition of quantitative data from mixed methods papers could have enhanced the findings. Unpublished dissertations were included in the search results to reduce publication bias.

Many studies included in the review were assigned a ‘weak’ global rating for methodological quality using the EPHPP. The EPHPP is a widely used risk of bias checklist; however, the global rating may not provide a completely accurate description of methodological rigour. One study, which received a global ‘weak’ rating (Salari et al., 2018), received two ‘weak’ ratings but four ‘strong’ ratings at the component level. This suggests that the overall rating criteria are extremely strict with studies only receiving a global rating of ‘strong’ if none of the components are rated as ‘weak’.

A strength of this review was the varied nature of included studies. Published studies and unpublished dissertations were included, capturing a range of study designs and interventions, with primary outcomes at both diagnostic and symptom level. Author descriptions of study design were varied, as such CONSORT guidelines (Eldridge et al., 2016) were required to define study methodology.

Clinical Implications and Future Research

The evidence presented in this systematic review suggests that parent-only interventions can be effective treatments for reducing child anxiety. This is particularly important in the context of the NHS Long Term Plan (NHS England, 2019) which aimed to improve access and waiting times for psychological support in children and young people's mental health services: parent-only interventions typically require less time and resources than the alternative of individual child-focused therapy. The efficacy of parent interventions in reducing symptoms of child anxiety disorders provides support for the stepped care model of mental health, demonstrating that low intensity, efficient interventions can lead to positive clinical outcomes.

Future research should consider consistency in the measurement of child anxiety symptoms, as a wide range of outcome measures were utilised across the studies included in the review. This research could support the completion of further meta-analyses in this area. It would also be beneficial to investigate the discrepancy between parent and child reported outcomes on measures of child anxiety symptoms. The interventions included in this review were relatively heterogeneous in terms of the type, length, therapist contact and duration. It would be beneficial for future research to investigate the acceptability of parent-only interventions to identify which intervention may be best to offer parents in clinical practice.

Only a small number of included studies used translated and/or culturally adapted materials; it would be important for further research to challenge the limited cultural variability of the evidence. Finally, a review of qualitative studies investigating parental experiences of these interventions would provide a valuable contribution to the literature.

Conclusions

To date, this is the first systematic review and meta-analysis of the efficacy of parent-only interventions for reducing symptoms of child anxiety disorders. The review provides an important contribution to the literature by demonstrating that low intensity interventions for parents can have a positive impact on clinical outcomes and reduce symptoms of anxiety disorders in children. Evidence suggests that these positive clinical outcomes for children can be maintained or improved over time beyond the completion of the intervention. The findings of this review should be considered in the context of improving access to psychological support in family and children's services.

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*Asterisk indicates studies included in this review.

Paper 2

The feasibility and acceptability of a brief cognitive behavioural group intervention for parents of young children experiencing mild to moderate anxiety

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Abstract

Parent-only interventions can be effective treatments for child anxiety. Involving parents in treatment may be beneficial for young children, ensuring that interventions are delivered effectively in a supportive environment. Few studies have investigated the feasibility and acceptability of parent-only interventions for child anxiety. In this study, we report on feasibility, acceptability and preliminary clinical outcomes of a brief cognitive behavioural group intervention for parents of children (4- to 10-years-old) experiencing mild to moderate anxiety. Parent participants attended a three-session group intervention delivered online. We collected feasibility information (recruitment and retention rates); parents and children (where appropriate) completed acceptability and clinical outcome measures after each session. Participants attended interviews regarding the acceptability of the intervention and study processes. Participant retention rates (76.47%) and intervention satisfaction were high. Qualitative analysis of interview data identified benefits such as connecting with parents and learning strategies, as well as challenges associated with the intervention. Attendance appeared to be associated with positive changes for parents and children. Overall, participants found this to be an acceptable and useful intervention. These findings demonstrated the potential benefit of a brief intervention for parents of anxious children. A larger trial is required to further investigate these preliminary findings.

Keywords: *Parent-only, Treatment, Child Anxiety*

Introduction

Children and young people are increasingly affected by mental health problems, with 8% of 5- to 19-year-olds in the United Kingdom (UK) experiencing an emotional disorder, such as anxiety, depression or bipolar disorder (NHS Digital, 2017). Anxiety disorders are the most commonly reported, with a worldwide prevalence rate of 6.5% (Polanczyk et al., 2015). In the UK, anxiety disorders affect 3.9% of 5- to 10-year-olds and 7.9% of 11- to 16-year-olds (NHS Digital, 2017). However, the true prevalence of anxiety problems is likely to be much higher since these figures fail to include children and young people who do not access mental health services.

Anxiety disorders are typically characterised by excessive, persistent feelings of fear and worry which create significant distress and have a negative impact on daily functioning (American Psychiatric Association, 2013). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) (American Psychiatric Association, 2013) includes panic disorder, agoraphobia, generalised anxiety disorder, specific phobia, social anxiety disorder, separation anxiety disorder and selective mutism within the criteria for anxiety disorders. Anxiety disorders can have a negative impact on children's academic ability, social functioning and general family life (Nail et al., 2015; Settipani & Kendall, 2013; Towe-Goodman et al., 2014) and have been associated with later development of mental health problems (Bittner et al., 2007).

Cognitive Behavioural Therapy (CBT) is an effective treatment for childhood anxiety. A Cochrane review of 88 randomised controlled trials (RCTs) investigated the efficacy of CBT for anxiety disorders in children and adolescents (James et al., 2020). Within this review, a meta-analysis of 39 studies demonstrated a response rate for remission of primary anxiety diagnosis of 49.4% for CBT compared to 17.8% in waitlist controls. Eleven of the 39 studies focused specifically on younger children aged 12 years

and under; all 11 studies found that CBT was effective, resulting in remission of anxiety diagnoses and reduction in child anxiety symptoms. However, the overall findings from the Cochrane review were inconclusive with regards to the superiority of CBT over other interventions, attention control or treatment as usual (James et al., 2020). Furthermore, due to increasing demands on psychology services, CBT is not widely available to all who may need it, particularly children with mild to moderate anxiety. These findings suggest that alternative interventions to child-focused CBT may also be needed.

Children typically rely on parents to seek help on their behalf, yet parents report barriers to accessing psychological help for their child, such as lack of knowledge about where and how to get help, long waiting lists, limited-service provision and difficulty in recognising the existence of a problem. According to Reardon et al. (2017), one of the most commonly reported barriers is perceived social stigma and perceived negative attitudes from others. Some parents believe their children are more likely to experience and be negatively impacted by stigma, suggesting that parents may prefer to attend an intervention which does not directly involve their child (Dempster et al., 2013).

A feasible alternative to child-focused CBT may be brief, low intensity interventions exclusively for parents. This approach is consistent with National Institute for Health and Care Excellence guidelines (NICE, 2013); family involvement in the treatment of child anxiety can create a supportive environment and ensure that interventions are delivered effectively, particularly with young children. The role of parents is especially important in the treatment of young children who would struggle to engage in child-focused CBT due to their developmental stage and the level of engagement required to create change (Minde et al., 2010).

Low intensity interventions are typically brief in nature and can be delivered in groups, making them less costly in terms of time and resources. As well as potential cost-

effectiveness, group interventions can help reduce feelings of isolation as participants hear other's experiences of similar difficulties, providing the opportunity for peer support and connection (Yalom & Leszcz, 2005). Low intensity interventions may be particularly well-suited to parents because longer, more intensive interventions would place a high burden on parents who are likely to have other family commitments and priorities (Tully & Hunt, 2016). Brief interventions could therefore improve accessibility and facilitate parent engagement with psychological support for their child.

Parent-only interventions can be effective treatments for child anxiety (for a systemic review and meta-analysis, see Jewell et al., under review). Typically, these interventions involve attending face-to-face sessions delivered in a clinical setting, or accessing self-help materials with or without additional support from a therapist. In a recent meta-analysis of six RCTs investigating the efficacy and acceptability of parent-only CBT for anxiety disorders in children and adolescents (Yin et al., 2021), parent-only CBT was significantly more effective than waitlist control for reducing child anxiety symptoms (*g* =-0.72, 95% -1.41-0.03, p = 0.04). However, acceptability of parent-only CBT was not significantly different to waitlist control (RR 0.92, 95% CI 0.53-1.62, p =0.77) and was significantly worse than parent and child CBT (RR 1.93, 95% CI 1.05-3.57, p=0.03). Two studies included in the meta-analysis focused on younger children under the age of 9 years old. Yin et al. (2021) found that attrition was higher for parent-only CBT compared to CBT involving both parents and children.

Very few other studies have specifically investigated the feasibility and acceptability of parent-only interventions for child anxiety (Chavira et al., 2014, 2018; Creswell et al., 2010; Lebowitz et al., 2014). These studies demonstrated that interventions were feasible and acceptable to parents, dropout rates were low and parents reported high satisfaction as well as improvements in child anxiety symptoms. However, each of these

studies identified eligible children as meeting diagnostic criteria for anxiety disorders and only one previous study focused specifically upon children under the age of 12 years old (Creswell et al., 2010).

As such, there is a gap in the research regarding brief interventions delivered as an early intervention for parents of young children with mild to moderate anxiety. Interventions for young children experiencing anxiety are important in order to prevent problems escalating into adolescence and adulthood. Interventions involving parents may be particularly valuable for younger children due to the significant influence of parents on child development and the opportunities for parents to utilise anxiety management strategies consistently through routine activities and interactions (Mahoney & Wiggers, 2007).

There is a need for studies to explore feasibility and acceptability during development and refinement of any intervention (Craig et al., 2008); this process may be particularly important with interventions for parents in relation to the reported barriers to accessing support and high demands for busy parents. The purpose of the present study was to investigate the feasibility and acceptability of a brief, cognitive behavioural group intervention for parents of young children experiencing mild to moderate anxiety. The intervention was offered in community settings with the intention of increasing accessibility and reducing any potential stigma for both parents and children. The aims of the study were:

1) to examine the feasibility of recruiting, engaging and retaining parents of children experiencing mild to moderate anxiety in a brief cognitive behavioural group intervention,
2) to investigate parents' views on the acceptability of the intervention and outcome measures and

3) to explore the potential clinical benefits associated with receiving the intervention in terms of anxiety symptoms in children reported by parent participants.

Method

Design and Ethical Approval

This study used an uncontrolled pre-post design to investigate the feasibility and acceptability of a brief cognitive behavioural group intervention. Ethical approval was obtained from the University Research Ethics Committee (Ref: 2020-7825-12919; see Appendix C). All participants were offered written information on the study prior to taking part and provided written, informed consent.

Inclusion Criteria

Inclusion criteria were parents of primary school children aged between 4 and 10 years old, who reported their child to be experiencing mild to moderate anxiety as indicated by T-scores of 60 or above on the Preschool Anxiety Scale (Spence et al., 2001) for parents of children aged 4- to 6-years-old, or the Spence Children's Anxiety Scale – Parent version (SCAS-parent; Spence, 1998) for parents of children aged 7- to 10-years-old. T-scores of 60 represent subclinical or elevated levels of anxiety (Spence, 1998). Due to the nature of the intervention, proficiency in English was required and parents with an existing diagnosis of a learning disability were excluded. Parents whose children had a prior diagnosis of Autism Spectrum Disorder were excluded from the study. It was also necessary for parents to have the use of an electronic device and access to the internet in order to participate.

Recruitment

Participants were recruited between 3 March and 10 December 2020. Two schools which differed in terms of their size, location and socio-economic status of pupils were identified to support recruitment. Due to school closures in response to the Covid-19 pandemic, only one school continued to support recruitment between March and September 2020. Other primary schools, children's centres, out of school clubs, children's sports clubs, girl guides and scouting groups were contacted between July and September 2020. Study information, including a poster, participant information sheet (Appendices D & E), recruitment email and social media text, was shared with potential participants via existing structures within the organisation (e.g., newsletter, email, social media, blog post).

Feasibility Outcomes

Feasibility Statistics. Feasibility was determined according to recruitment data (participants expressing interest, eligibility, rate of recruitment) and participant retention (number of sessions attended, number of participants who did not complete the study).

Client Satisfaction. Participants were asked to complete the 8-item Client Satisfaction Questionnaire-8 (CSQ-8; Larsen et al., 1979; Appendix F) which is widely used across mental health services to assess satisfaction with care and support. Responses are based on a scale from 1-4 with higher scores indicating higher satisfaction. Total scores range from a minimum of 8 to a maximum of 32. The CSQ-8 is highly reliable, valid and standardised (Attkisson & Zwick, 1982). For this study, Cronbach's alpha was 0.77.

Clinical Outcomes

The Preschool Anxiety Scale (PAS; Spence et al., 2001; Appendix G). The PAS is a questionnaire, completed by the parent, identifying anxiety symptoms in children aged

2.5 to 6.5 years old. The 28 items provide an overall measure of anxiety representing five anxiety subtypes: generalised anxiety disorder, social phobia, obsessive compulsive disorder, physical injury fears and separation anxiety. Responses are based on a 4-point scale from 0-3. Only the total score was used in the present study; higher scores indicate higher anxiety, with scores ranging from 0-112. The PAS has been found to have good construct validity, internal consistency and reliability (Spence et al., 2001).

The Spence Children's Anxiety Scale–Parent (SCAS-parent; Spence, 1998; Appendix H). The 38-item SCAS provides both a total anxiety score and six subscale scores. In addition to the five subtypes captured by the PAS, 'panic attack and agoraphobia' is included. Only the total score was used in the present study. Scores range from a minimum of zero to a maximum possible score of 114. The parent version of the SCAS has good reliability and validity (Nauta et al., 2004). Cronbach's alpha for this study was 0.70.

The Spence Children's Anxiety Scale (SCAS-child; Spence, 1998; Appendix I). The SCAS is a child self-report measure which also aims to assess symptoms relating to six subtypes of anxiety. It consists of 44 items, mirroring the SCAS–parent version with the exception of six positive filler items (e.g., "I am good at sports"). Cronbach's alpha for this study was 0.71.

The Child Adjustment and Parent Efficacy Scale (CAPES; Morawska et al., 2014; Appendix J). The CAPES is a self-report questionnaire identifying parents' self-efficacy in managing their child's behavioural and emotional difficulties. Parents' beliefs about their ability to parent effectively have been linked to child functioning and outcomes (Jones & Prinz, 2005). Higher scores indicate greater levels of emotional or behavioural difficulties in children. Separate scores are available for the four subscales of behaviour, emotion, intensity and efficacy. Scores for behavioural problems range from 0-72 and

emotional problems scores range from 0-9. The intensity score (sum of emotional and behavioural problems) has a maximum score of 81. The parent efficacy score represents the total of parent confidence ratings in managing emotional and behavioural difficulties with scores ranging from 19-190 and higher scores indicating greater levels of parent efficacy. A systematic review of 34 outcome measures suggested the use of the CAPES with parents of school aged children due to the quality of its psychometric properties (Wittkowski et al., 2017). The CAPES has been found to have good internal consistency and validity (Morawska et al., 2014). In this study, Cronbach's alpha for intensity scores was 0.73 and efficacy scores was 0.84.

Permission was sought and granted from the authors of the PAS, SCAS and CAPES to develop an online survey format of the questionnaire measures, using the Select Survey application at the University of Manchester.

Qualitative Outcomes

Participants were asked to complete a brief, bespoke, written evaluation questionnaire on completion of the intervention (Appendix K). All participants were offered the opportunity to participate in a semi-structured interview, conducted by the first author (CJ) who also delivered the intervention. The aim of the interview and evaluation form was to gather preliminary data regarding the intervention's acceptability, its delivery format and the suitability of the outcome measures. As such, the content of the interview topic guide and evaluation form was informed by literature on the feasibility of interventions and evaluation of parent interventions, discussions within the research team, and previous experiences of evaluating interventions. Participants were asked to identify any barriers/difficulties to attending and engaging in the intervention, as well as any future recommendations.

Procedure

Interested parents were asked to contact the research team directly and were then provided with further information about the study. If they decided to take part, participants were assigned a unique identifier code and their eligibility was assessed. Participants were asked to complete a consent form (Appendix L), a family background questionnaire (Appendix M) for demographic information and the PAS or SCAS-parent version as a screening tool depending on the child's age. All participants received an email indicating their eligibility status for the study; those who were not eligible were provided with recommendations for self-help books (e.g. "Overcoming your child's fears and worries: A self-help guide using cognitive behavioural techniques" by Cathy Creswell and Lucy Willetts) and information for further support (e.g. Place2Be, NHS Direct, Mind). Eligible participants received an email invitation to attend the intervention, delivered via the online videoconferencing platform Zoom. Participants were allocated to intervention groups on a first come first served basis, regardless of demographics (e.g. child age, school, parent/child gender). The intervention was delivered after a recruitment period of six weeks with the aim of maximising participant retention to the study. Recruitment to the study continued until a sufficient number of participants had completed the intervention to provide a meaningful analysis of the data, in line with sample sizes from previous feasibility studies investigating interventions for child anxiety (Comer et al., 2012; Jolstedt et al., 2018).

The intervention was offered at different times e.g., morning and evening, to facilitate engagement. Intervention dates were fixed prior to recruitment to prioritise the certainty of intervention delivery. To reduce attrition, delivery of the intervention was not dependent on participant numbers; as such, the intervention went ahead as planned if at least one participant had been recruited.

Parent participants were asked to complete either the PAS or SCAS-parent version, CAPES and CSQ-8 after each intervention session. Parents of children aged 7 years old and over were also asked to encourage their child to complete the SCAS-child questionnaire independently after each intervention session, offering support when required. At the end of the intervention, participants were asked to complete an evaluation questionnaire. Email reminders were sent by the researcher to the participants between sessions to encourage completion of questionnaires. Following completion of the intervention, participants were offered a £10 e-voucher thanking them for their time. Participants were also debriefed and provided with contact details for local services, should they need further support.

All participants were invited to attend an interview within four weeks of completing the intervention to gain more detailed information regarding acceptability. Interviews were led by a topic guide (Appendix N). Participants received written information about this aspect of the study and were asked to provide additional written confirmation of consent to be interviewed.

Intervention

The brief cognitive behavioural group intervention, developed by SC, was designed to be delivered over three sessions, totalling 5½ hours. It was decided that the intervention should be brief to maximise parent engagement and improve cost-effectiveness in line with NHS focus on providing efficient, high quality care (NHS, 2017). Sessions were delivered fortnightly over a six-week-period.

The development of the intervention was informed by NICE guidelines which identify CBT as the primary therapeutic intervention and recommend working collaboratively with parents in the treatment of child anxiety (NICE, 2013). The content of

the intervention was influenced by existing CBT interventions for parents of children experiencing anxiety (Cartwright-Hatton et al., 2010; Creswell & Willetts, 2007) as well as literature on attachment and parenting (Golding & Hughes, 2012).

It was initially planned to deliver the intervention in primary schools. Although there is limited evidence for parent-only interventions delivered in educational settings, the school environment was hypothesised to be a community setting where parents might feel more able to access support without perceived social stigma. However, the outbreak of COVID-19 and subsequent national lockdown across the UK in March 2020 removed the option of a face-to-face group. It was therefore decided to deliver the intervention online via a videoconferencing platform, consistent with the aim of improving accessibility of psychological support to parents. All groups were delivered by the same trained facilitator (CJ) who received training and supervision by SC. A fidelity checklist was developed to record treatment adherence. The structure and content of the intervention is described in Table 1.

Table 1

Structure and Content of the Intervention

Session	Content	Homework Tasks	Duration
Session 1: What is anxiety	Introduction/psychoeducation: • Discuss parents' aims, hopes and expectations • Introduction to anxiety • Explain fight or flight • Discuss chimp brain analogy • Discuss importance of meeting with parents using 'anxiety cake' analogy • Group activity - discuss signs, symptoms and triggers of anxiety in children • Discussion of what parents already do that helps CBT Formulation: • Discuss thoughts, feelings, behaviour cycle as a group using parent example Strategies: • Creating physical security (routine, boundaries, consistency) • Creating emotional security (playfulness, acceptance, curiosity and empathy; PACE) • Managing emotions (bubbles/balloons, newspaper punch, relax like a cat)	• Draw out basic CBT formulation for own child Practice strategies discussed during the session: • Creating physical security with routine, boundaries and consistency • Hearing worry with playfulness, acceptance, curiosity and empathy • Managing emotion with bubbles, balloons, newspaper punch and relax like a cat	2 hours
Session 2: Building on formulation and developing strategies	Introduction/psychoeducation • Recap of previous session and review of homework • Avoidance and maintenance of anxiety CBT formulation: • Discuss systemic CBT formulation as a group using parent example • Impact on parents and importance of self-care	Consider systemic CBT formulation Engage in own self-care activities Practice strategies discussed during session: • Praise and rewards • Spot warning signs and ask your child about their worries	2 hours

	Strategies: • Praise and rewards • Spotting anxious thoughts – talking to your child about anxiety • Evaluating thoughts using the worry tree • Problem solving • Thought challenging • Exposure to difficult situations • Discuss child's motivation to change	• Practice using the worry tree • Use 4-step problem solving • Evaluate anxious thoughts by weighing up the evidence • Help your child test out their fears by designing experiments or exposure to the situation	
Session 3: Review	Recap of previous session and review of homework Group discussion troubleshooting any difficulties implementing strategies Reflecting on positive changes	Continue to practice strategies from sessions 1 and 2	1.5 hours

Data Analysis

Descriptive statistical analysis was used to present information regarding the feasibility of intervention delivery and study procedures. Frequency statistics and percentages were calculated to establish recruitment rates, attendance and retention rates. Mean scores and standard deviations on the CSQ-8 were also reported.

Means and standard deviations were calculated for clinical outcome data. Pre-test post-test effect sizes (Cohen's *d*) were then computed (Morris, 2008) to provide preliminary information regarding any changes associated with receiving the intervention. Typically, d =0.2 represents a small effect, d =0.5 indicates a medium effect and d =0.8 represents a large effect size. Individual participant's pre and post scores were assessed for clinically significant change using the reliable change index (RCI); an RCI greater than 1.96 is indicative of clinically significant change (Jacobson & Truax, 1991).

Qualitative interviews were transcribed verbatim; transcripts and audio-recordings were then cross-checked for accuracy by the first author (CJ). Written evaluation forms and qualitative interview transcripts were analysed using thematic analysis (Braun & Clarke, 2006). NVivo 12 qualitative data analysis software was used to facilitate coding (QSR International Pty Ltd., 2018; see Appendix O for examples of coded transcripts). Familiarisation with the data began with the transcription itself; transcripts were then repeatedly read and any relevant thoughts and observations were noted. Initial codes identifying potential features, patterns and themes in the data were produced. These codes were then collated based on similarities or overlapping concepts, from which initial themes and subthemes were developed. Themes were then reviewed and refined in relation to the coded data. Broader main themes were developed and refined from the initial themes. All themes were agreed by the research team.

Reflexivity Statement

All authors were psychologists with previous experience of working with parents and families which is likely to have informed their assumptions and biases. The first author (CJ) facilitated the intervention and conducted and transcribed all interviews. This resulted in full immersion with the data; however, the potential for introducing bias is acknowledged. Participants were aware that the first author was a trainee clinical psychologist acting in the role of a researcher, which may have impacted their expectations and assumptions throughout the research process.

Results

Participant Characteristics

A total of 35 parents expressed an interest in participating in the study. Seven parents did not meet inclusion criteria because their children had additional needs (n=4), were outside of the study's age range (n=2) or presented with low levels of child anxiety (i.e., T-score <60; n=1). Three parents declined to participate and six parents did not complete eligibility screening questionnaires. Nineteen parents consented to take part; however, two participants did not attend any intervention sessions due to competing demands. Therefore, a total of 17 participants were included in the analysis. This demonstrates that 48.57% of those expressing an interest in the study were converted into study participants.

Participant characteristics are described in Table 2. The sample consisted of 14 mothers and three fathers. All participants self-identified as White British. The majority of participants were between 35-44 years of age (n =10, 58.82%) and were married or in a civil partnership (n=11, 64.70%). Children were 10 boys and seven girls from nine different schools in Greater Manchester and East Lancashire, with ages ranging from 4 to 9 years.

Table 2

Participant Characteristics

		N	%
Age	25-34	4	25.5
	35-44	10	58.8
	45-54	1	5.8
	Missing	2	11.7
Gender	Female	14	82.3
	Male	3	17.6
Ethnicity	White British	17	100
Child's age	Child's age M (SD)	6.41 (1.33)	
Child's gender (reported by parent)	Female	7	41.1
	Male	10	58.8
Relationship status	Single	1	5.8
	In a relationship/co-habiting	3	17.6
	Married/Civil Partnership	11	64.7
	Separated	1	5.8
	Divorced	1	5.8
Employment status	Full time	5	29.4
	Part time	6	35.2
	Student	1	5.8
	Unemployed	2	11.7
	Retired	1	5.8
	Missing	2	11.7
Previously offered/attended courses related to child's wellbeing	Yes	6	35.2
	No	11	64.7

Feasibility Outcomes

Recruitment. Nineteen of 35 parents (54.29%) expressing interest in the study consented to participate and 17 (89.47%) of those consenting actually took part. Participants were invited to attend one of eight groups delivered between March 2020 and February 2021. Four of the groups were delivered with just one participant (see Figure 1 for participant flow through the study). All 17 participants attending at least one intervention session were offered an interview after the intervention and 12 participants (70.58%) agreed to take part.

Retention. Frequencies and percentages for attendance and attrition are described in Table 3. Four participants only attended one session and as a result did not complete the intervention. Of these four participants, two reported work commitments as a reason for non-attendance and two participants did not provide reasons when contacted. Participants appeared engaged during the sessions, contributing during exercises and discussions, reflecting on homework tasks and sharing ideas. Of the 13 participants completing the intervention, 11 participants (84.61%) completed all questionnaire measures. The retention rates of over 70% for intervention completion and over 80% for questionnaire completion were considered to be high.

Table 3

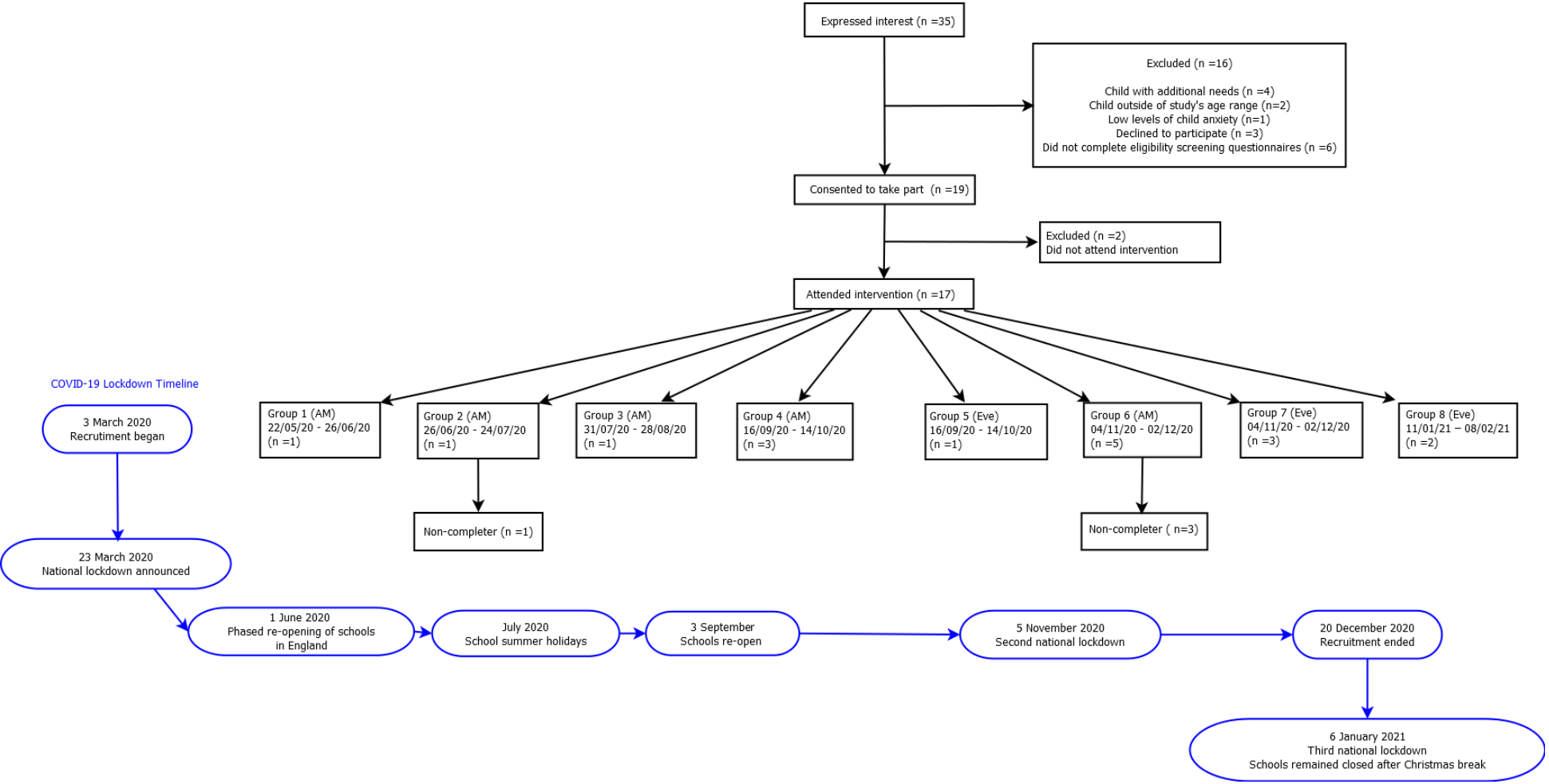
Retention Rates

		N	**%**
Overall attendance	Session 1	16/17	94.18
	Session 2	14/17	83.36
	Session 3	13/17	76.47
Attended 3/3 sessions		13/17	76.47
Non-completers (attended fewer than 2 sessions)		4/17	23.53

Treatment Fidelity. All intervention components were successfully delivered in all sessions across the eight intervention groups, as measured by the treatment fidelity checklist (Appendix P).

Figure 1

Flowchart of Participants Through the Study



Client Satisfaction Questionnaire. Mean CSQ-8 scores across the intervention are presented in Table 4. Session three obtained the highest satisfaction rating overall. The lowest scoring item was obtained in the first session for the question "to what extent has our service met your needs?" (2.93; SD = 0.73). The highest scoring items involved the quality of the service, overall satisfaction and recommending the service to a friend. Overall, scores on the CSQ-8 suggest that participants found the intervention to be acceptable.

Table 4

Mean Scores on CSQ-8

Item	**Mean (SD)**
1. How would you rate the quality of the service you received?	3.72 (0.46)
2. Did you get the kind of service you wanted?	3.59 (0.59)
3. To what extent has our service met your needs?	3.33 (0.74)
4. If a friend were in need of similar help, would you recommend our service to him or her?	3.69 (0.57)
5. How satisfied are you with the amount of help you received?	3.62 (0.54)
6. Have the services you received heled you to deal more effectively with your problems?	3.33 (0.53)
7. In an overall, general sense, how satisfied are you with the services you received?	3.69 (0.52)
8. If you were to seek help again, would you come back to our service?	3.56 (0.60)
Total mean score (out of a maximum of 32)	28.53 (3.80)
CSQ-8 completion: Session 1 n=14, Session 2 n=13, Session 3 n=12	

Clinical Outcomes

Mean scores, standard deviations and pre-test post-test effect sizes for clinical outcomes are presented in Table 5.

Table 5

Mean Scores and Effect Sizes for Clinical Outcomes

	Session 1			Session 2			Session 3			Effect Size
	N	Mean	SD	N	Mean	SD	N	Mean	SD	*d*
PAS	10	61.90	11.19	9	57.00	12.99	9	51.88	16.62	-0.90
SCAS parent	6	35.66	8.11	5	23.20	11.03	4	25.50	13.77	-1.25
SCAS child	5	31.20	15.10	3	33.00	22.91	4	24.25	13.40	-0.46
CAPES behaviour	16	27.56	10.41	13	22.38	11.53	12	23.83	11.06	-0.36
CAPES emotional	16	5.31	1.62	13	4.00	2.04	12	3.91	1.62	-0.86
CAPES Intensity	16	32.87	9.99	13	26.38	12.48	12	27.75	11.88	-0.51
CAPES Efficacy	16	114.43	46.58	13	132.15	50.54	12	137.25	23.57	0.49

ES = effect size, PAS = Preschool Anxiety Scale; SCAS = Spence Child Anxiety Scale, CAPES = *Child Adjustment and Parent Efficacy Scale*

Scores on both parent and child rated outcome measures reflected a reduction in child anxiety from session one to session three. More than half of participants (53.85%) showed improvement in terms of reduced T-scores on the PAS or SCAS-parent version. Almost a quarter of participants (23.08%) obtained a T-score of less than 60 post-intervention. However, no individual participant scores on the PAS, SCAS-parent and SCAS-child reached the threshold for clinically significant improvement when assessed using the RCI (Jacobson & Truax, 1991; Appendix Q).

Calculated effect sizes (Morris, 2008) were large for parent-rated outcomes (PAS *d* =-0.90; SCAS-parent *d* =-1.25), and a small to moderate effect size was found when measuring child self-reported anxiety (SCAS-child *d* =-0.46). The effect size for children's behavioural problems was small (*d* =-0.36) and a large effect size was found when

measuring children's emotional problems (*d* =-0.86). The effect size for the magnitude of change in total intensity was moderate (*d* =-0.51). Parents reported increased confidence/efficacy across all three sessions with a small to moderate effect size (*d* =0.49).

Qualitative Outcomes

Two main themes were identified following analysis of 12 interviews: benefits as well as challenges associated with the intervention (see Appendix R for additional quotes). Nine sub-themes within these main themes were identified (Figure 2).

Theme 1: Benefits Associated with the Intervention

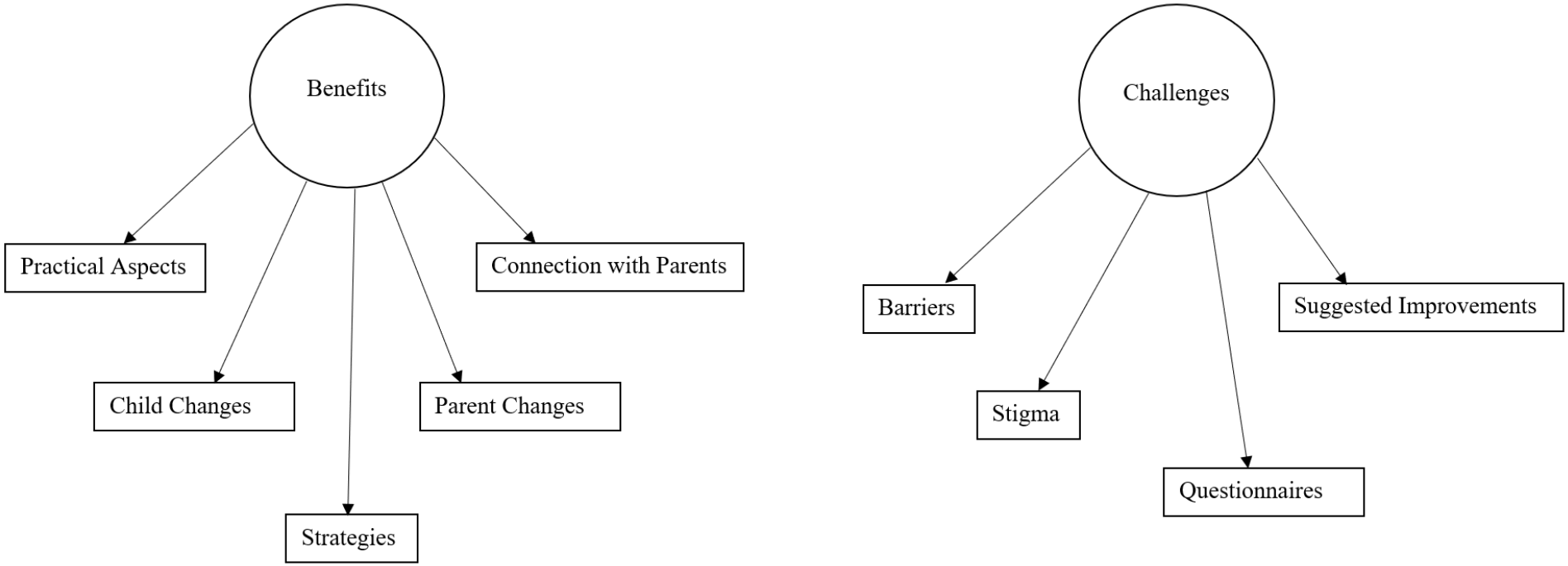
Practical Aspects. Participants commented on the informal, friendly atmosphere of the group, with parents explaining that the interactive nature facilitated their engagement and gave them the opportunity to talk about their concerns and difficulties. Participants found the length, pacing and time between sessions acceptable. Participants commented that they did not feel overwhelmed by information because the content was pitched at the right level.

Participants reported that attending the intervention from their own homes via Zoom was highly convenient. Some parents described feeling more comfortable and relaxed at home.

"It's so convenient because you don't have to go anywhere, erm…I think, it was…yeah as I say we're-we're time poor, we don't have to get a sitter or you know…that's a barrier for us sometimes, erm…it having to go somewhere is even more effort, erm so yeah it was very convenient." Participant 1429.

Figure 2

Diagrammatic Representation of Themes



Strategies. Participants reflected on the simplicity of the strategies which meant that they were accessible and easy to use without needing to refer to a manual or the use of any special tools. Parents found it relatively easy to incorporate the strategies learned during the intervention into their daily lives. Several parents reflected on sharing their learning with their partners and the importance of working together as a team. All participants who completed the intervention stated that they would continue to use the strategies in the future. The strategies described most frequently by participants were physical strategies for managing emotions (breathing and relaxation), developing skills in talking to their child about anxiety and using the worry tree.

"You know after the first session, it-it was work it really worked, don't wanna say oh it-it was a miracle you know but, just doing things slightly different had a very, quick effect on things getting better which, made things improve and made you wanna do more of it." Participant 1758.

Connection with Other Parents. All participants who attended the intervention with at least one other parent commented on the value of hearing other parents' experiences and sharing learning with each other, resulting in participants feeling less isolated with the difficulties they were experiencing with their child. Those who were the only participant in the intervention reflected on the potential benefits of learning from other parents in a group environment.

"It was also really supportive to have those other parents there, in similar situations going through similar experiences, that had such a massive effect on me more than I expected it to because, I found erm, I found it really reassuring to know that I wasn't alone." Participant 1397.

Parent Changes. All participants identified changes which they attributed to the intervention: improved understanding of anxiety and its impact, an increased awareness

and ability to recognise signs of anxiety and improved confidence in managing their child's anxiety. Some participants described developing a new perspective and a different way of thinking about their child's anxiety. Several participants described a new ability to remain calm when supporting their child to manage their anxiety, thinking about their response rather than reacting automatically. Participants recognised that they would not have felt empowered in this way if their child had attended an intervention with minimal parent involvement, or with no parent involvement at all. Some parents also reported that their own anxiety had reduced.

"I definitely feel calmer about the situation and when he's starting up into anxiety that would quite often make me feel (intake of breath) 'oh no it's happening again' you know so now I tend to take a step back from that and go okay and I'll just give myself a minute and give him a minute, to just get, to get there, err and to have that moment." Participant 1968.

Child Changes. All participants who completed the intervention noticed positive changes related to their child's mood and behaviour: a reduction in child anxiety and an improved ability to initiate or engage in conversations about fears and worries.

"I'm still waiting for the CAMHS referral so, but I don't feel like we need it now really." Participant 1586.

Theme 2: Challenges Associated with the Intervention

Barriers. The main barriers described by participants related to the online delivery of the intervention via online videoconferencing; participants expressed mixed views. Although participants seemed to value the convenience of being able to attend the intervention from their own homes, some reflected that the demands of family life made it difficult to fully engage in the sessions.

"I would have liked to have been able to give it my full, 100% concentration…Yeah having the brain capacity, to be able to think about it properly without people running up to me and saying 'mummy' or bouncing around or me feeling guilty that they're on tablets or (laughs)." Participant 1259.

Participants described issues with sound; this was due to background noise, or difficulties with Zoom only registering one voice if two people speak simultaneously. Participants also commented on the loss of personal connection with other parents, missing out on a sense of solidarity and the sociable conversations which would occur during a face-to-face group.

"I think sometimes when you meet people in a group, you've got a chance to share more you've got a bit more time together, and I think on Zoom as well because you very much, take turns and, whereas, like for example if we were having a break in a group, you'd probably chat amongst yourselves and you'd get to know the parents a little bit more." Participant 1586.

Questionnaires. Some participants found the wording of items on questionnaires confusing, particularly on the CAPES, which resulted in some missing data. Some participants reflected on concerns regarding their child completing a questionnaire about their own experience of anxiety, believing it to have a detrimental impact by reinforcing or increasing their child's anxiety. However, participants whose children completed questionnaires reported that their child's experience was generally positive and that these fears were not realised.

Stigma. All participants reported that they would still have attended the group if it was held in a clinical setting, such as a child and adolescent mental health service (CAMHS) or GP surgery. However, some parents described reservations citing practical issues, such as travel to and from the venue and arranging childcare.

Participants expressed more concerns about the intervention taking place in their child's school. Some participants were concerned that their child would feel singled out if their parents were in school when other children's parents were not; others were concerned about the opinions of other parents or teachers.

"I wouldn't have liked to bump into people either and, and say 'wait what are you here for' I'd almost feel like I'd have to lie, so yeah, I think definitely not you know in a school setting would be better." Participant 1381.

Suggested Improvements. Participants indicated that they would like more, or longer, sessions in order to facilitate practice of strategies and to provide more time for conversations relating to specific issues. Participants described the potential utility of larger groups, with some suggesting that it would be helpful for both parents to attend the sessions.

Participants also suggested changes to the online delivery, for example, asking participants to stay on mute when not talking, or providing instructions for accessing Zoom. Some participants stated that they would have preferred attending a face-to-face intervention, whilst acknowledging that this was not possible at the time due the restrictions in England resulting from the COVID-19 pandemic (March 2020-April 2021).

Discussion

The aim of the present study was to investigate the feasibility and acceptability of a brief cognitive behavioural group intervention for parents of primary school children with mild to moderate anxiety. The majority of participants completed the intervention and high satisfaction scores were obtained across all three sessions, suggesting that it was feasible to recruit and retain participants in the study. Retention rates were excellent for intervention completion (76.67%) and completion of outcome measures (84.61%). However, the first

four groups were delivered with just one participant. This initial delay with recruitment may be attributed to the closure of schools due to COVID-19, although only two of the eight groups were carried out with more than two parents. In this study, using a fixed start date for the intervention may have compromised the delivery of the intervention to larger groups of parents. In line with the aim of maximising retention, it was decided not to keep participants on a waiting list to attend a larger group. However, a future trial could consider increased flexibility, perhaps only carrying out the intervention when at least five participants have been recruited (Biggs et al., 2020) to provide more data regarding the feasibility of delivering this intervention in a group format. It may also be helpful to explore parent motivation and engagement with materials sent from schools and children's centres to inform recruitment processes for future research.

Almost a quarter of participants (23.53%) did not complete the intervention, i.e., attended fewer than 2 out of the 3 sessions. The groups were offered and delivered at different times (five in the morning, three in the evening); all attrition in the study resulted from the morning sessions. Participants providing reasons for non-completion cited work commitments as the main barrier to attendance. However, there may be some important differences between those participants who did or did not complete the study, such as socioeconomic status, competing demands or perceived suitability of the intervention. The timing of sessions should be considered to further improve retention rates.

Furthermore, participants found this to be an acceptable and useful intervention. Whilst participants were satisfied with session length and fortnightly delivery, qualitative data indicated that participants would like more or longer sessions. This finding is in contrast to previous research suggesting that parents would prefer briefer interventions to reduce burden on busy families (Tully & Hunt, 2016).

Participants commented on the value of connecting with other parents, which reduced feelings of isolation. This connection was achieved despite the intervention being delivered online via Zoom, which was identified as a barrier to social interaction by some participants. This feeling of connection was achieved when just two parent participants attended the intervention, which may be a reflection of the isolation and loss of support that parents may have experienced during lockdown. Group interventions can provide the opportunity for parents to receive peer support and validation (Navaneetham & Ravindran, 2017).

Participants described some confusion when completing the CAPES. These difficulties particularly related to items rating parent confidence for managing behaviours that their child did not engage in, or in relation to positive behaviours. This resulted in participants choosing not to complete all of the confidence ratings. Wittkowski et al.'s (2017) systematic review of parent self-efficacy measures identified three alternatives to the CAPES suitable for parents of children aged 4- to 10-years-old: Comfort with Parenting Performance (CPP; Ballenski & Cook, 1982), Me as a Parent (MaaP; Hamilton et al., 2015) and the Parental Self-Agency Measure (PSAM; Dumka et al., 1996). The CAPES was chosen for the current study due to the inclusion of specific emotional and behavioural items (e.g., 'rate your confidence: my child seems fearful and scared') rather than more general statements (e.g., 'I know I am doing a good job as a parent'; Hamilton et al., 2015). It may be that participants require some additional support or specific instruction regarding the completion of questionnaires.

It is important to consider how this intervention should be offered in the future. Participants valued the convenience of the online delivery of the intervention, which reduced barriers for engagement, such as organising childcare and travel. Our findings suggest that the intervention was successfully adapted to an online format. However, the

majority of barriers were related to the online delivery of the intervention. Some of these barriers could potentially be removed by providing participants with clear instructions and information about Zoom in advance. Parents expressed concerns about the original intention to deliver the intervention at their child's school. Previous literature has highlighted parental concern for negative consequences at school if their child were labelled as anxious, including anxiety being included on their child's school record, moving to a different class and bullying by peers (Chavira et al., 2017). Interestingly, all participants stated that they would have attended the intervention if delivered in a clinical setting (e.g., CAMHS, GP surgery). This highlights a bias in the current sample as wider literature has highlighted barriers for parents accessing psychological services (Reardon et al., 2017).

Clinical Outcomes

Intervention attendance appeared to be associated with beneficial change for both parents and children. Effect sizes for parent-rated outcome measures were large. However, a more modest treatment effect was found for child self-reported outcome measures. The reasons for this discrepancy are unclear, despite it being a longstanding feature within the literature (Engel et al., 1994). Participants reported that they did not have the opportunity to use all of the strategies during the six-week-timeframe of the intervention. Therefore, whilst parents received benefits such as validation of their difficulties and increased understanding of anxiety, their child may have had less opportunity to experience change.

Although positive changes were described by participants, only a quarter of participants (23.08%) obtained a T-score of less than 60 post-intervention, indicating that anxiety was no longer at a subclinical or elevated level. Over half of participants (56.25%) obtained T-scores of ≥70 during eligibility screening. Whilst the PAS and SCAS should

not be used diagnostically, this could indicate that children were experiencing more severe anxiety than expected in this study. An alternative possibility is that parents and children have different conceptualisations of anxiety (Nauta et al., 2004), or parents over-estimate their child's level of anxiety. Many of the participants experienced anxiety themselves, and parent beliefs about their child's experience of anxiety have been found to mediate the link between parent and child anxiety (Francis & Chorpita, 2011). It may be that the intervention was more effective at changing parent perceptions of child anxiety than having an indirect effect upon the child's experience of anxiety. These findings could also reflect the context of this study which took place during the global COVID-19 pandemic; anxiety and uncertainty were likely to be higher for both parents and children and access to usual coping strategies, such as support from friends and family, were limited due to lockdown restrictions.

Self-report data were not included for children under the age of 7 years old. This is due to difficulties in administering questionnaires to young children with limited literacy skills who developmentally are less able to reflect on their own mental state (Luby et al., 2007). However, the majority of parents with children under the age 7 years old reported that it would be beneficial for their child to complete a measure of anxiety themselves. It would be valuable to explore alternative methods of capturing young children's experience of anxiety in future research.

Strengths and Limitations

A considerable strength of this study was that both quantitative and qualitative data from parents were captured, obtaining richer information on the feasibility and acceptability of the intervention. However, as this study was a small scale, uncontrolled feasibility study, it cannot be concluded with certainty that reductions in child anxiety were a direct result of

the intervention. Due to the study design and small sample size, effect sizes may be inflated and so the results must be interpreted with caution. As such, clinical outcomes from this study can only be viewed as preliminary.

All participants self-referred into the study; many of the parents experienced anxiety themselves. The sample may reflect a group of particularly motivated parents which may not be representative of the wider parent population. All participants self-identified as White British, again limiting the generalisability of findings. The majority of participants in the study were mothers. Information on socio-economic status was not collected from participants; however, this data could have provided further information of any economic diversity within the sample.

Participants from two-parent families indicated that attendance was simply due to availability. Interview data from one father suggested that he was concerned about being the only father, though this did not affect his attendance. Understanding the barriers to father participation and successfully engaging fathers in parent-only interventions could lead to further positive outcomes for children.

The present study relied on self-report data from parents which is subject to response bias, social desirability and misunderstanding or misinterpretation of questionnaire items. The first author (CJ) delivered the intervention, conducted interviews, collected and analysed data, which may also have introduced bias in participants' responses.

Clinical Implications and Future Research

This study should be considered in the context of the UK's national focus on early intervention and prevention in children and young people's mental health (Department of Health & Department for Education, 2017). The results demonstrate that a brief cognitive

behavioural group intervention is feasible and acceptable for parents of young children with mild to moderate anxiety. This brief intervention could increase accessibility and improve parent engagement in psychological support for their child. Preliminary analysis also indicates that this intervention has potential clinical benefits in reducing child symptoms of anxiety.

Next steps for research should involve the development of a larger pilot trial of this group interventions for parents. It is important to consider how the intervention should be offered in a future trial to better understand the feasibility of an online intervention beyond the current context, where lockdown restrictions made online delivery the only available option for parents. A future trial could also evaluate the cost-effectiveness of the intervention to provide further data on the feasibility of a group intervention. This trial should recruit a larger, more diverse sample with an aim to include more fathers in the overall sample. Inclusion of a long-term follow up of six months would be beneficial in order to identify any long-lasting clinical benefits of the intervention, including whether child-rated outcomes show more change over time as parents have more opportunities to implement strategies.

Conclusions

This feasibility and acceptability study has demonstrated the potential for a brief cognitive behavioural group intervention, delivered exclusively to parents of young children experiencing mild to moderate anxiety. Participant retention rates and satisfaction scores were high. Calculated effect sizes indicated reductions in child anxiety symptoms rated by both parents and children. However, a definitive trial with a larger sample size is required to further investigate these preliminary findings.

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Paper 3

Critical Reflection

Word count: 4723

Introduction

This chapter provides a critical and reflective evaluation of the research process during completion of the systematic review and empirical study. The rationale and methodological considerations which informed the work will be discussed. Strengths and limitations and challenges faced, alongside the clinical impact of the work and its contribution to the literature will be considered.

Paper 1: The impact of parent-only interventions on child anxiety: A systematic review and meta-analysis

Rationale for Topic. The systematic review and meta-analysis aimed to investigate the efficacy of parent-only interventions in reducing symptoms of anxiety disorders in school aged children. As the first author held a strong belief about the research being clinically meaningful, the review and empirical study were closely linked. Therefore, the review question was developed in line with the aims of the empirical study. Initially, it was thought that reviews in this area already existed. Whilst there were a number of review papers on the topic of parent involvement in child treatment for mental health difficulties, it quickly became clear that there were few reviews which focused specifically on parent-only interventions for child anxiety. The review therefore addressed an important gap in the literature. An initial scoping search identified a number of relevant articles with varied designs. It was decided to include a range of quantitative study designs to reflect the diversity of the literature and to increase the clinical utility and comprehensiveness of this review. However, the decision to include designs other than randomised controlled trials (RCTs) meant that there was greater variation in the methodological quality of the included studies, increasing the risk of bias. This also meant that the review was not particularly

straightforward to conduct because a combination of methods for data analysis were required.

Search Strategy. The University of Manchester library systematic review service was consulted for guidance on the development of the search terms. Synonyms of the key concepts of "parent", "children", "intervention", "anxiety disorders" and "parent only" were identified through a search of relevant studies and reviews. Medical Subject Heading (MeSH) terms were also identified and any new synonyms were added to the search terms. The search strategy was revised and refined until new terms were no longer identified during pilot scoping searches of the literature. The search terms used in the review attempted to capture all terms related to parent-only interventions. However, other unknown terms may exist, particularly for parent-only interventions, and therefore some potentially relevant articles may have been excluded.

Inclusion Criteria. It was decided to focus on children with a diagnosis of anxiety disorders, rather than the broader topic of child anxiety, which helped to ensure the focus of the review was sufficiently targeted and allowed for a meaningful synthesis. This approach meant that studies investigating anxiety in children with physical illness, behavioural problems, learning disability and neurodiversity, where more specialist interventions would likely be required, were excluded. Studies investigating early intervention and prevention of anxiety or children with diagnoses of comorbid mental health problems were also excluded from the review.

Grey literature was searched and unpublished dissertations were included in the search results, with the aim of reducing publication bias and providing a more balanced view of the available evidence (Paez, 2017). The three dissertations included in this review identified treatments or research questions that were not captured by included peer-reviewed articles, for example, a videotape modelling intervention (Stone, 2000) and

comparing prescriptive vs non-prescriptive CBT (Neuhoff, 2006). However, unpublished papers may not reach the same methodological quality standards as peer-reviewed articles (Higgins & Green, 2011). All three unpublished dissertations received 'weak' ratings of methodological quality during risk of bias assessment; however, 16 published studies included in the review also received a 'weak' quality rating. As such, the inclusion of grey literature was thought to enhance the comprehensiveness of this review without influencing overall quality.

Six non-English language papers were identified in the search (Amoros et al., 2005; Carrillo et al., 2004; de Leon & Nunez, 2012; Goncalves et al., 1998; Mendez et al., 2003; Schlarb & Jager, 2015), four of which investigated a specific diagnosis of dark phobia or separation anxiety. These specific diagnoses were represented by a small number of papers included in the review. Unfortunately, suitable translations could not be found and the time constraints for completing this thesis meant that the papers could not be translated. If non-English papers could be included, the impact of publication bias could be further reduced in future reviews.

Methodological Quality and Risk of Bias Assessment. Assessing articles for methodological quality is a central feature of any systematic review, because the quality of included studies has an impact on the conclusions that can be drawn from the results (Wells & Littell, 2008). The variety of study designs included in the review meant that a number of quality assessment tools were considered, including the *Effective Public Health Practice Project* (EPHPP; Thomas et al. 2004), *Newcastle-Ottowa Scale* (NOS; Wells et al., 2013), *Quality Assessment Tool for Studies with Diverse Designs* (*QATSDD;* Sirriyeh et al., 2011) and the *Critical Appraisal Skills Programme* (CASP) checklists for RCTs, cohort studies, case control studies, etc. The advantages and disadvantages of these

different tools were carefully considered and after piloting each tool with one or two articles, the EPHPP was chosen.

Component scores and global ratings were included. However, it was surprising that only four out of the 29 studies included in the review received a 'strong' global rating, compared to 19 studies receiving a 'weak' global rating. Six studies which obtained three or more 'strong' component ratings were assigned 'weak' global ratings, despite certain aspects of the study being of high quality. Whilst the EPHPP is a widely used assessment tool, the research team considered the quality criteria to be too strict. However, in other areas the tool seemed to be too generous. For example, for many studies it was not possible to fully identify the blinding procedures. In accordance with the EPHPP dictionary, these studies were assigned a score of "moderate" for the blinding component rating. These findings suggest that relying on the global score may be problematic and using this approach has been criticised for being superficial and misleading (Liberati et al., 2009). For this reason, it was decided to present ratings at the component level for each study alongside global ratings in an attempt to reduce over-reliance on the global scores. However, removing global scores may have facilitated a more meaningful understanding of study quality. Alternatively, CASP checklists could have been utilised because they do not advocate the use of a scoring system, thus avoiding summarising methodological quality into a single score.

Any quality assessment tool is generally prone to some element of bias and subjectivity (Ma et al., 2020). It was challenging to provide an objective rating when some subjective interpretation was inevitably required during the quality assessment. However, substantial inter-rater reliability (k=.74) for quality assessment was obtained which is a strength of this review.

Data Analysis. It was decided to carry out meta-analyses on available data, despite studies included in the review offering heterogeneity in terms of the interventions (e.g., nature, format, duration, and therapist contact) and outcome measures. The rationale for this decision was that the population, interventions and reported outcomes across the studies were sufficiently similar (Borenstein et al., 2009); all studies investigated a parent-only intervention aimed at reducing symptoms of child anxiety. However, a number of articles did not report sufficient data for inclusion in the meta-analysis. Furthermore, separate meta-analyses were conducted for different study designs and parent-rated or child-rated outcomes to ensure that the data were combined and synthesised in the most meaningful way. However, only a small number of studies were included in some meta-analyses, with one combining data from just five studies. Conducting random effects meta-analyses with a small number of studies can lead to errors in estimating between-study variance, which has implications for the analysis and could lead to an overinflated summary effect (Borenstein et al., 2009). Despite this limitation, guidance suggests that meta-analyses can be completed with as few as just two studies (Higgins et al., 2021). Overall, the inclusion of meta-analysis is a relative strength of this paper because narrative reviews alone cannot provide the statistical integration of data provided by a meta-analysis (Higgins et al., 2021). A good balance between the narrative synthesis and presentation of information from meta-analyses was achieved.

Clinical Implications. The results of the systematic review and meta-analysis suggested that parent-only interventions can be effective in reducing symptoms of child anxiety. These findings fit well with the stepped care model of mental health (National Institute for Health and Care Excellence (NICE), 2011); parent-only interventions are low intensity interventions which typically require less time and resources than child-focused CBT or child CBT with additional parent involvement. However, it was difficult to

identify whether any particular intervention was superior to another. This was in part due to the heterogeneity of interventions; there was no clear evidence highlighting which intervention would be best suited to parents, clinicians or particular services.

The aims of the review were met successfully and the findings have particular relevance for child and family mental health services. Future research could consider the acceptability of parent-only interventions to help answer the question of which intervention may be preferred by parents. The review should be considered in the context of the NHS Long Term Plan (NHS England, 2019); the comprehensive findings fit well with the current national focus on expanding child and adolescent mental health services (CAMHS) and improving prompt access to psychological support.

Paper 2: The feasibility and acceptability of a brief cognitive behavioural group intervention for parents of young children experiencing mild to moderate anxiety

Rationale for Topic. The primary aim of the empirical study was to investigate the feasibility and acceptability of a brief cognitive behavioural group intervention for parents of young children experiencing mild to moderate anxiety. Early interventions targeting parents of young children experiencing anxiety are particularly important to prevent problems escalating into adolescence and adulthood (Yap et al., 2016).

As previously mentioned, it was important to the author that the research had a strong clinical focus. Informal discussions with other clinicians working in CAMHS indicated that not only was this an important area of research, but there was also a clinical need and an impression that parents would be interested in attending the intervention. More than half of the participants (64.7%) in the study indicated that they were not aware of any other courses related to improving their child's wellbeing, despite searching online and reading about anxiety in children. One parent reported that they had spoken to their GP

who referred the child to CAMHS, although no other interim interventions were offered. Again, this suggests that there is an unmet need for such interventions, particularly for children with mild to moderate anxiety whose symptoms do not reach diagnostic criteria.

The development of the current project was informed by the first author's awareness of a similar brief intervention having previously been delivered to parents of older children in CAMHS (mean age = 12.7 years); reductions in child anxiety were reported by parents. However, there is a need for further research on interventions delivered in community settings to address barriers to parents accessing psychological support, including a lack of knowledge about where and how to get help and perceived social stigma (Reardon et al., 2017). These barriers to parents accessing psychological support for their children highlight the value of exploring the feasibility and acceptability of a parent-only intervention delivered in the community, which may be more easily accessible and less stigmatising. To date, no other studies have been identified which investigate the delivery of a parent-only intervention for child mental health difficulties through schools.

Methodology. According to guidance from the Medical Research Council, development, feasibility/piloting, evaluation and implementation are key stages in the development and refinement of any complex intervention (Craig et al., 2008). In line with this guidance, paper two explored the feasibility and acceptability of the intervention through a small-scale study. Feasibility outcomes may be particularly important for studies involving parent participants in relation to the reported barriers to accessing support and high demands for busy, working or single parents. Feasibility studies provide important data regarding recruitment, sample size and intervention delivery, informing the development of future pilot trials or RCTs (Craig et al., 2008).

It was decided to collect, analyse and report both quantitative and qualitative data from participants in order to present a more comprehensive and detailed account of the feasibility and acceptability of the study procedures and the intervention itself. In addition, it was decided to collect preliminary data on the effectiveness of the intervention.

Whilst the sample size of the study is small, it is consistent with the primary aim of the study which was to provide preliminary information about the feasibility and acceptability of the intervention. The sample size is sufficient for a meaningful descriptive analysis of the clinical data, leading to conclusions about potential treatment effects. The sample size is comparable to other studies investigating the feasibility of interventions for child anxiety (Comer et al., 2012; Jolstedt et al., 2018).

Recruitment. Parents were recruited from primary schools and children's centres across the North West of England. Initially, the recruitment strategy for the study involved two primary schools in East Lancashire with pre-existing connections to one of the authors (SC). The schools differed in terms of their size, location and socio-economic status of the pupils, with the aim of obtaining a sample with diverse characteristics. Recruitment for the study began on 3 March 2020 and the first UK national lockdown due to COVID-19 was announced on 23 March 2020, resulting in school closures across the UK. One of the schools was able to continue with recruitment, contacting parents with study information remotely by mid-April (e.g., email and social media posts). However, the other involved school was unable to support recruitment to the study until October 2020. Eight out of the 17 participants included in the analysis were recruited from this school. Between July and September 2020, primary schools, children's centres, out of school clubs, children's sports clubs, girl guides and scouting groups were contacted in an attempt to continue recruitment. Recruitment was further impacted by school holidays in July and August

2020, although this barrier had previously been anticipated by the research team during the development of the study.

Only one participant per group attended in four of the groups delivered between May and October 2020, indicating that half of the groups were carried out with just one participant. Four participants therefore received an individual rather than a group intervention. Those who attended the intervention without other group members described their experience as "tailored" or "personalised", whilst also reporting that a larger group of participants would have been beneficial. The treatment fidelity checklist was closely followed to ensure that deviation from the format and content of the intervention did not occur during these first four groups. Whilst those participants still reported positive parent and child changes, this may have implications for the feasibility of intervention delivery.

Clinical Outcome Measures. The decision to include parents of children aged between 4 and 10 years old resulted in the use of multiple outcome measures, including questionnaires rated by both parents and children. A number of child anxiety questionnaires, including the Revised Children's Anxiety and Depression Scale (RCADS; Chorpita et al., 2000), were considered before the Spence Children's Anxiety Scale (SCAS; Spence, 1998) was chosen. The SCAS was chosen because it assesses the severity of anxiety symptoms and has different versions for parents, children (from the age of 7 years) and parents of preschool children under 7 years old (PAS; Spence et al., 2001). Utilising both the SCAS and PAS enabled parents of younger children to be involved in the study in line with the focus on early intervention, because the RCADS can only be completed be parents of children aged 8 years and above.

The inclusion of questionnaire measures inevitably relies on subjective reporting, is open to misunderstanding and misinterpretation, is subject to response bias and social desirability and may be more likely to result in missing data (Choi & Pak, 2005). During

the development of the study, use of the PAS-teacher version for children younger than 7 years old was considered, in an attempt to improve validity of questionnaire responses, as high concordance between parent and teacher ratings of child anxiety has been found with other measures (Miller et al., 2014). However, due to COVID-19 restrictions the involvement of schools in the study reduced, and children's contact with teachers was limited. It was therefore decided to discard this additional measure.

Intervention. It was planned to deliver the group intervention face-to-face in primary schools. However, the national restrictions across the UK due to COVID-19 meant that this was no longer a viable option. Instead, the intervention was adapted for online delivery via the teleconferencing application Zoom.

Head teachers of primary schools were asked to provide potential participants with study information; however, schools were less involved in the recruitment process and intervention delivery than originally planned as the whole study transitioned to the online platform. Unfortunately, this meant that parents without access to a mobile device, computer or internet were unable to take part in the study.

The online delivery format resulted in more groups being delivered than anticipated, each with a smaller number of participants. Both losses (e.g., social interaction) and gains (e.g., convenience, reduced travel) were associated with attending the intervention remotely. Where appropriate, some flexibility was offered to participants regarding their preference for the time of the intervention i.e., whether they would like to attend morning or evening sessions. All attrition in the study was attributed to intervention sessions delivered in the morning. Some parents reported that they would not have been able to attend the intervention if it had been delivered face-to-face due to practical issues, such as childcare and arranging transport. These findings highlight the need for flexibility in providing psychological support for parents of children with mental health needs.

As a facilitator, the aim was to deliver the intervention as if it were face-to-face, including as many of the original group discussions and planned activities as possible. This required adaptations such as sharing a word document in place of using flip chart paper. Consequently, only one activity was removed from the group session and included as a homework task instead. It was surprising how well participants engaged with the facilitator, the content and each other during the sessions due to the challenges in creating opportunities for interaction in an online environment. The online delivery required increased flexibility from the facilitator, for example, due to issues with sound quality or when participants' children entered the room; issues which would not have been present during a face-to-face intervention. However, some participants reported that they felt more comfortable in attending and sharing information about their difficulties from the comfort of their home. Future research could further investigate the advantages and disadvantages of delivering interventions online, as this may become a more permanent part of service delivery in future.

Interestingly, parent-reported stigma associated with school was revealed during interviews, in which parents expressed concerns about attending the intervention at their child's school. Due to participant self-selection, it is unlikely that this would have been discovered if the study had been able to proceed as planned.

Some participants reported that they would have liked more, or longer sessions. These findings are in contrast to the aim of providing parents with a brief intervention to facilitate engagement. It may be that parents would prefer ongoing support, or a point of contact for questions and concerns. Although parents were provided with helplines and local services for their own mental health support when debriefed from the study, it may also be helpful to provide parents with information regarding child mental health and parenting support in future.

Data Analysis. Quantitative data regarding feasibility and clinical outcomes and qualitative data regarding acceptability were collected. The study utilised a thematic analysis approach to explore qualitative data (Braun & Clarke, 2006). During the development of the study, content analysis was also considered as a potential method for analysing the interview data. Content analysis is a tool to determine the presence of particular words or concepts in data which involves counting the frequency of a pre-defined concept as it occurs (Hsieh & Shannon, 2005). As the study was more explorative, with no a priori hypotheses regarding feasibility and acceptability, it was decided that using this approach could be too restrictive, potentially missing important features of the data which were not anticipated by the research team. The limitations of thematic analysis were considered; however, this approach was chosen because it is a flexible approach, not grounded in any particular theoretical perspective, which provides a detailed account of the data (Braun & Clarke, 2006).

All interviews were conducted, transcribed and checked for accuracy by the first author, resulting in full immersion in the data. Due to detailed understanding of transcripts, a large number of codes were generated, with the aim of capturing all important patterns and themes in the data. Refining these codes into overarching themes and sub-themes was time-consuming and, at times, challenging. Being so close to the project (i.e., facilitating the intervention, conducting, transcribing and coding interviews) meant that the first author was eager to represent each participants' experience and capture all meaningful patterns in the data. It could have been beneficial for a portion of the transcripts to be checked by an independent coder to facilitate refinement of codes. Themes were agreed upon through discussion with the research team.

As previously mentioned, the first author also facilitated the intervention which is likely to have resulted in bias throughout the study. For example, whilst every effort was

made to ensure participants could provide constructive criticism, social desirability bias may have made this more difficult than if the intervention and interviews were carried out by different members of the research team. This lack of blinding would result in lower rating of methodological quality if the empirical study were evaluated using a quality assessment tool. However, this also meant that a professional rapport and alliance had already been developed with the first author during the intervention, which may have made it easier for participants to share information about their child's anxiety during the interview.

Limitations. Almost all of the participants shared that they had personal experiences of CBT for common mental health problems, such as depression or anxiety, prior to taking part in the current study. Some parents described self-blame, expressing fears that they had passed their own anxiety onto their child or that they were doing something to exacerbate their child's difficulties. Participant self-selection into the study may have resulted in a biased sample of particularly motivated parents with an existing awareness of mental health difficulties.

Despite attempts to recruit participants from diverse backgrounds, the sample was relatively homogenous, particularly in terms of sex and ethnicity. Only three participants were fathers, one of whom did not complete the study. The absence of fathers is an all too common feature of interventions for parents. A review of 199 studies reporting on father participation in parenting interventions identified a number of different barriers to father engagement, including the timing, location and delivery format of the intervention, involvement of both parents being undervalued and the needs of fathers being overlooked (Panter-Brick et al., 2014). Participants in the empirical study reported that their attendance was primarily based on parent availability. Some mothers reported that they would have also liked their partner to attend; both fathers who completed interviews were surprised

that more fathers did not engage with the intervention. Qualitative research exploring barriers to father's engagement has highlighted a perceived gender bias that parenting interventions are generally aimed at, and more likely to be attended by mothers, with some fathers reporting stigma around attending groups with mothers (Sicouri et al., 2018). The fact that all parents and caregivers were invited to take part in the research, not just mothers, could have been made more explicit in the recruitment materials and study information to counteract any implicit gender bias against the inclusion of fathers. Further research is needed to ensure that father's perspectives and experiences become a more prominent feature of the literature.

Clinical Implications. The findings of the empirical paper should be considered in the context of the UK's public health agenda around early intervention and prevention for children's mental health (Department of Health & Department for Education, 2017; NHS England, 2019), which highlights the need for improving access to psychological support for children. Low intensity parent-only interventions are typically efficient in terms of time and resources. Results from the empirical paper suggested that a brief parent only intervention was feasible and acceptable for parents. Preliminary findings also hinted at its efficacy; participants reported reductions in child anxiety symptoms and an increase in parent confidence from session one to session three of the intervention. The results of the study should be used to inform the development of a future pilot or feasibility trial of the intervention. Many of the study procedures were found to be acceptable; however, a future trial should aim to recruit a more diverse participant sample, employ a randomisation design, use blinding procedures and include a comparator group (e.g., waitlist control or treatment as usual).

Dissemination Plan

All participants consented to be contacted regarding dissemination of research findings and will be provided with a lay summary, along with head teachers of participating schools. It is planned that the lay summary will be published on the website of Greater Manchester Mental Health NHS Foundation Trust's Perinatal Mental Health and Parenting Research Unit (PRIME-RU). The research team are committed to disseminate the research findings presented in this thesis. It is planned to disseminate findings to the wider academic community via publication of papers in academic journals. Paper one has been prepared for submission to the *Journal of Affective Disorders.* Paper two has been prepared for submission to *Behaviour Research and Therapy.* The research team will also seek out relevant conferences, such as a British Association for Behavioural and Cognitive Psychotherapies (BABCP) conference, to present research findings.

Personal Reflections

Undertaking a large-scale research project as part of clinical psychology doctoral training has been equally challenging and rewarding. I was passionate about completing a project in an area of interest which would be clinically relevant to service users and clinicians, developing skills as a scientist-practitioner that will be invaluable throughout my career as a qualified clinical psychologist. Carrying out a feasibility and acceptability study has highlighted the importance of early evaluation in the development of interventions. Conducting semi-structured interviews with participants has enhanced my commitment to service-user involvement in the development of interventions. My understanding and appreciation of research in facilitating change will be a driver for continuing personal and professional development, engaging in service development and research.

Completing this piece of work has highlighted the huge amounts of work that go into developing a research project from start to finish; something which I had not previously been able to fully experience during either undergraduate or master degrees. Consequently, I have learned a lot about the research process and I have an enhanced appreciation for the value of research.

Furthermore, completing a doctoral thesis during the COVID-19 pandemic has been a challenging experience. The national UK lockdown resulted in a number of important changes to the empirical study as the screening questionnaires, intervention, outcome measures and interviews had to be adapted to an online format. I was concerned about the negative consequences of moving online, such as the loss of social connection or technical difficulties affecting the delivery of the intervention. However, I enjoyed facilitating the group interventions and participants commented on their experiences of creating connections with other parents – even if they had not been able to leave the house. Limited access to self-care activities and the lack of face-to-face peer support resulting from lockdown restrictions also increased the challenges of completing this thesis as cohort support in particular is an invaluable aspect of clinical training. Although the process was demanding, I feel a great sense of achievement for the work that has been completed and I am committed to disseminating the research findings in order to contribute to evidence-based practice and advance the field of clinical psychology.

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Appendix A: Journal of Affective Disorders Guide for Authors

JOURNAL OF AFFECTIVE DISORDERS

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AUTHOR INFORMATION PACK

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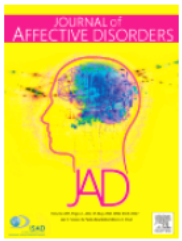

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Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's Author Services.

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Manuscript Submission

The *Journal of Affective Disorders* now proceeds totally online via an electronic submission system. Mail submissions will no longer be accepted. By accessing the online submission system, https://www.editorialmanager.com/JAFD/default.aspx, you will be guided stepwise through the creation and uploading of the various files. When submitting a manuscript online, authors need to provide an electronic version of their manuscript and any accompanying figures and tables.

The author should select from a list of scientific classifications, which will be used to help the editors select reviewers with appropriate expertise, and an article type for their manuscript. Once the uploading is done, the system automatically generates an electronic (PDF) proof, which is then used for reviewing. All correspondence, including the Editor's decision and request for revisions, will be processed through the system and will reach the corresponding author by e-mail.

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Authors may send queries concerning the submission process or journal procedures to our Editors-in-Chief

Paolo Brambilla: paolo.brambilla1@unimi.it or Jair Soares: Jair.C.Soares@uth.tmc.edu.

Please submit your article via https://www.editorialmanager.com/JAFD/default.aspx.

Types of Papers
The Journal primarily publishes:

Full-Length Research Papers (up to 5000 words, excluding references and up to 6 tables/figures)

Review Articles and Meta-analyses (up to 8000 words, excluding references and up to 10 tables/figures)

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Correspondence (up to 1000 words, 10 references, 1 table/figure).

At the discretion of the accepting Editor-in-Chief, and/or based on reviewer feedback, authors may be allowed fewer or more than these guidelines.

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Appendix B: Behaviour Research and Therapy Guide for Authors

BEHAVIOUR RESEARCH AND THERAPY

AUTHOR INFORMATION PACK

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ISSN: 0005-7967

DESCRIPTION

The major focus of *Behaviour Research and Therapy* is an experimental psychopathology approach to understanding emotional and behavioral disorders and their prevention and treatment, using cognitive, behavioral, and psychophysiological (including neural) methods and models. This includes laboratory-based experimental studies with healthy, at risk and subclinical individuals that inform clinical application as well as studies with clinically severe samples. The following types of submissions are encouraged: theoretical reviews of mechanisms that contribute to psychopathology and that offer new treatment targets; tests of novel, mechanistically focused psychological interventions, especially ones that include theory-driven or experimentally-derived predictors, moderators and mediators; and innovations in dissemination and implementation of evidence-based practices into clinical practice in psychology and associated fields, especially those that target underlying mechanisms or focus on novel approaches to treatment delivery. In addition to traditional psychological disorders, the scope of the journal includes behavioural medicine (e.g., chronic pain). The journal will not consider manuscripts dealing primarily with measurement, psychometric analyses, and personality assessment.The Editor and Associate Editors will make an initial determination of whether or not submissions fall within the scope of the journal and/or are of sufficient merit and importance to warrant full review.

AUDIENCE

For clinical psychologists, psychiatrists, psychotherapists, psychoanalysts, social workers, counsellors, medical psychologists, and other mental health workers.

IMPACT FACTOR

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GUIDE FOR AUTHORS

INTRODUCTION

The major focus of *Behaviour Research and Therapy* is an experimental psychopathology approach to understanding emotional and behavioral disorders and their prevention and treatment, using cognitive, behavioral, and psychophysiological (including neural) methods and models. This includes laboratory-based experimental studies with healthy, at risk and subclinical individuals that inform clinical application as well as studies with clinically severe samples. The following types of submissions are encouraged: theoretical reviews of mechanisms that contribute to psychopathology and that offer new treatment targets; tests of novel, mechanistically focused psychological interventions, especially ones that include theory-driven or experimentally-derived predictors, moderators and mediators; and innovations in dissemination and implementation of evidence-based practices into clinical practice in psychology and associated fields, especially those that target underlying mechanisms or focus on novel approaches to treatment delivery. In addition to traditional psychological disorders, the scope of the journal includes behavioural medicine (e.g., chronic pain). The journal will not consider manuscripts dealing primarily with measurement, psychometric analyses, and personality assessment.

The Editor and Associate Editors will make an initial determination of whether or not submissions fall within the scope of the journal and/or are of sufficient merit and importance to warrant full review.

Early Career Investigator Award
This award is open to papers where the first author on the accepted papers is within 7 years of their PhD. By endorsing candidature for the annual Early Career Investigator Award, your manuscript will be reviewed by the Associate Editors/Editor-in-Chief for an annual award for the most highly rated paper. The winner will be announced in print, and will have the option of being spotlighted (photo and short bio).

The CONSORT guidelines (http://www.consort-statement.org/?) need to be followed for protocol papers for trials; authors should present a flow diagramme and attach with their cover letter the CONSORT checklist. For meta-analysis, the PRISMA (http://www.prisma-statement.org/?) guidelines should be followed; authors should present a flow diagramme and attach with their cover letter the PRISMA checklist. For systematic reviews it is recommended that the PRISMA guidelines are followed, although it is not compulsory.

Contact details
Any questions regarding your submission should be addressed to the Editor in Chief:
Professor Michelle G. Craske
Department of Psychology
310 825-8403
Email: brat@psych.ucla.edu

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:
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• Journal policies detailed in this guide have been reviewed
• Referee suggestions and contact details provided, based on journal requirements

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BEFORE YOU BEGIN

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Declaration of interest

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Author contributions

For transparency, we encourage authors to submit an author statement file outlining their individual contributions to the paper using the relevant CRediT roles: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Roles/Writing - original draft; Writing - review & editing. Authorship statements should be formatted with the names of authors first and CRediT role(s) following. More details and an example

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Appendix C: Ethical Approval Letter (University Research Ethics Committee)

Research Governance, Ethics and Integrity
2nd Floor Christie Building
The University of Manchester
Oxford Road
Manchester
M13 9PL
Tel: 0161 275 2206/2674
Email: research.ethics@manchester.ac.uk

Ref: 2020-7825-12919

20/01/2020

Dear Miss Charlotte Jewell, Dr Daniel Pratt, Dr Anja Wittkowski

Study Title: Reducing Anxiety in Children: A Brief Group Intervention for Parents

University Research Ethics Committee 2

I write to thank you for submitting the final version of your documents for your project to the Committee on 15/01/2020 18:51 . I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

Please see below for a table of the title, version numbers and dates of all the final approved documents for your project:

Document Type	File Name	Date	Version
Additional docs	Participant Debrief Sheet V1	12/08/2019	V1
Default	PAS-teacher	23/08/2019	V1
Default	scas-preschool-scale	23/08/2019	V1
Default	Client Satisfaction Questionnaire-8	20/09/2019	V1
Default	CAPES	20/09/2019	V1
Additional docs	RSC Approval Letter	20/09/2019	V1
Advertisement	Social Media Text	15/10/2019	V1
Additional docs	Study Protocol V1	15/10/2019	V1
Data Management Plan	Data Management Plan	16/10/2019	V1
Advertisement	Poster V2	18/10/2019	V2
Participant Information Sheet	PIS V2 - Teachers	23/10/2019	V2
Additional docs	Letter of Support - Haslingden Primary	13/12/2019	V1
Additional docs	Letter of Support - Stubbins Primary	13/12/2019	V1
Consent Form	Consent Form - Teachers V2	13/12/2019	V2
Distress Protocol/Debrief Sheet	Distress Management Protocol V2	13/12/2019	V2
Additional docs	Invitation Letter (Intervention) V2	18/12/2019	V2
Default	Interview Topic Guide V2	18/12/2019	V2
Default	Evaluation Form V2.docx	08/01/2020	V2
Additional docs	Invitation Letter (Interview) - Info Sheet and Confirmation of Consent V1	08/01/2020	V1
Consent Form	Consent Form V2	08/01/2020	V2
Participant Information Sheet	PIS V2	10/01/2020	V2
Lone Worker Policy/Procedure	Lone Working Protocol V2	10/01/2020	V2
Additional docs	Demographics Form V2	10/01/2020	V2
Additional docs	Letter - Unable to Participate V1	15/01/2020	V1
Additional docs	Letter - Response to UREC	15/01/2020	V1

This approval is effective for a period of five years however please note that it is only valid for the specifications of the research project as outlined in the approved documentation set. If the project continues beyond the 5 year period or if you wish to propose any changes to the methodology or any other specifics within the project, an application to seek an amendment must be submitted for review. Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or

kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

1. Amendments: Guidance on what constitutes an amendment
2. Amendments: How to submit an amendment in the ERM system
3. Ethics Breaches and adverse events
4. Data breaches
5. Notification of progress/end of the study

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a **UREC Feedback Form**. Instructions for completing this can be found in your approval email.

We wish you every success with the research.

Yours sincerely,

Mrs Genevieve Pridham

Secretary to University Research Ethics Committee 2

Appendix D: Poster

MANCHESTER 1824
The University of Manchester

Version 3, 02/04/2020 Project ID: 7825

How can you help your child with anxiety?

Anxiety is very common in children.
We are conducting some research with parents of young children who are experiencing **mild to moderate anxiety**. If children are worried they might:
Feel irritable or angry
Be tearful or clingy
Have problems with eating or sleeping
Wake at night or have bad dreams
Complain of stomach ache
Avoid school or other every day activities

Research shows that **working with parents can help reduce child anxiety**. There are many ways of working with parents, but only a few studies have investigated whether these are **realistic**, **practical** and able to meet parent's needs. We would like to find out more about this to help parents help their children.

If you are suitable for the study, you will be invited to attend **three interactive online group sessions.**
The aim of these sessions is to help you **understand** and **manage** your child's feelings of anxiety.
Parents who attend all sessions will receive a voucher as a 'thank you' for taking part.

Who can participate?

- Parents of children with who are experiencing anxiety, aged between 5-11 years.
- You will need an electronic device with access to the internet.
- Either one parent or both parents can volunteer.
- You will be asked to complete an online questionnaire to see if you are suitable for the study.
- The study will involve attending online interactive group sessions and completing some questionnaires at each session.
- You may also be asked to take part in an interview.

If you would like to find out more about this study, or if you are interested in taking part, please contact the researcher:
Email: charlotte.jewell@postgrad.manchester.ac.uk
Telephone: 07852 996553

Appendix E: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Study Title: Reducing Anxiety in Children: A Brief Group Intervention for Parents

We would like to invite you to take part in our research study. Before you decide whether to take part, we would like you to understand why the research is being done and what it would involve for you. Please read the following information carefully and discuss it with others if you wish. Please ask if there is anything that seems unclear or if you would like more information. Take your time to decide whether or not you wish to take part.

About the research

Why are we doing this research?

Anxiety is very common in children and young people. It can cause problems for children at home and with their friends and might lead to more problems in later life. Young children may not be able to tell others how they feel; if they feel anxious they may become irritable or clingy, tearful and upset, wanting to avoid activities including going to school. They may have trouble sleeping, waking in the night or having nightmares. Stomach ache is also a common complaint with anxious children.

Research shows that working with parents can help reduce child anxiety. There are many ways of working with parents, but only a few studies have investigated whether these interventions are realistic, practical and able to meet parent's needs. The aim of this study is to find out whether it is practical and acceptable to run a brief online workshop for parents of anxious children.

Who will conduct the research?

The research is being conducted as part of the Doctorate in Clinical Psychology at the University of Manchester. It will be carried out by Charlotte Jewell (Trainee Clinical Psychologist) under the supervision of Dr Daniel Pratt (Clinical Psychologist), Dr Anja Wittkowski (Clinical Psychologist) and Dr Sarah Collinge (Clinical Psychologist, Lancashire Care Foundation Trust). This research is funded by the University of Manchester.

What will happen to the results of this study?

A summary of the overall study findings will be written for parents who took part. If you would like to receive this summary we will ensure that you are sent a copy by post or email once the study has finished after August 2021.

We intend to publish the results in a peer-reviewed, academic journal and present the results at scientific conferences. All information will be anonymous in written reports and conference presentations.

Who has reviewed the research?

The project has been reviewed by the University of Manchester Research Ethics Committee, who protect the rights, safety, dignity and wellbeing of research participants.

What would my involvement be?

Why have I been invited to take part in this study?

You have been asked to take part in this study because you have concerns that your child is experiencing anxiety. You may have seen the study advertised by email, blogs, newsletters or social media posts from school.

What does this study involve?

If you express an interest to participate in this research, we will ask you to complete an online consent form to indicate that you are happy to take part. You will then be asked to complete a screening questionnaire about your child's anxiety to make sure that you are eligible to take part in the research. If scores on the screening questionnaire indicate that your child may be experiencing very low levels of anxiety this will mean that you will not be able to take part.

If you are a suitable participant, you will be invited to attend interactive group sessions delivered online via the videoconferencing platform Zoom. You must have an electronic device with access to the internet in order to take part in the group. We do not expect both parents to attend the sessions, however if you and your partner would like to attend together you will both be able to take part. The aim of the sessions is to help you understanding and manage your child's feelings of anxiety.

The sessions will cover the following topics:

- What is anxiety?
- Developing strategies to help manage your child's anxiety
- Follow up and review

Participants will be asked to respect the confidentiality of all group members by not disclosing any information discussed during the session with other people outside of the group setting.

We will ask you to complete online questionnaires at the end of each session. These will include questions about your child's mood and behaviour, your confidence in managing your child's behaviour and your experience of the session. Your child's teacher may also be asked to complete a questionnaire about the child's mood and behaviour seen at school.

You may be asked to attend a telephone or Zoom interview within 4 weeks after the final session. This will focus on things like your experience of the sessions, what you found helpful/unhelpful and any changes you may have noticed since attending.

Do I have to take part in this study?

No, you do not have to participate in this study if you do not want to. It is up to you to decide whether or not you would like to take part. Participation is completely voluntary. If you do decide to take part, you will be given a copy of this information sheet to keep. You will be asked to give your consent to take part and to complete a questionnaire to identify whether you are eligible to

take part in the study. If you decide to participate, but change your mind later, you are free to withdraw at any point during the study, without giving a reason and without detriment to yourself. Once the data is pseudo-anonymised it will not be possible to identify your specific information and as such it will not be possible to remove data from the study after this point. For this reason, if you wish to withdraw your data you must inform the researcher within 7 days of the last questionnaire that you completed. This does not affect your data protection rights. Once you have informed the researcher that you no longer want to take part, you do not need to do anything further.

What will happen if I am interested in taking part in this study?

If you are interested in taking part in this study, please email Charlie Jewell at charlotte.jewell@postgrad.manchester.ac.uk. You can ask any questions you might have about the study and she will send you a questionnaire to complete to decide whether you are eligible to take part. If you are suitable to take part and still interested, we will give you some time to think about whether you would like to take part (a minimum of 24 hours).

Will I be compensated for taking part?

Participants who have attended all three online sessions and completed all questionnaires will receive a £10 voucher as a 'thank you' for taking part.

What are the possible benefits of taking part in this study?

You may enjoy attending the sessions. You may feel more confident in managing your child's emotions. You may find it interesting to complete questionnaires about your experiences and your child's mood and wellbeing. The information gained will inform future research on brief intervention workshops which are practical and acceptable to deliver to parents online, which may help other families in the future.

Are there any disadvantages to taking part in this study?

There are minimal risks to taking part in this study. We understand that answering questionnaires and talking about issues related to your child's emotional wellbeing may cause some distress. If you feel uncomfortable during any of the sessions you will be able to step out and take a break at any point by turning off your video and audio on the zoom meeting. You will be able to take as many breaks as you wish and the group facilitator will be available during the break or at the end of the session to speak to if you would like some extra support. You do not have to answer any questions you don't want to. If you do not want to continue, you can withdraw from the study at any time. You can discuss anything with us during and after each session and completion of the questionnaires.

Data protection and confidentiality

What information will you collect about me?

In order to participate in this research we will need to collect some information that could identify you, called "personal identifiable information". Specifically we will need to collect:

- Names and email addresses
- Demographic and family background information
- Next of kin contact details

- Email addresses
- OPTIONAL: Telephone numbers for text reminders for group sessions
- OPTIONAL: Postal address if participants wish to be contacted with a summary of the overall results from the study

Under what legal basis are you collecting this information?
We are collecting and storing this personal identifiable information in accordance with data protection law which protect your rights. These state that we must have a legal basis (specific reason) for collecting your data. For this study, the specific reason is that it is "a public interest task" and "a process necessary for research purposes".

What are my rights in relation to the information you will collect about me?
You have a number of rights under data protection law regarding your personal information, for example you can request a copy of the information we hold about you. If you would like to know more about your different rights or the way we use your personal information to ensure we follow the law, please consult our Privacy Notice for Research.

Will my taking part in the study be kept confidential and my personal identifiable information be protected?
In accordance with data protection law, the University of Manchester is the Data Controller for this project. This means that we are responsible for making sure your personal information is kept secure, confidential and used only in the way you have been told it will be used. All researchers are trained with this in mind, and your data will be looked after in the following way:

You will be given a unique identifier number to protect your anonymity. All data collected will be kept strictly confidential and only viewed by members of the research team. It will be stored securely on the University of Manchester servers. Data will be entered onto a password protected computer database. All information collected during the course of the research will be kept in accordance with the Data Protection Act (1998).

There may be instances during the course of your participation when information is revealed which means that the researchers will have to break confidentiality. Information will be kept confidential unless we discuss something which suggests that your own, or another person's safety is at risk. In this case information may need to be shared with others, for example your next of kin, another health professional or a safeguarding team. We will not routinely contact anyone else and where possible, sharing of information would be discussed with you first.

What if I have a complaint?

If you have any concerns about any aspect of the study, please contact a member of our research team who will do their best to answer your questions:

Dr Daniel Pratt
Email: Daniel.pratt@manchester.ac.uk
Address: Division of Clinical Psychology, 2nd Floor, Zochonis Building, University of Manchester, Brunswick Street, Manchester, M13 9PL.

Dr Anja Wittkowski
Email: Anja.Wittkowski@manchester.ac.uk
Address: Division of Clinical Psychology, 2nd Floor, Zochonis Building, University of Manchester, Brunswick Street, Manchester, M13 9PL.

If they are unable to resolve your concerns, or you wish to make a formal complaint to someone independent of the research team, or if you are not satisfied with the response you have gained from the researchers in the first instance, please contact:

The Research Governance and Integrity Officer, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674.

If you wish to contact us about your data protection rights, please email dataprotection@manchester.ac.uk or write to The Information Governance Office, Christie Building, The University of Manchester, Oxford Road, M13 9PL at the University and we will guide you through the process of exercising your rights.

You also have a right to complain to the Information Commissioner's Office about complaints relating to your personal identifiable information Tel 0303 123 1113

Contact details

If you have any queries about the study or if you are interested in taking part then please contact the researcher:

Charlotte Jewell
Telephone: 07852 996553
Email: charlotte.jewell@postgrad.manchester.ac.uk
Address: Division of Clinical Psychology, 2nd Floor, Zochonis Building, University of Manchester, Brunswick Street, Manchester, M13 9PL.

Thank you for considering taking part in this study.

If you are experiencing any distress, there are a number of people and organisations that you can contact for support which are listed below.

Minds Matter (Lancashire Care NHS Foundation Trust) A wellbeing service offering a range of brief therapeutic interventions to people aged 16 and over in Lancashire. www.lancashirecare.nhs.uk/Mindsmatter	**NHS Direct** **111** Open 24 hours a day, providing health advice and information
Healthy Minds (East Lancashire) www.eastlancshealthyminds.co.uk Talking therapies provided by Lancashire care – self referral Find organisations within your local area and across Lancashire that provide mental health support.	**Samaritans** **116 123 - from any phone** https://www.samaritans.org/ Confidential, non-judgmental support available 24 hours a day for people who are experiencing feelings of distress.
Lancashire Mental Health Helpline **0800 915 4640** Freephone out of hours, person centred listening environment for people requiring emotional support in relation to their own mental health or that of someone they know. Open 365 days a year Monday - Friday 7pm until 11pm Saturday - Sunday 12pm until midnight	**Mind** **Rochdale Mind - 01706 752338;** **info@rochdalemind.org.uk** **Lancashire Mind - 01257 23166;** **admin@lancashiremind.org.uk** https://www.mind.org.uk/ An independent local mental health charity committed to improving the lives of people with mental health needs
Place2Be A national charity working in schools in the UK to improve children's confidence and wellbeing.	**If you are struggling to cope or feel low in mood, it is important that you contact your GP for support and advice.** **If you would like to speak to one of the researchers, please contact us on charlotte.jewell@postgrad.manchester.ac.uk**

Appendix F: Client Satisfaction Questionnaire-8

http://csqscales.com/products/csq-8/

Appendix G: Preschool Anxiety Scale

PRESCHOOL ANXIETY SCALE
(Parent Report)

Your Name: _____ **Date:** _____

Your Child's Name: _____

Below is a list of items that describe children. For each item please circle the response that best describes your child. Please circle the **4** if the item is **very often true, 3** if the item is **quite often true, 2** if the item is **sometimes true, 1** if the item is **seldom true** or if it is **not true at all** circle the **0**. Please answer all the items as well as you can, even if some do not seem to apply to your child.

		Not True at All	Seldom True	Sometimes True	Quite Often True	Very Often True
1	Has difficulty stopping him/herself from worrying.....	0	1	2	3	4
2	Worries that he/she will do something to look stupid in front of other people.....	0	1	2	3	4
3	Keeps checking that he/she has done things right (e.g., that he/she closed a door, turned off a tap).....	0	1	2	3	4
4	Is tense, restless or irritable due to worrying.....	0	1	2	3	4
5	Is scared to ask an adult for help (e.g., a preschool or school teacher).....	0	1	2	3	4
6	Is reluctant to go to sleep without you or to sleep away from home.....	0	1	2	3	4
7	Is scared of heights (high places).....	0	1	2	3	4
8	Has trouble sleeping due to worrying.....	0	1	2	3	4
9	Washes his/her hands over and over many times each day.....	0	1	2	3	4
10	Is afraid of crowded or closed-in places.....	0	1	2	3	4
11	Is afraid of meeting or talking to unfamiliar people.....	0	1	2	3	4
12	Worries that something bad will happen to his/her parents.....	0	1	2	3	4
13	Is scared of thunder storms.....	0	1	2	3	4
14	Spends a large part of each day worrying about various things.....	0	1	2	3	4
15	Is afraid of talking in front of the class (preschool group) e.g., show and tell.....	0	1	2	3	4
16	Worries that something bad might happen to him/her (e.g., getting lost or kidnapped), so he/she won't be able to see you again.....	0	1	2	3	4
17	Is nervous of going swimming.....	0	1	2	3	4

		Not True at All	Seldom True	Sometimes True	Quite Often True	Very Often True
18	Has to have things in exactly the right order or position to stop bad things from happening.....	0	1	2	3	4
19	Worries that he/she will do something embarrassing in front of other people.....	0	1	2	3	4
20	Is afraid of insects and/or spiders.....	0	1	2	3	4
21	Has bad or silly thoughts or images that keep coming back over and over.....	0	1	2	3	4
22	Becomes distressed about your leaving him/her at preschool/school or with a babysitter.....	0	1	2	3	4
23	Is afraid to go up to group of children and join their activities.....	0	1	2	3	4
24	Is frightened of dogs.....	0	1	2	3	4
25	Has nightmares about being apart from you.....	0	1	2	3	4
26	Is afraid of the dark.....	0	1	2	3	4
27	Has to keep thinking special thoughts (e.g., numbers or words) to stop bad things from happening.....	0	1	2	3	4
28	Asks for reassurance when it doesn't seem necessary.....	0	1	2	3	4
29	Has **your child ever experienced anything really bad or traumatic** (e.g., severe accident, death of a family member/friend, assault, robbery, disaster)	**YES**	**NO**			

Please briefly describe the event that your child experienced.....

_____

_____

_____

_____

_____

If you answered **NO** to **question 29,** please **do not** answer questions 30-34**. If you answered YES, please DO** answer the following questions**.**

Do the following statements describe your child's behaviour since the event?

30	Has bad dreams or nightmares about the event.....	0	1	2	3	4
31	Remembers the event and becomes distressed.....	0	1	2	3	4
32	Becomes distressed when reminded of the event.....	0	1	2	3	4
33	Suddenly behaves as if he/she is reliving the bad experience.....	0	1	2	3	4
34	Shows bodily signs of fear (e.g., sweating, shaking or racing heart) when reminded of the event	0	1	2	3	4

Appendix H: Spence Child Anxiety Scale – Parent

SPENCE CHILDREN'S ANXIETY SCALE
(Parent Report)

Your Name: _____ **Date:** _____

Your Child's Name: _____

BELOW IS A LIST OF ITEMS THAT DESCRIBE CHILDREN. FOR EACH ITEM PLEASE CIRCLE THE RESPONSE THAT BEST DESCRIBES YOUR CHILD. PLEASE ANSWER ALL THE ITEMS.

1.	My child worries about things.....	Never	Sometimes	Often	Always
2.	My child is scared of the dark.....	Never	Sometimes	Often	Always
3.	When my child has a problem, s(he) complains of having a funny feeling in his / her stomach	Never	Sometimes	Often	Always
4.	My child complains of feeling afraid.....	Never	Sometimes	Often	Always
5.	My child would feel afraid of being on his/her own at home.....	Never	Sometimes	Often	Always
6.	My child is scared when s(he) has to take a test.....	Never	Sometimes	Often	Always
7.	My child is afraid when (s)he has to use public toilets or bathrooms.....	Never	Sometimes	Often	Always
8.	My child worries about being away from us / me.....	Never	Sometimes	Often	Always
9.	My child feels afraid that (s)he will make a fool of him/herself in front of people.....	Never	Sometimes	Often	Always
10.	My child worries that (s)he will do badly at school.....	Never	Sometimes	Often	Always
11.	My child worries that something awful will happen to someone in our family.....	Never	Sometimes	Often	Always
12.	My child complains of suddenly feeling as if (s)he can't breathe when there is no reason for this.....	Never	Sometimes	Often	Always
13.	My child has to keep checking that (s)he has done things right (like the switch is off, or the door is locked)..	Never	Sometimes	Often	Always
14.	My child is scared if (s)he has to sleep on his/her own.....	Never	Sometimes	Often	Always
15.	My child has trouble going to school in the mornings because (s)he feels nervous or afraid.....	Never	Sometimes	Often	Always
16.	My child is scared of dogs	Never	Sometimes	Often	Always
17.	My child can't seem to get bad or silly thoughts out of his / her head.....	Never	Sometimes	Often	Always
18.	When my child has a problem, s(he) complains of his/her heart beating really fast.....	Never	Sometimes	Often	Always

19.	My child suddenly starts to tremble or shake when there is no reason for this.....	Never	Sometimes	Often	Always
20.	My child worries that something bad will happen to him/her.....	Never	Sometimes	Often	Always
21.	My child is scared of going to the doctor or dentist	Never	Sometimes	Often	Always
22.	When my child has a problem, (s)he feels shaky.....	Never	Sometimes	Often	Always
23.	My child is scared of heights (eg. being at the top of a cliff).....	Never	Sometimes	Often	Always
24.	My child has to think special thoughts (like numbers or words) to stop bad things from happening.....	Never	Sometimes	Often	Always
25.	My child feels scared if (s)he has to travel in the car, or on a bus or train	Never	Sometimes	Often	Always
26.	My child worries what other people think of him/her.....	Never	Sometimes	Often	Always
27.	My child is afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds).....	Never	Sometimes	Often	Always
28	All of a sudden my child feels really scared for no reason at all.....	Never	Sometimes	Often	Always
29.	My child is scared of insects or spiders.....	Never	Sometimes	Often	Always
30.	My child complains of suddenly becoming dizzy or faint when there is no reason for this.....	Never	Sometimes	Often	Always
31.	My child feels afraid when (s)he has to talk in front of the class.....	Never	Sometimes	Often	Always
32.	My child's complains of his / her heart suddenly starting to beat too quickly for no reason	Never	Sometimes	Often	Always
33.	My child worries that (s)he will suddenly get a scared feeling when there is nothing to be afraid of.....	Never	Sometimes	Often	Always
34.	My child is afraid of being in small closed places, like tunnels or small rooms.....	Never	Sometimes	Often	Always
35.	My child has to do some things over and over again (like washing his / her hands, cleaning or putting things in a certain order).....	Never	Sometimes	Often	Always
36.	My child gets bothered by bad or silly thoughts or pictures in his/her head	Never	Sometimes	Often	Always
37.	My child has to do certain things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
38.	My child would feel scared if (s)he had to stay away from home overnight.....	Never	Sometimes	Often	Always
39.	Is there anything else that your child is really afraid of?	YES	NO		
	Please write down what it is, and fill out how often (s)he is afraid of this thing: _____	Never	Sometimes	Often	Always
	_____	Never	Sometimes	Often	Always
	_____	Never	Sometimes	Often	Always

Appendix I: Spence Child Anxiety Scale – Child

SPENCE CHILDREN'S ANXIETY SCALE

Your Name: _____ **Date:** _____

PLEASE PUT A CIRCLE AROUND THE WORD THAT SHOWS HOW OFTEN EACH OF THESE THINGS HAPPEN TO YOU. THERE ARE NO RIGHT OR WRONG ANSWERS.

1.	I worry about things	Never	Sometimes	Often	Always
2.	I am scared of the dark	Never	Sometimes	Often	Always
3.	When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4.	I feel afraid	Never	Sometimes	Often	Always
5.	I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6.	I feel scared when I have to take a test	Never	Sometimes	Often	Always
7.	I feel afraid if I have to use public toilets or bathrooms	Never	Sometimes	Often	Always
8.	I worry about being away from my parents	Never	Sometimes	Often	Always
9.	I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
10.	I worry that I will do badly at my school work	Never	Sometimes	Often	Always
11.	I am popular amongst other kids my own age	Never	Sometimes	Often	Always
12.	I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
13.	I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
14.	I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
15.	I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
16.	I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
17.	I am good at sports	Never	Sometimes	Often	Always
18.	I am scared of dogs	Never	Sometimes	Often	Always
19.	I can't seem to get bad or silly thoughts out of my head	Never	Sometimes	Often	Always
20.	When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
21.	I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
22.	I worry that something bad will happen to me	Never	Sometimes	Often	Always
23.	I am scared of going to the doctors or dentists	Never	Sometimes	Often	Always
24.	When I have a problem, I feel shaky	Never	Sometimes	Often	Always
25.	I am scared of being in high places or lifts (elevators)	Never	Sometimes	Often	Always

26.	I am a good person.....	Never	Sometimes	Often	Always
27.	I have to think of special thoughts to stop bad things from happening (like numbers or words).....	Never	Sometimes	Often	Always
28	I feel scared if I have to travel in the car, or on a Bus or a train.....	Never	Sometimes	Often	Always
29.	I worry what other people think of me.....	Never	Sometimes	Often	Always
30.	I am afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds).....	Never	Sometimes	Often	Always
31.	I feel happy.....	Never	Sometimes	Often	Always
32.	All of a sudden I feel really scared for no reason at all.....	Never	Sometimes	Often	Always
33.	I am scared of insects or spiders.....	Never	Sometimes	Often	Always
34.	I suddenly become dizzy or faint when there is no reason for this.....	Never	Sometimes	Often	Always
35.	I feel afraid if I have to talk in front of my class.....	Never	Sometimes	Often	Always
36.	My heart suddenly starts to beat too quickly for no reason.....	Never	Sometimes	Often	Always
37.	I worry that I will suddenly get a scared feeling when there is nothing to be afraid of.....	Never	Sometimes	Often	Always
38.	I like myself.....	Never	Sometimes	Often	Always
39.	I am afraid of being in small closed places, like tunnels or small rooms.	Never	Sometimes	Often	Always
40.	I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order).....	Never	Sometimes	Often	Always
41.	I get bothered by bad or silly thoughts or pictures in my mind.....	Never	Sometimes	Often	Always
42.	I have to do some things in just the right way to stop bad things happening.....	Never	Sometimes	Often	Always
43.	I am proud of my school work.....	Never	Sometimes	Often	Always
44.	I would feel scared if I had to stay away from home overnight.....	Never	Sometimes	Often	Always
45.	Is there something else that you are really afraid of?.....	YES	NO		
	Please write down what it is_____				
	_____				
	_____				
	How often are you afraid of this thing?.....	Never	Sometimes	Often	Always

Appendix J: Child Adjustment and Parent Efficacy Scale

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Child Adjustment and Parent Efficacy Scale (CAPES)

Please read each statement and select a number 0, 1, 2 or 3 that indicates how true the statement was of your child (aged 2-12) **over the past four (4) weeks**. Then, using the scale provided, write down the number next to each item that best describes how confident you are that you can successfully deal with your child's behaviour, even if it is a behaviour that rarely occurs or does not concern you.

There are no right or wrong answers. Do not spend too much time on any statement.

Example:

My child:
Gets upset or angry when they don't get their own way 0 (1) 2 3 | [9]

The rating scale is as follows:
0. Not true of my child at all
1. True of my child a little, or some of the time
2. True of my child quite a lot, or a good part of the time
3. True of my child very much, or most of the time

	How true is this of your child?				Rate your confidence
My child:	Not at all	A little	Quite a lot	Very much	1 = Certain I can't do it 10 = Certain I can do it
1. Gets upset or angry when they don't get their own way	0	1	2	3	
2. Refuses to do jobs around the house when asked	0	1	2	3	
3. Worries	0	1	2	3	
4. Loses their temper	0	1	2	3	
5. Misbehaves at mealtimes	0	1	2	3	
6. Argues or fights with other children, brothers or sisters	0	1	2	3	
7. Refuses to eat food made for them	0	1	2	3	
8. Takes too long getting dressed	0	1	2	3	
9. Hurts me or others (e.g., hits, pushes, scratches, bites)	0	1	2	3	
10. Interrupts when I am speaking to others	0	1	2	3	
11. Seems fearful and scared	0	1	2	3	
12. Has trouble keeping busy without adult attention	0	1	2	3	

1

13. Yells, shouts or screams	0	1	2	3	☐
14. Whines or complains (whinges)	0	1	2	3	☐
15. Acts defiant when asked to do something	0	1	2	3	☐
16. Cries more than other children their age	0	1	2	3	☐
17. Rudely answers back to me	0	1	2	3	☐
18. Seems unhappy or sad	0	1	2	3	☐
19. Has trouble organising tasks and activities	0	1	2	3	☐

My child:	**How true is this of your child?** Not at all	A little	Quite a lot	Very much
20. Can keep busy without constant adult attention	0	1	2	3
21. Cooperates at bedtime	0	1	2	3
22. Can do age appropriate tasks by themselves	0	1	2	3
23. Follows rules and limits	0	1	2	3
24. Gets on well with family members	0	1	2	3
25. Is kind and helpful to others	0	1	2	3
26. Talks about their views, ideas and needs appropriately	0	1	2	3
27. Does what they are told to do by adults	0	1	2	3

Citation:

Morawska, A., & Sanders, M. R. (2010). *The Child Adjustment and Parent Efficacy Scale (CAPES)*. Brisbane: Parenting and Family Support Centre.

Morawska, A., Sanders, M. R., Haslam, D., Filus, A., & Fletcher, R. (2014). Child adjustment and parent efficacy scale (CAPES): Development and initial validation of a parent report measure. *Australian Psychologist 49*, 241-252. doi:10.1111/ap.12057

Appendix K: Evaluation Questionnaire

Evaluation Form

Reducing Anxiety in Children: A Brief Group Intervention for Parents

Please take some time to complete this form.

1. What did you like the most about the group? What was most helpful? *

2. What did you like the least about the group? What was not helpful? *

3. What would change about the group/please tell us any ways it could be improved? *

4. Which strategies/ideas from the group do you use with your child? How often? *

5. What did you think about the group being delivered online? *

6. Did you have any concerns about knowing other parents at the group? *

7. Would you have attended the group if it was held in a clinical setting e.g. GP surgery, mental health service. Why/why not? *

8. What did you think about completing the online questionnaires at the end of every session? Were they easy to understand, relevant and meaningful to you? *

9. Do you think that it would be useful for your child to complete an appropriate questionnaire themselves? *

10. Please tell us about anything that made it difficult to join the sessions. *

Thank you for taking the time to provide your feedback.

Done [javascript:submitCheck(1);] Save [javascript:submitCheck(4);] Cancel

The University of Manchester, Oxford Road, Manchester M13 9PT | Email administrator

Appendix L: Consent Form

Participant Information and Consent Form

Consent Form

1. Participant Code*

2. I confirm that I have read the participant information sheet for the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.
*
Yes No

3. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself. I understand that it will not be possible to remove my data from the project once it has been anonymised and forms part of the data set. I agree to take part on this basis.*
Yes No

4. I agree to complete a screening questionnaire with the understanding that I may not be eligible to participate in this research.*
Yes No

5. I agree that my child's teacher can be approached and asked to complete a questionnaire about my child's mood and behaviour at school. This will be completed at the start and end of the intervention. **
Yes No

6. I agree to take part in online group sessions delivered via the videoconferencing platform Zoom. *
Yes No

7. I agree that I will respect the confidentiality of all group members by not disclosing any information discussed during the session with others outside of the group setting.*
Yes No

8. I understand that there may be instances during the course of my participation when information is revealed which means that the researchers will have to break confidentiality. This has been explained in more detail in the information sheet.*
Yes No

9. I understand that I may be contacted after the group has ended and asked to participate in an interview. I agree that the interviews will be audio recorded. I agree to take part in this interview if invited to do so. *
Yes No

10. I agree that any data collected may be published in anonymous form in academic journals or reports and presented at conferences. My identity will not be revealed in any publication.*
Yes No

11. I understand that data collected during the study may be looked at by responsible individuals from the University of Manchester or from regulatory authorities when it is relevant to my taking part in the research. I give permission for these individuals to have access to this data. *(This part refers to when the quality of research may be checked to make sure it is being done properly).**

○ Yes ○ No

12. I understand that the content of the group sessions may cause some distress and I agree to provide details of an emergency contact or next of kin below.*

○ Yes ○ No

13. **OPTIONAL**: I agree to receive a text reminder up to 48 hours before attending each session of the workshop, providing my telephone number below.

○ Yes ○ No

14. **OPTIONAL**: I agree that the researchers may retain my contact details in order to provide me with a summary of the findings for this study.

○ Yes ○ No

15. I agree to take part in the above study.*

○ Yes ○ No

16. Please provide an electronic signature (type your name in the box below):*

Data Protection

The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the Privacy Notice for Research Participants. [http://documents.manchester.ac.uk/display.aspx?DocID=37095]

17. Full name: *

18. Email address:*

19. Telephone number:*

Next of Kin:

20. Full name: *

21. Relationship to participant:*

22. Telephone number:*

23. Would you like to receive a **text reminder** up to 48 hours before the start of each session?*

○ Yes ○ No

24. Would you like to receive a **summary of the findings**?*

☐ Yes - by email
☐ Yes - by post
☐ No thanks

25. If you have chosen to receive a summary of findings by post, please provide your home address.

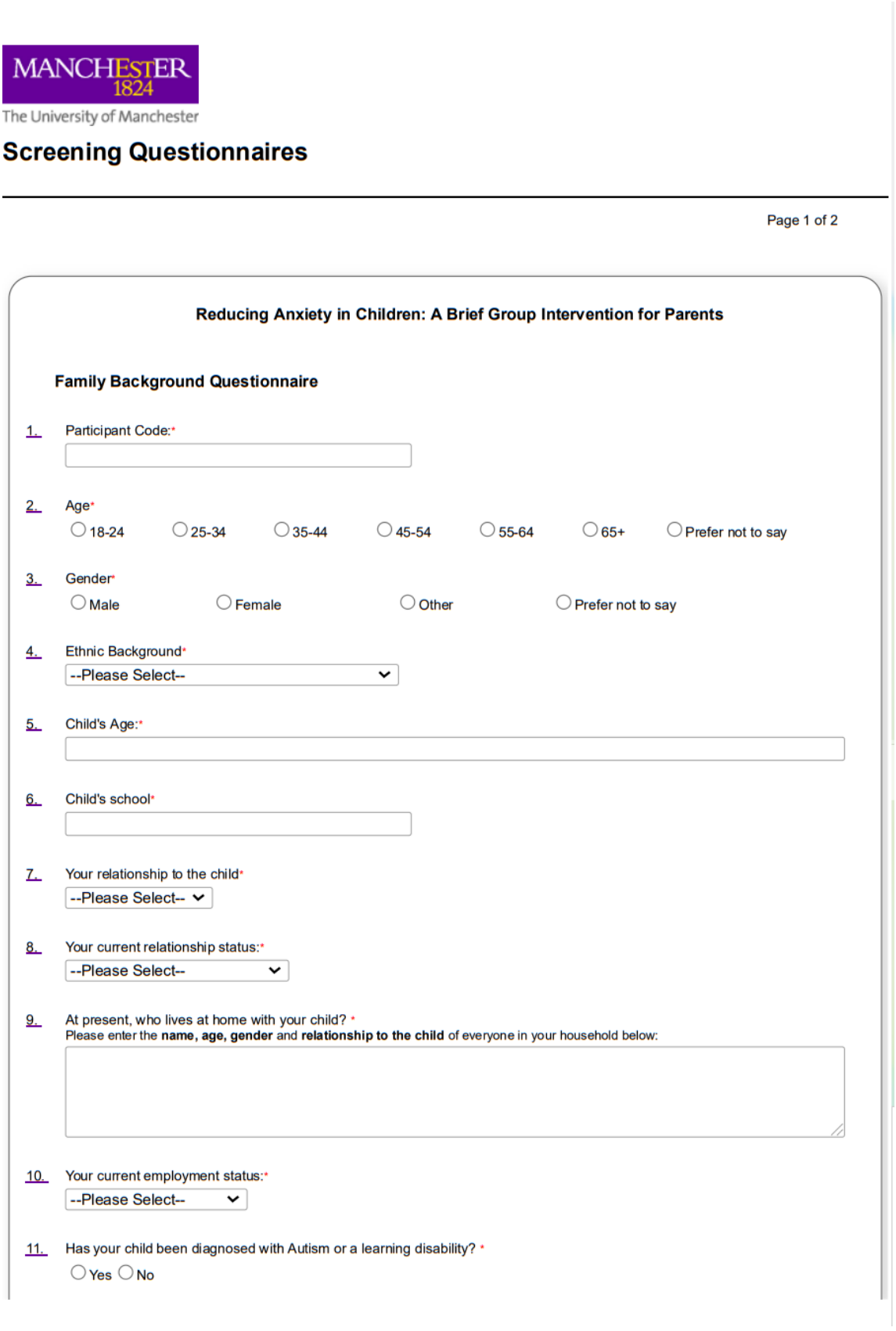
Thank you for completing the consent form. Please click Done to submit your response.

Back [javascript:submitCheck(2);] Done [javascript:submitCheck(1);] Save

[javascript:submitCheck(4);] Cancel

The University of Manchester, Oxford Road, Manchester M13 9PT | Email administrator

Appendix M: Demographics Form (Family Background Questionnaire)



MANCHESTER 1824
The University of Manchester

Screening Questionnaires

Reducing Anxiety in Children: A Brief Group Intervention for Parents

Family Background Questionnaire

1. Participant Code:*

2. Age*
○ 18-24 ○ 25-34 ○ 35-44 ○ 45-54 ○ 55-64 ○ 65+ ○ Prefer not to say

3. Gender*
○ Male ○ Female ○ Other ○ Prefer not to say

4. Ethnic Background*
--Please Select--

5. Child's Age:*

6. Child's school*

7. Your relationship to the child*
--Please Select--

8. Your current relationship status:*
--Please Select--

9. At present, who lives at home with your child? *
Please enter the **name, age, gender** and **relationship to the child** of everyone in your household below:

10. Your current employment status:*
--Please Select--

11. Has your child been diagnosed with Autism or a learning disability? *
○ Yes ○ No

12. If **yes**, please provide details:

13. Do you consider yourself to have a disability/have you been diagnosed with a learning disability?*

○ Yes ○ No

14. If **yes**, please provide details:

15. Have you attended or been offered any other groups or classes related to improving your child's wellbeing?*

○ Yes ○ No ○ Prefer not to say

16. If **yes**, please provide details:

Please click next to move on to the next questionnaire.

Next [javascript:submitCheck(3);] Save [javascript:submitCheck(4);] Cancel

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Appendix N: Interview Topic Guide

MANCHESTER 1824
The University of Manchester

TOPIC GUIDE FOR INTERVIEWS

Study Title: The feasibility and acceptability of a brief CBT informed intervention for parents of mildly to moderately anxious children

Introductions: Reminder of purpose of study, principles of informed consent, audio recording equipment turned on.

Overall Topic	Possible Questions
Hopes and expectations for the intervention	• Where did you hear about the group – what was it that interested you about it? • What did you hope to gain from attending this group? • What were your initial expectations of the group? • Have you been to anything similar before re: supporting your child with anxiety – did this influence your expectations of a parent-only group? • Previous experiences of CBT? Own experience of anxiety? • How did you decide between you and your partner who would come? • If dads – how did you feel about being the only dad in the group? hoping other dads would be there?

Overall opinions of the intervention	• How would you describe your experience of taking part in the group?
	• What was it like being the only person?
	  ○ What was it like to realise you were the only participant, how did you feel. Good or bad news? Has that opinion changed – if so how?
	  ○ Do you feel like you missed out on anything being the only person in the group?
	  ○ OR – how would you have felt if you were the only person in the group and have 1-1 support?
	  ○ Would it have been better/worse/different?
	• What did you like the most/least about the group?
	• What was helpful/ not helpful about the group?
	• How did that fit with your expectations of what the group would be like?
	• What you would change about the group/any ways it could be improved?

	• Can you tell me a bit about what it was like to carry out activities/strategies described in the session at home?
	
	• How did you find the information on the handouts?
	  ○ Were the instructions clear?
	  ○ Were they doable, realistic goals?
	  ○ Were you provided enough information to try things out at home?
	• How did you feel about being an acting/lay therapist for your child?
	•

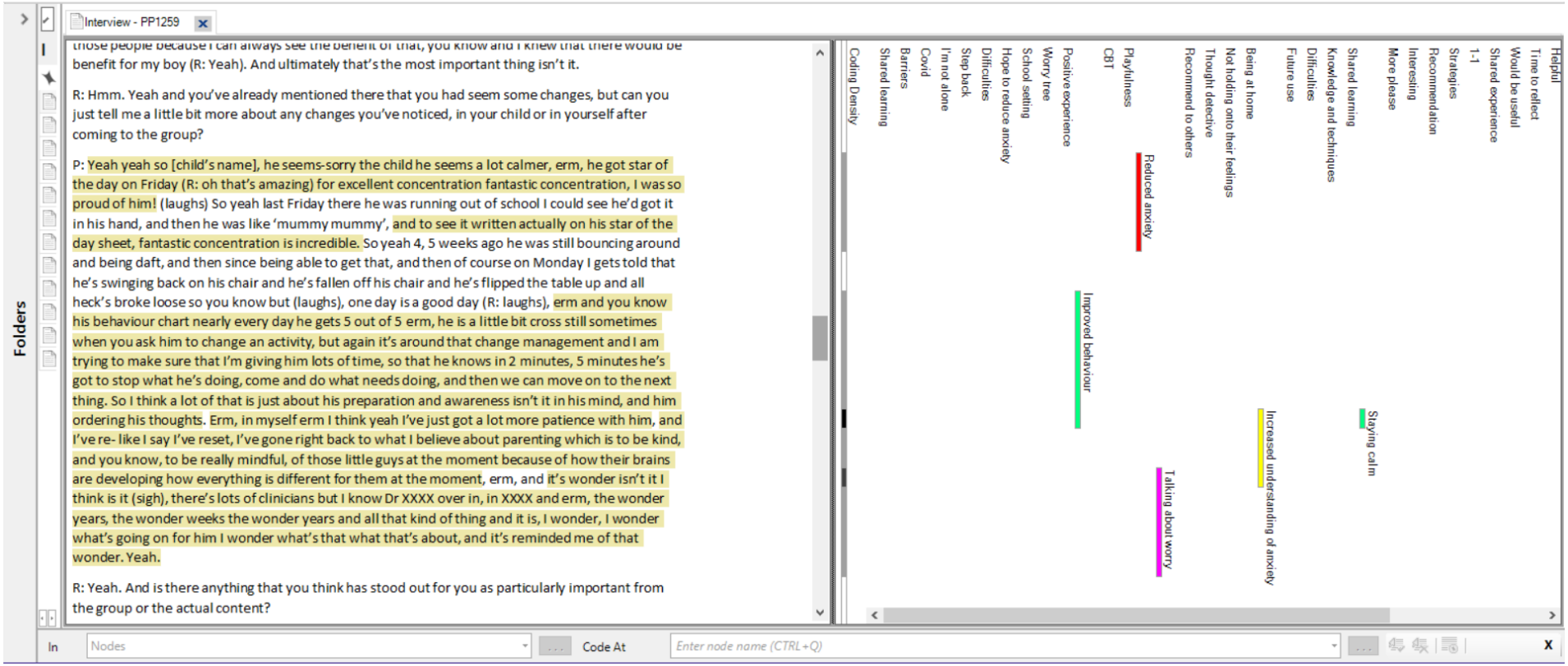
Change elements	• Can you tell me about any differences you've noticed in yourself or your child as a result of taking part in the group? What have you noticed? • Can you tell me about anything from the group that stood out for you as particularly important? • What did you learn from the group that was new? • Can you tell me a bit about how you have used some of the strategies in your day to day life? ○ How often do you use the strategies/principles from the group? • Can you tell me a bit about how you've shared these ideas with your partner? • Will you continue to use the strategies/approach now that the intervention has finished? Which ones?

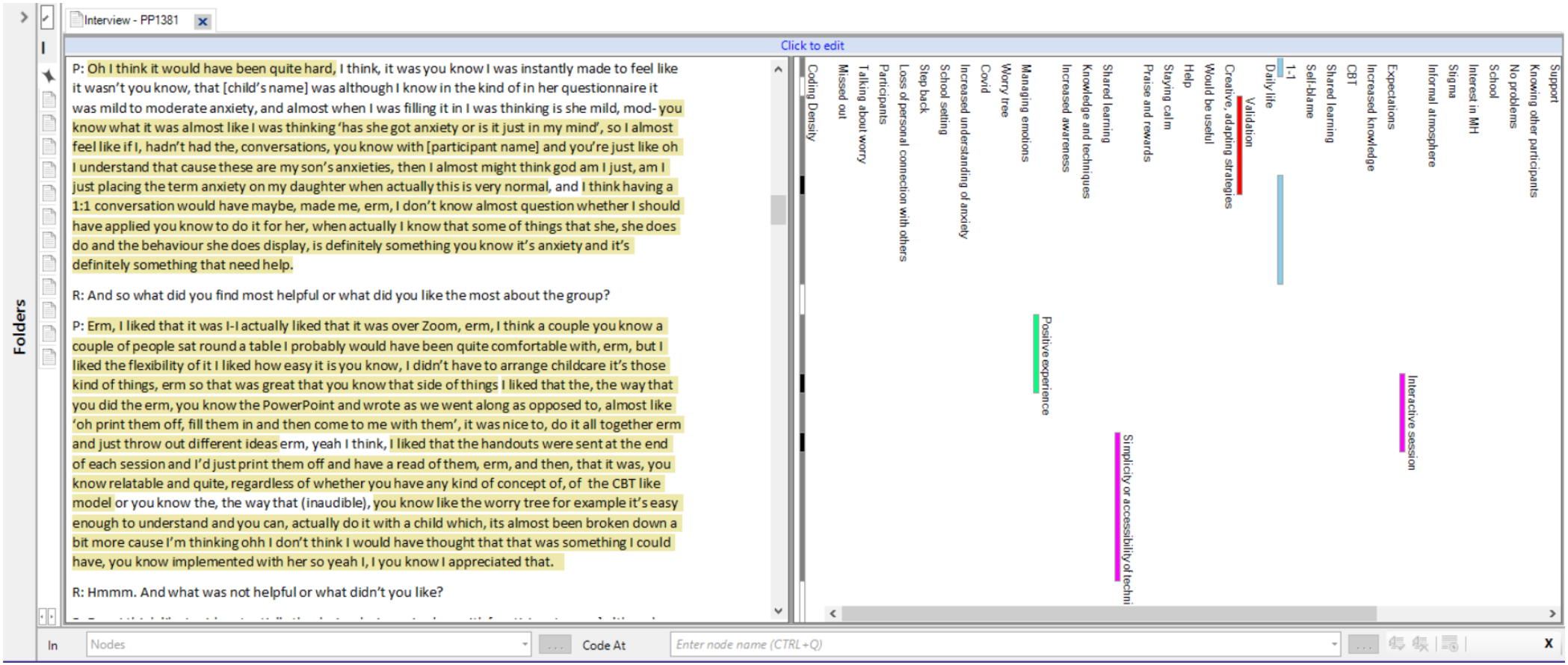
Acceptability of the delivery method	• What did you think about the group being delivered online through Zoom?
	  ○ Sessions too long? Pacing? More frequent, shorter sessions?
	  ○ Did you use phone/laptop?
	• What did you like most/least about the online delivery of the group?
	• Do you think you missed out on anything by accessing the group online?
	• Did you have any concerns about knowing other parents at the group before it started?
	• How did you feel when you realised that you knew the other parents in the group?
	• How did knowing the other parents affect your engagement or participation in the group?
	• Would you have attended the group if it was held in a clinical setting e.g. mental health service? Why/why not?
	• Is there anything you would change?

Acceptability of the outcome measures	• Can you tell me a bit about your experience of filling in the questionnaires?
	  ○ Was the content of questionnaires relevant to you?
	  ○ Were the questions easy to understand?
	  ○ How did you find the length of the questionnaires? – Time taken to complete them
	  ○ Would you have liked more?
	• Do you think it would be useful for your child to complete an appropriate questionnaire themselves? What would be good/bad about it?
	• Can you tell me about your experience of having your child complete a questionnaire themselves. Do you think it was useful?

Difficulties/barriers	• Was there anything that made it difficult to attend the sessions? (e.g. practical considerations) • What made it difficult to attend the sessions? • How easy was it to find a private space at home where you wouldn't be disturbed too much? • Was there anything that encouraged to you attend the sessions? ○ Did the online delivery make it easier to attend sessions? • If missed sessions: what things affected your decision to miss the sessions? • You and your partner joined together at first; how did you feel when you then couldn't attend but he carried on? • Does the delivery make a difference e.g. is it easier not to attend if you are just logging in online vs. if you are expected to turn up somewhere • Any thoughts about what it means for you as a parent – link in with ideals/values about being a mum/dad

Appendix O: Example of Coded Interview Transcripts




Folders
Interview - PP1381
Click to edit
P: Oh I think it would have been quite hard, I think, it was you know I was instantly made to feel like it wasn't you know, that [child's name] was although I know in the kind of in her questionnaire it was mild to moderate anxiety, and almost when I was filling it in I was thinking is she mild, mod- you know what it was almost like I was thinking 'has she got anxiety or is it just in my mind', so I almost feel like if I, hadn't had the, conversations, you know with [participant name] and you're just like oh I understand that cause these are my son's anxieties, then I almost might think god am I just, am I just placing the term anxiety on my daughter when actually this is very normal, and I think having a 1:1 conversation would have maybe, made me, erm, I don't know almost question whether I should have applied you know to do it for her, when actually I know that some of things that she, she does do and the behaviour she does display, is definitely something you know it's anxiety and it's definitely something that need help.
R: And so what did you find most helpful or what did you like the most about the group?
P: Erm, I liked that it was I-I actually liked that it was over Zoom, erm, I think a couple you know a couple of people sat round a table I probably would have been quite comfortable with, erm, but I liked the flexibility of it I liked how easy it is you know, I didn't have to arrange childcare it's those kind of things, erm so that was great that you know that side of things I liked that the, the way that you did the erm, you know the PowerPoint and wrote as we went along as opposed to, almost like 'oh print them off, fill them in and then come to me with them', it was nice to, do it all together erm and just throw out different ideas erm, yeah I think, I liked that the handouts were sent at the end of each session and I'd just print them off and have a read of them, erm, and then, that it was, you know relatable and quite, regardless of whether you have any kind of concept of, of the CBT like model or you know the, the way that (inaudible), you know like the worry tree for example it's easy enough to understand and you can, actually do it with a child which, its almost been broken down a bit more cause I'm thinking ohh I don't think I would have thought that that was something I could have, you know implemented with her so yeah I, I you know I appreciated that.
R: Hmmm. And what was not helpful or what didn't you like?
Coding Density
Missed out
Talking about worry
Participants
Loss of personal connection with others
Step back
School setting
Increased understanding of anxiety
Covid
Worry tree
Managing emotions
Positive experience
Increased awareness
Knowledge and techniques
Shared learning
Praise and rewards
Staying calm
Help
Would be useful
Creative, adapting strategies
Validation
Daily life
1-1
Self-blame
Shared learning
CBT
Increased knowledge
Expectations
Informal atmosphere
Sigma
Interest in MH
School
No problems
Knowing other participants
Support
Simplicity or accessibility of techni
Interactive session
In
Nodes
Code At
Enter node name (CTRL+Q)

Appendix P: Treatment Fidelity Checklist

Group →	1	2	3	4	5	6	7	8
SESSION 1								
Session starts on time								
Introduction & housekeeping								
Confidentiality explained								
Aims, hopes and expectations								
What is anxiety								
Fight or flight								
Anxiety cake								
Signs of anxiety								
Triggers								
T F B cycle								
Physical security								
Emotional security								
Managing emotion								
Questionnaires reminder								
Link to questionnaires emailed out								
Opportunity for participants to ask questions; time to respond and discuss								
Able to manage any technical difficulties								
Handouts emailed to participants								
SESSION 2								
Session starts on time		Did not complete						
Introduction & housekeeping								
Confidentiality explained								
Review last session								
Review practice								
Dragon in the mountain								
Figure of 8 formulation								
Impact on parents								
Praise								
Noticing anxious thoughts								
The worry tree								
Problem solving								
Evaluating thoughts								
Avoidance graphs								
Testing								
Motivation to change								
Questionnaires reminder								
Link to questionnaires emailed out								
Opportunity for participants to ask questions; time to respond and discuss								

Able to manage any technical difficulties								
Handouts emailed to participants								
SESSION 3								
Session starts on time		Did not complete						
Introduction & housekeeping								
Confidentiality explained								
Review last session								
Review practice								
Take questions from participants								
Troubleshoot problems								
Questionnaires reminder								
Link to questionnaires emailed out								
Opportunity for participants to ask questions; time to respond and discuss								
Interview reminder								
Voucher reminder								
Able to manage any technical difficulties								

Appendix Q: Reliable Change Index Scores

PAS

Mean Pre	Mean Post	SD Pre	RCI
65	35	1.22	1.27
55	42	1.32	1.37
70	76	1.32	1.37
66	60	1.36	1.41
77	53	1.32	1.37
46	28	1.42	1.47
47	62	1.06	1.1
52	40	1.3	1.35
75	71	1.09	1.13

SCAS-parent

Mean Pre	Mean Post	SD Pre	RCI
50	31	0.81	0.74
34	18	0.76	0.7
31	11	0.87	0.8
40	42	0.93	0.85

SCAS-child

Mean Pre	Mean Post	SD Pre	RCI
24	20	1.21	0.95
11	9	1.03	0.81
51	41	0.83	0.65

Appendix R: Additional Quotes

Themes	**Subthemes**	**Quotes**
Benefits	Practical Aspects	"The informal flexible nature of it which instantly put you at ease and the way that it was a two way discussion, rather than attending a lecture type session, which meant you could talk about the theory in relation to the issues you were facing with your child." *Participant 1968* "It's so convenient because you don't have to go anywhere, erm…I think, it was…yeah as I say we're-we're time poor, we don't have to get a sitter or you know, we just had to find a time that I could you know, the kids were out… that's a barrier for us sometimes, erm…it having to go somewhere is even more effort, erm so yeah it was very convenient." *Participant 1429* "The level it was delivered at all that kind of thing was spot on really." *Participant 1572*
	Strategies	"You can just kind of put it into everyday life, it's its' not been anything that we've had to, I've not had to get anything extra or we've not had to go out of our way to do anything it's all things that you can kind of just do, as as you're going along so it's, and it's just, like I said it's just really useful to have extra tools that you can try if something else isn't working." *Participant 1572* "you know after the first session, it-it was work it really worked, don't wanna say oh it-it was a miracle you know but, just doing things slightly different had a very, quick effect on things getting better which, made things improve and made you wanna do more of it." *Participant 1758*

	Connection with Other Parents	"It was also really supportive to have those other parents there, in similar situations going through similar experiences, that had such a massive effect on me more than I expected it to because, I found erm, I found it really reassuring to know that I wasn't alone, erm and they were saying similar things and I was like oh yeah, I know that happens to me as well sort of thing so, yeah I found that really supportive." *Participant 1397* "Talking to the other parents about their experiences hearing, different techniques that they, they use, erm getting the techniques to use myself I thought it was, was a really good experience." *Participant 1624*
	Parent Changes	"So much of the stuff was sort of new, a new way of thinking as opposed to something specific or a different way of thinking and a different way of looking at things…I think what I learnt was, it didn't have to be the way it was which again I guess that's really what we wanted out of it you know, where we sort of dreaded family life because it's just everything's a battle and, what we learned was it doesn't have to be like that we can, we can change things just by knowing a little bit more and understanding." *Participant 1758* "I definitely feel calmer about the situation and and when he's starting up into anxiety that would quite often make me feel (intake of breath) 'oh no it's happening again' you know so now I tend to take a step back from that and go okay and I'll just give myself a minute and give him a minute, to just get, to get there, err and to have that moment, because there's really nothing I can do when it's high anyway so I might as well take that moment to go how are we gonna talk about that how are we gonna…tackle this…like it's given me a little sense of calm, that I can handle things" *Participant 1968* "So, being able to implement things and see that they effect change and see his confidence come up and I've been part of that…it's quite an emotional thing really you know so it, it's empowering… to be able to, fix something or help somebody yourself, is more empowering and confidence building for yourself" *Participant 1968*

	Child Changes	"Yeah definitely seen a change in him, he's more confident and he's his anxiety is definitely sett-settling down with some of the things we're doing" *Participant 1397* "His anxiety just seems to be really reduced now" *Participant 1259* "I'm still waiting for the CAMHS referral so, but I don't feel like we need it now really." *Participant 1586*
Challenges	Barriers	"I would have liked to have been able to give it my full, 100% concentration…Yeah having the brain capacity, to be able to think about it properly without people running up to me and saying 'mummy' or bouncing around or me feeling guilty that they're on tablets or (laughs)." *Participant 1259* "I think some of the technical erm issues like background noise and erm, sometimes erm especially with-with Zoom if one person's talking if two people are talking you can either hear one of them or you can hear a sort of breakup of both conversations so I think that was the hardest thing" *Participant 1624* "I think sometimes when you meet people in a group, you've got a chance to share more you've got a bit more time together, and I think on Zoom as well because you very much, take turns and, whereas, like for example if we were having a break in a group, you'd probably chat amongst yourselves and you'd get to know the parents a little bit more" *Participant 1586*

	Questionnaires	"Some of the wording was a bit confusing" *Participant 1429* "I found the questionnaires difficult at times. The questions were easy to understand but not always relevant to my child. Sometimes I found the process a little upsetting." *Participant 1735* "Erm, I think he found it interesting but a bit kind of confusing, probably more cause of his age you know. Yeah erm…and I-I was a bit concerned that it was kind of going to reinforce any issues like, what you're scared of and, so he was having to think about it and it was reminding him of his anxieties kind of thing….no I don't think [that did happen] but I was just it was just more of my concern." *Participant 1892* "Yeah, yeah I think sometimes that might help because then you can…get it from their perspective see how they feel and if you know I think he's probably old enough to understand and be able to fill it in himself then actually you might get a true reflection on…to to what his his kind of thoughts are really so yeah that probably would be good." *Participant 1572*
	Stigma	"I know there's a stigma for some people attached with that [mental health settings] but that wouldn't have influenced me personally, it would have been just from a more practicality point of view." *Participant 1683* "I don't feel, intimidated by school but I know some people would have, and I think it depends on the relationship that you have with your school as well." *Participant 1259* "I wouldn't have liked to bump into people either and, and say wait what are you here for I'd almost feel like I'd have to lie, so yeah, I think definitely not you know in a school setting would be better." *Participant 1381.*
	Suggested Improvements	"It would maybe work a little better if the groups were longer or there were more sessions" *Participant 1397*

		“I would love to have a refresher in 6 months time or something, erm, at a time when I didn’t have both children around. That would be very helpful.” *Participant 1259* “So I think, if we’d had a little bit longer for us as a family, we might have had more to bring to-to that third session, erm, that’s the only thing I’d thought it did feel like a lot to cover” *Participant 1586* “I wish my husband had done them alongside me as I think it is helpful for both parents to be involved as so much is covered in the course.” *Participant 1586* “I think the only thing is to maybe consider if you’re not talking or if you do have background noise to, to mute yourself erm, just to, to help with, but then you sometimes feel like you can’t unmute yourself so it is a, a difficult juggling act.” *Participant 1624*